"Contemporary Views on Consultation-Liaison Psychiatry"

Thesis

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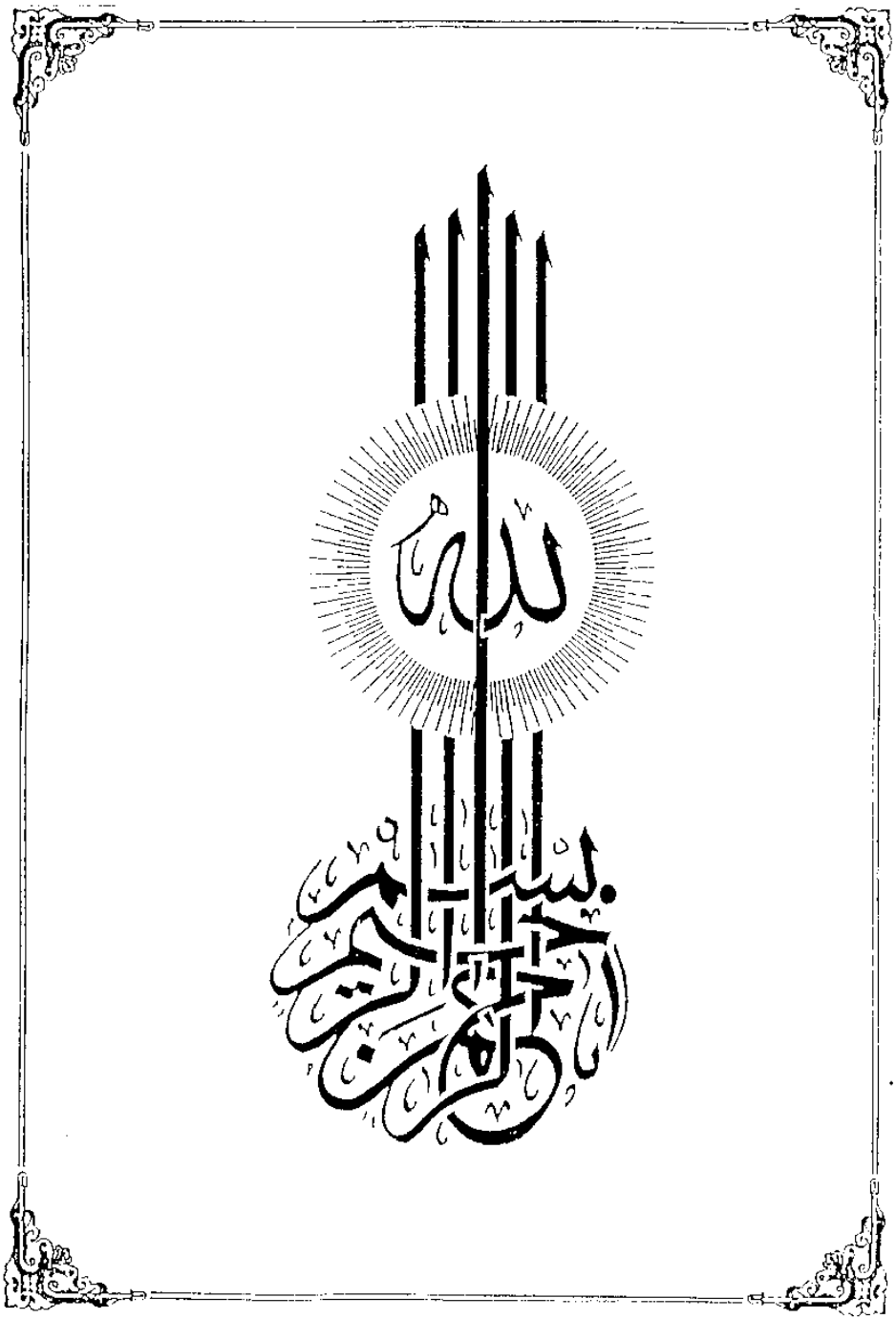

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To

my family
with lots of love
& gratitude

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INTRODUCTION

INTRODUCTION AND AIM OF THE WORK

If the practice and teaching of medicine and psychiatry have been integrated, there would probably be no need for Consultation Liaison (C–L.) psychiatry to exist today *(Lipowski, 1986 b)*. However, in the present climate of biological reductionism in both psychiatry and medicine, the C–L psychiatrists play a vital role in practising and teaching an integrated, biopsychosocial approach to health care *(Lipowski, 1989)*.

C–L psychiatry explores the borderland between medicine and psychiatry and meanwhile explains to nonpsychiatric physicians what is happening in psychiatry and to psychiatrists what is happening in the rest of medicine *(Pasnau, 1982)*.

It is an essential link for providing a properly humanistic medical care for any patient, but especially the physically ill and the somatizing patient *(Gomez, 1992)*. Actually, C–L psychiatry encompasses a body of knowledge about the complex interaction of psychological, social and biological factors that codetermine the course, response to treatment, and outcome of a wide range of physical illnesses and injuries. Moreover, C–L psychiatry involves knowledge of the psychosocial reactions to, mechanisms for coping with, and psychiatric complications of physical illness. The impact of hospitalization, the doctor – patient relationship, the proper use of psychotropic drugs on the physically ill, the application of behavioral treatment methods to medical problems, the impact of a patient's illness on his or her family – these are also components of the body of knowledge that C–L psychiatrists need to be familiar with and able to apply and teach. This

is besides, the whole area of somatization, a common, complex and costly problem which belongs here too *(Lipowski, 1992)*.

This clinically applicable knowledge base largely distinguishes C–L psychiatry from general psychiatry *(Lipowski, 1992)*.

The most cogent argument for the continued existence of C–L psychiatry is that the prevalence and incidence of psychiatric morbidity in the general hospitals and in primary care practice are high *(Lipowski, 1985 and Cavanaugh, 1984)*.

Nowadays, and as the end of the century approaches, the contemporary view of C–L psychiatry is that it is a full– fledged subspecialty of psychiatry that reduces diagnostic and therapeutic floundering, shortens the hospital stay for the patient and thereby saves the hospital, patient and community money *(Lipowski, 1992)*.

So, the rapid growth and developments in C-L psychiatry especially during the last decade - paralleling the aspect of adolescence - point to the need for a contemporary view on its field.

CHAPTER ONE:

CONCEPT & EVOLUTION OF CONSULTATION LIAISON PSYCHIATRY

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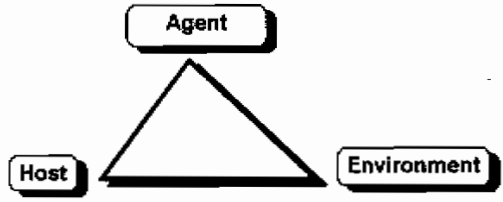
Today, it is believed that any disease is the outcome of a complex interaction between an "agent", a "host" and that host's "environment". Simple linear causality is no longer acceptable today *(Lipowski, 1986 a)*.



This view is quite congruent with the ancient Greek thinkers' postulates that the study and treatment of the sick need to take into account the whole person rather than isolated parts for the part will never be well unless the whole is well. These postulates date back to 400 BC in the writing of Hippocrates, Plato, Aristotale and others. Aristotale, for example, asserted that it was no more meaningful to ask if the soul and the body were one, than to ask if a piece of wax and the imprint of a seal on it were one *(Barnes, 1982)*.

While the Greek philosophers made a distinction between mind, or soul, and body, it was never sharp, and a holistic view of man as a mind – body unity prevailed.

It was only in 1637 that the French philosopher, Descartes, formulated a radical and almost unbridgeable distinction between mind and body. Although his dualistic view was compatible with the notion of psychogenesis(=the belief that psychological factors may cause bodily

disease), yet it dealt a blow to the holistic view of a man and to the related concepts in medicine *(Pasnau, 1982,b)*.

This exerted a far-reaching influence on Western medicine, in that it encouraged it to focus predominantly on the machine like body, to relatively neglect the psychosocial aspects of illness, and fostered biological reductionism in medical thought and research *(Lindeboom, 1979)*.

Despite Descartes' profound influence on Western medicine, the holistic conceptions survived and were expressed in one form or another, by many medical writers of the 17th, 18th, and 19th centuries. Yet all had little impact *(Lipowski, 1985)*.

Since about 1850 on, several major developments propelled medicine powerfully in the direction of biological reductionism: formulation by Virchow of the cellular theory of disease, discovery of micro-organisms by Pasteur, and the setting forth of the postulates of the germ theory of disease by Koch. All these urged medicine to become more technological and biologically oriented. As a result, treatments were directed to diseases rather than to human beings as a whole *(Lipowski, 1984)*.

It was actually the influence of the Descartian Dualism and its resultant biological reductionism on modern medicine which has led to the emergence of psychosomatic medicine and C-L psychiatry as a "reaction" against them 60 years ago.

This "reaction" began to take shape early in this century and followed two main directions: **First,** a revival of interest in psychogenesis which was inspired by the emergence of psychoanalysis; **second,** the formulation of a set of holistic concepts by an American psychiatrist of Swiss origin, Adolf Meyer, under the label of "Psychobiology" *(Meyer, 1957)*.

Meyer conceived of psychobiology as a science of man as a person, both in health and disease. Mind and body were two distinct yet integral aspects of the human organism, a psychobiological unit, as a whole. The study of the dynamic and complex interaction between the mind (psychological aspects) and the body (biological aspects) is the correct route for advancing knowledge about man, and about health and illness. Confining study to either the mental or the physical aspects would not do *(Lipowski, 1986)*.

Meyer's holistic views gave impetus to the development of general hospital psychiatry, of psychobiological research on mental illness, and of eclecticism in psychiatric practice *(Lipowski, 1981)*.

Moreover, psychobiology facilitated the emergence of psychosomatic medicine in the early 1930s and the acceptance by it of the holistic viewpoint as a basic premise *(Lipowski, 1986 a)*.

Relatively little attention was paid by the early psychosomatic investigators to the social environment as a factor contributing to health and disease in individuals *(Lipowski, 1986 a)*.

The work of James Halliday (1948) drew attention to the need to take into account the social environment in the study of human morbidity. He asserted that studying the influence of "sick society", one characterized by social disintegration, contributed to the development of information of high etiologic relevance.

Thus the road was paved for developing a "biopsychosocial model" one that integrates the biologic, psychologic, and social needs of the patient *(Engel, 1977)*.

This is exactly the approach provided by C–L psychiatry to patients who are treated in hospitals and clinics outside the psychiatric setting.

The earlier biomedical model assumed that disease can be explained by understanding pathophysiology at the cellular, if not the molecular, level and ignored the contribution that external social and internal psychodynamic factors may play in the precipitation, prolongation, and recovery from illness.

The new biopsychosocial model embraces different sets of treatment goals, attained through collaborative supervision of each patient by both psychiatrist and nonpsychiatrist physicians at the same time.

The goals of the new models entail:

1) Biotherapy (drugs or other physical modalities) has the goal of providing physical survival, pleasure attainment, and regulation of mood.
2) Psychotherapy (individual treatment) has the goal of developing productive work and intimate relationships.
3) Sociotherapy (group or family therapy) has the goal of developing a balance between social belonging and individual freedom *(Abroms, 1981)*.

Thus, C–L psychiatry includes that area of psychiatry concerned with the study, diagnosis, treatment and prevention of psychiatric morbidity in the physically ill, and of studying psychologic factors affecting physical conditions, and somatopsychic and psychosomatic disorders. The term includes psychiatric consultation and collaboration with non psychiatric physicians and other health workers in all types of medical care settings but especially in general hospitals *(Strain, 1975)*.