



BY PAUL J. FINK, M.D.

## FINK! STILL AT LARGE

*A study shows that ‘psychological distress’ rather than depression might increase the risk of stroke. How might psychiatrists think of this concept of psychological distress?*

Psychiatry is such a screwed-up field that we cannot retain a language that is scientific and meaningful.

Several months ago I railed against the bastardization of the word “depression.” Now we have a new one, “distress,” which a recent study on causes of stroke equates with emotional distress (see details about the study in article below).

I’m also disturbed—rather than depressed or anxious—by the constant annual effort to rediscover Freud. Rename it, and call it a new finding. Freud said: “Analysis exchanges the pain of neurons for the misery of everyday life.” Was he stealing the idea from Henry David Thoreau, who said, “The mass of men lead lives of quiet desperation”?

I don’t use the terms stress and distress to have significant measurable diagnosable meaning. But now, researchers in the United Kingdom have determined that psychological distress is linked to increased risk of stroke (Neurology 2008;70:788-94). I take that to mean that *all* normal people are at risk for stroke.

Someone has to make very clear to me and the general public what psychological distress means. Is that more than the psychological pain related to the death of a loved one or the loss of a job? For me, stress and distress are lay terms and not psychiatric terms. We need to guard our areas of interest and concern very closely.

Perhaps when the study’s authors refer to distress, they are alluding to anxiety. If anxiety, not depression, were linked to increased stroke risk, I would be very interested. Now I think I know why we separated neurology from psychiatry. Emotional disease is nothing about which we should be casual. It is our bread and butter.

About 2 years ago, I became excited about new scientific information suggesting that if a person feels any symptoms that could presage a stroke, he or she should get to a hospital for a CT scan and the medicine that can abort a stroke (if it is not being caused by hemorrhage). The individual should get to a hospital in 15 minutes. Knowing the life-altering and life-endangering nature of stroke, I thought

this was a terrific piece of information, but no layperson I know seems to have heard of it. Furthermore, it is highly unlikely that anyone would bypass denial and get to the hospital. Whenever I have a friend or patient tell me about an episode of illness, the story is always exasperating, because the individual first self-diagnoses and delays calling a doctor or rushing off to an emergency department.

My mother became blind as she got older, but I will never forget how it started. I went to Florida for her 75th birthday party, and she complained that her eyesight was getting bad. I asked if she had called the doctor, to which she gave her usual reply, “I didn’t want to bother him.” I insisted on going with her to the doctor the next morning, before I was scheduled to fly out. She had hemorrhagic macular degeneration, and I believe she might have had many more years of sight had she seen the value of going to a doctor and getting proper care immediately.

In this context, the U.K. researchers are eager to show that depression, while it often follows a stroke, is not a causative factor. That is important, but one form of human distress is depression. Are we sure that some of those designated as “distressed” were not depressed?

I continue to have great difficulty with researchers and neurologists making psychiatric diagnoses, particularly when the big category is psychological distress, a term of no use or meaning to psychiatrists. No one is free of distress. We are all in conflict about some aspect of our lives. There are lots of categories where we feel confused, fearful of hurting someone, or where we want something we cannot afford or desire sex with someone who is uninterested.

I’m allowing for these conflicts as examples of psychological distress. Or are the authors really talking about some kind of personality disorder in which the patient is always complaining, chronically discontented, or backfilling for things either said or done? Several personality disorders are characterized by psychological distress. The most common is obsessive compulsive disorder, but I’m sure each reader can recall a patient who was always bitching about someone else. It’s a very common defense for people to complain about others rather than look at their own role in their unhappiness. My pa-

tients with OCD are in terrible pain. Their obsessive thoughts torment them. Is that the distress? The U.K. researchers are talking about every diagnosis in DSM-IV to get the meaning of distress. I think we should try to help them become better diagnosticians of psychiatric disorders. What they have done is demonstrated their stigma and disdain for psychiatry by trivializing distress as a nondescript concept against which to compare depression.

The question posed by the study—Are there psychiatric disorders that help precipitate a stroke?—is an important one. Psychiatrists and neurologists should be working together to either retrospectively or prospectively discover who has strokes.

It seems to me that we should be singling out those who develop arterial sclerosis or other vessel-blocking disorders, testing carotid arteries for blockages, or looking at those who have other evidence of vessel blockage for signs of imminent stroke, weakness, difficulty speaking, etc. Since I obviously am not impressed with the discovery that psychological distress may increase strokes, it means nothing to me. I wouldn’t know whom to warn.

In the biopsychosocial world in which we live, a need for greater precision is needed. We analytic types often have been accused of imprecision, guesswork, and flawed theories, and we have, in fact, often lacked the necessary precision that is considered in the biomedical world to be scientific. But as I experience more and more of how the rest of medicine operates, I am amazed by how sloppy others can be in their science! Add to that the institutionalized rudeness of office staff, the lack of concern about the patient’s time, and the habitual lack of feedback to the patient and/or the family, and you can begin to understand why I find the misuse of terms and the failure of accurate diagnosis so exasperating.

The use of the anomalous and meaningless word “distress” is obviously one of the nodal points that gets to me. It’s worse if you are a physician, because the doctor will often answer my questions with “you know what to do.” If I knew, I wouldn’t ask! I assume that he doesn’t act the same way with nonphysician patients.

What I’m begging for in this column is a better recognition of the body of knowledge called psychiatry with all of its theo-

ries, diagnoses, and treatments. I have resisted for decades the stigma against psychiatry practiced by nonpsychiatric physicians, which is passed on by residents to medical students. No matter how hard we fight to erase the stigma, we are stuck with chronic joking and gentle harassment by our colleagues. I believe that much of our thinking is incomprehensible to these men and women who appear to be offended that we seem to know something about how the human mind works and what makes people tick.

I have avoided using the word “castration” in my teaching and scientific talks for years, but today I saw a patient with the residents and students where it was absolutely appropriate. A 56-year-old man with depression and anxiety had severe chronic obstructive pulmonary disease, the result of smoking three packs of cigarettes a day for more than 40 years and drinking two cases of beer a day for decades. Now totally incapacitated, unhappily living with his daughter and son-in-law whom he despises, unable to get out of the house, work or “do” anything, he is depressed, largely because of his unfitness and the death of his wife. Also, he is reliving the death of his mother when he was 7 years old. Today, he is a shadow of his former self: a vibrant husband, father, and construction worker.

This patient is jumping out of his skin to rejoin the living but “doesn’t have the energy” and can hardly breathe. Does the pulmonologist, who is recommending a lung transplant, care about any of this, or does he know that his treatment can actually help this man get his life back?

We in psychiatry have to resist glib and often unnecessary research in areas that do not further our work and might start whole new areas of thought that are of no practical use.

Both stroke and depression are important areas for our concern. Knowing the relationship between the two can be helpful to scores of patients. Let’s make sure that we don’t go along with “scientific” nonsense. ■

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## Findings Based on Population Study of More Than 20,000

The study aimed at assessing what kinds of factors increase the risk of stroke clarifies the relationship between mental health and stroke, according to the lead investigator and his colleagues.

Paul Surtees, Ph.D., and his colleagues conducted a large population study of more than 20,000 residents of Norfolk taking part in the United Kingdom arm of the 10-country European Prospective Investigation Into Cancer.

They found that lower baseline scores on a mental health inventory (indicating greater distress) were associated with an 11% increased risk of stroke over 8 years of follow-up after adjustment for known stroke

risk factors. The association indicated a dose-response relationship.

Having a major depressive episode in the 12 months before the baseline mental-health assessment or at any point in their lives was not significantly associated with a greater stroke risk, however (Neurology 2008;70:788-94).

Dr. Surtees and his colleagues found that of the 20,627 study participants aged 41-80, 5% reported having an episode of major depressive disorder (MDD) in the previous 12 months and 15% reported having such an episode any time during their lives. The mean score on the MHI-5 was 55.2 for those who had experienced an MDD episode in the past 12 months, 76.5 for those who

had an MDD episode at any time, and 78.5 for participants who reported never having an MDD episode. The researchers identified 595 strokes in 8.5 years of follow-up, 167 of which were fatal.

For every standard deviation lower score on the MHI-5, overall stroke risk increased by 11%, after adjustment for cardiovascular risk factors.

A single standard deviation lower score on MHI-5 resulted in an adjusted hazard ratio of 1.22 for fatal stroke. A significantly elevated risk of stroke was not found among participants who had experienced an MDD episode in last 12 months or in their lives.

—Jonathan Gardner