UPDATED:

UNIVERSITY OF IOWA HOSPITALS AND CLINICS

Psychosomatic Medicine

Handbook of Psychosomatic Medicine
for Residents and Fellows
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Introduction

The psychiatry consultation-liaison service has been in existence here since 1968. It handles approximately 80-100 consultation requests a month, both outpatient and inpatient. It has provided service to many medical specialties including digestive disease, obstetrics and gynecology, the pain clinic, and organ transplant. Consultants provide 24/7 availability to the transplant team. Combined with our 12-bed capacity medical-psychiatry inpatient unit, UIHC is well equipped to assist in the evaluation and management of challenging problems of our patients who have combined medical and psychiatric illness.

Research in consultation-liaison psychiatry included contributions by Dr. Williams Yates, MD (a former member of the UIHC Psychiatry Department), in establishing the Academy of Psychosomatic Medicine practice guidelines for psychiatric consultation in the general medical setting (Psychosomatics 39(4): S8-30, 1998 Jul-Aug), and problem-based learning in consultation psychiatry (General Hospital Psychiatry 18(3): 139-44, 1996 May).

About 3% of the members of the American Psychiatric Association indicate that consultation-liaison is their primary subspecialty. But most psychiatrists see patients with serious medical illness and are often called upon to assist colleagues in medicine when their patients need evaluation and treatment of mental illness.

The American Board of Psychiatry and Neurology (ABPN) and the American Board of Medical Specialties (ABMS) have recently recognized the importance of this role. The issuance of subspecialty certificates in Psychosomatic Medicine has been approved. Certification examinations are planned and the Residency Review Committee at the Accreditation Council for Graduate Medical Education (ACGME) is evaluating fellowship programs in the subspecialty for certification.

Psychosomatic medicine is a synonym for consultation-liaison psychiatry. It focuses on the treatment of complex patients who have:

- A medical or surgical condition in which a psychiatric illness affects the medical condition and/or the quality of life
- A somatoform disorder or a psychological factor affecting the medical condition
- A psychiatric illness that is the consequence of a medical condition
This manuscript is intended to serve as a practical guide to residents, fellows, and medical students for learning what psychiatric consultants do and how they do it. I expect it to be a work in progress for a long time to come. Many thanks to contributors to specific chapters:

Raymond Crowe, MD: family medicine resident orientation section and helpful editor for the alcohol treatment chapter. The family medicine resident orientation is also an excellent guide for psychiatry residents and medical students.

Caroline Carney-Doebbeling, MD, MS (now with the University of Indiana):

Jill Liesveld, MD: provided assistance with writing the alcohol treatment chapter.

Jim Amos, MD

UIHC Psychosomatic Medicine
Psychiatric Consultation Service

Get a bird’s eye view of the UI Consult Service.

The work day on the Consultation/Liaison service is from 8:00 am until 5:00 pm or until all of the consults have been seen.

**Review Rounds:** Review rounds are held each morning from 8 to 8:30 in the consultation service staff office in 2945 JPP. We review the active inpatient cases and discuss administrative issues. On Wednesday morning, a teaching conference is held from 8 to 8:30 am and a brief review rounds follows.

**New Outpatient Consults:** Most outpatient consultations are scheduled in the morning to leave the afternoons open to see inpatient consults promptly. If the residents need to see emergency inpatient consults in the morning, the consultation service staff can help out by seeing some of the outpatient consults.

**Return Outpatient Consults:** Returning consults are scheduled preferentially in the morning and are seen either by residents or staff.

**Inpatient Follow-Up Consults:** Follow-up consults are reviewed at 8:00 am. Each day the staff and residents coordinate a time to round on these patients.

**Consult Referrals:** We try to see outpatients on the day of referral to the extent possible because scheduling a return visit causes us to lose patients. When you are called to see an outpatient, ask whether we can see the patient today.
Consultation/Liaison Case Conference

A half-hour Clinical Problems in Consultation Psychiatry conference is held on Wednesdays at 8:00 am. Each week, a case is selected from the Daily Review Rounds Records to illustrate a clinical problem for the next week’s meeting. The residents are assigned dates on a rotating basis.

The assigned resident is responsible for searching the literature and selecting one or two teaching papers for the conference. Presentations will begin with a review of the case, followed by a summary of the references. Please allow time for discussion; a frequent mistake is to select too many papers for the time allowed.

Memorandum__________________

Date:    July 1, 2004

To:    Consult Service Faculty, Residents, and Medical Students

From:    Jim Amos, MD, Associate Professor Clinical Psychiatry

Re:    Clinical Problems in Consult Psychiatry (CPCP)

The CPCP Conference is a required conference for residents and medical students rotating on the consultation service. It has been popular for several years as a part of residency and medical student education. It’s an opportunity to get practical experience in conducting computer searches of the medical literature, applying the results of the search to clinical problems, and presenting the work to colleagues. CPCP is normally held each Wednesday from 8-8:30 am in the Psychiatry Consult Staff room in 2945 JPP. A weekly review of the Daily Record will be done to select a clinical problem for the following week’s discussion.

A resident will be assigned a specific week for giving the presentation. It is the responsibility of the scheduled presenter to trade weeks in the event of scheduling conflicts.

Consult staff are happy to assist, if necessary, with literature searches if residents are unfamiliar with the Ovid system. Circulate copies of 2-4 pertinent articles to team members including psychiatric nurses and faculty. A copy machine is available in the clinic. Consult staff can also assist with obtaining copies.

Presentations begin with a 5-minute summary of the case with discussion of both psychiatric and medical aspects of evaluation and management. The remaining time is spent summarizing the pertinent data in the articles. Residents and medical students are encouraged to use the case conference material as preparation for submitting a case report or letter to the editor.
Please contact Dr. Amos at 3-6844 or the attending staffing for the month for further information. See schedule below.

### CPCP Assignments

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Medical Records

The preferred method for documenting the consultation report is to dictate the note (or type it) on the computerized INFORMM PATIENT RECORD (IPR) using the dictation template code #55 (E-1 Consultation). Always specify whether the note is initial or follow-up, inpatient or outpatient, and identify the requesting clinical staff.

The resident can generate this note, to which the attending can make corrections. The attestation component is built into the template, so that in many cases, all the attending need do is to add comments to the “Staff Physician Comments” section, electronically sign the note, which satisfies the billing requirement. The advantage of this is to make the consultation note immediately and legibly available on the IPR.

The Consultation Service also has a paper form for the medical record. The resident or medical student fills out the form up to the teaching physician attestation. The attending signs the Attestation and fills out the narrative response to the requesting physician on the first page of the consultation form.

The review of systems and vital signs are mandatory on the inpatient consults. Pain assessment is required on all forms. The attending may link his/her note only to the medical student’s review of systems, and past social and family history to satisfy billing requirements.

The “Formulation and Impression” section is an important part of the assessment portion of the note. It is intended to be a succinct statement that attempts to summarize the essential features used to justify the diagnosis applied and to explain, often in psychodynamic and/or developmental terms, why and how the clinical syndrome developed.

Weekend/Holiday Call

Consultations seen on weekends and holidays will have been seen earlier by the psychiatry resident on call. We have asked the psychiatry residents on call to fill out the consultation forms to the extent that time allows. The following morning the Consultation Service resident and attending review the record together, examine the patient, and finalize the consultation record.

The Consultation Service residents rotate for weekend/holiday call. The attendings cover these days with a rotating call schedule that includes the consult service clinical faculty.

The resident covering the consult service on a weekend or holiday is responsible for the following:

1. Paging the psychiatry on call resident on pager 3322 at 7:00-7:15 a.m. to see if there were any new consults over night.
2. Next paging the staff psychiatrist around 7:30 a.m. to tell them how many patients need to be seen and agree where to meet at the hospital.

3. Being familiar enough with the patients well enough to present their cases to the regular consult staff on Monday if the psychiatry service will need to continue to follow them.

The consult resident is not responsible for the initial work up of new consults after 5pm during the week or after 8:00 a.m. on weekends as they will be seen first by the on call psychiatry resident.

**Objectives for Psychiatry Residents in Consultation-Liaison Psychiatry**

Upon completion of their core Consultation-Liaison Psychiatry rotation, residents should be able to demonstrate the capacity to:

1. **Consultation-Liaison Process**
   a. Engage in effective interactions with a variety of consultees, including determination of consultation questions, and reporting of findings and recommendations.
   b. Gather data from appropriate sources, including chart, hospital staff, family, and other relevant individuals.
   c. Write a pertinent and useful consultation note.
   d. Monitor the patient’s course during hospitalization and provide continuing input as needed.

   **Examination Skills**
   e. Interview medically ill patients in a variety of settings.
   f. Quickly develop a therapeutic alliance with medically ill patients.
   g. Evaluate for psychopathologic processes in patients with concomitant medical and surgical conditions.
   h. Evaluate cognitive ability in medically ill patients.

2. **Therapeutic Interventions**
   a. Advise and guide consultees about the role of the medical disease and medications in the patient’s presenting symptoms.
   b. Understand the indications for a variety of somatic therapies in medically ill patients.
   c. Understand the use of psychotropic medications and ECT in medical/surgical patients, and appreciate physiological effects, contraindications, drug interactions, and dosing concerns.
   d. Understand the use of non-organic treatments, including brief psychotherapy, behavioral management techniques, family therapy, and psychoeducation.
e. Work as a member of a multidisciplinary staff to maximize the care of complex medically ill patients.

The above is copied from “Recommended Guidelines for Consultation-Liaison Psychiatry Training in Psychiatry Residency Programs. The full text is available at the Academy of Psychosomatic Medicine website at www.apm.org.

Family Medicine Residents

Brief Description

The Psychiatry Consultation Service is located in 2945 JPP across the hall from the Psychiatry Department Administrative Offices. It evaluates approximately 100 patients per month, of which about half are inpatients and half outpatients. The Team consists of psychiatry and family practice residents, medical students and members of the nursing consultation service. It meets each morning at 8:00 in the consult staff office to review the cases of the previous day and discuss the work of the day. On Wednesday mornings, this meeting begins at 8:30 following the case conference.

All residents on the Consultation Service rotate weekend/holiday coverage. The Psychiatry resident on duty works up new consults that occur overnight. The Consult Resident calls the on-duty resident at 7:00 AM the following morning to find out if there are consults to be seen. If so, the Consult Resident calls the Psychiatry Attending on call for the Consultation Service and arranges a time to meet on the unit and review the case.

Psychiatry Grand Rounds are held on Tuesday mornings from 11:00 until 12:30 during the academic year.

During the same period, a weekly Research Seminar is held on Mondays from 12:45 until 2:00. Family medicine residents, when they cover weekend/holiday consult call, should adhere to the same protocol outlined in the previous section on page 4.

Learning Objectives

1.0 Learn the basic elements of a Psychiatry Consultation
2.0 Perform at least one consultation on each of the most common consultation requests:
   2.1 Depression in the medically ill
   2.2 Unexplained somatic complaints
2.3 Assessment and management of dementia/delirium
2.4 Psychiatric care of patients with an overdose in the MICU
2.5 Alcohol dependence, withdrawal or drug abuse

3.0 Understand the basic drug classes used in psychiatry
4.0 Become familiar with the learning resources used to solve clinical problems in consultation psychiatry
5.0 Present one clinical consultation in the weekly CPCP conference using Healthnet and a problem-based learning approach
6.0 Recognize when to refer a patient for psychiatric evaluation

See AAFP Reprint #270 - Recommended Core Curriculum Guidelines on Psychiatry for Family Practice Residents (pages III-47 & 48).

Reading List


*Brief references.

Consultation/Liaison Case Conference

The Case Conference is held on Wednesday mornings from 8:00 until 8:30. Residents are assigned in rotation to present. A teaching case is selected from among the patients seen during
the previous week, and the assigned resident conducts a literature search and selects one or two key papers for discussion. A common mistake is to attempt to review too many papers for the 30 minutes allotted. Bring enough copies of the papers for all attendees.

**Objectives for C/L Conference:**

1.0 Review current/recent cases for specific clinical problems that would be of educational value to psychiatrists, residents, nurses and medical students.

2.0 Become familiar with computerized literature searches to build reference lists and collect selected papers for discussion on specific clinical topics.

**Elements of Psychiatric History and Mental Status for Consultation**

1.0 **Identifying Information** – Name, age, marital status, race, gender, occupation, home city, hospital location, referral question

2.0 **History of the Present Illness**

2.1 Present a brief synopsis of the patient’s medical history (date of admission, reason for admission, major medical/surgical problems, course of hospitalization, and expected date of discharge)

2.2 Summarize the psychiatric symptoms

2.2.1 Describe symptom(s), date of onset, severity, course, contributing or alleviating factors, how the symptoms have affected the patient’s functioning and medical care

2.2.2 Describe any attempts to evaluate or treat the patient’s symptoms by the ward team (medications, tests ordered, restraints)

2.3 Present historical information to assist in confirming a DSM-IV-TR Diagnosis

2.3.1 Significant stressors, associated symptoms, i.e., effect on sleep, appetite, sexual functioning, relationship of symptoms to medical illness, medication, hospitalization

3.0 **Psychiatric Review of Systems.** Review for symptoms of disorders commonly seen in the consultation setting: major depression, adjustment disorder, dysthymia, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, alcohol abuse/dependence, drug abuse/dependence, somatoform disorders, organic mental disorders, schizophrenia, bipolar disorder, personality disorder.
4.0 Past Psychiatric History. Review for previous psychiatric conditions, i.e., previous history of treatment for a nervous or mental disorder, counseling, psychiatric medication, psychiatric hospitalization, history of suicide attempt or previous violent behavior.

5.0 Family Psychiatric History
   5.1 Describe the basic outline of the patient’s family of origin and current family
   5.2 Evaluate for first-degree family member nervous/mental disorder, i.e., depression, nervous breakdown, psychiatric treatment/medication, hospitalization, alcohol or drug abuse, suicide attempts or completed suicide

6.0 Significant Additional History – Describe additional information from nurses, other health team members and family about the patient’s current and past condition.

7.0 Developmental/Social History
   7.1 Describe any significant childhood traumas, i.e., illness, abuse, neglect
   7.2 Describe highest educational achievement
   7.3 Marital history, i.e., age at marriage, number of marriages, spouse’s occupation, significant marital support or dissatisfaction issue
   7.4 Occupational history, i.e., current work status, previous jobs obtained, significant financial or occupational stressors
   7.5 Interpersonal support – describe social contacts with friends, church member, etc. outside of family members

8.0 Medical History
   8.1 List all current medical diagnoses
   8.2 List all current medications
   8.3 List major surgical procedures
   8.4 List drug allergies

9.0 Mental Status Examination
   9.1 Appearance & Attitude: describe the patient’s appearance, cooperativeness and attitude toward psychiatric evaluation
   9.2 Mood: describe the patient’s mood state, range of affect, and level of anxiety
   9.3 Affect
   9.4 Thought – Describe any evidence of hallucination, delusions, suicidal or homicidal thoughts, or formal thought disorder
   9.5 Psychomotor Activity
   9.6 Insight – Describe whether the patient is aware of any mental disorder that is present
   9.7 Judgment – Describe whether the patient seems to understand current medical condition, ability to make decisions about informed consent, care of ADL’s, etc.
   9.8 Mini-Mental Status Exam Score – Present score; describe individual items the patient had problems with

10.0 Physical Exam – List pertinent exam findings focused on primary medical/psychiatric illness
11.0 Laboratory/X-ray/EKG
11.1 Describe any pertinent laboratory information, i.e. blood gases, electrolytes, hemoglobin, thyroid functions
11.2 Describe any important CNS studies, i.e. head CT, EEG
11.3 Report on patient’s last EKG rate, rhythm, conduction defects

12.0 Diagnosis/Treatment Plan
CASE EXAMPLE

Identifying information: John Doe is a 43-year-old single white male from Charles City, IA currently an inpatient on General Medicine. This unemployed man is being treated for complications of AIDS and is sent for consultation because of recent onset of confusion. Information is obtained from the patient, family and ward team.

History of Illness: Mr. Doe was admitted on May 20, 1992 for pneumonia. He has a history of AIDS that was first diagnosed in June of 1991. Since that time he has been receiving daily AZT therapy. He has had recurrent pulmonary infections due to opportunistic organisms. This has resulted in three previous UIHC hospitalizations. He became ill with this episode two days prior to admission with cough, fever, headache and dyspnea. After local outpatient therapy failed, he was admitted for more intensive medical therapy.

On admission, Mr. Doe was noted to have some confusion. This was documented by the medical intern as disorientation to place and date. There is no known history of confusion prior to this hospitalization. The patient’s level of confusion appears to fluctuate although it never clears completely. Over the last 48 hours the confusion has worsened and has been accompanied by wandering, agitation and non-compliance with medical staff. Behavioral problems have included the pulling out of IV necessary for care.

The ward team has attempted to control the target symptoms with wrist restraints and diazepam 5-10 mg. These attempts have not resulted in improvement.

Additional symptoms have included nocturnal agitation with daytime somnolence, poor oral intake, and suggestions of possible visual hallucinations. No new psychotropic medications were added prior to the onset of confusion.

Psychiatric Review of Symptoms: The patient was minimally cooperative to questioning about psychiatric symptoms. There is no evidence of pre-existing mood or anxiety disorder or evidence of suicidality. The patient has a history of drug use including marijuana, cocaine and amphetamines. These had been used in the past on a daily basis. Use has included intravenous administration. Since the diagnosis of AIDS the patient has stopped all drug and alcohol use. There is no history of pre-existing neurological problems such as severe head trauma or epilepsy. Although there is some evidence of conduct disorder symptoms as a young man, criteria for adult antisocial personality disorder is not met.

Past Psychiatric History: Prior to admission, the patient had only minimal psychiatric/mental health contact. At the time of learning about his diagnosis, Mr. Doe received some brief counseling from the AIDS team and social worker. His emotional response to his illness seemed within expectations. He did not become depressed. He has not received prior psychotropic medication, been hospitalized or had a history of suicide attempts or violent behavior.
**Family Psychiatric History:** Mr. Doe is the third of four sons. His father and mother are alive and well, living on a farm in the Charles City area. Mr. Doe has not been married and has no children. There are no first-degree family members with known mental/nervous disorders or alcohol or drug abuse. No family members have received psychiatric treatment, been hospitalized for psychiatric illness, or attempted or completed suicide.

**Developmental/Social History:** Mr. Doe grew up on the family farm. There is no history of childhood abuse or neglect. He attended school through high school in Charles City. He graduated from high school but did not receive any additional vocational or college education. He was known as a student who did little studying but received average grades. He has worked odd jobs throughout his life in the Charles City area. He has never been regularly employed for more than 18 months. He last worked in 1991.

Since his diagnosis of AIDS, he has been receiving Social Security disability and living in an apartment in Charles City. The patient reports his sexual preference is heterosexual. He has not had any homosexual relationships. Although he has had several intimate relationships with women, he has never married stating “Women are just too much trouble.” Since his diagnosis of AIDS he has not had sexual relationships. He has several friends in the Charles City area; unfortunately, most of these friends are involved in drug use.

**Medical History:**

- **Medical Illnesses:** Aids, pneumonia
- **Medications:** fluconazole, AZT, Vancomycin, Valium 5-10 mg prn
- **Operations:** none
- **Allergies:** none

**Mental Status Exam:** Mr. Doe was seen in his hospital room. He was dressed in his hospital gown. Cooperativeness was variable during the interval. Occasionally, he would ignore questions and have attention problems. His mood was irritable. His affect range was not restricted. Thought processes were concrete and responses showed a poverty of content with limited patient-initiated conversation. The stream of thought would occasionally not be goal oriented. There was no evidence of hallucinations, delusions, suicidal or homicidal thought. There was no insight into the mental status problem. Judgment was considered impaired. Mini-mental state exam score was 19/30. Impairment noted in orientation, immediate recall, attention and visuographic performance.

**Physical Exam:** Temperature 39.0 cachexia, rales in right and left lung fields

**Laboratory/X-ray/EKG:** Hemoglobin 9.2, T-cell count 100, chest x-ray bilateral pneumonia, spinal fluid no evidence of infections, EEG pending, HCT not done, EKG normal.
Medical Students C/L (consultation-liaison and general hospital psychiatry)

Medical students find the Consultation service interesting and challenging. The expectations are as follows:

1. Report to the Consult Staff Office 2945 JPP on the first day of service
2. Review rounds are held from 8-8:30 AM, M-F with all member of the C/L team.
3. Student’s primary responsibility will be evaluating outpatient consults and staffing cases with the attending. Most of these patients are scheduled in the mornings, and we will assign each student one patient each morning to the extent that patient flow permits. These patients will be evaluated with a resident present initially, and by the student alone as students gain more experience with the examination.
4. Students will present a complete psychiatric history and mental state examination to the attending, who will examine the patient with the students. Students will record the findings of their evaluation on the C/L forms available in the consult offices.
5. Students are expected to accompany the C/L residents on their evaluations of inpatient consults when the students do not have patients assigned to them. Students will normally not be assigned inpatients for student evaluations.
6. Students are expected to be available between 8:00 AM and 5:00 PM, Monday through Friday (when they’re not in required classes and departmental rounds). When the service is called for a consult, we must be able to locate the students in order for them to participate.
7. Students will be evaluated by the C/L attending at the end of their C/L rotation.
**Psychiatric Evaluation**

Chief Complaint
Source of information & reliability
Present Illness
Past History
psychiatric illness
personal history
Family History
Social History
Medical History
illnesses, injuries
operations
allergies
Medications
Mental State Exam
Physical Findings
Labs

Assessment: Axes I-V

**Plan**

**Mental State Exam**

Appearance
Mood & Affect
Thought & Speech
Psychomotor activity
Insight & Judgment
Cognition

• orientation
• memory: recent, remote
• general information
• attention & concentration
• other cognitive assessments

**MICRO DSM-IV-TR**

Key concepts and common symptoms of the major mental disorders are summarized:

DSM-IV-TR should be consulted for the complete diagnostic criteria.

**Major Depressive Episode**

5+ sx lasting >2 wks. (#1 or #2 required):
1) depressed mood
2) loss of interest
3) weight loss or gain
4) insomnia or hypersomnia
5) agitation or retardation
6) fatigue
7) guilt, worthlessness
8) impaired concentration
9) thoughts of death, suicide

**Anxiety Disorder**

• Key: persistent anxiety/worry for > 6 mo.
3+ of the following:
1) restlessness
2) fatigue
3) poor concentration
4) irritability
5) muscle tension
6) insomnia

**Substance Dependence**

• Key: physical dependence and/or loss of control (i.e., compulsive use)
3 or more of the following:
1) Tolerance
   a) increased amt needed to produce same effect
   b) diminished effect with cont use of same amount
2) Withdrawal
   a) characteristic withdrawal syndrome
   b) substance taken to avoid withdrawal
3) Substance used in larger amounts of longer than intended
4) Persistent desire or unsuccessful efforts to control use
5) Excessive time spent obtaining, using or recovering from subst
6) Social, occupational, recreational activities curtailed by subst
7) Continue use despite knowledge of harmful effects

**DSM-IV-TR Axes**

**Axis I Clinical disorders**

**Axis II Person. dis., M.R.**

**Axis III General medical cond.**

**Axis IV Psychosocial stresses**

**Axis V Global Assessment of Functioning**

**Selective Serotonin Reuptake Inhibitors (SSRIs)**

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**Miscellaneous Antidepressants**

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**2nd Generation Antipsychotics**

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Psychiatry Consultation Process

*It doesn’t take long to figure out that you have more than one customer.*

Fundamental Principles of Consultation

Try to figure out what the consultee wants and respond to that. Sometimes the real reason for consultation is hidden between the lines.

Try to be prompt in your response to the request. Ask if it’s an emergency. Avoid delays longer than 24 hours.

Review the medical record and the medication list. Talk to the medical staff, nurses, social worker, family members, and other informants to get a balanced view of the issues. You may find out who really wants the consult.

Make specific recommendations and avoid jargon in a succinct, legible document.

Follow up to review progress, medication reactions, and test results.

Try to be aware that the patient may not be thrilled to see you; the consultee may not have prepared her for the visit. Ask how you may be of service to the patient.
<table>
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<th>Common problems that trigger psychiatric consultations:</th>
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<td>Delirium</td>
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<td>Dementia</td>
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<td>Depression</td>
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<td>Adjustment disorders</td>
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<td>Somatoform disorders, Factitious disorders, and malingering</td>
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<td>Determination of mental capacity</td>
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<td>Personality disorders</td>
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<td>Suicidality</td>
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<td>Transplantation issues</td>
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<td>Substance abuse</td>
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<td>Pregnancy related care</td>
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<td>Agitation and psychosis</td>
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<td>Anxiety</td>
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<td>Psychopharmacology of medically ill</td>
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<td>Post traumatic stress disorder</td>
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<td>Psychiatric care in the ICU</td>
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<td>Psychological factors affecting medical illness</td>
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<td>Coping with illness</td>
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<td>Burn sequelae</td>
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<tr>
<td>Psychiatric manifestations of medical illness</td>
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</table>
Here are several elements of the psychiatric consultation. Formats for it vary. Some clinicians prefer placing the identifying data, question and referral source, diagnoses, and recommendations at the beginning. This has the advantage of putting the data that’s most relevant for the consultee at the top of the page, where it’s most likely to be readily noticed.

<table>
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<th>Date and time:</th>
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<tr>
<td>Identifying information, referral source and question:</td>
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<tr>
<td>Multiaxial DSM-IV-TR diagnoses and formulation:</td>
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<td>Recommendations:</td>
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<td>HPI</td>
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<td>FH/SH</td>
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<td>ROS</td>
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<td>MSE</td>
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HPI = History of Present Illness  PMH = Past Medical History
PPH = Past Psychiatric History  FH/SH = Family and Social History
ROS = Review of Systems        MSE = Mental Status Exam

Most formats flip this arrangement, assuming that most clinicians skip to the end of a document anyway to get to the most important issues: what’s the problem and what to do about it.
Mental

Status Exam

- General alertness, orientation, level of distress, attitude
- Physical agitation, tremor, waxy flexibility
- Speech rate, fluency, naming, repetition
- Thought process logical flow, concreteness, latency
- Mood/affect quality, range, lability
- Perceptions hallucinations
- Thought content delusions, OCD, phobias
- Cognitive memory, concentration, clock drawing
- SI/HI hopelessness, burden to family, guilt
- Insight & judgment pertinent to consult question

Defense mechanisms and case formulation

“If we understand that we are using a given defense, it no longer works.”-George E. Vaillant

In a paper published in 1987 in the American Journal of Psychiatry, Samuel Perry, M.D. et al., lamented that psychiatric evaluations almost never included a psychodynamic formulation. They cited several misconceptions about formulations that might have contributed to their disuse:

- Belief that they’re indicated only for patients in long-term, expressive psychotherapy
- Belief that it’s mainly a training exercise
- Belief that it’s a complicated, lengthy process
- Belief that it needn’t be written
- Belief that therapists will be over invested in them

In fact, a formulation is a brief, preliminary, condensed summary that describes the patient’s current problems (preferably with as little jargon as possible), and puts them in the context of a particular conceptual model of the patient’s current life situation and developmental history, sharpening the clinician’s understanding of the central issues and therefore allowing the development of a treatment strategy, prediction of response and resistance, which enables planning of countermeasures. The conceptual model is often psychodynamic, but others are possible and may be more practical.
The consultation-liaison psychiatrist, for example, can communicate a formulation to the consulting physician that will facilitate understanding of what factors are important to address in the care of a medically ill patient with psychiatric illness. Placed in the medical record, it can be a useful starting point for a psychotherapist, who may be involved at some point in the course of treatment. The therapist is very likely to obtain additional historical and clinical exam data over several visits that can (and often do) change the initial formulation. It therefore has widely applicable utility throughout academic and community psychiatry. The formulation starts with the psychiatric diagnostic evaluation.

In any psychiatric evaluation, the examiner must use three skills:

1. Listening to the patient
2. Eliciting valid information from the patient
3. Understanding the patient

In order to do case formulations or identify defense mechanisms, the psychiatric consultant must learn to be effective at all three skills. Listening means not only hearing words, but also attending to nonverbal behaviors and eye contact. Eliciting valid information means asking the right questions the right way (see the chapter on suicide assessment for an abbreviated discussion).

It’s beyond the scope of this section to delineate the why’s and how’s of the first two skills. The reader is referred to the outstanding treatments of them by Othmer and Othmer, Gabbard, and Shea.

The third skill (arguably the hardest), means putting together what was gleaned from the first two and coming up with both a description and an explanation for the patient’s suffering that will guide the kind of help offered. This is one of many definitions of the formulation. Formulating a case implies an orientation toward the facts that are gleaned. Paul McHugh summarized the issue in his book, The Perspectives of Psychiatry:

Life can be altered by what a patient “has” (diseases), what a patient “is” (dimensions), what a patient “does” (behaviors), or what a patient “encounters” (life stories).

Formulating a case of a psychiatric illness that is disease-like in presentation, such as schizophrenia, will be very different from that of an adjustment disorder (which is more life story in nature). The psychodynamic formulation for schizophrenia, i.e., the “schizophrenogenic mother,” has long been abandoned. Nevertheless, when the subject of case formulation is broached, usually what is meant is the psychodynamic case formulation. This tends to emphasize the life story perspective. This also usually implies a link to a theoretical position, or model. Three common models are:

1. Ego-Psychological: emphasizes the role of ego in adaptation during development and in therapy. Behavior is a compromise, mediated by the ego, among drives (id), conscience (superego), and reality. Focus is on characteristic defense mechanisms, Freudian psychosexual stages (mainly oedipal). Interpersonal issues are not emphasized. Major figure-Freud.

2. Self-Psychological: emphasizes a postulated structure, the “self” that develops toward both innate and learned goals. Normal persons develop a stable sense of self because parents display interest and empathy in their achievements. They can then form empathic, healthy
relationships of their own. Empathic failures lead to distorted sense of self and inhibitions, making it difficult to maintain ties. Formulations keyed to this model describe how the person defensively compensates for these empathic failures of self-development. Addresses narcissistic problems; less useful for describing repetitive maladaptive patterns that arise from intrapsychic conflict. Major figure-Heinz Kohut.

3. Object Relations: starts with conceptualizing psychic structures as arising from child’s construction of internal representations of self and others. They can be primitive or realistic and are typically linked to a broad array of basic emotions (anger, fear, pleasure) and fantasies, e.g., sex, control. Early in childhood, bad representations are split from the good, with normal maturation resulting in eventual integration of “the good and the bad mother” along with sensible representations of the self giving the ability to see the world in shades of gray, rather than black and white. Formulations in this model tend to focus on the conflicts among self and object representations, developmental failures in integration of contradictory representations leading to displacement and defensive misattribution of aspects of the self (projection). Meant mainly for the borderline personality organization, it may be less useful for the “neurotic.” Defense mechanisms are also key components of the formulation here, often the immature defenses described by Vaillant. Major figure-Melanie Klein.

There are other ways to organize formulations that emphasize newer forms of psychotherapy, e.g., cognitive-behavioral psychotherapy (CBT). The silent assumptions and core beliefs leading to the dysfunctional thinking and behavior characterized in this modality can be parallel to the defensive styles. Automatic thoughts, depressogenic assumptions, and cognitive distortions are observable, inferable data that can be incorporated into a formulation using Aaron Beck’s CBT model.

But the process is similar: abstracting data from the clinical exam into a conceptual model that permits the building of a descriptive and explanatory framework that will guide planning of coherent, effective strategies for treatment. If the model emphasizes cognitive distortions, then identifying them during the exam will be as important as identifying defense mechanisms would be in a psychodynamic model. Examples:

- Polarized thinking in CBT: Things are black and white, good or bad. You have to be perfect or you’re a failure. There is no middle ground. Compare with splitting, a defense mechanism.
- Mind reading in CBT: Without their saying so, you know what people are feeling and why they act the way they do. In particular, you are able to define how people are feeling toward you. Compare with projection, a defense mechanism.

The CBT model is particularly well suited to formulations in consultation-liaison psychiatry because of the wealth of research demonstrating cognitive therapy’s effectiveness in treating depression in medical illness.

The Interpersonal Psychotherapy (IPT) model of depression in the medically ill can also be used in making formulations. It addresses four main areas of potential dysfunction: grief, role transitions, interpersonal disputes, and interpersonal deficits. Here the challenge is to identify a problem area that
would be amenable to an IPT approach. IPT tends to focus on the patient’s social assets rather than defenses, current interpersonal stressors rather than childhood experiences, and more on how to help the patient recover in the here and now than on why he/she became symptomatic. Techniques for therapy include nondirective, open-ended questions, encouragement of affect, clarification, and communication analysis.

Conflicts can also be cast in terms of one’s progress in developmental life stages. Erik Erikson’s eight stages of the life cycle are well known and are based on his epigenetic principle, which says that development occurs in distinct, sequential stages that must be worked through satisfactorily. If a stage is not successfully resolved, maladjustment occurs in all subsequent stages.

Erikson’s Stages (abbreviated)

1. **Trust v. Mistrust: birth to 18 months**: Assumes that first component of healthy personality is a sense of basic trust. Gross inconsistencies in parenting and early social deprivation can result in major mental disorder in adulthood. Associated with depression, psychosis, and addictions. Task is mutual recognition v. autistic isolation. Temporal perspective v. time confusion.

2. **Autonomy v. Shame and Doubt: 18 months to 3 years**: During the period of toilet training. Too much or not enough parental control can lead to problems with conflict between self-expression and compulsive self-restraint. Associated with paranoia, OCD, impulsivity. Task is will to be oneself v. self-doubt. Self-certainty v. self-consciousness.

3. **Initiative v. Guilt: 3 years to 5 years**: During the time of exploration, oedipal conflict resolution. Adequate resolution permits normal ambition outside the family. Associated with conversion disorder, phobia, psychosomatic disorder, inhibition. Task is anticipation of roles v. role inhibition. Role experimentation v. role fixation.

4. **Industry v. Inferiority: 5 years to 13 years**: During the time of learning new skills, identification with teachers. Incomplete negotiation may lead to mediocrity, avoidance from sense of incompetence. Associated with creative inhibition, inertia. Task is task identification v. sense of futility. Apprenticeship v. work paralysis.


6. **Intimacy v. Isolation: 21 years to 40 years**: During the time of finding a job and a mate. Task is to find a balance between work and love. Incompletely resolved, can lead to conflicts about intimacy, prejudice. Associated with schizoid personality and avoidance. Sexual polarization v. bisexual confusion.

7. **Generativity v. Stagnation: 40 years to 60 years**: During the time of guiding the next generation, hitting the stride in productivity and creativity, and needing to feel needed by children, students, society. Failure to negotiate this stage can lead to escapism, substance abuse, marital infidelity, and restrictive focus on the technical aspects of occupation at the expense of general
principles of leadership, governance, leaving a legacy, and doing the right thing as well as doing the thing right. Associated with mid-life crisis, premature invalidism. Leadership and followership v. abdication of responsibility.

8. **Integrity v. Despair: 60 years to Death:** During the time of decline in physical and mental powers, feeling the proximity of death, and reappraisal of accomplishments (and who actually deserves credit for them). Not so much like Sinatra, “I Did It My Way”; more like Stevie Ray Vaughn, “Livin’ Life by the Drop.” Successfully negotiating this stage means handing over the reins to the next generation—and not being too nervous about it. Associated with extreme alienation and despair. Ideological commitment v. confusion of values.

The point is that there are many roads to a working formulation, depending on what is emphasized in the model used to conceptualize people’s problems. The dynamic model is just one of those, but one for which a fairly detailed discussion is helpful.

There are many examples of maladaptive defensive functioning in general hospital patients that the psychiatric consultant is called upon to identify and to assist with:

- The cancer or heart failure patient displaying denial
- The patient with pseudoseizures on the Neurology service
- The patient with severe personality disorder who splits the staff on the surgical floor.

Case formulations can be both descriptive and explanatory. One way to outline the structure could be as follows:

**Case Formulation:**

**Summary statement**

**Diagnostic and pathophysiologic (what kind of illness does the patient have?)**

- Brief, concise distillation of facts bringing patient to clinical attention
- Description of symptoms
  - Predisposing factors
  - Precipitating factors
  - Promoting factors
  - Protective factors
- Fit behavior to diagnostic criteria

**Psychodynamic explanation**

**Etiologic (What kind of patient has the illness?)**

- Nondynamic factors
− State pertinent genetic, medical factors playing role
− Psychodynamic explanation of central conflicts
  − Interpretation of how past developmental conflicts or trauma led to symptoms or the present maladaptive behavior pattern

**Therapeutic approach**

**Prognosis (defenses and resistance)**

The description of defenses (or resistance, which amounts to the same thing) rests on an adequate knowledge of what defenses are. George Vaillant referred to them one of the three different means by which people cope with threats, the other two being social supports and cognitive coping strategies.

Defenses are largely involuntary regulatory coping processes. They are unconscious distortions of inner and outer reality in the service of protecting the ego from disorganizing anxiety and depression. They often strike other people as being odd, but are not invariably the product of diseased minds. They may also mature over time.

Confronting people with their defenses or eagerly interpreting them at inopportune times is almost always wrong. Learning to recognize them in order to make sense of otherwise inexplicable behavior and to make rough predictions about response to therapy is almost always helpful.

The authors of the Diagnostic and Statistical Manual IV-TR (DSM IV-TR) believe that defense mechanisms could be noted on a proposed separate Axis. This would be called the Defensive Functioning Scale:

**Recording Form: Defensive Functioning Scale (adapted from DSM IV-TR)**

A. Current Defenses or Coping Styles: List in order, beginning with most prominent defenses or coping styles.

1. _______________________
2. _______________________
3. _______________________
4. _______________________

B. Predominant Current Defense Level: ____________________

Example:

Axis I: Major Depressive Disorder
Axis II: Borderline Personality Disorder
Axis III: Diabetes Mellitus
Axis IV: legal problems
Axis V: 50

A. Current Defenses or Coping Styles:
   1. Projective identification
   2. Acting out
   3. Splitting

B. Predominant Current Defense Level: Acting out level

Ego defenses in DSM-IV-TR generally follow the taxonomy of Vaillant. The abbreviated list that follows defines the more commonly observed defenses. The reader is encouraged to supplement understanding by reading the relevant references, e.g., Vaillant’s “The Wisdom of the Ego,” and the DSM-IV-TR appendix on defensive functioning:

**Psychotic Defenses/Level of Defensive Dysregulation:** Profoundly alters perception of external reality to reduce unbearable conflict.

- Psychotic denial: gross impairment in reality testing resulting from attempting to cope with stress by ignoring external reality.
- Delusional projection: distortion of external reality, (often driven by overactive conscience) usually by disavowing one’s own unacceptable impulses by tossing them out to others, usually creating a persecutory environment.
- Distortion: distortion of external reality, but this is driven more by the need to get one’s own needs met. In delusional projection, unacceptable impulses are assigned to others, but in distortion they tend to be replaced with their opposites.

**Comments:** The above defenses are most often seen in patients with psychotic disorders, but may be seen in normal children under the age of five, and in adult dreams and fantasy. One example of how they might trigger a psychiatric consult in the general hospital is the patient who is irrationally refusing evaluation and treatment for a life-threatening disease such as cancer because he doesn’t believe or accept the medical diagnosis (psychotic denial). Treatment is usually antipsychotics, hospitalization.

**Immature Defenses/Major Image-Distorting, Action, and Disavowal Levels:** Common in personality disorders, in many adult patients in psychotherapy, and in most children and adolescents from age 3 to 15. They provide a means to reduce stress in interpersonal relationships threatened by intimacy or loss, often by tossing out (projecting) insupportable conflict or unacceptable emotions.

- Acting out: Direct expression of unconscious wish or impulse in order to block out the unacceptable emotion or idea that rides along with it. The behavior is often provocative or obnoxious enough to strain credibility that the patient is completely unaware of why he’s misbehaving.
- Projection: Tossing out one’s own unacknowledged feelings to others. These individuals may appear abrasive, eccentric, prejudiced, even somewhat paranoid, but are not completely divorced from external reality.
Projective identification: Usually distinguished from projection by involving another person upon whom the unacceptable impulses are projected (call her the “object”). If the object identifies with the impulse that the subject is tossing out, and reacts with a reciprocal defense, a dyadic interplay develops in which the subject in some way attempts to master the conflict he’s experiencing by inducing it in the object (“Why are you so mad?” “I’m not mad.” “Stop yelling.” “I’M NOT YELLING!” “You should see a therapist.”)

Hypochondriasis: The patient transforms unacceptable reproach toward others arising from unacceptable aggression, or loneliness into, first, self-reproach, and then somatic complaints. Unlike conversion hysteria, in which pain and distress are often ignored, pain and distress are amplified in order to burden others.

Dissociation (Neurotic Denial): Temporary but profound modification of one’s sense of personal identity to avoid emotional distress. This may include fugues, conversion reactions, counterphobic behavior, the acute use of religious joy or intoxicants to blot out unhappiness. This is listed in the Neurotic Defenses category in the *DSM-IV-TR*, but seems more appropriate, according to Vaillant’s 1993 organization, in the Immature category because it turns up so frequently in patients with severe Borderline Personality Disorder, who may report having multiple personalities, i.e., Dissociative Disorder. It denies internal, not external, reality. Although Vaillant himself thought of dissociation as not annoying others (and therefore just as accurately placed in the Neurotic category as he did in earlier work), there are probably many who would argue the point. However, this could be because of the difficulty of distinguishing dissociation from lying, the latter often suspected when someone claims that one of her “alters” was actually responsible for some misdeed.

Comments: Patients with severe personality disorders can wreak havoc on open medical-surgical wards. The utility of recognizing what role defense mechanisms play in these arenas lies, not so much in making ill-advised interpretations to the patients, but in educating the sometimes beleaguered nursing and medical staff about how and why they’re being interfered with. Fundamentally altering these behaviors in conventional psychotherapy is an uncommon feat.

Neurotic Defenses/Minor Image-Distorting and Mental Inhibitions (Compromise Formation)
Levels: These are common in otherwise normal people who may appear quirky to others. They alter private feelings or instinctual expressions, and may be less intrusive in interpersonal relationships than the Immature Defenses. They can often be changed in psychotherapy. People who deploy them often are able to sustain relationships by other more adaptive means.

Intellectualization (Isolation of Affect): These are listed as separate categories in the *DSM-IV-TR*, but Vaillant considers them as occurring together frequently, along with rationalization, ritual, and undoing. The person deploying this usually thinks about instinctual wishes in an affectively arid way without acting on them. An observer might find someone like this “coldly scientific” when describing experiences generally assumed to have an affective charge. They pay too much attention to external and irrelevant details in order to avoid expression of inner feelings.

Repression: Unlike intellectualization, affect is prominent in repression, but the accompanying idea is absent. According to Vaillant: “If a man were weeping but forgot for whom he wept, this would be repression; if he denied the existence of his tears or insisted that the mourned one was still alive, this would be denial.”
Reaction Formation: Behavior that is diametrically opposed to an unacceptable wish or impulse. Someone may overtly care for someone when one wishes to be cared for, or “loving” a hated rival. To paraphrase Vaillant, does the Iraqi insurgent truly believe he’s immortal (distortion), or only that he’s very lucky to die in a suicide bombing (reaction formation)?

Displacement: The redirection of strong feelings away from the original people or situation that aroused them to less cared for objects. It involves the substitution of things or strangers for emotionally important figures. Conversion reactions, practical jokes, phobias, and some forms of prejudice involve displacement. An important variant of displacement is transference, used in psychodynamic psychotherapy to create an attenuated approximation of a past important relationship (often parent-child). The attachment to the parent is displaced or transferred to the therapist, who can then act as a supportive witness, guide, and interpreter of key emotions that arise within the transference.

**Comments:** These defenses are common, and probably are the most amenable to change via psychotherapy. They may become more prominent in acute medical illness, or persons deploying them may regress while struggling with a medical crisis and use the more immature defenses. Making interpretations for these patients should be done sparingly unless one is prepared to help them deal with the anxiety that often ensues. This is a rare luxury in the general hospital, where stays are often short, the consultant having time only for one or two visits.

**Mature Defenses/High Adaptive Level:** These allow people to experience their affects, ideas, objects of relationships and experiences in the round more or less. They result in optimal adaptation. However, like all defenses, they are deployed unconsciously.

Altruism: Vicarious but constructive and emotionally gratifying service to others. It provides real benefit both to others and the subject.

Humor: Deployed to help one deal with emotional or situational stressors by focusing on the amusing or ironic aspects. It’s not synonymous with wit, sarcasm, practical jokery, or parody, as there tends to be an element of passive-aggression in these. Humor accrues with maturity and allows enjoyment of pleasure in spite of distressing affects that interfere with it. Difficult to describe or analyze, but instantly recognizable in the field, when a seriously medically and psychiatrically ill patient displays it, the psychiatric consultant usually responds with a smile, wonder, and a sigh of relief.

Suppression: The conscious or semiconscious decision to postpone thinking about difficult problems, impulses, or conflicts. Its consistent use correlates highly with ego strength.

**Comments:** Under sufficient stress in the medical setting, anyone may regress from mature defensive functioning to less adaptive forms.

Try this short exercise in identifying some defense mechanisms. Answers are at the end of the section.

- Repression, the removal of threatening thought forms awareness.
- Projection, the attribution of unacceptable impulses to others.
• Denial, the refusal to recognize a threatening external situation or thought.
• Rationalization, giving a reasonable explanation for an event.
• Regression, the return to a less mature, anxiety-reducing behavior.
• Reaction formation, the expression of the opposite of disturbing ideas.
• Displacement, the substitution of a less threatening object for impulses.
• Sublimation, the channeling of impulses to socially acceptable outlets.

Match the defense mechanism with the situations below:

1. Agnes refuses to let the surgeons do a biopsy of her breast lump, claiming that “I don’t know what the fuss is all about; there’s nothing wrong with me.”
2. After some especially frustrating and direct criticism from her primary care doctor, Sybil starts an argument with her roommate during lunch.
3. Wayne has no memory of this third grade class field trip which was marred by his being fondled by a teacher’s aide who threatened him if he told anyone about it.
4. Frank explains his high blood sugars at the family practice clinic by noting that he has a lot of work and parental responsibilities that prevent him from doing regular Accu-Checks.
5. Katie, who was a heavy pot smoker just a few months ago, writes the clinic supervisor demanding mandatory random urine drug screens for all clinic employees.
6. Lyle uses his anger over a disagreement with a colleague to set a hospital record in the number of laparoscopic surgeries performed.
7. George, who thinks that all his female patients are sexually attracted to him, automatically subtracts 10 beats from their pulses when he examines them because he thinks that their heart rates soar just being near him.
8. After an especially traumatic day, during which three doctors told her that she had to lose weight, Oprah curls up in a blanket and rocks herself to sleep.

Making useful case formulations can be frustrating for both trainees and experienced clinicians. On the other hand, if it’s not, there’s a good chance that oversimplification is becoming a problem. One pitfall that ironically comes with experience is dashing off a formulation that sounds deep using “psychobabble” but which misses the mark in describing the patient’s problems in the real world. Striking a balance between over inclusiveness and superficiality takes practice. Often, tying the formulation to only one model seems constrictive.
In general, making an integrative synthesis of the relevant factors in a patient’s clinical situation (abstracted from the history) is easier than making an integrative inference about why her problem exists. It helps to look for clues in the form of repetitive themes in a patient’s life that lead to conflicts that are resolved in maladaptive ways. There is no standardized format, and so there may seem to be as many formulation strategies as there are clinicians. Starting with a manageable framework can help:

This is a **age, employment status, illness state (acutely v. chronically ill), marital status, male/female, with psychiatric symptoms list, duration of** complicated by, **head injury, substance abuse, medical syndromes**, that we were asked to evaluate because of **consult requestor question**. She meets criteria for **DSM-IV-TR diagnosis**.

Her psychiatric symptoms **can be associated with or precipitated by medical diagnoses**. They are also known **to have familial pattern, affected/exacerbated by drugs, environmental triggers**.

The current behavior may have been determined by a developmental background **marked by abuse, neglect, conflict in family of origin, maintained longitudinally by pattern of maladaptive management of relationships and situational stressors**. Although cross-sectional exam cannot typically confirm one central conflict, she may have difficulties with **independence v. dependence, intimacy v. isolation, generativity v. stagnation**.

Typical defenses may include **acting out, denial, reaction formation, etc**. which appears to be **interfering with medical management, not an issue on the ward**, and may be predictive of **chronic noncompliance with therapy, conflict with caregivers, eventual return to adaptive coping, etc**.

Although the scaffold looks unwieldy and long, in practice (and with practice) it can be tailored to fit the clinical need. The phrases in bold type are the connectors that guide thinking and writing about the patient and help keep the focus on central issues.

Certain neuropsychiatric problems seen by consultants don’t require any detailed analysis of defenses, e.g., uncomplicated drug-induced deliria in patients without any psychiatric histories. But just because someone does have a complicated psychiatric history doesn’t imply that the formulation must be long and detailed. The goal is always to succinctly summarize the central issues that describe and explain the patient’s current problems so as to guide recommendations for management.

**Example case formulations:**

- 44 year old multiply divorced, alcoholic, unemployed white male without formal psych history, but with acute subsyndromal depressive symptoms without suicidality in the context of recent diagnosis of diabetes mellitus after being hospitalized with DKA. His father (who also had diabetes) died of suicide when the patient was 9 years old. Consult triggered by patient refusing to get up to toilet himself, crying, insulting the nurses, yet constantly on his call light. Depression is known to be associated with DM and can run in families. He may be conflicted between dependence and independence or struggling with stagnation developmentally, given his social and occupational marginalization. Regression appears to be major defense. Tolerance of nonthreatening behavior and allowing him control over non-essential features of his care may facilitate face-saving return to more adaptive coping with grief. Monitor for development of a more well-defined depressive syndrome; supportive approach
with encouragement of affect but engage effective coping by modeling; query into past successful
problem solving.

- 37 year old divorced white female teacher aide with abrupt onset of medically unexplained slow,
garbled speech. Previous psych history notable for one brief hospitalization in her mid-teens after
impulsive overdose over a breakup with boyfriend. Temporal association of dysarthria with her
discovering her current boyfriend in bed with her teenage daughter (reported by a friend). Consistent
with conversion reaction. Major conflict is desire to confront boyfriend but fear of rejection and
abandonment. Major defense is somatization. Confrontation generally contraindicated; suggest that
recovery will be fairly rapid; no invasive procedures or specialist referrals needed, condition not
dangerous. Quick followup in mental health clinic scheduled.

- 57 year old disabled man status post liver transplant with polysubstance dependence in remission and
longstanding sociopathy referred for subsyndromal depression and anxiety along with insomnia.
Recently arrested for shoplifting. Also engaging in reckless driving and fistfights, neither of which he's
done in decades either. No organic brain disease identified that could explain the behavior. Possibly
struggling with generativity v. stagnation because of chronic unemployment leading to regressive acting
out. Refer to psychotherapy, although resistance expected with more acting out and non-adherence.

- 49 year old woman with Hepatitis C (HCV) on interferon (IFN) for last 3 months and with gradually
increasing symptoms of syndromal depression, personality change with marked irritability, and somatic
complaints. Previously diagnosed recurrent depression in the context of Cluster B personality traits
complicated by alcoholism and cocaine abuse, now in sustained full remission. Consult triggered by her
erupting in the GI clinic at the gastroenterologist’s suggestion that cutting interferon dose might be
recommended in light of her psychiatric status. She thinks that this means she’ll get cirrhosis, be denied
liver transplant because of her drug history, and be condemned to die of liver failure. She blames
doctors for missing the HCV diagnosis for years, yet feels stigmatized by everyone because of the
diagnosis, and at the mercy of doctors who control the only effective treatment. Several cognitive
distortions could be the issues in her depression including personalization, catastrophizing, control
fallacies and blaming. Interferon is also known to be associated with depression and cognitive
impairment. CBT intervention may be influenced by the latter side effect; SSRIs are effective drug
treatment of IFN-induced depression.

Answers to defense mechanism quiz:

1. Agnes is using denial because she refuses to acknowledge the possibility she may harbor a
cancer.

2. Sybil shows evidence of displacement in that she expressed her anger to a safer target than her
doctor.

3. Wayne has apparently repressed his memory of the field trip, probably because it was so
humiliating and frightening to him.
4. Frank’s apparently rational explanation doesn’t really explain why he failed to check his blood sugars, so this is an example of \textit{rationalization}.

5. Katie’s new interest in preventing others from doing what she used to do illustrates \textit{reaction formation}.

6. Lyle has directed his anger into his operating room schedule, which describes \textit{sublimation}.

7. George’s physical exam taking behavior illustrates \textit{projection}.

8. Oprah’s rocking and curling up with a blanket illustrates \textit{regression}.

\textbf{REFERENCE LIST:}


Basic Systems and Disposition Pointers

Psychiatric Nursing

The Psychiatric Nurses are complementary to the Psychiatry Consult Service. Nurses on the inpatient Medical-Surgical units contact them directly for assistance with patients who need mainly medical psychotherapy. They also are in a better position to provide counseling interventions for family members of patients.

The Psychiatry Consult service finds the Psychiatric nursing staff invaluable when both psychotherapeutic and pharmacologic management issues are prominent. Referrals flow between the two services.

Medical-Psychiatry Inpatient Unit 4SE

The Medical-Psychiatry unit is a locked 12 bed ward where patients with complex medical and psychiatric problems are treated by a multidisciplinary team led by physicians boarded both in psychiatry and medicine, and consisting of nurses, a social worker, medical students, pharmacists, occupational and physical therapists who meet regularly to manage the overall care of these patients. Patients from other hospitals in the state and on the open medical and surgical units at UIHC can be transferred voluntarily or involuntarily to the unit.

The Medical-Psychiatry inpatient unit, in collaboration with the Chemical Dependency Unit, also sponsors and runs an opioid detoxification program for patients with chronic pain. This is designed for patients who have developed an opioid dependency (or other psychoactive medication dependency) and for whom outpatient detoxification efforts have been unsuccessful. They also must be willing to be admitted to the program voluntarily.

There are 4 steps to the program:

Step 1. Outpatient assessment by the Chemical Dependency Consultation Service to determine appropriateness for the program.

Step 2. Voluntary admission to Medical Psychiatry for 4-5 days for
   1. Detoxification
   2. Workup of medical problems as indicated
   3. Optimization of nonnarcotic pain medication regimen
   4. Initiation of counseling for chemical dependency

Step 3. A 2-3 week admission to the Chemical Dependency Partial Hospital Program.

Step 4. Discharge planning for aftercare and communication with health care providers in the local community to prevent relapse.

Patients can be referred by submitting a consultation request to the Chemical Dependency Service. State that the referral is for management of a narcotic (or other drug) dependent pain patient.
References


Medical Psychotherapy

Get a bird's eye view of the UI Consult Service.

Don't just do something; stand there.

In the highly specialized world of modern medicine, which uses sophisticated technology tending to increase the distance between physician and patient, the biomedical model meticulously focuses on the body and disease often to the exclusion of psychological and social influences. The person gets lost in the shuffle. The biopsychosocial model of medicine emphasizes the importance of recognizing how the human organism, achieves equilibrium between health and disease utilizing biological, psychological, and social means. Before the advent of advanced medical technology, physicians had to learn how to simply be with their patients, especially at difficult times, helping them grieve, clarifying the meaning of illness, and being willing to accept the idiosyncratic nature of coping with disease.

It's probably more important now than ever to learn the skills of medical psychotherapy, a specialized form of psychotherapeutic intervention. Our ability to help patients make sense of or withstand their reactions to illness and its treatment must keep pace with our ability to transplant their organs, install internal cardiovertor-defibrillators, keep them alive longer and longer with debilitating cancers and chronic infections like AIDS and Hepatitis C, and alter their body images with bariatric and cosmetic surgery. Otherwise they'll be at higher risk for suffering pathologic grief, depression, anxiety, post traumatic stress reactions, and existential crises, to name only a few of the negative consequences. And these adverse psychological reactions in turn can and do influence response to medical treatment, recovery and healing.

Enter the consulting psychiatrist, who is expected to apply these skills as a specialist in medicine. These skills can be used in the consultant's office, in traditional ways and means, including the couch, depending on the theoretical orientation. More often than not, the consultant must use them under “field” conditions: in crowded hospital wards with televisions blaring, IV pumps bleeping, assaulted by odors of the bedside commode, with frequent interruptions as the patient is whisked off to this or that diagnostic test (to return only hours later stuporous from sedatives).

It's easy to be put off by the name “medical psychotherapy”, and the oft used alternative, “psychotherapy in the medically ill” because it may suggest that there is something fundamentally different about who does it,
who gets it, and how it’s done. It may imply to some an attempt to make something special out of something mundane.

Medical psychotherapy is reasoned attention and communicated understanding between physicians and patients about intense emotions triggered by ill health so as to facilitate an adaptive response to illness, thereby preventing or moderating an abnormal illness response. It isn’t always necessarily a verbal exchange; sometimes all you have is someone on a ventilator who has frightened eyes and your own soothing voice-and your hand.

There are a great many questions asked by consultees and a wealth of literature about the types of problems, goals, patients, and techniques of medical psychotherapy. Sticking to the basics is critical. The first is what issues are typically addressed with medical psychotherapy?

Coping with medical illness is probably the most frequent issue addressed. According to Schlozman, this is problem-solving behavior with the main goal of re-establishing equilibrium or peace of mind. It may not include resolution of the primary problem, although it provides a coherent definition of it.

Assessment of coping skills:

- Focus on the here and now; past issues are relevant if they help delineate present problem and current mechanisms for dealing with problem
- Focus on problem solving skill sets and past successful problem solving
- Focus on the patient's strengths: intellectual, self-image, emotional, social supports
- Remember that medical illness is almost always stressful
- Remember that reaction to medical illness is often not proportional to actual risks and danger of the illness

Positive coping:

- Optimism about dealing with the problem
- High morale
- Realistic view of the problem
- Practical approach to the problem
  - Identify obstacles
  - Figure out how to overcome obstacles
  - Postpone thinking about long term until short term dealt with
- Resourceful and flexible in approach to the problem
- Willing to experience and comfort with expressing emotion
- Able to modulate strong emotion that may impair coping
- Open to suggestions and willing to learn
- Tend to avoid excessive conscious and unconscious assumptions about the problem and their knowledge of the problem
Negative coping:

- Tend to be rigid and inflexible in their ability to wrestle with the problem
- Tend to be rigid and inflexible in their expectations of others and of themselves
- Tend to be excessively suggestible without asking questions
- Tend to excessively rationalize
- Tend to deploy denial excessively
- Tend to neglect current issues
- Tend to be passive
- Tend to be impulsive (rigidity interrupted by rash decisions or actions)
- May have other problems in addition to the defined problem
  - Demoralization
  - Anhedonia with or without meeting criteria for depression
  - Substantial anxiety
  - Substantial pain
  - Substantial grief
  - Post traumatic stress reactions

The above are collective qualities; almost no one has all positive or all negative coping traits, and they are not uniformly present under all circumstances. Assess which qualities are present, support the positive ones, and gently encourage the patient toward adopting the qualities that may be lacking. Combining psychotherapy with medication for depression and anxiety that are impairing coping is a very useful strategy.

The Role of Religion and Spirituality

A great many people find religious faith and spirituality an important force in their lives. The point is not to minimize it as simply another coping mechanism, but to assess for it, and endorse it if it’s a positive part of the patient’s life story. One should never encourage religious conviction otherwise.

Studies of religious convictions during medical illness have led to contradictory findings:

- Some suggest that being “at peace with a sense of a higher power” predicts better outcome
- Others suggest that resentment and frustration with God, and a tendency to endorse Satanic influence predict worse outcome

Inquiring about the patient’s attitude toward religion and spirituality may yield important clues to how existential concerns are dealt with in the context of medical illness. Patients may have questions about whether or it’s just or fair for them get sick at this time in life, the personal meaning of terminal cancer or the possibility of death.

The Role of Self Identity and Relationships in Coping with Medical Illness

The developmental expectations and concerns of a 16 year old differ markedly from that of a 50 year old (see Erikson’s developmental stages). Disfigurement in a 16 year old may lead to worries about status among schoolmates; in 50 year old, it may trigger worries about the security of family. Developmental leaps as well as
regressions can occur. Try to get a sense of the patient’s sense of obligation to family, religion, employer, teacher, society.

**Examples of Coping Strategies Employed and What to Ask**

There are a variety of coping strategies that patients use in medical illness, some are classic defense mechanisms by themselves or influence other strategies:

- Get more information: intellectual approach
- Talk with others: social sharing
- Laugh it off: minimizing or reversal of affect
- Just don’t think about it: denial and suppression
- Accepting and redefining: reframing
- I give up: fatalism and passivity
- Gotta do something: impulsivity
- Focus on stress reduction
- Isolate and withdraw
- Blame someone else: externalizing and displacement
- Focus on important tasks other than the illness: sublimation
- Do whatever the doctors tell me: compliance and trust
- Atone and self-doubt

These strategies can be effective or ineffective, depending on the situation. Rather than assigning too much value to any one strategy, it may be preferable to assess how the strategy is working, and base recommendations on that assessment.

One may ask patients open and closed ended questions about their view of the problem and their typical method of coping:

- What has been most difficult for you since your illness started?
- What is currently most difficult for you?
- Are there any other concerns in addition to these difficulties?
- What have you done to cope with these difficulties?
- How has this strategy worked?

**The Process of Bereavement**

Since grieving was mentioned earlier as one of those additional issues that can complicate coping with medical illness, it’s worthwhile discussing it in more detail. In fact, it’s often the most salient aspect of a person’s response to illness, whether it’s a broken leg or a stroke. Illness is experienced as a loss—the loss of health. Even a minor illness can trigger feelings of loss because of the symbolic significance to the patient. This may, in turn, determine how they react affectively, behaviorally, and cognitively to an episode of illness.

Grief reactions to loss of health are commonly experienced as a process involving movement up or down through various stages as identified by Kubler-Ross: denial, anxiety, anger, depression, helplessness, and
resolution. Most patients work through these states (not necessarily sequentially), and reach a new state of emotional equilibrium. This usually entails a realistic assessment of the specific limitations caused by their disease, and a general acknowledgement of their frailty and ultimate mortality.

When a patient cannot negotiate this bereavement process effectively, then an abnormal emotional response to illness can result. Complete denial of all emotions or, more commonly, the experience of a specific emotion, e.g., depression or anxiety, to the relative exclusion of all others can occur. Getting stalled in the grief process can delay resolution of the emotional conflicts surrounding the loss of health. It can also lead to disruptions in relationships, trigger regressions, acting out, and depression, which are all signs of pathologic grief. It can also have effects on somatic functioning, leading to psychobiologic disequilibrium that may be more disabling than the original illness.

The most frequent abnormal psychological reactions to illness are denial, anxiety, anger, depression, and dependency. Not all patients will tolerate exploration of their disordered grief reactions. It provokes insupportable anxiety and regression in certain patients with immature defenses or a fundamentally concrete style of perceiving, evaluation, and discussing life events:

Alexithymia is a trait defined as the inability to express psychological distress in verbal terms. These patients are only frustrated by questions about their feelings, which they can’t recognize or describe. Whether or not this is hard wired in the brain is debatable, but it should be distinguished from repression, one of the neurotic defense mechanism (see previous chapter’s section on formulation), in which an affect is displayed without the conscious awareness of the inciting impulse or conflict. It should also be distinguished from isolation of affect and intellectualization, in which stressful wishes or impulses are described without the accompanying affect. Patients deploying defenses mechanisms like these are more often than not amenable to insight oriented psychotherapy, while alexithymic individuals generally get along better with a supportive approach.

Somatothymia, a concept described by Stoudemire, is the tendency for some patients to use somatically based words to describe subjective perceptions of physical sensations that accompany psychological distress. This may go unrecognized by physicians, leading to frustration in both sides of the doctor-patient dyad. It can be a feature of patients with somatoform disorders, and may be susceptible to supportive psychoeducation.

The above suggests a widely recognized notion, which is that some patients may tolerate primarily supportive, anxiety-suppressing psychotherapy while others may do better with introspective, anxiety-provoking psychotherapy.

Who gets what? This prescriptive psychotherapeutic decision is largely driven by an examination of the illness dynamics of the patient, which involves the interplay among biologic, psychological, and social components and is highly idiosyncratic (table adapted from Green):

**Illness Dynamics:**

- **Biologic**
  - Nature of the disease
  - Baseline physical resilience

- **Psychological**
  - Maturity of ego function and object relationships
    - Intellectual skills
• Educational and occupational achievements
• Level of autonomy and ability to assume responsibility
• Defensive functioning level
• Pattern of interpersonal interactions, e.g., passive, superficial, idealize/devalue, mutual
  o Personality type
  o Life cycle stage
  o Interpersonal aspects of doctor-patient dyad
  o Past psychiatric history
  o Effect of medical history on attitude toward treatment

• Social
  o Dynamics of family relationships
  o Family attitude toward illness
  o Level of interpersonal functioning
  o Cultural attitudes

Psychiatric illness, level of ego functioning, and the disease itself, e.g., brain cancer, affect the decision about which form of psychotherapy to prescribe. In general, the more willing a patient is to tolerate self-scrutiny, and the more motivated for emotional change, the more likely that introspective, anxiety-provoking psychotherapy will be helpful. On the other hand, desire for quick symptomatic relief, immature defensive structure, and long-standing patterns of maladaptive coping argue for supportive, anxiety-suppressing psychotherapy.

Supportive, Anxiety-Suppressing Psychotherapy:

• Active, supportive, personable, conversational style
• Focus on symptomatic relief rather than structural intrapsychic change
• Set concrete, controllable, practical goals
• Dissipate strong emotions
• Exploit positive transference; prefer clarification over interpretation
• Modify external environment, prescribe medications
• Suggestion, education, and guidance
• Identify and maintain adaptive defensive structure, e.g., denial is not uniformly evil, such as that deployed following myocardial infarction
• Bolster self esteem
• Focus on the here and now

Introspective, Anxiety-Provoking Psychotherapy:

• Promote psychological maturation
• Exploit turmoil of emotional upheaval
• Help patients acknowledge, tolerate, and put into proper perspective painful feelings
• Clarify and interpret positive and negative transference, defenses, interrelationships between:
  o Libidinal impulses, the anxiety they provoke and defenses used to contain them
  o Lifelong patterns of object relationships that characterize historical past, current existence, and transference relationship
• Move the patient through the grief process over loss of health to resolution

By way of review of definition of two key terms, transference is the positive or negative displacement by a patient of libidinal impulses, affects, conflicts that originated in a historical past relationship (often parent-child) on to a current relationship, either in or out of formal therapy. Countertransference just takes this process and spins it around, so that the displacer is the therapist, reminding one that everybody carries around some sort of emotional baggage. When transference is “metabolized”, feelings, conflicts, etc., are acknowledged, contained, and integrated with a newly synthesized sense of self (hopefully more mature). You can make your own guesses about what gets “excreted”, but “flushing” with excitement can occur during this process as one external manifestation.

Abnormal illness responses mentioned earlier, e.g., denial, anger, etc., are generally dealt with by some combination of supportive and introspective techniques in the patient who is generally emotionally healthy and only temporarily demoralized or mildly regressed. Those with chronic medical illness may do better with a preponderance of supportive techniques. Those who are acutely unraveling may also do better with medications adjunctively with supportive therapy.

Then there is the special group of patients, often identified as “difficult”. Groves referred to them as the “hateful” patients. Two major sub-groups are chronic somatizers and Cluster B personality disordered individuals, mainly with Borderline and Antisocial personality disorders. They often co-occur, complicated by substance abuse. The consultation requests often have a depressed, testy, exhausted, arrogant, or frightened tone because of the pressure these patients place on caregivers. Often, there’s an expectation that the consultant take over the patient’s care, or at least talk him/her into cooperating. How would medical psychotherapy be applied under these circumstances?

Medical Psychotherapy in Special Cases:

In some cases, it’s preferable to think outside the box when conceptualizing psychotherapy in the context of a one time consultation. An example would be the request to “evaluate” the chronic somatizer, either in the outpatient clinic or in the hospital. There is often no distinctly formulated question, and the primary problem may be misidentified as depression and anxiety, rather than abnormal illness behavior. The patient may be undergoing or about to undergo yet another series of invasive diagnostic tests or trials of obnoxious or potentially addictive drugs—all for unexplained somatic complaints. At some point, the consultee gets exasperated, throws up her hands and wants the psychiatric consultant to “counsel” the patient about these complaints that are “all in his head”.

Firstly, it’s vital for the consultant to avoid interpreting the consultee’s negative countertransference. After that, the consultant’s negative countertransference must be “metabolized”. Check your own pulse. The psychodynamically informed interviewer in these situations may often make use of a few therapeutic techniques:

• **Validation**: empathic statements acknowledging the “real” nature of the patient’s suffering without endorsing the belief that a physiologic abnormality or specific disease is present

• **Clarification**: operationally, this is repeating of the patient’s description of symptoms, her appraisal of her illness, etc. back to her, so as to assure her that you’re listening, and to give her an opportunity to reassess the sensibility or lack thereof of her understanding of the problem
• **Affirmation:** positive acknowledgement of what is accurate in the patient’s estimation of the problem, and the right she has to equal opportunity to evaluation and treatment of medical illness

• **Reattribution (a form of strategic reframing):** gently suggesting alternative explanations for somatic illness, including psychosocial causes, or redefining the symptoms in terms of a different paradigm, e.g., “both/and” rather than “either/or” concept of illness to avoid the problematic Cartesian dualism often a part of their set of assumptions about the world

The consultant generally cannot accomplish all of the above in a single visit; usually reattribution can take many months, even years. Some patients never accept reattribution. Contrary to traditional belief, some, (perhaps a sizable number) will tolerate delivery of the diagnosis of somatoform illness during a single consultation visit. This is useful for a couple of reasons. Psychoeducation about the disorder as psychiatry defines it forestalls shocked surprise and indignation from the patient when she sees the diagnosis listed on an insurance statement. And frequently, many patients are relieved to finally have a definite name given to what has been troubling them for so long. This strengthens the alliance and may foretell future readiness for more structured forms of intervention, such as cognitive behavioral psychotherapy.

Unfortunately, a few will not tolerate delivery of the diagnosis, reattribution, or even clarification. Unless they are doing deliberate harm to themselves, confrontation generally threatens them too much and weakens the alliance. Some may deploy primitive defenses such as splitting, projective identification, acting out, denial, and dissociation. This usually signals the presence of a **borderline personality organization**. Although it is dangerous to try to confront and change primitive defenses in brief encounters in the general hospital, it is critical to be aware of them.

Common characteristics of the patient with borderline personality organization:

- Narcissistic entitlement
  - Limited empathy
  - No benefit of a doubt
- Paranoid distrust
  - Exquisitely sensitive to foibles, vulnerabilities, inconsistencies of treaters
- Dramatic over involvement
- Demanding, rageful, absorbed by shame
- Elicit dangerous countertransference: overconcern, revulsion, counter-attacking

Such patients can wreak havoc in the medical setting, which is a social system with its own history, hierarchy, customs, and boundaries. The stress of illness and treatment overwhelms the patient’s already shaky defenses. This in turn leads to the mobilization of more primitive defenses, which can lead, eventually, to rejection of the patient. Often, rather than focusing on the patient, the consultant is advised to adopt a consultee-oriented approach. This involves conceptualizing the patient and the medical staff as a single entity and dealing as much as possible with the healthy part. With this approach, countertransference hatred and fear are drawn away from the patient and metabolized within the staff-consultant relationship. The consultant places a behavior management plan in the chart (taken from Groves):

- Acknowledge the real stresses of the patient’s situation
- Avoid breaking down needed defenses
• Avoid overstimulation of the patient’s wish for closeness
• Avoid overstimulation of the patient’s rage
• Avoid confrontation of narcissistic entitlement
• Promote daily communication among all members of treatment team involved in the patient’s care to avoid splitting
• Provide consistent staffing as much as possible
• Set firm limits on obnoxious, dangerous, manipulative, rageful, dependent behavior

Guidance on specific details, especially about setting limits and avoiding confrontation of entitlement, is necessary. It should be tailored to the patient and the ward culture.

Making the alliance with the staff rather than the patient may seem counterintuitive. After all, shouldn’t the patient be the one receiving the psychotherapy? According to Grove, such patients are incapable of forming a real alliance, since what they tend to do is engage in primitive idealization, followed quickly by devaluation. The consultant is just one more element to split into a “good” or a “bad” camp. In the early stages, visiting with the patient is done mainly in the service of a strategic building of an alliance with the medical staff. After the initial interview, the consultant returns mainly:

• When a magical gesture of “taking over” is needed to comfort a desperate staff
• When staff members feel that the consultant doesn’t know how much they are suffering
• When staff need a specific model for carrying out recommendations on limit-setting or reality testing

At all times, under these circumstances it is best to observe noninterpretive intervention. This means that the consultant consistently avoids pointing out unconscious motivations of the patient or the staff to either of them. This tends to foster regression, and the medical-surgical ward is no place for that, since there is no consistent way to control it.

Confrontational versus non-confrontational methods of dealing with patients who are engaging in factitious behavior (see chapter 6) are the subject of some debate. Confrontation in this context has less to do with psychotherapy and more to do with control of self-harm behavior and patient safety.

One form of non-confrontational communication (the so-called therapeutic double bind) about intentional self-harm behavior that does not have imminent, life or limb threatening consequences is controversial. It should generally be reserved for use after all other attempts at therapeutic engagement have failed (Eisendrath). The consultation is generated by a clinician who sometimes has sufficient and convincing evidence of the patient’s pattern of engaging in conscious disease manufacturing and refers her for “counseling”.

Almost invariably, the patient professes to be completely ignorant of the reason why she was referred to a consulting psychiatrist. Approximate or near-miss interpretations, which involve the consultant saying something like, “Sometimes when patients are feeling very depressed or guilty, they think they deserve punishment, and so they may torture themselves in various ways because they think they deserve it. Have you ever punished yourself in this way?”, may result in bland denial. The factitious disorder patient is motivated to conceal her self-harm and disease-production, making the development of an alliance impossible.
The therapeutic double-bind is employed when the consultant and the consultee perceive no other way possible to interrupt a pattern of intentional disease production which is threatening to become dangerous or slowly escalating. It capitalizes on the dilemma that a patient of this type has when confronted with a choice of either giving up the abnormal illness behavior or being identified as a psychiatric patient. The underlying assumption of the treater is that the patient, in order to avoid discovery, will be more inclined to give up the illness behavior, at least temporarily, then to allow herself to be diagnosed with a severe mental illness.

The consultant conducts the double-bind by pretending not to be aware of the factitious nature of the patient’s disorder. Instead, he adopts a conditional approach:

“I’m not clear on what’s going on here. If this condition is purely medical, then it will resolve shortly after Dr. X’s proposed next conservative treatment trial. If it does not resolve, then the actual explanation for your difficulty may be a serious mental illness called Factitious Disorder.”

The consultant then goes on to carefully explain the diagnosis and the potential consequences for the patient of being identified as psychiatrically ill, all the way up to being certified and confined on a locked psychiatric unit for her safety.

The technique has obvious ethical and practical ramifications. In actual practice, most patients figure out that “the game is up” while the speech is being made and simply flee to carry out the charade with another set of doctors elsewhere. And it tends to be ineffective with those who manufacture psychiatric illness. It’s legitimate to ask if concern about patient safety is sufficient grounds to justify being less than straightforward with the patient. And is the other reason to employ it, that confrontation usually results in the immediate angry Against Medical Discharge and litigious threats, a legitimate reason as well? Does this take therapeutic manipulation too far and become coercion, especially when, in most clinical situations, both the patient and the psychiatric consultant are tacitly aware of what the stakes are? Are we doing the patient and our profession a disservice by engaging in the very kind of duplicity that we condemn in her?

There are no easy answers to questions like these; each patient has to be considered individually on a case by case basis in order to decide on the proper approach to therapeutic management.

Fortunately, there are some difficult patients who may respond to therapeutic negotiation. Often, in the general hospital, patients, medical staff, and consultants seem to be at an impasse. Therapeutic negotiation has been divided into three stages by Gordon:

1. **Beginning:** getting the Nod
2. **Middle:** finding the edge; generating options
3. **End:** negotiating a path forward

*Getting the Nod* refers to gaining just enough rapport that the consultant gets permission to at least have a place to start negotiating with the patient. *Finding the edge* means getting to a place where the patient gets a glimmer that part of the problem may lie within him. At that point he may be more open to exploring more choices of action. Negotiating a path forward may mean not much more than agreeing to meet again.

After the consultant gets the nod, she may try formulating the problem to the patient almost in the same way that she would formulate the case in the consultation report, though there are important differences, i.e.,
common sense terms instead of clinical language. Using four models in specific ways may help organize the patient’s struggle for himself and the medical staff:

- **Biological:** “chemical imbalance”
- **Social:** current stressor, e.g., financial straits
- **Psychological:** past stressor, a pattern that may be hard to see and change, e.g., unresolved grief
- **Spiritual:** crisis in life’s meaning, e.g., death of a child

As much as possible, the consultant should try to employ “pull” strategies rather than “push” strategies (from Rubin). Pushing implies trying to influence someone to do what the consultant wants. Pulling means trying to let the patient do what he wants:

- **Push**
  - Describe
  - Prescribe
  - Appreciate
  - Inspire
- **Pull**
  - Attend
  - Ask
  - Understand
  - Empathize

Putting the patient into the position of principal and participant, even a teacher, is important in reaching an agreement to a crisis plan. Avoid common pitfalls:

- Counter-attacking
- Shaming
- Overindulging
- Abandoning
- Accommodate, accommodate, accommodate…explode

**REFERENCES:**


Chapter 4

Diagnosis and Management of Delirium

Delirium is the great masquerader. It can look like a great many primary psychiatric disorders because it is a total brain disturbance.

Delirium is a common psychiatric disorder in the medically ill. It is mainly a disturbance of consciousness that has an abrupt onset and is associated with fluctuating abnormalities in cognition, perception, emotions, and behavior. The disturbance is often not recognized by non-psychiatric clinicians and sometimes psychiatrists. Those afflicted with delirium are usually inpatients and, in the population, we are often called upon to control agitation, determine a cause, or treat “depression” with which delirium is often confused. Delirium is a sign of serious underlying systemic illness, and frequently, the afflicted patients need emergency treatment. It is often a harbinger of significant morbidity and mortality, and frequently leads to increased in-hospital complications and length of stay. Many patients with delirium have severe agitation that places them and others involved in their care at risk for physical injury.

Epidemiology

The estimated prevalence of delirium in the general hospital is about 20% and can be as high as 40% in the elderly. About 25% of hospitalized cancer patients have delirium and nearly 80% of the terminally ill develop delirium near death. The rate is high on services where medical acuity is high, e.g., burn units and intensive care units.

Risk Factors for Delirium Include:

- Age over 65
- Dementia
- CNS abnormalities
- Low albumin
- Multiple medications
- Multiple medical illnesses
SURGERIES AND MEDICAL ILLNESSES ASSOCIATED WITH HIGHER RISK FOR DELIRIUM INCLUDE:

- cardiotomy
- hip surgery
- transplant surgery
- burn injuries
- central nervous system lesions

In-hospital complications of delirium include decubitus ulcers, pulmonary emboli, and pneumonia. Seizures can occur in alcohol withdrawal delirium. Delirious patients also have longer recuperation times and often incur long-term disability. High mortality is associated mainly with severe medical illness and advanced age.

**ETIOLOGY**

There are many causes of delirium and more often than not, the disorder has multiple etiologies. Some causes of delirium are associated with irreversible central nervous system injury or death if they are not recognized and treated quickly. A useful mnemonic is WHHHHIMP for remembering these etiologies that require urgent attention:

- Wernicke’s encephalopathy
- Hypoperfusion
- Hypoglycemia
- Hypertensive encephalopathy
- Hypoxia
- Intracranial bleed
- Meningitis
- Poisons / medications
MEDICATIONS FROM JUST ABOUT EVERY CLASS HAVE BEEN ASSOCIATED WITH DELIRIUM, AS EXEMPLIFIED BY THE FOLLOWING LIST:

- anticholinergic drugs
- antimicrobials
- antiasthmatics
- muscle relaxants
- antihypertensives & cardiovascular medications
- benzodiazepines & alcohol
- narcotics

An excellent source of information about prescription drugs that may be associated with delirium is Psychiatric Side Effects of Prescription and Over-The-Counter Medications by Stoudemire and Brown. This book is available in the staff consult office.

**CLINICAL PICTURE AND COURSE**

Delirium most often has an acute onset but some patients experience a prodrome of severe anxiety and autonomic instability. They may have poor short-term memory, display dependent behavior, or experience illusions, e.g.; an over-the-bed exercise bar may look like a gun. Later, they may become frankly disoriented, disorganized and have visual hallucinations. In most cases, the disorder lasts one to two weeks and resolves without residual. However, a few patients develop a chronic course or progress to dementia.

Fragmented sleep, sometimes with a complete reversal of the sleep-wake cycle is common in delirium. Asking family members or nurses about this is helpful in making the diagnosis. Sundowning is a deterioration of behavior marked by worsening agitation and disorientation that tends to occur at night. Frightening visual hallucinations and paranoid delusions may cause patients to jump out of bed and attempt to flee the ward. Fluctuations in behavior often lead to conflicting reports by clinical staff about the status of the patient, that, in themselves, are valuable clues to the diagnosis.

Depressed mood often leads clinicians to believe that primary mood or anxiety disorders are present. Although almost any psychiatric disturbance may co-exist with delirium, it is generally unwise to diagnose a primary psychiatric disorder, such as major depression, in the face of a delirium. When the delirium resolves, these associated features also tend to disappear. Adding antidepressants or anxiolytics may further confuse the clinical picture by adding psychotropic side effects to an already overburdened brain.

Disturbed psychomotor activity is also seen in delirium. Hypoactive and hyperactive delirium are subtypes described in the literature. The hyperactive or agitated patients quickly get the attention of clinicians because they climb out of bed, pull out their catheters and intravenous lines, and wander about the ward. Their agitation puts them at risk for injuries and other complications and leads to urgent requests for psychiatric consultation and pharmacologic management. Patients with hypoactive delirium are often ignored because they do not “raise a ruckus.” They may
generate consultation requests to evaluate for “depression” because they are immobile and display a flat affect. However, when carefully evaluated, they have the usual disorientation, inattentiveness, and perceptual disturbances diagnostic of delirium.

**DIAGNOSIS AND ASSESSMENT**

A. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.

B. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.

C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.

There is usually evidence from the history, physical examination, or laboratory tests for a physiological cause in the form of a general medical condition, substance intoxication or withdrawal. Etiologies include:

1. Delirium due to a general medical condition
2. Substance-induced delirium
3. Delirium due to multiple etiologies
4. Delirium not otherwise specified (idiopathic)

Simple bedside tests of attention and cognition are often helpful in making the diagnosis. The clock-drawing task is a quick test that assesses ability to sustain attention, use working memory, and organize. It has been standardized. The patient is instructed to draw a clock face from memory and to indicate the time 10 minutes after 11. The delirious patient typically makes a variety of errors including repeating or omitting numerals, placing numerals in the wrong quadrants and indicating the wrong time.

The 3-stage command from the Folstein Mini Mental Status Exam (see attachment) can be adapted as another quick test. The patient is told to stick out his tongue and touch his left earlobe with his right thumb. Surprisingly often, the patient touches his tongue with his thumb or stretches his tongue in a comical effort to reach his earlobe. It is important to remember that these tests are sensitive but not specific for delirium. Demented individuals will also frequently have trouble completing these tasks.

The Mini Mental Status Exam can be used to assess cognition. A score of less than 24 out of 30 should raise suspicion of a cognitive disturbance. However, limited education, learning disabilities, below average intelligence, and sensory impairment are factors that may alter interpretation of the MMSE.
The diagnostic work-up of delirium includes the usual complete history and physical exam along with a mental status exam. A close review of the medication list is essential. Suggested laboratory and special test evaluation is outlined in the following table:

<table>
<thead>
<tr>
<th>DELIRIUM WORKUP</th>
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<tr>
<td><strong>Common tests</strong></td>
</tr>
<tr>
<td>Electrolytes</td>
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<tr>
<td>Arterial blood gases</td>
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<td>Hemogram</td>
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<td>Urinalysis</td>
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<td>Chest x-ray</td>
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The electroencephalogram (EEG) can sometimes help to distinguish organic brain syndromes such as delirium from functional psychiatric syndromes such as depression. Usually the EEG shows a pattern consistent with diffuse brain dysfunction with slow wave activity in non-alcohol withdrawal delirium syndromes. Faster beta wave activity is typical for alcohol withdrawal delirium. However, not every patient with delirium will have an abnormal EEG.

Rating scales can also be used as diagnostic aids and to assess response to pharmacologic treatment. The Delirium Rating Scale (DRS) and the Memorial Delirium Assessment Scale (MDAS) are examples (see attached).

**DIFFERENTIAL DIAGNOSIS**  Delirium is common to several other organic psychiatric syndromes. It is important to recognize them because they are treated quite differently from delirium due to general medical causes.
Dementia should be distinguished from delirium. The onset of delirium is abrupt while that of dementia is gradual. Delirious patients have problems sustaining arousal. Clarity of awareness is preserved in dementia.

Catatonia is a rare neuropsychiatric syndrome marked by a variety of motor signs such as waxy flexibility, purposeless agitation, and rigidity. Behavioral signs such as mutism, immobility, psychosocial withdrawal, and bizarre repetitive behaviors are also seen. It is caused by many medical and psychiatric insults. Catatonia can be complicated by hyperpyrexia, elevated white blood cell count, elevated CPK, myoglobinuria resulting in renal failure, pulmonary embolism, and, until recently, it carried a 25% mortality rate. Antipsychotics ought to be avoided in catatonia, as they can cause the syndrome. Interviewing a patient after the administration of 1-2 mg of intravenous lorazepam may result in dramatic, although temporary, improvement and may be a diagnostic aid. The drug may also enable verbal communication with the patient. Scheduled doses of IV lorazepam have been effective in breaking the stupor and catalepsy, although benefit may not be sustained. Electroconvulsive therapy is the treatment of choice.

Neuroleptic malignant syndrome is similar in many ways to catatonia, except that it is caused by neuroleptic medication. Offending agents include anti-emetics, such as metoclopramide, as well as antipsychotics. Stopping the neuroleptic and supportive measures are the mainstays of management. Debate about the effectiveness of more specific forms of medical management, such as dantrolene and bromocriptine, continues. The role of electroconvulsive therapy is less than fully established but case reports indicate that some patients respond.

Serotonin syndrome is marked by autonomic instability, myoclonus, fever, diarrhea, shivering, and confusion. It is associated with increased serotonin levels and results from combinations of selective serotonin reuptake inhibitors and monoamine oxidase inhibitors as well as other combinations of serotonergic agents. The offending agents should be stopped, and supportive measures are the indicated treatment. However, lorazepam and cyproheptadine have been used with limited success according to case reports. Atherosclerotic heart disease and hepatic insufficiency have been identified as possible risk factors based on theoretical considerations about the pathogenesis.

Psychotic mania or disorganized schizophrenia may make patients appear delirious but usually they retain a clear sensorium.

Factitious disorder (Munchausen's Syndrome) or malingering is distinguished by the presence of feigned psychiatric symptoms including those of delirium. These disorders are rare.

**TREATMENT**

A few situations call for urgent interventions to prevent irreversible injury or death. Catatonia is considered an emergency because it is associated with a high mortality. Several deaths have occurred from toxic serotonin syndrome as well. Other causes of delirium requiring urgent management include hypoxia, malignant hypertension, and septicemia.

The management of delirium begins with treatment of the underlying medical illness and/or removal of the offending toxin. The need to monitor the patient closely to ensure safety cannot be overemphasized. Protecting the patient may require restraints even though their use may increase agitation. However, improper use of restraints may lead to serious injuries, even death. Assigning a sitter to observe the patient on a 24-hour basis is feasible only if someone is available.
When the patient cannot be managed on an unlocked medical ward, transfer to the locked medical-psychiatry unit (4SE) is necessary. If the patient is unable or unwilling to be admitted voluntarily, an order for involuntary hospitalization should be sought. The steps are

1. Notify the social worker on the floor of the intention to file for psychiatric commitment.

2. During normal working hours, complete both parts of Form L affidavit on the IPR for an immediate involuntary hold order describing the treatable mental illness and reason why immediate confinement on a locked unit is needed. After 3 PM, this option is not available. One must then wait until 5 PM to telephone the magistrate on call at 331-9858. If unanswered, call Johnson County Jail, 356-6025.

3. During normal working hours, the unit social worker will fax the order to the courthouse for the magistrate to review. If the order is signed, either the unit or the Psychiatry Business Office is notified. After 5 PM, depending on the magistrate’s preference, the magistrate gives the order by telephone and delivers a written document later, or he/she comes to the hospital and holds a brief hearing in the patient’s room.

When agitation becomes a problem, pharmacologic management is necessary. The medication of choice for the treatment of agitation in delirium is haloperidol. Numerous uncontrolled case studies show that it is effective in reducing the psychosis, disorganization, and psychomotor agitation. A controlled study by Breitbart, et al (1996) compared chlorpromazine, haloperidol, and lorazepam in delirious HIV patients. The results showed clear superiority for haloperidol in this population.

The intravenous route of administration of haloperidol is often preferred for two reasons, although the FDA has not approved this. In medically ill patients who are agitated, in restraints or unable to take medications orally, the intravenous route is the only one easily available. Secondly, the incidence of extrapyramidal side effects appears to be lower.

The common side effects of haloperidol include dystonias, parkinsonism, and an intense form of anxiety and motor restlessness called akathisia. Akathisia can be mistaken for worsening agitation, leading to rapidly escalating doses of haloperidol. Since this only exacerbates the problem, it is important to ask the patient if he or she is experiencing an inner restlessness which makes him or her want to move around or get up and pace. If the patient cannot speak, she may be observed to constantly move his or her legs in bed, bounce them incessantly, or “bicycle.”

Rare side effects include neuroleptic malignant syndrome and malignant cardiac arrhythmias. The latter may be heralded by a prolonged corrected QT interval (greater than 450 milliseconds) and torsades de pointes. Both of these adverse events are potentially life threatening and, if suspected, haloperidol should be immediately discontinued.

Dosing of haloperidol should be individualized based on the level of agitation. In general, a starting dose range of between 1-2 mg every 2-4 hours is reasonable. In the elderly start with 0.25-0.50 mg every 4 hours. The intravenous dose is approximately half the oral dose. Severely agitated patients will require much higher doses, and hundreds of milligrams over a 24-hour period are often well tolerated. Severely ill patients with cancer or AIDS may tolerate lower doses combined with lorazepam. A starting dose of 3 mg of haloperidol followed by 0.5-1.0 mg of lorazepam has been recommended in these populations.
The starting dose of haldol can be adjusted to the level of agitation:

<table>
<thead>
<tr>
<th>Level</th>
<th>Dose</th>
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<tbody>
<tr>
<td>Mild</td>
<td>2 mg</td>
</tr>
<tr>
<td>Moderate</td>
<td>5 mg</td>
</tr>
<tr>
<td>Severe</td>
<td>10 mg</td>
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In the severely agitated it is sometimes necessary to start with 10 mg and double the dose every 30 minutes until the patient is calm but awake. Patients who require more than 80 mg IV in a 12-hour period may need a continuous infusion of the drug. A starting rate of 5 to 10 mg/hr following a 10-mg bolus dose is recommended.

Alcohol withdrawal delirium (delirium tremens) is not treated with haloperidol primarily. The pharmacologic treatment of choice is a benzodiazepine. It may be possible to prevent delirium tremens by giving scheduled doses of a benzodiazepine. The age of the patient and whether or not liver disease is present that would slow the metabolism of longer acting agents can guide the choice of drug. In general, chlordiazepoxide (Librium, a long acting agent) is administered unless the patient is elderly or has compromised hepatic function. Lorazepam (Ativan, a shorter acting agent) is substituted in these conditions. A suggested regimen follows:

- If 3 of following criteria are met:
  - temperature >38.3
  - systolic blood pressure >160
  - diastolic blood pressure >110
  - heart rate >110
  - nausea or vomiting
  - sweating
  - tremulousness
  - give

  1. Librium 50 mg or Ativan 2 mg q4 hr for 6 doses
  2. Librium 50 mg or Ativan 2 mg q6 hr for 4 doses
  3. Librium 25 mg or Ativan 1 mg q4 hr for 6 doses
  4. Librium 25 mg or Ativan 1 mg q6 hr for 4 doses

  Then, stop the drug. Doses should be withheld for nystagmus, sedation, ataxia, or dysarthria. Supplemental doses of haloperidol can be given to control agitation or psychosis.

  Benzodiazepines as monotherapy should be avoided except in alcohol or sedative-hypnotic withdrawal delirium. There are significant drawbacks including disinhibition, over-sedation, respiratory depression, ataxia and falls. They are contraindicated in hepatic encephalopathy because of the accumulation of glutamine, which is related to gamma-aminobutyric acid.

The following list of references includes thorough reviews of delirium and related subjects that are recommended for further reading. The American Psychiatric Association practice guidelines (reference no. 1) is an excellent reference.

References


Depression in the Medically Ill

Psychiatric disorders may have a significant impact on the course of medical illnesses.

Fundamental concepts

Historically this has been an area of uncertainty and limited investigation due to diagnostic and nosologic difficulties. Currently, in medicine this is an area of active inquiry and conceptual restructuring. The field is recognizing that psychiatric disorders may have significant impact on the course of medical conditions.

Possible Relationships of Depressive Disorder and Axis III Conditions

1. The Axis III condition accounts for the Axis I condition; when Axis III is redressed or corrected, the Axis I presentation remits.
2. The Axis I condition accelerates the progression of the Axis III condition
3. Axis I and Axis III conditions impact each other
4. Axis I and Axis III conditions are independent, unrelated.

Guideposts

1. Does the patient have a well-established history of an affective disorder that predates the physical illness?
2. Is there a familial history of affective disorder?
3. Is depression best seen as a reactive response to illness as stressor?
4. Can the depression be physiologically attributed to the physical illness process or its treatment?

Diagnostic Options

1. Recurrent Affective Disorder and an Axis III condition
2. Adjustment Disorder with Depressed Mood with the Axis III illness as the precipitating stressor (Maladaptive Reactive Response)
3. Mood Disorder Due to a General Medical Condition (Medical Depression)
4. Substance-Induced Mood Disorder
1. “You’d be depressed too….” in the face of stroke, malignancy, cardiac disease and comparable conditions, clinicians are often too understanding and accepting of depressive symptoms and overlook possible interventions.

2. “One-way street”…the perspective that one need consider only the psychiatric response to physical illness and not its impact on the course of the medical condition.

Prevalence Rates
1. The National Comorbidity Survey Replication (Kessler et al, 2003) reported the lifetime prevalence of major depression to be 16% and found one year prevalence of MDD to be 6.6%.

2. The majority of studies of depression in the setting of medical illness find prevalence rates 1.5 to 3 times greater than in the general population.

| Lifetime prevalence rates of depression in various Axis III disorders | 1. Coronary Artery Disease: 18%-49% |
| 2. Diabetes Mellitus: 16%-30% |
| 3. Cushing’s Syndrome: Up to 67% |
| 4. Neurological Illnesses: 30-50% |
| 5. Cancer: 5%-60% |
| 6. Hepatitis C: about 33% |

Impact of Depression in Medical Illness
Depression has been shown to be associated with increased functional impairment, increased symptom burden, decreased quality of life, and an approximate 50% increase in the medical costs of chronic medical illness. Katon, 2003

There is more variability in the lifetime prevalence rates of depression in medical illness. Treatment of the medical condition does not always result in the resolution of the psychiatric condition.

Interplay: The two way street
1. Depression is now identified as a potential risk factor for increased morbidity and mortality across a number of medical conditions.

2. Most of the attention along these lines has centered on Coronary Artery Disease, Breast Cancer, HIV-AIDS, and ESRD-hemodialysis.

Depression as a risk factor
1. Breast cancer pts with depression had a modestly but significantly higher risk of mortality depending on the stage of the cancer and the time of depression…Not explained by death from unnatural causes…Hjerl et al, 2003

2. Depression was independently associated with higher risks of mortality and hospitalization among hemodialysis pts in the DOPPS study…Lopes et al, 2002

3. Depression is associated with declining CD4 cell count and increased mortality among HIV seropositive women…Ickovics et al, 2001
4. Depression more commonly preceded pancreatic cancer than it did other gastrointestinal malignancies or all other cancers …OR 4.6, Carney et al 2003

5. Premorbid depression significantly increases the risk of stroke over an ensuing 10-15 year period Robinson, 2003

6. How does depression exert its effect?
   a) Major Depressive Disorder brings with it significant and extensive physiological changes in a range of the body’s systems and functions
   b) Depression has a maladaptive effect on adherence to medical regimens
   c) Depression has an adverse effect on health habits (smoking, diet, activity)

7. Limited number of studies demonstrating the effectiveness of antidepressant treatment of this condition…

8. Cochrane Database 2000: 18 studies, 6 with SSRIs/ 4pts need tx to produce one recovery

9. Literature has supported the use of ECT

10. Prophylaxis in stroke (Narushima et al, 2002 Rasmussen et al 2003) and re interferon-alpha

11. Most instructive areas: DM and CAD

**Chronic hepatitis C, alpha-interferon therapy and depression**

Hepatitis C virus infects more than 4 million Americans and it’s the leading cause of liver failure leading to transplantation. Depression afflicts about 30% of patients with Hepatitis C who receive treatment with alpha-interferon. Currently, the only FDA approved treatment for chronic Hepatitis C infection is alpha-interferon, with or without ribavirin, which is associated with a number of adverse neuropsychiatric side effects. One of the main side effects is depression. Other psychiatric side effects include cognitive impairment, personality changes, psychosis, delirium, and suicidality.

The main role of the psychiatric consultant is to evaluate patients about to undergo alpha-interferon therapy or those already in treatment and who may be afflicted with psychiatric side effects of interferon.

Patients with Hepatitis C have high rates of significant comorbid psychiatric disorders at baseline, including substance abuse, depression, and anxiety. It’s important to recognize this and document it at the initial evaluation prior to starting interferon in order to distinguish any interferon-induced mental disorder. Identifying treatable mental disorders prior to interferon treatment and providing prophylactic treatment, especially for depression, is important for several reasons:
Treating psychiatric syndromes improves functioning and quality of life.

Adequately managing psychiatric syndromes may help retain patients in interferon treatment, since eradicating the virus depends on tolerating the effective dose of interferon for the indicated length of time—6 months to a year, depending on the viral genotype.

**What is the mechanism of interferon-induced depression?**

- Neurotransmitter levels
  - serotonin synthesis suppression may play a role
- suggested by review: Menkes. Psychol Med 2000
  - IFN alters serotonin transporter mRNA
  - SSRIs require serotonin to work
  - Case report of interferon over-riding SSRI
  - SSRI-induced tumor growth promotion?

**Automatic prophylactic antidepressant therapy for every patient?**

The debate about whether or not to place everyone with Hepatitis C on prophylactic antidepressant continues. Currently the recommendation is to evaluate patients on a case by case basis. Not everyone needs or wants antidepressant. Those with a strong personal or family history of depression, for example, probably merit prophylaxis with antidepressant prior to undergoing interferon therapy. The only controlled trial of prophylactic antidepressant therapy in patients undergoing treatment with interferon was conducted with those who had malignant melanoma, not Hepatitis C. The study did find a protective effect for paroxetine.

A variety of antidepressants are effective in treating interferon-induced depression, although breakthrough depressions while on antidepressant do occur. The selective serotonin reuptake inhibitors are usually the best tolerated in most patients with liver disease.

**Treatment of interferon-induced depression**

- Antidepressants in patients with Hepatitis C
  - Severity of liver disease important factor
  - SSRIs preferred, e.g., Celexa, Zoloft
- Exception: Nefazodone (Serzone) linked to fulminant liver failure, interaction with post-transplant anti-rejection drug Tacrolimus(Prograf) linked to delirium and renal failure
References


Recognition and Management of Somatoform Illness

25%-75% primary care visits are due to somatization.

Somatoform disorders definitions

One definition of somatization is the tendency to experience psychosocial distress as somatic distress and seek medical help. The patient’s symptoms often medically unexplained. Psychiatric illness may be present; e.g., depression and anxiety. The patient tends to engage in excessive health care utilization, often may have conflictual relationships with doctors.

- 25%-75% primary care visits due to somatization
- Hospital costs 6 times higher than controls
- Ambulatory costs 14 times higher than controls
- Psychiatric comorbidity high

Somatoform disorder categories overview

- Somatization disorder
  - Multiple complaints in many organ systems starting prior to age 30
- Pain disorder
  - Chief problem is medically unexplained pain
- Conversion disorder
  - Unexplained symptoms suggesting neurological problem; e.g., pseudoseizures
• Hypochondriasis
  – fear that a specific disease is present

• body dysmorphic disorder
  – groundless belief that body part looks abnormal

• other “subsyndromal” forms
  – undifferentiated somatoform disorder (>6 mos duration)
  – somatoform disorder NOS (<6 mos duration)

Special cases of somatic presentations of psychiatric illness

FACTITIOUS DISORDER: voluntary production of physical/psychological symptoms; secondary gain not apparent

MALINGERING: voluntary production of physical/psychological symptoms; secondary gain apparent

DEPRESSION: with prominent vegetative symptoms including fatigue, anorexia, pain

ANXIETY: with panic-like features including dyspnea, palpitations, diaphoresis

Somatoform disorders: approach to the patient

The facultative somatizer is willing to discuss the role of psychosocial stressors in the production and intensification of symptoms. But the chronic somatizer is usually unwilling to acknowledge them, and often has a well-established history of chronic somatization.

The development of the therapeutic relationship may be conceptualized as occurring in phases:

• Validation phase
  – ask for patient’s opinion on why psychiatric consultation requested: “Doc thinks I’m crazy”
  – consultant’s reply would be: “Your pain is real”
  – take a history of physical complaint first
• Assessment phase
  – abnormal illness behavior
  - inconsistencies between complaint and behavior
  - la belle indifference or denial of concern
  - unusual or overvalued ideas about physical symptoms
  - hostility toward previous doctors
  - frank depression or anxiety
• Reattribution phase
  – acknowledge both physical and psychological problems and link them
  – emphasize psychological or physical approach depending on insight
  – if possible, deliver diagnosis while avoiding dualistic mind/body conflicts
• Management phase
  – assign one primary care practitioner
  – regular follow-up visits
  – avoid invasive procedures, medications, specialist referrals unless objective evidence justifies them
  – treat co-morbid mood and anxiety disorders
References:


Transplantation Psychiatry

Is the consultant’s primary responsibility to the transplant team, or the patient?

The availability of organs and threat to life and health seem to be associated with the use of psychosocial screening and the intensity of scrutiny of transplant candidates. In general, candidates are screened more carefully for heart and liver transplants than for kidney transplants. The psychiatric liaison member may be viewed as a gatekeeper in some instances. Some transplant psychiatrist believe that their primary responsibility is to the transplant team, not to the patient, and may refer their continuity of care patients with end stage organ disease in need of transplant to colleagues in the event of a request for pre-transplant psychiatric evaluation.

**Comprehensive Role with Transplant Program**

- Assessment and evaluation
- Referral for appropriate treatment
- Education of transplant team regarding special needs (literacy, cultural issues)

- Assist in allowing candidates to demonstrate motivation
- Assist in objective examination of ethical issues
- Facilitate family-transplant team communication

**Psychiatrist as Gatekeeper**

- **Pro’s:**
  - Ability to impact quality of life of potential candidates through recognition and treatment of psychiatric syndromes.
  - Potential to avert the need for transplantation by recognition of noncompliance and assistance in addressing it.
- Ability to dispel commonly held stereotypes about mental illness.

- Con’s
  - Difficulty involved in the rationing of life altering health care resources.
  - Acclimation and integration into paternalistic model of medical care.
  - Counter-transference issues raised by illness of candidate, close contact, or family member.

**Psychosocial Candidate Assessment**

1. assess psychosocial function of candidate and support group
2. assess mental status and competence
3. ascertain suitability of candidate
4. diagnose psychiatric disorders that may interfere with suitability
5. identify means of enhancing suitability

**Psychiatric Disorders in Transplant Candidates**

- Depression
- Anxiety
- Adjustment Disorders
- Organic Mental Disorder
- Delirium
- Dementia
- PTSD

**Components of Comprehensive Evaluation**

- Reaction to transplant proposal
- Health behaviors
- Coping skills
- Compliance
- Social and family connections
- Psychiatric and substance use symptoms
- Mental status examination
Reaction to Transplant Proposal

- Ability to accept the severity of present condition.
- Ability to assume realistic expectations.
- Tolerance of inevitable future rejection or complications.
- Common Contra-indications
- Primary motivation to have the procedure.
  - Active psychosis
  - Active substance abuse
  - More common to cardiac programs
  - Mental retardation
  - Suicide ideation or previous suicide attempts

Data Supporting Psychosocial Evaluations

- Pre-morbid functional status predicts post-transplant performance.
- Preoperative employment predicts postoperative employment.
- Preoperative misery predicts postoperative misery.

- Chaotic families become more chaotic.
- Substance abusers have recidivism rates ranging from 0-25%.
- Careful diagnosis
- Establishment of alcoholism as a disease with individual and family
- Social stability factors
- Effective time structuring
- Smooth medical course
- Personality disorders predict poorer outcome in terms of survival and medical morbidity.
- Antisocial and borderline patients have more noncompliance and rejection episodes.
• High psychosocial risk recipients have significantly impaired survival
  - One year: 70% vs 90%
  - Three year: 0% vs 80% (Argentina)

• Preoperative psychiatric syndromes persist and worsen post-operatively.

• Delirium present in 33% liver transplants, 70% of lung transplants, 50% heart transplants

• Affective Disorders & Anxiety Disorders are exacerbated by steroid use perioperatively and for rejection.

• Psychotic Disorders are under represented (data are presently being collected).

**Psychosocial scales used in liver transplant evaluations**

**PACT Rating Scale**
Psycchosocial Assessment of Candidates for Transplantation
developed in 1980’s; score >32 standard
Focus on specific psychosocial issues relevant to transplant rather than psychiatric diagnoses
Social support, personality & psychopathology, compliance, substance abuse, lifestyle factors, knowledge regarding transplant

**HRAR Scale**
High Risk Alcoholism Relapse Scale
Assigns point values to items on number of drinks daily, years of heavy drinking, number of inpatient treatment programs developed in 1990’s score 3 or less associated with low risk of relapse

**APST**
Alcoholism Prognosis Scale for Transplantation
predictive factors associated with alcoholism
acceptance of alcoholism, substitute activities replacing drinking
score of 10-15 standard for good psychosocial functioning in alcoholism
Liver transplant psychosocial scales
Psychiatric contraindications to transplant

- Active psychosis
- Active substance abuse
- Severe personality disorder
- Highly conflicted relationship with t/p team
- Severe, untreated psychiatric disorders
- Serious, documented noncompliance
- Serious cognitive impairment without support system to ensure compliance

**Substance Abuse Disorders**

Usually absolute contraindication if active

post-transplant survival rates similar for alcoholic liver dz v nonalcoholic liver dz

dual diagnosis carries higher risk relapse

return to drinking post-transplant does not necessarily predict poor survival

Specific period abstinence requirement controversial

6 month period usually recommended

length sobriety measured in months has limited value in predicting long-term abstinence

most transplant centers require rehab in complicated cases, e.g., co-morbidity, brief duration of abstinence, rather than reject

Factors predicting long-term abstinence

substitutive dependencies, e.g., AA

supportive significant other

certain, immediate noxious consequence of relapse

hope

acceptance of diagnosis of addiction

social stability
Personality Disorders

Relative contraindication, though not based on formal outcome studies may be linked to post-transplant non-compliance. Transference & counter-transference reactions may develop.

Psychosocial Assessments & ADA

Americans with Disabilities Act . . . prohibits discrimination on basis of eligibility criteria that disproportionately affect those with disabilities. Denials of organs should be based on scientifically valid criteria. Transplant program should make reasonable steps to compensate disability.

Common Neuropsychiatric Syndromes Associated with Transplantation

- Headache and visual symptoms
- Impaired taste sensation
- Cortical blindness
- Central pontine myelinolysis
- Incontinence
- Seizures
- Sexual dysfunction
- Delirium
- Isolated visual hallucinations
- Dementia-like syndromes
- Frontal-lobe syndromes
- Secondary mood, anxiety, and thought disorders
- Movement disorders
Antirejection Medications

1) Cyclosporine (neoral, sandimmune)
   a) inhibits production interleukin-2 by T-helper cells
   b) trough levels must be measured
   c) hirsutism, gingival hyperplasia (body image)
   d) tremor, anxiety, visual hallucinations, disorientation
   e) toxicity potentiated by high-dose solumedrol

2) Corticosteroids
   a) high doses immediately after transplant; initial treatment of rejection
   b) weight gain, hirsutism, truncal obesity (body image)
   c) depression, mania, delirium
   d) doses usually exceed 40 mg/day prednisone

3) Tacrolimus (FK 506, Prograf)
   a) more potent than cyclosporine
   b) nausea, vomiting, hair loss
   c) headache, tremor, insomnia, delirium
   d) delirium more common when plasma levels exceed 3 ng/ml

4) Acyclovir
   a) antiviral for Herpesvirus infections
   b) tremor, confusion, delusional depression, lethargy, seizures

5) Ganciclovir (DHPG)
   a) antiviral for Cytomegalovirus
   b) headache, confusion, hallucinations, seizures

6) Interferon alpha
   a) used with recurrent hepatitis C, post-transplant
   b) long-term use: depression, anxiety, irritability, delirium, suicide

Other drug Issues

1) Neuroleptics
   a) delirium most common disorder in transplant patients
   b) metabolites can accumulate in liver & kidney insufficiency
c) prefer high potency agents
d) akathisia can be mistaken for immuno-suppressant induced tremor

2) Tricyclics
   a) usually poorly tolerated
   b) prefer secondary amines, e.g., nortriptyline
   c) monitor blood levels
   d) avoid in cardiac transplant patients

3) SSRIs
   a) fluoxetine metabolites can reach toxic levels in cirrhosis
   b) sertraline, citalopram less potent inhibitor of hepatic p450 enzymes

4) Trazodone
   a) milder than TCA; useful hypnotic

5) Bupropion
   a) low rate of ECG changes, arrhythmias, tachycardia
   b) can cause psychosis and delirium in susceptible patients

6) Psychostimulants (e.g., ritalin)
   a) safe, well-tolerated
   b) improve appetite, mood, energy
   c) rapid response in 24-72 hrs

7) Lithium
   a) post-transplant use can be complicated by fluctuating renal, electrolyte, fluid status
   b) monitor levels at least 3x/week
   c) cyclosporine, methylprednisolone may increase levels
   d) contraindicated in acute renal failure
   e) caution with cardiac patients

8) Benzodiazepines
   a) more sedating in cirrhosis
   b) prefer lorazepam in liver insufficiency if BZD must be used
Psychiatrist as Team Member (Liaison)

- Ease of collaboration.
- Trust developed over time.
- Provide indirect stress reduction for team members.
- Provide expert consultation regarding behavioral issues.
- Provide support and empathy for *difficult cases*.
References:


Suicide Assessment

Frequently, the last person to see a patient alive before suicide is carried out is a physician.

Making suicide assessment a practical and routine part of psychiatric consultation will help the clinician become more proficient with this part of the examination, and may help prevent some suicides. There are about 30,000 suicide attempts annually in the United States alone. Some estimates indicate that 5%-6% occur in hospitals. One million die annually of suicide worldwide. Over 90% are linked to psychiatric illness, chiefly depression and psychosis.

Motivation for Suicide

One mnemonic for remembering some of the common reasons for suicide are the 3 Rs:

1. Revenge
2. Rebirth
3. Riddance of pain that is perceived as intolerable, interminable, and inescapable

Psychiatric Disorders

Psychiatric disorders often associated with suicidality include depression with anxiety and agitation. Psychosis marked by command hallucinations, alien delusions of control, and hyperreligious delusions are also known to be linked to suicide. Finally, personality disorders are also known to be associated with higher rates of suicide. The two most often identified are Antisocial and Borderline Personality Disorders.

The bare essentials of any suicide assessment are to elicit suicide ideation, assess risk factors, and then to formulate an assessment and plan based on the evaluation. An expanded outline of the process follows:

- Detect predisposing factors
  - Affective, psychotic, substance abuse disorders
• Detect potentiating factors
  - Lack of competent social support
    o Personality disorder
    o Medical illness, increasing pain
    o Availability of firearms
• Detect protective factors
  - Valued spirituality, family
• Conduct a specific inquiry into suicidality
  - Presence of plan, intent, means, etc.
  - Determine level of intervention
  - Document the assessment

**Interview techniques**

**Clues to invalid patient report:**

• Agitation and anxiety
• Blanket denials of lethality contradicting chart and/or history from other informants
• Breaking eye contact when questioned directly about suicidality
• Crying while professing safety

**Common interview pitfalls**

1. Superficial reassurance
2. Avoidance of strong feelings
3. “Professionalism”
4. Failure to identify triggering event
5. Advice giving
6. Passivity
7. Insufficient directiveness
8. Stereotypical responses
9. Defensiveness
10. Inadequate assessment of suicidal intent
Specific interview techniques

The following techniques are designed to facilitate getting valid information from patients about subjects that are sensitive, and may be subject to minimization, or failure to disclose, e.g., sexual functioning, substance abuse, legal history, and suicide thinking. These are adapted from – “The Practical Art of Suicide Assessment” 1999 by Shawn Shea, M.D. & J Clin Psychiatry 1998; 59

Behavioral incident

This consists of asking many detailed, directed questions to get a verbal walkthrough of a suicide event, such as an aborted or completed suicide attempt. It’s time consuming, so should be used judiciously early in the interview, after sufficient rapport building has been done.

Denial of the specific

Often, asking simple, open-ended questions (sometimes called “gate” questions), e.g., “Have you ever had a suicide plan?” yields negative answers. If the examiner follows by asking a series of close-ended questions, e.g., “Well, for example, have you ever thought of: shooting yourself, hanging, overdosing?” this may jog the patient’s memory. This kind of sifting through a list may result in a surprising array of responses not obtainable by simple open-ended questions. This is also potentially time consuming, because the examiner may then follow up with Behavioral incident type questions.

Shame attenuation

Sometimes, the examiner can break the taboo against talking about subjects typically freighted with shame and guilt, such as suicidal thoughts. This entails using openers designed to help destigmatize the subject, e.g., “With all this pressure, I would think that you might think things are pretty hopeless, even think about ending the pain once and for all.” This is based on the patient’s perception of the difficulties that triggered their thoughts and behavior.

Normalization

Some people are very sensitive to being viewed as different, so helping them by pointing out that a lot of people under similar circumstances might feel the same way, e.g., “Many people I’ve talked to who have these stressors may sometimes begin to think about suicide. Does that ever happen to you?” This is based on what other people sometimes think or do.

Gentle assumption

This technique can be used by experienced examiners when a good deal of information about the patient is gathered by observation, collateral history, close listening, followed by application of a well-practiced algorithm-type assessment. One is playing the odds that this will permit an educated guess to be used in gently confronting a patient about an assumption that the examiner arrives at. For example, if the patient is brought to the ER by a relative who’s told the nurse that she’s concerned about the patient being “desperate,” the chart reveals a history of previous suicide attempts, and the patient breaks eye contact and cries several times during general history taking about self-harm, the examiner might ask, “So, what are some ways that you’ve thought about killing yourself, if any?” It should be used sparingly, as patients can sometimes feel affronted by it.
Symptom amplification

This is another advanced technique that may offset the tendency of patients to minimize suicidality. The examiner strategically exaggerates in anticipation of this tendency, and may be more effective when used with patients who have a reputation for minimizing, and have been confronted about it previously. For example, “So, what do you estimate the percentage of time is that you spend thinking about suicide in a given week, 75% or 95%?” The examiner might get a more accurate answer of, say, 50%, while, without the technique, the patient may underestimate or deny altogether thinking about suicide. The exaggerated number should make sense; if it’s fantastic, it may either tip the patient off or put him off.

Chronological Assessment of Suicide Events: CASE Approach

One method of systematic suicide assessment is the Chronological Assessment of Suicide Events (CASE). This also is adapted from—“The Practical Art of Suicide Assessment” 1999 by Shawn Shea, M.D. & J Clin Psychiatry 1998; 59.

It involves using a systematic inquiry into suicidal thoughts and events:

- Presenting suicidality (immediate suicide ideation and plans)
- Recent suicidality in the last 2 months
- Past suicidality

The idea is to use the interview techniques to optimize validity of self-report in patients who are suicidal, and to systematically assess suicidality over time from the immediate present to the past 2 months, to the past. Behavioral incidents are useful for the present and recent past. It’s probably more effective time management to assess just the most serious aspects of past suicidal behavior, such as medically and psychologically serious suicide attempts. Judicious use of the other techniques facilitates this as well. Getting the relevant details involves keeping the important categories of information in mind.

Background Risk Factors

- Middle-aged or older white male
- Hopeless
- Depression, schizophrenia, personality disorder
- Alcoholic
- Single, separated, divorced
- Previous suicide attempt(s)
- Chronic medical illness with pain
Foreground Risk Factors
  - Presents immediately following serious suicide attempt
  - Psychotic processes: command hallucinations, alien control, hyperreligiosity
  - Shares serious suicidal thinking, plan, intent during interview

  - Severe anhedonia
  - Severely anxious, agitated, intoxicated
  - Depressive turmoil, severe insomnia

Clinical decision making
  - If not imminently suicidal and discharging from clinic
    - No intent or plan
    - Not psychotic
    - Not agitated or hopeless
    - Cognitively intact

  - Establish crisis plan
    - Avoid alcohol
    - Call competent support persons
    - Write down what problem caused upset

  - Schedule psych clinic appt.; small supply meds

  - If imminently suicidal
    - Hospitalize
    - Adequately treat severe anxiety & agitation
      - 1:1 observation

A word about no-suicide contracts - there’s nothing inherently right or wrong about making them. In general, they don’t substitute for making systematic suicide assessments. They won’t protect clinicians in court, and there’s no evidence to support their utility in preventing suicide. Working on a crisis plan with the patient and making out a suicide contract both can enable the clinician to do one very important thing-assess the patient’s readiness to engage in a therapeutic alliance and level of resolve in keeping herself safe in the short term. They should be viewed as yet another assessment tool.
Making a contract assumes that a suicidal patient is in a rational frame of mind and able to understand what she’s signing. This is debatable in most emergency situations. Moreover, there is nearly always the implied threat of involuntary hospitalization if she doesn’t sign it, making the exercise seem coercive. On the other hand, if the patient can cooperate with the clinician in thinking of several rational alternatives to killing herself, this could demonstrate that she may not pose an imminent threat to herself. Writing it on a 3 x 5 index card with the patient’s signature on it can signify a resolve by the patient to keep herself safe using ideas that she herself has created. However, neither of these documents by itself substitutes for an adequate suicide assessment.

Clinical decision making, continued

- Relationship with patient
  - Well known vs. unknown
- Presence or absence of personality disorder
- Psychosis?
  - Alien influence, command hallucinations, hyperreligious delusions of self-harm
- Agitation or anxiety
- Profound hopelessness, humiliation
- Cognitive impairment
Gate questions are commonly used to shorten structured interviews, by not probing negative responses with more detailed questions. This study quantified cases of aborted suicide attempts that would have been missed, if we had skipped detailed questions following a gate. To accomplish this, we interviewed a random sample of 135 adult psychiatric inpatients concerning their past suicidal behavior. Using our structured interview, subjects were asked a general question about aborted suicide attempts, and then asked method-specific questions regardless of their response to the general "gate" question. Of the seventy subjects who were found to have histories of aborted attempts, 44.3\% answered "no" to the gate question. Comparing these "false negative" subjects to "true positives," who had answered "yes" to the gate question and reported bona fide aborted attempts yielded no significant associations with demographics, psychiatric diagnoses, or reported histories of actual suicide attempts. Thus, a large number of subjects with aborted attempts would have been missed if a negative response to the gate question had not been probed. Clinical and research implications generally, as well as implications for suicide assessment, are discussed.

Suicide assessment is one of the cornerstones of daily clinical practice for both mental health professionals and primary care clinicians. A practical interviewing strategy for efficiently eliciting valid suicidal ideation is presented. The strategy is illustrated via a reconstructed interview designed...
to highlight key teaching points. The strategy, the Chronological Assessment of Suicide Events (CASE Approach), helps the clinician to uncover critical data in four contiguous time frames: (1) presenting suicidal ideation/behavior, (2) recent suicidal ideation/behaviors, (3) past suicidal ideation/behaviors, and (4) immediate suicidal ideation. The CASE Approach is an easily learned interviewing strategy, designed for busy, frontline clinicians in both the mental health and primary care settings. [References: 10]

Notes: Review
Reference Type: Journal Article
Record Number: 252
Author: Busch, K. A.; Fawcett, J.; Jacobs, D. G.
Year: 2003
Title: Clinical correlates of inpatient suicide.[comment]
Journal: Journal of Clinical Psychiatry.
Volume: 64
Issue: 1
Pages: 14-9

Abstract: **BACKGROUND**: Previous suicide assessment research has led to standard predictors of risk. Despite this, there are approximately 30,000 suicides per year in the United States, 5% to 6% of which occur in hospitals. The primary purpose of this study is to improve our ability to assess risk and intervene successfully. **METHOD**: Charts from 76 patients who committed suicide while in the hospital, or immediately after discharge, were reviewed. The week before suicide was rated for both standard risk predictors and, using items from the Schedule for Affective Disorders and Schizophrenia (SADS), for presence and severity of symptoms found to be correlated with acute risk in recent studies. **RESULTS**: Regarding standard predictors, only 49% (N = 37) had any prior suicide attempt and 25% (N = 19) were admitted for this reason. Thirty-nine percent (30/76) were admitted for suicidal ideation, but 78% denied suicidal ideation at their last communication about this; 46% (N = 35) showed no evidence of psychosis; of those on precautions (N = 45), 51% (N = 23) were on q 15 minute suicide checks or 1:1 observation; and 28% (N = 21) had a no-suicide contract in effect. On SADS ratings, 79% (N = 60) met criteria for severe or extreme anxiety and/or agitation. **CONCLUSION**: Standard risk assessments and standard precautions used were of limited value in protecting this group from suicide. Adding severity of anxiety and agitation to our current assessments may help identify patients at acute risk and suggest effective treatment interventions. The importance of a matched comparison group to ascertain if this sample can be blindly discriminated from inpatients who do not commit suicide is clear.

Reference Type: Edited Book
Record Number: 249
Editor: Maris, Ronald W.; Berman, Alan L.; Silverman, Morton M.
Year: 2000
Title: Comprehensive Textbook of Suicidology
City: New York
Publisher: The Guilford Press
Abstract: Purpose of Review: Suicide risk assessment and management can be particularly challenging in patients with personality disorders. This paper reviews recent research into the assessment and clinical management of suicide risk in patients with personality diagnoses.

Recent Findings: The DSM cluster B personality diagnoses carry the most serious suicide risk—similar to that of non-personality disordered patients with major mood disorders. Factors increasing suicide risk in these patients include the presence of co-morbid mood or addiction disorders (often inadequately treated), severity of childhood sexual abuse, degree of antisocial or impulsive characteristics, and a history of irregular psychiatric care discharges. Complicating suicide risk management in this population, suicide gestures without lethal intent are common and suicide threats may be presented in a manipulative manner (contingent or instrumental suicidality). Hospitalization, the traditional intervention for imminent suicide risk, may be counter-productive and regressive in some personality-disordered patients.

Summary: this review highlights the importance of a careful evaluation of personality-disordered patients with suicidal ideation and presents some suggestions for suicide risk management in this population.
Additional references:

Reference Type: Journal Article
Record Number: 255
Author: Stanford, E. J.; Goetz, R. R.; Bloom, J. D.
Year: 1994
Title: The No Harm Contract in the emergency assessment of suicidal risk
Journal: Journal of Clinical Psychiatry.
Volume: 55
Issue: 8
Pages: 344-8

Abstract: BACKGROUND: The No Harm Contract has been widely accepted in clinical practice, yet there is no broad consensus as to its value. This paper examines the contract and offers recommendations for its use as well as cautions about its misuse. METHOD: After a literature review, the No Harm Contract is examined from diagnostic, therapeutic, and medicolegal perspectives. RESULTS: Diagnostically, the No Harm Contract can be used to assess the nature and severity of a patient's suicidality, uncover specific troubling issues precipitating suicidal thoughts, and evaluate the patient's competency to contract. Therapeutically, the contract affords an opportunity to initiate a therapeutic alliance, establish the limits of the psychotherapeutic framework, and reduce both patient and clinician anxiety. Medically, the contract is not legally binding and grants no suicide malpractice suit protection. CONCLUSION: Although the No Harm Contract is a frequently used clinical tool that can provide diagnostic information and therapeutic advantage, it can also short-circuit comprehensive suicidal assessment and disposition decisions.

Reference Type: Journal Article
Record Number: 256
Author: Kelly, K. T.; Knudson, M. P.
Year: 2000
Title: Are no-suicide contracts effective in preventing suicide in suicidal patients seen by primary care physicians?
Journal: Archives of Family Medicine.
Volume: 9
Issue: 10
Pages: 1119-21
Keywords: Family Practice
          Human
          Physician-Patient Relations
          *Suicide/pc [Prevention & Control]
          Suicide/px [Psychology]
Reference Type: Journal Article
Record Number: 257
Author: Kroll, J.
Year: 2000
Title: Use of no-suicide contracts by psychiatrists in Minnesota
Volume: 157
Issue: 10
Pages: 1684-6

Abstract: OBJECTIVE: The no-suicide contract is widely recommended as an important intervention in the care of suicidal patients; however, there are no data demonstrating its effectiveness or its acceptance in the professional community. This study examines the use of no-suicide contracts by psychiatrists in Minnesota. METHOD: A postcard questionnaire was mailed to 514 psychiatrists in Minnesota inquiring about their practices and experiences with no-suicide contracts. RESULTS: There were 267 responses, yielding a response rate of 52%. No-suicide contracts were used by 152 (57%) of the respondents. Within this group, 62 (41%) of the psychiatrists had patients who committed suicide or made serious attempts after entering into a no-suicide contract. CONCLUSIONS: Among the respondents to the questionnaire, slightly more than half used no-suicide contracts, indicating that such contracts are not universally accepted as standard practice among these psychiatrists. More data are needed to determine the effectiveness of no-suicide contracts in preventing suicide.

Reference Type: Journal Article
Record Number: 258
Author: Farrow, T. L.; O'Brien, A. J.
Year: 2003
Title: No-suicide contracts' and informed consent: an analysis of ethical issues
Journal: Nursing Ethics: an International Journal for Health Care Professionals.
Volume: 10
Issue: 2
Pages: 199-207

Abstract: The 'no-suicide contract' is a frequently utilized tool in both the assessment and dispersal of suicidal patients. However, little attention has been given to questioning whether suicidal persons are able to give informed consent to enter such a contract. This article utilizes both the existing literature on no-suicide contracts and the results of recent research into the effects of this tool, to examine whether its use is consistent with the legal and ethical doctrine of informed consent. Particular attention is given to issues of competence, fullness of information, voluntariness and paternalistic intervention when no-suicide contracts are used. This analysis finds the tool to be problematic and suggests that individual patients' ability to give informed consent about a no-suicide contract needs to be carefully considered by clinicians.
Abstract: Although negotiation of no-suicide contracts is common practice, research regarding the outcomes of contracting is inadequate. The purpose of this retrospective review of medical records was to examine how no-suicide contracting affected the likelihood of self-harm behavior in psychiatric inpatient settings. Thirty-one patients (4.8%) engaged in self-harm behaviors representing 2.64% of all patients admitted to both study settings during the 6 (1/2)-month period from which data were collected. Approximately half of those patients expressed suicidal intent. Logistic regression analysis suggested that patients with no-suicide contracts and with higher levels of restriction had a significantly higher likelihood of self-harm behavior (OR = 7.43 and 2.47, respectively, p = .005). Consistency of nursing assignment is likely associated with a lower probability of self-harm (OR = .07) but p.068 when this variable was included in the model. Prevention of self-harm behaviors by the use of no-suicide contracting is not shown. Negotiation of a contract is likely a reflection of staff assessment that the patient was at high risk for suicide. These findings confirm the need for thorough, ongoing assessment of suicidal risk, whether or not a patient has agreed to a no-suicide contract. Copyright 2001 by W.B. Saunders Company
Mental Capacity Assessment

Courts decide on competency; physicians assess decisional capacity.

Mental capacity to make medical decisions can be assessed by any physician. Psychiatrists are often asked to decide if a patient is or is not “competent.” The role of the psychiatrist most of the time is to help the consulting physician decide whether or not a patient is able to give informed consent for some procedure or to refuse medical care. Often the question of whether or not a mental disorder is affecting a patient’s decisional capacity is the one the psychiatrist is in the best position to answer.

**Competence vs. Capacity**

- **Capacity**
  - Elements of informed consent
    - Voluntariness
  - No coercion

- **Competence**
  - Ability to make meaningful choices about treatment

- **Adequate information**
  - Can be assessed by any physician
  - Task specific

- **Capacity**
  - Assessment of decision-making capacity
  - Physicians can perform

- **Competence**
  - Legal judgments left to courts

- In practice, decisional capacity evaluations can have the same practical consequences as competence determinations
Ethical Foundations

“Rules governing the assessment of competence reflect a balance between the desires to protect persons from potentially harmful decisions, and deeply held beliefs about the inviolability of individual choice. There is no doubt that, in our society, the balance between these two interests is weighted to favor autonomy in decision making, as evidenced by the general presumption of competence in the absence of convincing evidence to the contrary.”

Grisso and Appelbaum, Assessing Competence to Consent To Treatment; A Guide for Physicians and Other Health Professionals; Oxford Univ. Press 1998

Psychiatric Assessment of Competence in the Medical Setting

The psychiatric consultant may be viewed in several different ways according to some authors:

- Psychiatric consultant as “informed consent technician”
  - “Efficiency model” scenario
    - Incompetence is presumed
    - Psych consultant expected to remove legal barriers expeditiously to obtaining surrogate decision maker

- “Pseudoconsultation” scenario
  - Consultee lacks patience, interest, time to do an assessment

- “Persuasion” scenario
  - Psych consultant expected to persuade the patient to reverse his refusal of needed treatment.

- “Protection” scenario
  - Psych consultant expected to provide documentation to protect against potential litigation

- “Punishment” scenario
  - Stigma associated with psychiatric evaluation used unconsciously to punish treatment refusal behavior

- Corollary occurs when psychiatrists request “medical clearance” to begin essential psychiatric treatment, e.g., electroconvulsive treatment

- Alternative
– Consult advice requested and accepted in “the true spirit of dialogue as the result of a genuine evaluation of the patient’s mental state as a whole.”

– Consulting psychiatrist’s role
  o Detect subtleties of incompetence
  o Evaluating the role of mood influence on competence
  o Identify treatable forms of incompetence

• Most important common pitfalls by referring physicians
  – Assumption that patient who lacks capacity for one task lacks capacity for all tasks
  – Lack of understanding that capacity is not “all or nothing,” but specific to a decision
    o L. Ganzini et al, Psychosomatics 44(3) May-June 2003

**Understanding & Assessing Capacity Grisso & Appelbaum**

• Important features
  – Functional abilities
  – Mental disorders as explanations for deficits in abilities
  – Situation-specific demands on functioning
  – Consequences of decisions
  – Recognition that capacities may change

• Assessments
  – Functional abilities
  – Psychopathology
  – Determination of task demands
  – Consider consequences of decisions
  – Employment of reassessment of functioning

When to assess capacity

• Abrupt change in mental status
• Refusal of recommended treatment, especially
  – Unwilling to discuss the refusal
  – Based on misunderstanding, irrationality
• Overly hasty consent to risky treatments
• Presence of known risk factor for impaired decision-making
  – Chronic psychiatric, neurologic disorder
  – Cultural/language barrier
  – Education level concern; age extreme

Abilities Related to Competence

• Ability to express a choice
• Ability to understand relevant information
• Ability to appreciate significance of information for one’s own situation; ability to appreciate consequences of decisions
• Ability to reason through treatment options

Case: ability to express choice

56 year old man with bipolar disorder on medical unit with dehydration and deep venous thrombosis. He has many signs and symptoms of catatonia: immobility, muteness, waxy flexibility. His disorder is now threatening his life, and electroconvulsive therapy (ECT) is recommended. An intravenous lorazepam challenge test is performed. He wakes up long enough to correctly answer orienting questions, to acknowledge his mental illness, and to listen to a beginning discussion of ECT. Just as psychiatrist starts talking about risks and benefits, the patient lapses back into catatonia. He is again mute and motionless.

Case: understanding

A 49 year old disabled engineer with chronic schizophrenia has diabetes and is hospitalized with worsening urinary retention, (the latter due to long-term anticholinergic psychiatric medication administration). In the past year, he’s stopped his insulin on two occasions because voices told him to do so. However, he’s been stable on a new atypical antipsychotic for the last 6 months. He needs to do self-catheterization and demonstrates understanding of the procedure by doing it by himself under nurse supervision for several days. He wants to go home.

Case: appreciation

67 year old woman with metastatic breast cancer has to choose between aggressive chemotherapy that could extend her life 6 months to a year, but would induce severe anorexia, nausea and vomiting, and would entail her to be bedridden much of that time. She demonstrates understanding of risks and benefits of proposed intervention.

  a. She chooses to forego chemotherapy because she wants to spend more time being active with her grandchildren, even though time would be brief.

  b. She chooses to forego chemotherapy because she believes that the world will end soon anyway because aliens are going to invade earth.
Case reasoning

21 year old man with mild mental retardation and poor impulse control has inflammatory bowel disease. His gastroenterologist carefully explains risks and benefits of 3 alternatives: continuing present medication regimen, trying a new medication, or surgery. Surgery would have meant hospitalization, which he’d always found difficult to tolerate in past. He chose surgery after seeming to show understanding and appreciation of alternatives. However, he was completely unable to discuss how he’d arrived at his decision. He couldn’t compare any of the alternatives.


Questions to ask when assessing capacity

• Understanding
  – What’s your understanding of your condition?
  – What are the risks and benefits?
  – What are the consequences if nothing is done?

• Appreciation
  – What do you really believe about your condition?
  – Why do you think the treatment is the best for you?

• Reasoning
  – How are you balancing the pluses and minuses of treatment?

• Expression of Choice
  – We’ve discussed several options; what do you want to do?
Capacity Threshold Determinations adapted from M. Tunzi, American Family Physician 2001

Table 0-1

Capacity threshold determinations

<table>
<thead>
<tr>
<th>Risk benefit analysis</th>
<th>Risk-benefit analysis intermediate, regardless of whether or not patient consents or refuses</th>
<th>Risk-benefit analysis favorable and patient refuses or risk-benefit analysis unfavorable and patient consents</th>
</tr>
</thead>
<tbody>
<tr>
<td>favorable and patient consents or risk benefit analysis unfavorable and patient refuses</td>
<td>Low threshold/low level of certainty needed to uphold capacity</td>
<td>Intermediate threshold/intermediate level of certainty needed to uphold capacity</td>
</tr>
<tr>
<td>Low threshold/low level of certainty needed to uphold capacity</td>
<td>No further action</td>
<td>High threshold/high level of certainty needed to uphold capacity</td>
</tr>
<tr>
<td>No further action</td>
<td>Consider reassessment of capacity, depending on magnitude of decision’s consequences</td>
<td>Perform reassessment of capacity and consider legal intervention, depending on consequences</td>
</tr>
</tbody>
</table>

Formal capacity rating scales

- Aid to Capacity Evaluation
  - [www.aafp.org/afp/20010715/299.html](http://www.aafp.org/afp/20010715/299.html)
  - Developed at Univ. Toronto Center for Bioethics
  - Brief (5-10 minutes)
  - Advantage: useful tool to organize process
  - Caveat: still requires evaluator judgment

- MacArthur Competence Assessment Tool (MacCAT)
  - Lengthy (30 minutes)
  - Caveat: still requires evaluator judgment
Religious issues

- Premises
  - Spirituality is neither rational nor irrational
  - Patients’ beliefs can be both adaptive and/or maladaptive
- Suggestions
  - Ascertain whether or not beliefs are, e.g.:
    - Genuine
    - Related to other psychopathology
    - Regression in face of medical problems
- Capacity
  - religious issues

43 year old woman with advancing breast cancer. Metastases impinging on spinal cord. Intravenous steroids and radiation recommended. Extensive discussion revealed she understood risks and benefits, including quadriplegia, respiratory paralysis and death without rapid treatment. She declined treatment. She believed that accepting medical treatment would interfere with spiritual healing. She had been active in a religious group. She had adhered to their doctrine of emphasis on the power of spiritual healing for many years.

-adapted from Grisso & Appelbaum, “Assessing competence to consent to treatment.”

Capacity Determination in a nutshell

- Determine if patient understands, appreciates, manipulates data rationally, indicates a voluntary choice
- View capacity assessment as process
- Treat impediments & reassess: depression, psychosis, delirium
- Involve other disciplines
  - Occupational therapy, neuropsychology, spiritual services, for example
- Clearly document the process
References:


Treatment of Alcohol Withdrawal

Learning how to recognize when alcohol withdrawal is not occurring is as important as recognizing when it is.

Alcoholism is defined as a pattern of uncontrolled drinking leading to medical, legal, and psychosocial adverse consequences. It is a major public health problem costing well over a $100 billion dollars annually in the U.S. alone, with nearly 14 million Americans afflicted. The first episode of alcohol intoxication usually occurs in the mid-teens. The onset of alcohol dependence peaks in the 20s to 30s. The first evidence of alcohol withdrawal is not likely to occur until several features of dependence have developed (12, 1).

Alcohol dependence can be screened for with the CAGE questionnaire. The CAGE questionnaire is a brief assessment with excellent sensitivity. The clinician should suspect alcoholism if she elicits three or more positive answers to the following:

- Have you often tried to cut down on your drinking?
- Have you often been annoyed by others complaining about your drinking?
- Have you often felt guilty about your drinking?
- Have you often taken a morning drink as an “eye-opener”?

Patients who respond positively to three or more questions should be considered at high risk for alcohol dependence and undergo a thorough medical and psychological diagnostic evaluation.

Alcohol dependence is frequently marked by alcohol withdrawal when alcohol intake is stopped or reduced. The following section will focus on minor withdrawal, major withdrawal (DT’s), withdrawal seizures and the treatment issues for each.

Signs of alcohol withdrawal occur in 13%-71% of those presenting for detoxification. About 15% of those hospitalized for detoxification develop withdrawal seizures. The prevalence estimates for delirium tremens
vary with the population studied; 0.6% in non-medical detoxification centers, and perhaps 5% overall in those undergoing withdrawal(12).

The proposed mechanism of alcohol withdrawal involves the adaptation of the central nervous system to repeated exposure of alcohol on inhibitory GABA A-type neuro-receptors and excitatory NMDA receptors. Animal studies reveal that chronic ethanol administration results in reduced GABA-mediated chloride flux through GABA A-type receptors, indicating tolerance. Chronic ethanol exposure also leads to upregulated NMDA receptor complexes, possibly resulting in the neuronal hyperexcitability that can present clinically as alcohol withdrawal seizures, anxiety, and sleep disturbances(14, 6).

The alcohol withdrawal syndrome can be defined as either minor or major. Minor withdrawal criteria are met if the patient has at least 3 of the following:

1. temperature >38.3
2. systolic blood pressure>160
3. diastolic blood pressure>110
4. pulse>110
5. nausea and vomiting
6. tremulousness
7. diaphoresis

Some of the objective signs of withdrawal can be masked by even low doses of beta-adrenergic antagonists, such as propranolol. Criteria 1-4 and 6 could all be below diagnostic threshold if a patient has been taking a beta-adrenergic antagonist, leading to delirium tremens as the first sign of withdrawal. Certain populations, such as those treated with propranolol for portal hypertension, are at higher risk for masked withdrawal and may present to medical care with delirium tremens.

Uncomplicated minor alcohol withdrawal may begin within 12-18 hours after the cessation of drinking or simply the reduction of usual intake. It tends to peak between 24-48 hours, and usually subsides in 5-7 days. Major alcohol withdrawal or delirium tremens typically begins within 48-72 hours of the last drink, with peaking of symptoms on days 4 and 5. Major withdrawal may persist from 3 days to several weeks.

Major withdrawal or delirium tremens (DT’s), is marked by all the signs and symptoms of minor withdrawal plus delirium. Delirium tremens classically begins about three to five days after stopping or decreasing alcohol intake. However, the DT’s may occur up to two weeks after the last drink. There is marked autonomic hyperactivity with elevation of the pulse and blood pressure. Confusion, perceptual disturbances with visual and auditory hallucinations, and marked agitation are prominent features. Often there are associated medical problems such as pneumonia, pancreatitis, subdural hematoma, or myocardial infarction. Patients are often dehydrated and may have multiple fluid and electrolyte imbalances. The mortality rate was as high as 40% in the early part of the 20th century. Improvements in recognition and treatment have led to a decrease in the mortality to approximately 5%(3).

Alcoholic patients presenting with delirium should be monitored closely for delirium tremens. Importantly, other causes of delirium should be considered given that medical co-morbidity may be present. Stoudemire (reference 13) suggests the medical workup for delirium include a thorough medical history and complete physical examination.
The following laboratory tests should be performed (13):

- Complete blood count with white cell differential
- Serum electrolytes
- Liver function tests
- Blood urea nitrogen
- Creatinine
- Fasting blood sugar
- Calcium
- Magnesium
- Albumin
- B12 and folate levels
- Stool guiac
- Urinalysis including toxicology screen
- Electrocardiogram

Benzodiazepines are the treatment of choice in the pharmacologic management of alcohol withdrawal (10, 8, 7). Chlordiazepoxide (Librium) and lorazepam (Ativan) are most frequently used because their long half-lives provide for a smoother taper. In general, lorazepam is preferred over longer acting agents such as chlordiazepoxide for patients with liver disease and in the elderly (10, 11). For patients who meet criteria for withdrawal, one suggested protocol is as follows:

1. Chlordiazepoxide 50 mg q4 hr for 6 doses
2. Chlordiazepoxide 50 mg q6 hr for 4 doses
3. Chlordiazepoxide 25 mg q4 hr for 6 doses
4. Chlordiazepoxide 25 mg q6 hr for 4 doses

The drug is discontinued after the last dose. Lorazepam can be substituted for chlordiazepoxide at a ratio of 1 mg of lorazepam to 25 mg of chlordiazepoxide. Doses should be withheld for nystagmus, sedation, ataxia, or dysarthria. Because the patient is often nutritionally depleted, thiamine 100 mg either intramuscularly or intravenously, folate 1 mg, and a multivitamin should be given daily. Thiamine should be given to every patient suspected of alcoholism prior to the administration of dextrose or food to prevent the development of Wernicke’s encephalopathy (2, 4).

The withdrawal protocol may prevent the development of delirium tremens. For patients in delirium tremens, a suggested regimen is to give 2 mg intravenous lorazepam, increasing the dose until the patient is calm but not obtunded. Adjunctive haloperidol can be used for agitation and psychosis, when benzodiazepines alone are not effective. However, antipsychotics alone are not effective in the management of delirium tremens. One can combine 5 mg haloperidol and 2-4 mg lorazepam and administer this every 2 hours until agitation is controlled. Flexibility in dosing is extremely important as simple tapering of the medication according to a schedule may leave the patient inadequately covered for major withdrawal. Clinicians should follow vital signs and the clinical examination. The patient may be comfortable when mild sedation is maintained throughout the course of delirium. The taper should be continued from the dose at which mild sedation is obtained.
Other medications that have been used to treat withdrawal include ethanol, barbiturates, carbamazepine, propofol, beta-blockers, and centrally acting alpha2-agonists such as clonidine(9) . None have been as well studied as the benzodiazepines. They may mask the hemodynamic signs of withdrawal, or even cause delirium themselves(17, 18). Attempting to use ethanol is especially problematic since intravenous administration requires close monitoring of blood concentrations because of toxicity at higher doses. Administering ethanol in the form of beverage alcohol often causes more problems than it solves because of drug interaction issues, unpredictable absorption. Moreover, there is the wide variability in tolerance; well known hepatic, gastrointestinal, hematologic, and neurologic toxicity, and exacerbation of delirious states(8). Moreover, since the effectiveness of ethanol has never been proven, its use has been discouraged(16).

Alcohol-withdrawal seizures occur about 6-48 hours after stopping alcohol. One third of those having a seizure go on to develop delirium tremens(17). The seizures usually occur as 1-6 generalized tonic-clonic convulsions, which are self-limited(5). In some series, 10% of patients with chronic alcoholism have recurrent seizures. Other seizure patterns should raise the suspicion of alternative etiologies, such as intra-cranial masses, meningitis, and epilepsy. In most cases of alcohol withdrawal seizures, adding anticonvulsants to benzodiazepines is unnecessary, unless the patient develops status epilepticus. Lorazepam, administered intravenously, usually aborts status epilepticus(15). Dilantin loading may be done if necessary, but this should be administered with cardiac monitoring. In general, it is unnecessary to prescribe prophylactic anticonvulsants for alcohol withdrawal seizures.
References:


Bariatric Surgery

Psychiatry Consultation for Bariatric Surgery

Situational depression and anxiety related to obesity are common, but may improve with Bariatric Surgery.

The prevalence of morbid obesity, defined as a body mass index (BMI) more than 40 kg/m² is around 2.2% in women and 0.4% in men in the United States. It’s associated with a two-fold increase in total mortality and greater increases in mortality due to diabetes mellitus, cerebrovascular and cardiovascular disease.

Obesity is associated with situational depression and anxiety, often linked to low self-esteem and frustration with failure at repeated attempts at weight loss. Discrimination against the obese is common.

Dietary regimes are often ineffective for the morbidly obese, leading to the recommendation of bariatric surgery. Jejunoileal bypass operations have been abandoned in favor of restrictive procedures, which produce fewer complications. Several controlled studies have demonstrated the superiority of gastric bypass over vertical banded gastroplasty (VBG) in producing weight loss. Most patients can expect a BMI reduction of about 15 kg/m² over the first year and a half to two years, with a trend to regain small amounts at three years. In experienced hands, surgical mortality is generally less than 1%.

Some authors estimate the prevalence of psychopathology in the severely obese requesting obesity surgery to be as high as 84%. Roughly 30%-70% are identified as having personality disorders.

Obesity is probably a product of behavioral, metabolic, and genetic factors. Accumulating evidence shows that severe obesity cannot be ascribed to psychopathology alone. One notable exception would be binge eating disorder, in most series said to have a prevalence of about 30%.

Reductions in energy expenditure with activity may account for some of the tendency for people to become obese. Basal metabolic rate and thermal effect of food play smaller and more controversial roles. Energy expended in activity can account for up to 80% of total energy expended in training athletes down to about 10% in the bedridden.
Patients presenting to the Bariatric Surgery Department may say they gain weight despite adequate adherence to exercise and dietary restrictions. They in fact may tend to underestimate the number of calories consumed. When morbidly obese patients are placed in hospital on metabolic wards, and energy intake and energy expenditure carefully monitored, there’s no evidence to support the claim that they can consume 600 calories and still gain weight.

Bariatric surgery candidates are increasingly referred at the request of some insurance companies who decline to reimburse for the procedure without psychiatric clearance. Anecdotally, some psychiatrists decline to perform these evaluations, based on the view that a one-time consultation is insufficient to formulate a clear recommendation that would satisfy the consultation question, which is often to predict “lifelong” ability to adhere to dietary and behavioral restrictions to ensure a satisfactory weight loss outcome.

Currently the medical literature does not support making a recommendation of this kind based on a single consultation visit. Some authors even cast doubt on the value of psychological assessments in terms of predicting outcomes.

The literature does tend to support the view that certain forms of mild psychopathology and quality of life may significantly improve after successful Bariatric surgery. It also tends to show that mainly it’s the more severe forms of psychopathology, such as binge eating disorder, untreated depression, addictions, psychosis, and longstanding personality disorder that may be relative contraindications to surgery.

One suggested list of issues to address during a one-time psychiatric consultation of this kind follows:

- Evaluate for major psychiatric disorders including untreated and active major depression, phobic and generalized anxiety disorders, binge eating disorders, personality disorders, active substance abuse, and suicidality.

- Assess why the patient is planning to undergo the obesity surgery now, which may uncover unrealistic expectations, and distorted body image. In general, many patients request this surgery for health maintenance reasons, since they suffer from obesity related illnesses including diabetes mellitus, hypertension, and obstructive sleep apnea.

- An assessment of how the patient’s family is reacting to the plan for surgery is important. Anecdotally, some spouses may have difficulty adjusting to the changes in the patient’s self image, and altered roles in the family (e.g., the patient may become more assertive and independent).
Assess the patient’s understanding of postoperative dietary and behavioral requirements. Often by the time of the psychiatric evaluation, the patient will have already been participating in a diet and exercise plan framed by the Bariatric Clinic dietician. Look through the dietician’s notes and compare the assessments with the patient’s subjective report.

Mild forms of depression, anxiety, and personality dysfunction may improve after surgery. Entrenched syndromal personality disorders tend not to change.

**Binge Eating Disorder**

The prevalence of binge eating in the bariatric surgery population ranges from 39% to 46%. The relevant category is included under the rubric of Eating Disorder Not Otherwise Specified (EDO NOS):

Binge Eating Disorder (BED): binge eating or near continuous grazing without compensatory purging behavior to avoid weight gain followed by shame and guilt. Some authorities believe this is a variant of bulimia nervosa. Binge behavior can be driven by a number of factors including hunger, distressed moods, relationship difficulties, habits and boredom.

Eating disorders are commonly comorbid with mood, anxiety, substance abuse, and personality disorders.

Data on binge behavior after exclusively restrictive procedures are conflicting, some showing a decrease in binge eating but an increase in vomiting. Similar results are reported following gastric bypass procedures. Contrary to restrictive interventions, biliopancreatic diversion procedures have been reported to result in improvement on several standardized eating disorder questionnaires regarding binge eating.

Bringing the eating disorder under control first before considering obesity surgery is generally recommended:

- Frame a lifetime nutritional plan
- Regular exercise to improve lean muscle mass
- Psychological treatments to encourage assertiveness, manage depression, e.g., cognitive-behavioral and interpersonal psychotherapies
- Selective serotonin reuptake inhibitors for management of mood and anxiety disorders

**Treatment of BED**
References:


Management of the Acutely Violent, Agitated Patient

If a violently agitated patient suddenly seems unable to hear you, that is not the time to speculate about the neurobiological determinants of aggression.

There are many ways to conceptualize algorithms for managing the acutely agitated and potentially violent patient. Here is a suggested mnemonic:

Containment before
Assessment before
Non-violent

Intervention before
Take Down

Frequently the consultant is called to intensive care units and emergency rooms to assist in the management of patients who either are rapidly getting out of control or already out of control.

The idea behind CAN IT is to facilitate recall of basic principles of assessment and management of acute agitation. Containment refers to ensuring that you and the patient both feel relatively safe in the assessment area. Preferably, both of you should have an easy access to the door for escape if necessary. At first, it may seem odd to recommend letting the patient escape from the room, but the point is not to force them to run over you in order to get to the door.

Another issue of containment is to ensure that the patient gives up any weapons before you agree to do the evaluation. Sometimes offering food or drink (not hot enough to injure if hurled in your face) will help set a more non-threatening atmosphere. It’s helpful to avoid making intense or prolonged eye contact with the patient as this may be viewed as threatening. Always make sure that there are plenty of other people available to help you if a take down situation develops.
Recognizing the gut feeling that a threat exists is imperative in maintaining a safe environment for you, the patient and others in the evaluation area. Denial, freezing, and bravado are some of the symptoms of unacknowledged fear of a threat. They can rapidly contribute to rapid escalation of agitation in the patient, who will almost certainly be more ready to obey gut impulses than you will be. Containment under these conditions is sometimes achievable by simply being honest with the patient who is still able to hear you by admitting that he/she is saying or doing things that make you afraid. This may seem counterintuitive. But, provided it’s delivered calmly as a statement followed by reassurance that you and everyone else involved are committed to maintaining the safety of all persons present (including the patient), this may capitalize on the patient’s own fear of losing control by assuring that you’ll do everything in your power to keep the lid on the situation. Now it won’t contain the occasional sadistic psychopathic personality who enjoys making people afraid. In this case, it has to be abundantly clear to this individual that there are many people around who could physically control him if absolutely necessary.

Assessment is vital, but can only be adequately carried out if safety issues have been addressed first. In order to manage the agitated patient, it’s critical to understand the origin of the behavior. And that doesn’t mean theorizing about the neurobiological underpinnings. The following list indicates some of the most common associated disorders in agitated patients:

**Primary Psychiatric Disorders**
- Psychotic disorders
- Schizophrenia
- Affective illness
- Bipolar Affective Disorder, manic with psychosis
- Major Depression can be accompanied by anger attacks and psychosis
- Cognitive disorders
- Dementia with psychosis and behavior disturbance
- Mental retardation
- Personality disorders
- Antisocial and Borderline
- Substance abuse disorders
- Intoxications

**Medical Disorders**
- Delirium due to a general medical condition
- Seizure disorder
- CNS malignancy, trauma, or infection
- Medications
- Cerebrovascular disease
- Systemic disorders
- Toxic, metabolic
- Infectious
- Environmental

Thinking both/and rather than either/or about etiologies is prudent. Treatment of the underlying cause is always advisable, but often not feasible in some situations. The underlying illness may be chronic, for example, or the patient may be too agitated to allow a full medical examination initially.
Many authors agree that the best predictor of future violence in psychiatric patients is past violence, especially recent past violence. High arousal states including fear, anger, confusion, or humiliation may underlie aggression.

Attempts to de-escalate agitation with non-violent means is the next step. Offering to inject the patient with an antipsychotic would not usually be welcomed as a first intervention. Paying attention to your own body language is important. Crossed arms or hands held behind the back can be seen as threatening. Stay out of arms reach. Avoid challenging the patient by “correcting” faulty reality testing. Open-ended questions may invite excessive, non-productive scapegoating, overinclusive rumination, and suspicion (e.g., “you trying to crawl inside my head; what do you mean by that?”).

Try to keep questions to the point, obtaining as much information as possible about such things as triggering social crises. If a therapeutic alliance is achieved, capitalize by giving the patient a sense of control by offering choices regarding requests for urine drug screens or blood tests.

Only if non-violent means fail, should the take down be considered. This is when seclusion and restraints, and involuntary administration of medications happen. It’s unfortunate when this occurs, because it wrests freedom and control away from the patient. At all times there should be an effort to utilize the least restrictive alternative doctrine. If the patient will accept an oral formulation of a sedative rather than an injection, this choice should be respected if there is no medical reason not to do so.

Sometimes a show of force is all that is required to convince someone that it would be too costly to fight. This entails gathering at least 5 people to non-violently simply confront the patient with an overwhelming number of potential opponents.

**CODE GREEN SITUATIONS**

At UIHC, there is an established policy and procedure called Code Green Violence Management in the event of a failure of de-escalation methods by clinicians or other staff members. It is the absolute last resort for helping an out of control patient and avoiding injury to others. There is a standing multidisciplinary team specifically trained in non-violent behavior management who will respond to requests for non-violent interventions throughout the general hospital.

Any staff member can mobilize the Code Green Violence Management Team by calling a Code Green (dial 192) if assaultive, combative, or out-of-control patients pose a threat to themselves or others. The consult resident and staff are members of the team. *Neither is expected to physically intervene with a patient.* Moreover, nursing staff generally has had more experience and direct training with verbal de-escalation and negotiating with patients under these conditions. They are educated initially in an all-day non-violent crisis management intervention program, and must attend annual reviews thereafter.

Everyone on the team has an assigned responsibility, including a team leader (often the nurse manager or designee) who is the one person negotiating with the patient or assigning that duty, restrainers, controllers (non-restraining support), unit runners to obtain equipment and make calls as needed, and psychiatric physicians. The consulting psychiatrist determines ongoing assessment, medical treatment for violent behavior and need for civil commitment (involuntary psychiatric hospitalization). A medication kit is available and includes injectable haloperidol and equipment necessary for its administration.
Psychopharmacologic Management of the Agitated, Violent Patient

There is no specific medication approved by the FDA for control of agitation and combative behavior. Medications of choice are haloperidol and lorazepam, used either singly or in combination. Droperidol is another very effective agent, although recent FDA black box warnings about the risk for cardiac arrhythmias and case reports of sudden death reported with it's use have led to more caution. Of course, the first questions you should ask before administering any sedatives are:

Does the patient have any known general medical relative or absolute contraindications to specific agents, e.g., cardiac, pulmonary, renal or liver disease?

Does the patient have any known specific drug allergies or potentially life threatening idiosyncratic drug sensitivities?

Antipsychotics often provide non-specific but effective control of violent behavior regardless of its cause. Some judgment needs to be exercised in the choice of these agents, depending on the underlying psychiatric and medical conditions.

For example, it's debatable whether attempts at rapid tranquilization with haloperidol alone are optimally beneficial in someone who is primarily violent because of antisocial personality traits. An angry sociopathic individual may require one or more injectable or oral 2mg doses of lorazepam alone, rarely requiring more than 3 doses. Sedation is achieved often in minutes with an amnestic effect as well.

Agitation of delirium is generally responsive to monotherapy with antipsychotics, and haloperidol is the agent with which physicians have the most experience and for which there is the most efficacy supported by the medical literature. Attempting to treat this condition with benzodiazepines alone usually leads to worsening delirium, except in the special case of alcohol or benzodiazepine withdrawal delirium. Please see the chapter in this handbook regarding this topic for further details.

Rapid tranquilization is referred to in the medical literature with variable recommendations about dosing schedules. One suggested regimen is haloperidol 5mg IM/concentrate q30 minutes until calm but awake. Cogentin can be made available for management of extrapyramidal adverse effects at 2mg IM/oral q4 hours prn. Other regimens call for increasing (usually doubling) doses of haloperidol every 20-30 minutes until the patient is calm or until a set total dose is reached, after which alternative combination regimens of haloperidol and lorazepam are recommended.

Combinations of haloperidol and lorazepam are effective and reduce the total dose of each required to achieve sedation. One suggested regimen starts with 5mg haloperidol and 1-2mg of lorazepam.

Recently, the FDA required a black box warning suggesting that unexpected cardiovascular deaths could occur using normal therapeutic doses of droperidol. This has had consequences for the use of the agent in emergency rooms and on hospital wards lacking the capacity for cardiac monitoring. Mullins, et al reviewed this topic in the January 2004 issue American Journal of Emergency Medicine, in addition to Shale et al in the May 2003 Journal of Clinical Psychiatry. They concluded that cardiovascular deaths are rare with doses at or below 2.5mg, that mandatory electrocardiographic screening appears unnecessary, that it's an extremely effective and safe method for treating severely agitated or violent patients provided that the drug is administered in 5mg intramuscular doses (with or without lorazepam). Since it is absorbed almost as quickly with intramuscular injection as with intravenous, there is not a great advantage to the latter.
It would be prudent to exercise caution when administering droperidol to patients with underlying cardiac disease. It has been associated with postural hypotension (due to alph-adrenergic blockade) and QTc interval prolongation, which could potentially progress to torsades de pointe and malignant ventricular arrhythmias. The latter problem has also been known to occur with large doses of intravenous haloperidol (though it has no black box warning), thioridazine, and ziprasidone (both of which have a black box warning). It may be more likely to occur if the baseline corrected QTc interval is in excess of 500 milliseconds in length, so a baseline ECG should be reviewed if it’s available.

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