Introduction

Almost always, physical illness has some kind of emotional impact. It stands to reason that having a serious illness will cause anxiety or depression. Yet of the thousands of medical disorders to which humankind is heir, there are just a few that directly cause mental symptoms. This relative handful makes up the subject matter of this book.

The sort of diagnostic problem I have addressed can arise in a variety of contexts:

- The situation often arises when you, the clinician, must determine whether depressive symptoms are caused by a physical disorder, in contrast to a depressive disorder. An exactly analogous case can be made for symptoms of anxiety or psychosis.
- In another common scenario, you need to know whether a patient's already proven physical illness can account for a given set of mental symptoms. Examples might be drawn from the entire contents of this book.
- The diagnosis of somatization disorder (in current diagnostic parlance, somatic symptom disorder, though I prefer the earlier term) and other similar conditions has been a staple of

mental health differential diagnosis for many years. Unhappily, this is still an area where far too few practitioners, whether in medical or mental health arenas, have adequate training and experience.

- Over a period of days or weeks, or even longer, you notice a change in your patient's behavior (it's less reserved, perhaps, or you note some mannerisms). Is the change caused by the gradual onset of a primary mood disorder or by physical illness?
- Altered appearance, which may be quite external, such as changes in the condition of your patient's skin, or (by inference) internal, as hinted by the beginnings of a limp or tremor, can herald either physical or mental disease. How do you determine which interpretation is correct? For that matter, how do you even know where to go to find out?
- Your patient is being treated for "typical" symptoms of, say, a depressive disorder but doesn't get well. Could the cause of these symptoms actually be a physical disease?
- Finally, in my experience with well over 15,000 mental health patients, it is distressingly easy—perhaps it is the norm—to see a patient for several months, long enough to become comfortable with the mental health diagnosis for which you are providing treatment. So it is another goal of this book to stimulate practitioners to think outside the mental health box and consider other diagnoses for patients with whom they have had long acquaintance.

In each of the situations above, knowledge of disease and the diagnostic process can be critical for a patient who, with less careful consideration, might retain an inaccurate diagnosis until incapacitated—by a disease that, with earlier detection, could have been corrected.

I don't plan to discuss those conditions (such as uncomplicated asthma) that may be worsened by stress but do not cause mental symptoms themselves. And I have omitted the genitourinary diseases, whose emotional symptoms are primarily sexual; of course, they are important, but these sexual problems are a bit specialized for most mental health practitioners. Although drugs and other toxins need entire books to do them justice, their importance to our patients and to the diagnostic process requires their mention here.

DEFINITIONS

I have tried to define the more specialized medical terms I've used; usually, I've redefined them for each section of the book. In this regard, I apologize for omissions and redundancies.

Several terms deserve special explanation. I have been a bit cavalier with *symptom*. Strictly speaking, a symptom is what a patient complains of (back pain, swollen joints, an anxiety attack, hearing voices), whereas a *sign* is what an observer notices about the patient (reddened skin, swollen joints, worried facial expression, clenched fists). In this book, I have allowed *symptom* to refer to either; it seems perfectly understandable and a bit more relaxed. Until late in the 19th century, the two terms were used more or less interchangeably. Even today, the distinction is not razor-sharp: Note that "swollen joints" appears on both of the lists just given as examples.

The term *syndrome* I have used in the traditional sense, to mean a collection of symptoms that commonly occur together. (The word has Greek roots, and it means "running together.") Most patients who have any given syndrome will experience some, but not all, of the symptoms usually associated with it.

In assigning degree of rarity to the illnesses described in Part II, I confess to a certain arbitrariness. But epidemiology has yet to become an exact science, and for many of these diseases the data are sparse, contradictory, or even nonexistent. Often the numbers must be estimated. Nevertheless, for better or for worse, I have tried to categorize all of these illnesses as follows:

Common. Most adults have at least one friend or acquaintance who has, or will have, the condition in question. The prevalence ranges to as low as 1 in 200.

Frequent. A town or small city will be home to one or more of these people. Frequency ranges downward from 1 in 200 to 1 in 10,000.

Uncommon. There will be at least one such person in a large city (or small state). These patients occur as infrequently as 1 in 500,000. When one is identified, it is often cause for a grand-rounds presentation in a hospital or medical school.

Rare. Less frequent than 1 per million. When encountered, such a patient is likely to be written up in a medical journal.

Keep in mind that the frequencies stated are those of the illnesses themselves; mental complications will generally occur in only a minority of cases. Also note that most frequencies are given in terms of *lifetime prevalence*—the likelihood that a person will develop the illness at some time prior to death.

In discussing evaluation, I have tried to indicate only the one or two tests that are the simplest, most helpful, or most commonly used. Of course; the workup of most patients will include far more tests and procedures than can be usefully described in a book of this nature.

USING THIS BOOK

You can use this book in a number of ways.

1. Use the first portion of Part I as a guide to the sorts of observations you can make that might indicate a physical disorder. I have arranged these within the framework of the typical mental status examination (MSE), familiar to any mental health professional. The descriptions* given here will point the way to some of the illnesses discussed later in the book.

2. Part II discusses some 66 disorders that can have important implications for mental health patients. You can learn something about the typical appearance (physical and mental) of patients who have these disorders. Of course, the disorders can include many symptoms besides those I have detailed in this section, which attempts only to list those that are most important, common, or prominent.

3. Part III cross-tabulates every disorder discussed in Part II against the mental and physical symptoms discussed. At a glance, you can see how, for example, typical neurological symptoms of hypo- and hyperparathyroidism compare.

4. You can also use Part III as an index to the disorders in which any given symptom might be found. But heed the warning that almost

* In discussing the various symptoms, syndromes, and disorders, I have described patients who are composites of the people I have known throughout my professional life; any similarity to an actual, individual person is unintentional.

anything is possible in medicine, and that any compilation of symptoms can be neither exhaustive nor exclusive.

5. Finally, I have included a brief list of Suggested Readings.

I hope that by the time you finish this book, you will have become:

- More aware of mental symptoms that occur in the course of physical disease.
- More alert to the physical symptoms (and signs!) that could indicate the need for a medical intervention.
- Increasingly curious about illness beyond the usual interests of the mental health practitioner.

IN APPRECIATION

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