Part 18:
'It's all in your head'

Have so many people suddenly gone from active lives to cyclical, chronic or grave illness because of an explosion of hypochondria? That's not what some psychiatrists are reporting.

Dr. Robert Bransfield, a psychiatrist, is the current president of ILADS at this writing (2011). He is well qualified: the Associate Director of Psychiatry and Chairman of Psychiatric Quality Assurance at the Riverview Medical Center; Vice President of the New Jersey Psychiatric Association; Vice Chair of the American Psychiatric Association Managed Care Committee and is a member of many medical societies and advocacy organizations. Dr Bransfield is board certified by the American Board of Psychiatry and Neurology, certified in psychopharmacology by the American Society of Clinical Psychopharmacology and is a Distinguished Fellow of the American Psychiatric Association.

At the ILADS annual Lyme Disease Conference, held in Jersey City, Oct. 15-17, 2010, Dr. Bransfield addressed the diagnosis of hypochondria directly:

"A person is reasonably healthy throughout most of their life, and then there is a point in time where a multitude of symptoms progressively appear. The number and complexity of these symptoms may be overwhelming and illness may be labeled hypochondriasis, somatization disorder, or psychosomatic.

"However, both hypochondriasis and psychosomatic illnesses begin in childhood and are life long conditions which vary in intensity depending upon life stressors. If a complex illness with both mental and physical components begins in adulthood, the likelihood that this is psychosomatic is very remote."

Dr. Virginia Sherr is a psychiatrist from Lyme/+-ravaged region of Holland, Pennsylvania. She reports, "Doctors can destroy patients by telling them that a true physical disease is all in the head, and suicide is a possible result."

Sherr states, "I am a psychiatrist. These are not people who are referred to me because they have Lyme disease—they are sent because they have panic attacks, hallucinations, obsessive compulsive disorder, depression. They are in agony—not only neuropsychiatric pain, but physical pain as well. They have never been hypochondriacal in their lives, but that is how they have been labeled before they come to me. They are encephalopathic, but they have been told they are not by physicians who wouldn't know of case a encephalopathy if they fell over it.

"They are physically sick, but are blamed for their illness by doctors who say things like,

‘You belong to a cult if you think you have Lyme disease,’ or ‘You look okay to me.’” (“Lyme Disease: The Great Imitator,” Pamela Weintraub; psychologytoday.com)

Many doctors too quickly relegate patients’ reports of pain and illness as “idiopathic”—an official-sounding diagnosis that means physicians don’t know yet.

Too many doctors are also quick to label patients who report illness and pain as “depressed.” This becomes a garbage can opinion, made clear by the fact that no further attempt is made to develop evidence on which to back up the “diagnosis.” Removed from the scientific process of actual diagnosis, depression becomes a metaphor for “irrational.”

Depressed people, however, who work hard to survive every day, know when they’re getting sicker or are experiencing an increase in levels of pain. Dismissing the credibility of people who are suffering because of brain chemistry is patronizing and prejudiced.

Patients find themselves reduced to scrawled doctors' conclusions on their charts that will become indelible: "hypochondriac," “faker,” “malingerer,” “depressed,” "attention seeker," "addict," "hysterical," "crazy.”

Language such as “lazy,” “feather-bedder” and “faker” have traditionally been the slurs of the bosses as they deny health care and instead cast workers on the slag heap. This scapegoating against the “unproductive” is a dangerous witch hunt, particularly in this era of widespread joblessness. It’s an open appeal to prejudices.

Next: Lack of science appeals to prejudices