Psychological factors affecting other medical conditions: Management

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INTRODUCTION

Psychological factors affecting other medical conditions (PFAOMC) is a disorder that is diagnosed when a general medical condition is adversely affected by psychological or behavioral factors; the factors may precipitate or exacerbate the medical condition, interfere with treatment, or contribute to morbidity and mortality [1]. In addition, the factors are not part of another mental disorder (eg, unipolar major depression).

This topic reviews the management of PFAOMC. The epidemiology, pathogenesis, clinical features, assessment, diagnosis, and differential diagnosis of PFAOMC are discussed separately. (See "Psychological factors affecting other medical conditions: Clinical features, assessment, and diagnosis".)

WHEN TO REFER

For psychological factors affecting other medical conditions, we suggest consultation with a mental health clinician when the:

- Factors appear to represent a poorly controlled psychiatric disorder, such as depressive disorders (eg, unipolar major depression), anxiety disorders (eg, generalized anxiety disorder), or personality disorders (eg, borderline personality disorder).

- Psychological factors are extreme, persistent, or interfering significantly in treatment, or patients are unable to change maladaptive behaviors.
- Clinicians and patients are at a standoff; however, clinicians should not expect the consultant to compel patients to become better patients. Instead, the psychiatrist attempts to help patients understand how their behavior or emotional state causes poor health behaviors, exacerbates the medical condition, or interferes with treatment.

APPROACH FOR ALL PATIENTS

The general approach to psychological factors affecting other medical conditions (PFAOMC) is to [2]:

- Listen empathically as patients present the story of their medical condition
- Elicit feelings and behaviors; patients with alexithymia (difficulty describing one's own emotions) need help naming their feelings
- Educate patients about the medical condition and its treatment
- Help patients understand that their feelings and behaviors need not sabotage their treatment
- Convey appropriate reassurance and hope
- Describe examples of other patients with good outcomes
- Inform patients about disease-specific, self-help support organizations and online resources

In addition, clinicians should attempt to establish a therapeutic alliance (relationship). The therapeutic alliance is better when clinicians and patients [3]:

- Agree on the goals of treatment
- Agree on the tasks to be completed to achieve the goals
- Develop a bond (like and trust one another)

One adaptive coping style that may benefit patients with PFAOMC is problem solving, which involves [2]:

- Identifying the problem (eg, maladaptive health behavior such as smoking)

- Specifying it accurately
- Generating multiple solutions
- Considering the consequences of each solution
- Choosing one solution
- Acting upon it

It is generally best to not challenge or interfere with a patient's defensive style unless the defense is having an adverse impact on the medical illness or its management. If the patient has an entrenched maladaptive personality, the physician should modify the patient's treatment plan accordingly, which is usually accomplished more easily than trying to change the patient's personality. As an example, suspicious or mistrustful patients should receive more careful explanations, particularly before invasive or anxiety-provoking procedures. With narcissistic patients, the physician should take special care to avoid relating in ways that may be perceived by the patient as paternalistic or authoritarian.

Physicians should provide specific, realistic reassurance as part of a constructive treatment plan. Facile, nonspecific reassurance can undermine the physician−patient relationship and alienate patients, who may conclude that the physician does not understand them. In addition, premature or unrealistic reassurance or an overly cheerful attitude may leave discouraged or demoralized patients feeling that the clinician lacks empathy.

Clinicians should attempt to reflect upon their own reactions to patients and recurring patterns of behavior [4]. As an example, when patients mention their imminent death from cancer, clinicians may unwittingly avoid discussing this subject. The clinician may be cognizant of feeling tense and anxious, but otherwise not recognize other feelings and thoughts, such as personal fear of death, fear of discussing "unpleasant" topics, and uncertainty about what to do.

The following section discusses some particular common psychological factors and how physicians should respond when these factors adversely affect a general medical condition. Treatment of psychiatric syndromes (eg, depressive disorders, anxiety disorders, substance use disorders, or psychotic disorders) is discussed separately.

SPECIFIC FACTORS

Any intervention directed at a particular emotion or behavior should be individualized. Generic interventions can seem superficial and artificial, and at worst miss the mark entirely. As an example, if the physician wrongly presumes to know why a patient is depressed without asking, the patient is likely to feel misunderstood.

Regression — When regression is excessive (eg, creates invalidism), clinicians often become impatient and angry. Physicians should avoid scolding or shaming regressed patients (which may reflect regression in the physician). It is more helpful to [2]:

- Politely explain that feeling needy is typical in serious medical illness
- Provide appropriate reassurance
- Reinforce independence without pushing
- Schedule regular patient visits and set limits (eg, length of visit) as needed
- Avoid extra visits or withdrawing from the patient
- Explain that excessively demanding behavior (eg, constantly calling for staff) may lead the staff to avoid the patient

Anxiety — To address anxiety that is amplifying symptoms of a general medical illness or interfering with treatment, clinicians should first explore the patient's particular fears, such as pain, disfigurement, disability, or death [2]. One should not presume to know why patients are anxious without asking.

Knowing a patient's fears can lead to appropriate interventions such as cognitive therapy or education, which target unrealistic fears. As an example, patients who have suffered a myocardial infarction may be frightened of having sex; discussions in which clinicians are careful to respect the patient's privacy can reduce the fear by reassurance that normal intercourse does not entail excessive cardiac demand. In addition, fear of pain can be addressed by explaining anticipated pain management strategies, and fear of losing abilities may be managed through plans for rehabilitation.

When clarifying the patient's anxieties and intervening with psychotherapy does not allay anxiety sufficiently, the short-term use of benzodiazepines may be helpful, but pharmacotherapy is no substitute for targeted reassurance and support.

Depression — Depression in the context of PFAOMC refers to subsyndromal symptoms such as dysphoria, rather than a full syndrome or mental disorder (eg, unipolar major depression). (See "Psychological factors affecting other medical conditions: Clinical features, assessment, and diagnosis", section on 'Depression'.)

Some patients are helpless in confronting their general medical illness; one can enhance their sense of control by encouraging expression of preferences about health care, giving inpatients

more control over the hospital and nursing routines, and emphasizing active participation in treatment, rather than just passively accepting prescribed care. Patients who are demoralized by the prospect of major treatment (eg, transplantation, amputation, dialysis, chemotherapy, or colostomy) can benefit from speaking with others who have successfully gone through the same procedure.

Pharmacotherapy is generally not indicated for treating sadness or other depressive mood states (eg, emptiness, hopelessness, or irritability), in the absence of a syndrome such as major depression. Additional information about managing minor (subsyndromal) depression is discussed separately. (See "Unipolar minor depression in adults: Management".)

Denial — Management of denial depends upon the clinical judgement that it is maladaptive (eg, refusing critical treatment or threatening to leave against medical advice) and needs to be modified [2]. (See "Psychological factors affecting other medical conditions: Clinical features, assessment, and diagnosis", section on 'Denial'.)

Interventions for excessive denial are directed at the feelings (eg, fear and anxiety) that underlie the denial [2]. Directly challenging the patient's claims or trying to scare the patient into cooperating is typically avoided because it is not beneficial; confrontation can exacerbate the underlying fear, and intensify the denial and impulse to flight (leave against medical advice). Empathy and expressing concern for the patient is more productive, while simultaneously maximizing the patient's sense of control. Psychotherapy can also allay negative emotions. If interpersonal relationships are reinforcing denial, these should be addressed as well. Involving helpful family members may convince patients that accepting medical care is in their best interest.

For patients with denial that does not interfere with treatment or lead to endangerment, we suggest leaving it alone rather than directly confronting it [2]. Physicians are obligated to inform patients about the illness and treatment; following that, if the patient accepts treatment but manifests an irrationally optimistic outlook, physicians should respect the patient's need to cope by denying the prognosis.

Denial in some patients is fragile, and physicians must judge whether the patient is better served by forgoing the denial and instead discussing their fears with their physician. Denial should never be instilled by giving patients false hope (eg, by deliberate omission of information), which is different from the support of hope and optimism.

Anger — The temptation is to spend less time with angry patients, but spending extra time is indicated. Avoid becoming defensive and counterattacking, respond calmly with facts, and treat patients with respect while attempting to understand why they are angry and how it is

adversely affecting their health or interfering in their care. For patients who are justifiably angry (eg, waiting an hour to see the doctor), apologies and explanations for the problem that precipitated the patient's anger should be forthcoming [5]. In addition, patients can be told about the link between chronic anger and adverse effects on health (eg, blood pressure and cardiac function), and the benefits of better anger management. Referral for stress management may be helpful as well.

NONADHERENCE

Adherence to pharmacotherapy involves taking medication as prescribed with regard to dose, frequency, and timing [6,7]. Adherence (compliance) can be quantified on a continuum as a percentage of doses taken as prescribed during a specific interval, or expressed categorically (eg, good, partial, and poor adherence). For many illnesses, common but arbitrary cutoffs for good compliance are taking at least 70 or 80 percent of prescribed doses. Adherence within patients can change over time and vary between different drugs.

The first step in managing poor adherence is to determine why the patient is nonadherent; the reasons for noncompliance influence the interventions that are selected. Multiple studies have found that psychological factors are associated with poor adherence [6]. However, nonadherence takes many forms, and it is important to distinguish patients who are noncompliant because of psychological problems from patients who are willing to take their medications but do not do so because they forget, misunderstand instructions, or are misinformed about pharmacotherapy (eg, "I don't want to get addicted"). Other causes of noncompliance include adverse effects, complex treatment regimens, inadequate follow-up, asymptomatic disease states, poor relationship between clinicians and patients, as well as financial problems.

Psychological factors that may disrupt compliance include [2]:

- Stigma, shame, or humiliation regarding the general medical illness
- Helplessness (depression) regarding the illness
- Mistrusting clinicians
- Anger with clinicians or illness

It is worth determining how patients understand their illness (eg, asking "What do you think causes heart attacks?", "How does it affect you?", and "Can it be controlled?"), and exploring patients' attitudes and expectations of treatment. Patients may believe that they are not ill or that the illness is not severe. In addition, it is helpful to know whether patients think they are at

risk for consequences of the disease. Patients who understand the personal consequences may better absorb general information about the illness.

It is important to ask about adherence in a nonjudgmental manner (eg, "It must be hard to take all of your pills. How often does this happen?"), and to not scold patients when they acknowledge nonadherence, to foster open communication about the problem [2,6]. Patients who are prescribed maintenance pharmacotherapy are likely to be nonadherent at some point. Clinicians should adopt a long-term perspective and try to use episodes of nonadherence as a learning tool for patients.

Three prerequisites for patient adherence to pharmacotherapy are that the regimen should be [2]:

- Acceptable – Patients are more likely to accept pharmacotherapy if they can acknowledge their illness
- Understandable – Does the patient understand the rationale for the drug regimen? It may be helpful to have patients repeat in their own words how they understand the illness and treatment options
- Manageable – Practical issues often affect adherence

The medication regimen should be simplified by minimizing the number of drugs and the times per day they need to be taken. A review of 76 observational studies found that adherence declines as the number of medications increases, such that adherence with one dose per day was approximately 80 percent and with four doses per day was 50 percent [8]. When complex regimens are necessary, physicians should help patients determine which aspects of treatment are most important. It may also help when possible to implement a complex regimen gradually, adding one drug at a time, and to tailor dosing schedules to the patient's lifestyle.

Techniques that can improve medication adherence include the following [2,6,9-11]:

- Ask about prior use of pharmacotherapy.
- Discuss with patients their expectations of benefits and adverse effects, how the clinician will monitor the use and benefit of medications, the clinician's availability for questions about treatment, and plans for dose titrations.
- Elicit and emphasize benefits that are important to the patient (see 'Negative expectations' below).

- Elicit and address irrational or erroneous beliefs about medications, negative attitudes towards pharmacotherapy (eg, "Drugs are useless," "I'm tired of taking medications," or "They remind me that I'm sick"), and the desire to manage the illness without medication.
- Incorporating patient preferences, which may be based on realistic factors (eg, differing side effect profiles) or less objective beliefs (eg, requesting the drug that successfully treated the patient's friend).
- Provide simple and clear written instructions for taking prescribed medications.
- Suggest pill boxes to organize daily doses.
- Suggest the use of cues as a reminder to take medications; options include smart phone alarms, a written record, or pairing pill taking with another regular activity such as eating breakfast.
- Ask about the patient's ability to follow the regimen and address barriers to adherence.
- Involve family members.
- Discuss the need to maintain pharmacotherapy despite feeling better.
- Reinforce desirable behavior and results.

In addition, randomized trials suggest that specific interventions, either solely or in combination, can improve adherence to pharmacotherapy across different conditions, including chronic obstructive pulmonary disease [12], epilepsy [13], human immunodeficiency virus (HIV) infection [14], hypertension [15], solid organ transplantation [16], and stroke [17]. Interventions include changing the medication regimen, cognitive-behavioral therapy, education, motivational interviewing, telephone calls, and text messaging to mobile telephones. However, these interventions have not been clearly shown to improve quality of life or disease outcomes.

Trying to improve adherence by frightening patients is rarely successful [2]. As an example, patients who are noncompliant because they are anxious may become more anxious as a result of scare tactics. In addition, scolding, shaming, or threatening is seldom beneficial.

Physicians should exercise restraint in pursuing therapeutic goals and compromise with patients who want some control of their treatment. It is incumbent upon physicians to maximize patients' health and important to inform patients of the consequences of not following recommendations. However, therapeutic perfectionism fails to recognize that for a particular patient, other values may outweigh some aims of treatment. Physicians are also

obligated to respect the patient's autonomous wishes and not ignore them in the pursuit of an ideal therapeutic outcome.

Additional information about managing nonadherence is discussed in the context of bipolar disorder. (See "Bipolar disorder in adults: Managing poor adherence to maintenance pharmacotherapy", section on 'Management'.)

Negative expectations — Negative expectations about the effects of medications can diminish therapeutic efficacy and amplify unwanted side effects; adverse outcomes that are induced by psychological factors are referred to as nocebo effects [18]. Clinicians can manage negative expectations about medications by:

- Explaining the desired therapeutic effects (eg, "Lowering your cholesterol with this drug after your heart attack can reduce your risk of dying") when discussing potential side effects. It may be helpful to elicit benefits that are meaningful and specific to the patient.
- Ensuring that patients understand that many side effects are transient and benign. In addition, side effects can be reframed as an indication that the medication is working.
- Discussing techniques for coping with side effects other than stopping the drug.

SUMMARY

- Psychiatric consultation for psychological factors affecting other medical conditions (PFAOMC) is indicated when the factors appear to represent a poorly controlled psychiatric disorder; are extreme, persistent, or interfering significantly in treatment; or when clinicians and patients are at a standoff. (See 'When to refer' above.)
- The general approach to PFAOMC is to listen empathically, elicit feelings and behaviors, educate patients about the medical condition and its treatment, help patients understand that their feelings and behaviors need not sabotage their treatment, and convey appropriate reassurance and hope. One adaptive coping style that may benefit patients with PFAOMC is problem solving. We attempt to reflect upon our own reactions to patients and our recurring patterns of behavior to ameliorate difficult interactions. (See 'Approach for all patients' above.)
- When regression is excessive, clinicians should avoid scolding or shaming regressed patients; it is more helpful to politely explain that feeling needy is typical in serious medical illness, schedule regular patient visits and set limits (eg, length of visit) as needed,

avoid extra visits or withdrawing from the patient, and explain that excessively demanding behavior may lead the staff to avoid the patient. (See 'Regression' above.)

- To address anxiety that is amplifying symptoms of a general medical illness or interfering with treatment, clinicians should first explore the patient's particular fears. Knowing a patient's fears can lead to appropriate interventions such as cognitive therapy or education, which target unrealistic fears. (See 'Anxiety' above.)

- Depression in the context of PFAOMC refers to subsyndromal symptoms such as dysphoria, rather than a full syndrome or mental disorder (eg, unipolar major depression). Some patients are helpless in confronting their general medical illness; one can enhance their sense of control by encouraging expression of preferences about health care, giving inpatients more control over the hospital and nursing routines, and emphasizing active participation in treatment. (See 'Depression' above.)

- Interventions for excessive denial are directed at the feelings (eg, fear and anxiety) that underlie the denial. Directly challenging the patient's claims or trying to scare the patient into cooperating is typically avoided; empathy and expressing concern for the patient is more productive, while simultaneously maximizing the patient's sense of control. Involving helpful family members may convince patients to accept medical care. (See 'Denial' above.)

- The temptation is to spend less time with angry patients, but spending extra time is indicated. Avoid becoming defensive and counterattacking, respond calmly with facts, and attempt to understand why patients are angry and how it is adversely affecting their health or interfering in their care. (See 'Anger' above.)

- The first step in managing poor adherence is to determine why the patient is nonadherent. Psychological factors that may disrupt compliance include shame regarding the general medical illness, helplessness, mistrusting clinicians, or anger with clinicians or the illness. It is worth determining how patients understand their illness and important to ask about adherence in a nonjudgmental manner. The medication regimen should be acceptable, understandable, and manageable.

  Techniques that can improve medication adherence include:

  - Emphasizing benefits that are important to the patient

  - Addressing erroneous beliefs about and negative attitudes towards medications

  - Providing simple and clear written instructions for taking prescribed medications

- Suggesting pill boxes to organize daily doses
- Suggesting the use of cues as a reminder to take medications
- Involving family members
- Discussing the need to maintain pharmacotherapy despite feeling better

Trying to improve adherence by frightening, scolding, shaming, or threatening patients is rarely successful. In addition, physicians should exercise restraint in pursuing therapeutic goals and compromise with patients who want some control of their treatment. (See 'Nonadherence' above.)

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