Modern Life and Mental Health Newsletter

Issue 2 *Mark D Rego, MD* *September 18, 2021*

Hello Everyone,

I thought I'd squeeze in one more newsletter before I have some book news on Oct. 1st. This piece, and another one of mine linked to at the end, are about common life experiences that are often preludes to emotional difficulties or even mental illness. I think everyone will know someone in these situations (if not yourself).

Thanks for reading and Happy Fall!

Sincerely,

Why Aren't Patients With Medical Problems Getting Mental Health Care?

I opened my first psychiatric office in 1989 right across the street from our local hospital. I joined the hospital staff, did consultations on in-patients and, joined the local medical society. In other words, I was visible.

My plan was to make my presence as a psychiatrist known to the medical community. This, I hoped, would coincide with the blossoming knowledge about psychiatric problems among medical patients. Physicians were just beginning to learn that cancer, cardiac, and rheumatology (arthritis) patients, among others, commonly had depression, anxiety and other mental health issues. This may seem obvious now, but was not always so; or at least was not treated seriously enough to carefully study.

Although I did receive many patient referrals, the flood of people with these medical conditions never materialized. Not even in the following 23 years of my practice. Little did I know that I would join not one, but two classes of these patients: rheumatology and cancer. In the unplanned way many important journeys unfold, I would learn about this issue from both sides.

I am disappointed to report—from both sides of the issue—that medical patients develop mental health issues frequently (especially those with certain diagnoses) and that they are mostly not attended to. What was blossoming when I began my practice is now a developed series of studies that show cardiac patients being at high risk of death when depressed; rheumatology patients struggling with how to function and how to cope with pain and disability; and cancer patients dealing with pain, chemo side effects, multiple medical complications and the obvious fear of death. There are many things we could add to this list such as: disfigurement, being kept alive by a piece of technology (e.g. an internal cardiac defibrillator), or isolation and poor quality of life.

The strength of these many studies, along with my experience in hospitals and rehab facilities, left me convinced that a mental health professional should be part of the teams that manage care of: the heart, pain and disability, cancer and, other issues likely to have a mental health fallout. Unfortunately, this is rarely the case.

Mental health interventions cannot reverse diagnoses, difficult treatments or loss. What they do is help you cope. This can take the form of helping with anxiety, depression, grief over losses, coping with changes

treatment of depression and anxiety can help lessen pain. (We should leave the care of terminally ill patients to hospice, as their team approach is proven best for this groups' needs).

Why then, aren't these treatments routine? There are some clear candidate answers. One, is that specialists are not trained enough in the mental health aspects of their specialty. Another is time pressure. Physicians and other staff are under tremendous strain to see and document many patient visits. This leaves important conversations left undone. Last, is the lack of availability of mental health professionals to refer to. More and more clinicians are dropping insurance as billing requirements become burdensome or they are simply fully booked.

These problems are all quite real. But I am left unsatisfied that we have explained such a glaring chasm in meeting the psychological needs of our sickest patients. I believe we are left, not with the stigma of mental illness, but the lack of awareness that it exists, is common, and occurs predictably during stressful periods in our lives.

For many, mental illness remains something that happens under the cover of secrecy, to other people. It lives in the shadows, is always "crazy," and no doubt is partly their own fault. This is a cynical assessment, but it is an honest one, made from years of discussions overheard and pointed directly at me because I am a psychiatrist.

I have no easy solution to the society-wide problem other than education. But for the medically ill, who commonly suffer mental health problems as a consequence of their illnesses, there must be an experienced, well-trained mental health professional embedded in the teams that take care of them. Pastoral counselors, who are in most hospitals, perform an important service, but it is not this. Staff should not wait until someone voices suicidal thinking or becomes agitated to ask for a psychiatric consultation. We now know enough to predict when someone is likely to be struggling, and of course a sit-down conversation can tell you what you need to know.

This is just one area within the large area of under-recognized and under-treated mental health problems. I discussed another such area previously. Nothing short of continually voicing the reality and commonality of mental illness will get it the attention it deserves.

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