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13.8 Consultation-Liaison Psychiatry

therapies. They provide extensive physical conditioning through physical therapy and exercise and offer vocational evaluation and rehabilitation. Concurrent mental disorders are diagnosed and treated, and patients who are dependent on analgesics and hypnotics are detoxified. Inpatient multimodal treatment programs generally report encouraging results. REFERENCES Bak JA. Review of pain comorbidities: Understanding and treating the complex patient. J Neurosci Nurs. 2013;45(3):176– 177. Brown RJ, Schrag A, Trimble MR. Dissociation, childhood interpersonal trauma, and family functioning in patients with somatization disorder. Am J Psychiatry. 2005;162:899–905. Grabe HJ, Meyer C, Hapke U, Rumpf HJ, Freyberger HJ, Dilling H, John U. Specific somatoform disorder in the general population. Psychosomatics. 2003;44:304. Keefe FJ, Abernethy AP, Campbell LC. Psychological approaches to understanding and treating disease-related pain. Annu Rev Psychol. 2005;56:601–630. Mayou R, Kirmayer LJ, Simon G, Kroenke K, Sharpe M. Somatoform disorders: Time for a new approach in DSM-V. Am J Psychiatry. 2005;162(5):847–855. Noll-Hussong M, Otti A, Wohlschlaeger AM, Zimmer C, Henningsen P, Lahmann C, Ronel J, Subic-Wrana C, Lane RD, Decety J, Guendel H. Neural correlates of deficits in pain-related affective meaning construction in patients with chronic pain disorder. Psychosom Med. 2013;75(2):124–136. Sansone RA, Pole M, Dakroub H, Butler M. Childhood trauma, borderline personality symptomatology, and psychophysiological and pain disorders in adulthood. Psychosomatics. 2006;47:158–162. Wasserman RA, Brummett CM, Goesling J, Tsodikov A, Hassett AL. Characteristics of chronic pain patients who take opioids and persistently report high pain intensity. Reg Anesth Pain Med. 2014;39(1):13–17. 13.8 Consultation-Liaison Psychiatry Consultation-liaison (C-L) psychiatry is the study, practice, and teaching of the relation between medical and psychiatric disorders. In C-L psychiatry, psychiatrists serve as consultants to medical colleagues (either another psychiatrist or, more commonly, a nonpsychiatric physician) or to other mental health professionals (psychologist, social worker, or psychiatric nurse). In addition, C-L psychiatrists consult regarding patients in medical or surgical settings and provide follow-up psychiatric treatment as needed. C-L psychiatry is associated with all the diagnostic, therapeutic, research, and teaching services that psychiatrists perform in the general hospital and serves as a bridge between psychiatry and other specialties. In the medical wards of the hospital, C-L psychiatrists

must play many roles: skillful and brief interviewer, good psychiatrist and psychotherapist, teacher, and knowledgeable physician who understands the medical aspects of the case. The C-L psychiatrist is part of the medical team who makes a unique contribution to the patient's total medical treatment. The scope of C-L psychiatry is outlined in Table 13.8-1.

Table 13.8-1 Scope of Consultation-Liaison Psychiatry DIAGNOSIS Knowledge of psychiatric diagnosis is essential to C-L psychiatrists. Both dementia and delirium frequently complicate medical illness, especially among hospital patients. Delirium occurs in 15 to 30 percent of hospitalized patients. Psychoses and other mental disorders often complicate the treatment of medical illness, and deviant illness behavior, such as suicide, is a common problem in patients who are organically ill. C-L psychiatrists must be aware of the many medical illnesses that can have psychiatric symptoms. Lifetime prevalence of mental illness in chronically physically ill patients is more than 40 percent, particularly substance abuse and mood and anxiety disorders. Interviews and serial clinical observations are the C-L psychiatrist's tools for diagnosis. The purposes of the diagnosis are to identify (1) mental disorders and psychological responses to physical illness, (2) patients' personality features, and (3) patients' characteristic coping techniques to recommend the most appropriate therapeutic intervention for patients' needs. TREATMENT The C-L psychiatrists' principal contribution to medical treatment is a comprehensive analysis of a patient's response to illness, psychological and social resources, coping

style, and psychiatric illness, if any. This assessment is the basis of the patient treatment plan. In discussing the plan, C-L psychiatrists provide their patient assessment to nonpsychiatric health professionals. Psychiatrists' recommendations should be clear, concrete guidelines for action. A C-L psychiatrist may recommend a specific therapy, suggest areas for further medical inquiry, inform doctors and nurses of their roles in the patient's psychosocial care, recommend a transfer to a psychiatric facility for long-term psychiatric treatment, or suggest or undertake brief psychotherapy with the patient on the medical ward. C-L psychiatrists must deal with a broad range of psychiatric disorders, the most common symptoms being anxiety, depression, and disorientation. Treatment problems account for 50 percent of the consultation requests made of psychiatrists. Common C-L Problems Suicide Attempt or Threat. Suicide rates are higher in persons with medical illness than in those without medical or surgical problems. High-risk factors for suicide are men over 45 years of age, no social support, alcohol dependence, previous suicide attempt, and incapacitating or catastrophic medical illness, especially if accompanied by severe pain. If suicide risk is present, the patient should be transferred to a psychiatric unit or started on 24-hour nursing care. Depression. As mentioned, suicidal risk must be assessed in every depressed patient. Depression without suicidal ideation is not uncommon in hospitalized patients, and treatment with antidepressant medication can be started if necessary. A careful assessment of drug–drug interactions must be made before prescribing, which should be undertaken in collaboration with the patient's primary physician. Antidepressants should be used cautiously in cardiac patients because of conduction side effects and orthostatic hypotension. Agitation. Agitation is often related to the presence of a cognitive disorder or associated with withdrawal from drugs (e.g., opioids, alcohol, sedative hypnotics). Antipsychotic medications (e.g., haloperidol [Haldol]) are very useful for excessive agitation. Physical restraints should be used with great caution and only as a last resort. The patient should be examined for command hallucinations or paranoid ideation to which he or she is responding to in an agitated manner. Toxic reactions to medications that cause agitation should always be ruled out. Hallucinations. The most common cause of hallucinations is

delirium tremens, which usually begin 3 to 4 days after hospitalization. Patients in intensive care units (ICU) who experience sensory isolation may respond with hallucinatory activity. Conditions such as brief psychotic disorder, schizophrenia, and neurocognitive disorders are associated with hallucinations, and they respond rapidly to antipsychotic medication. Fornication, in which the patient believes that bugs are crawling over the

skin, is often associated with cocainism. Sleep–Wake Disorders. A common cause of insomnia in hospitalized patients is pain, which when treated, solves the sleep problem. Early morning awakening is associated with depression, and difficulty falling asleep is associated with anxiety. Depending on the cause, antianxiety or antidepressant agents may be prescribed. Early substance withdrawal as a cause of insomnia should be considered in the differential diagnosis. Confusion. Delirium is the most common cause of confusion or disorientation among hospitalized patients in general hospitals. The causes are myriad and relate to metabolic status, neurological findings, substance abuse, and mental illness, among many others. Small doses of antipsychotics may be used when major agitation occurs in conjunction with the confused state; however, sedatives, such as benzodiazepines, can worsen the condition and cause sundowner syndrome (ataxia, disorientation). If sensory deprivation is a contributing factor, the environment can be modified so that the patient has sensory cues (e.g., radio, clock, no curtains around the bed). Table 13.8-2 lists the probable causes of confusional states that require urgent attention. Table 13.8-2 Some Clues to Causes of Acute Confusional States Demanding Urgent Attention

Noncompliance or Refusal to Consent to Procedure. Issues such as noncompliance and refusal to consent to a procedure can sometimes be traced to the relationship of the patient and his or her treating doctor, which should be explored. A negative transference toward the physician is a common cause of noncompliance. Patients who fear medication or who fear a procedure often respond well to education

and reassurance. Patients whose refusal to give consent is related to impaired judgment can be declared incompetent, but only by a judge. Cognitive disorder is the main cause of impaired judgment in hospitalized patients. No Organic Basis for Symptoms. The C-L psychiatrist is often called in when the physician cannot find evidence of medical or surgical disease to account for the patient’s symptoms. In these instances, several psychiatric conditions must be considered, including conversion disorder, somatization disorder, factitious disorders, and malingering. Glove and stocking anesthesia with autonomic nervous system symptoms is seen in conversion disorder; multiple bodily complaints are present in somatization disorder; the wish to be in the hospital occurs in factitious disorder; and obvious secondary gain is observed in patients who are malingering (e.g., compensation cases). C-L Psychiatry in Special Situations Intensive Care Units. All ICUs deal with patients who experience anxiety, depression, and delirium. ICUs also impose extraordinarily high stress on staff and patients, which is related to the intensity of the problems. Patients and staff members alike frequently observe cardiac arrests, deaths, and medical disasters, which leave them all autonomically aroused and psychologically defensive. ICU nurses and their patients experience particularly high levels of anxiety and depression. As a result, nurse burnout and high turnover rates are common. The problem of stress among ICU staff receives much attention, especially in the nursing literature. Much less attention is given to the house staff, especially those on the surgical services. All persons in ICUs must to be able to deal directly with their feelings about their extraordinary experiences and difficult emotional and physical

circumstances. Regular support groups in which persons can discuss their feelings are important to the ICU staff and the house staff. Such support groups protect staff members from the otherwise predictable psychiatric morbidity that some may experience and also protect their patients from the loss of concentration, decreased energy, and psychomotor-retarded communications that some staff members otherwise exhibit. Hemodialysis Units. Hemodialysis units present a paradigm of complex modern medical treatment settings. Patients are coping with lifelong, debilitating, and limiting disease; they are totally dependent on a multiplex group of caretakers for access to a machine controlling their well-being. Dialysis is scheduled three times a week and takes 4 to 6 hours; thus, it disrupts patients' previous living routines. In this context, patients first and foremost fight the disease. Invariably, however, they also must come to terms with a level of dependence on others probably not experienced since childhood. Predictably, patients entering dialysis struggle for their independence; regress to childhood states; show denial by acting out against doctor's orders (by

breaking their diet or by missing sessions); show anger directed against staff members; bargain and plead; or become infantilized and obsequious; however, most often they are accepting and courageous. The determinants of patients' responses to entering dialysis include personality styles and previous experiences with this or another chronic illness. Patients who have had time to react and adapt to their chronic renal failure face less new psychological work of adaptation than those with recent renal failure and machine dependence. Although little has been written about social factors, the effects of culture in reaction to dialysis and the management of the dialysis unit are known to be important. Units are run with a firm hand, which is consistent in dealing with patients; clear contingencies are in place for behavioral failures; and adequate psychological support is available for staff members, which tend to produce the best results. Complications of dialysis treatment can include psychiatric problems, such as depression, and suicide is not rare. Sexual problems can be neurogenic, psychogenic, or related to gonadal dysfunction and testicular atrophy. Dialysis dementia is a rare condition that evidences loss of memory, disorientation, dystonias, and seizures. The disorder occurs in patients who have been receiving dialysis treatment for many years. The cause is unknown. The psychological treatment of dialysis patients falls into two areas. First, careful preparation before dialysis, including the work of adaptation to chronic illness, is important, especially in dealing with denial and unrealistic expectations. Predialysis, all patients should have a psychosocial evaluation. Second, once in a dialysis program, patients need periodic specific inquiries about adaptation that do not encourage dependence or the sick role. Staff members should be sensitive to the likelihood of depression and sexual problems. Group sessions function well for support, and patient self-help groups restore a useful social network, self-esteem, and self-mastery. When needed, tricyclic drugs or phenothiazines can be used for dialysis patients. Psychiatric care is most effective when brief and problem oriented. The use of home dialysis units has improved attitudes toward treatment. Patients treated at home can integrate the treatment into their daily lives more easily, and they feel more autonomous and less dependent on others for their care than do those who are treated in the hospital. Surgical Units. Some surgeons believe that patients who expect to die during surgery often will. This belief now seems less superstitious than it once did. Chase Patterson Kimball and others have studied the premorbid psychological adjustment of patients scheduled for surgery and have shown that those who show evident depression or anxiety and deny it have a higher risk for morbidity and mortality than those who, given similar depression or anxiety, can express it. Even better results occur in those with a positive attitude toward impending surgery. The factors that contribute to an improved outcome for

surgery are informed consent and education so that patients know what they can expect to feel, where they will be (e.g., it is useful to show patients the recovery room), what loss of function to expect, what tubes and gadgets will be in

place, and how to cope with the anticipated pain. If patients will not be able to talk or see after surgery, it is helpful to explain before surgery what they can do to compensate for these losses. If postoperative states such as confusion, delirium, and pain can be predicted, they should be discussed with patients in advance so they do not experience them as unwarranted or as signs of danger. Constructive family support members can help both before and after surgery. Transplantation Issues. Transplantation programs have expanded over the past decade, and C-L psychiatrists play an important role in helping patients and their families deal with the many psychosocial issues involved: (1) which and when patients on a waiting list will receive organs, (2) anxiety about the procedure, (3) fear of death, (4) organ rejection, and (5) adaptation to life after successful transplantation. After transplant, patients require complex aftercare, and achieving compliance with medication may be difficult without supportive psychotherapy. This is particularly relevant to patients who have received liver transplants as a result of hepatitis C brought on by promiscuous sexual behavior and to drug addicts who use contaminated needles. Group therapy with patients who have had similar transplantation procedures benefits members who can support one another and share information and feelings about particular stressors related to their disease. Groups may be conducted or supervised by the psychiatrist. Psychiatrists must be especially concerned about psychiatric complication. Within 1 year of transplant, almost 20 percent of patients experience a major depression or an adjustment disorder with depressed mood. In such cases, evaluation for suicidal ideation and risk is important. In addition to depression, another 10 percent of patients experience signs of posttraumatic stress disorder, with nightmares and anxiety attacks related to the procedure. Other issues concern whether or not the transplanted organ came from a cadaver or from a living donor who may or may not be related to the patient. Pretransplant consulting sessions with potential organ donors help them to deal with fears about surgery and concerns about who will receive their donated organ. Sometimes, both the recipient and donor may be counseled together, as in cases where one sibling is donating a kidney to another. Peer support groups with both donors and recipients have also been used to facilitate coping with transplantation issues. PSYCHO-ONCOLOGY Psycho-oncology seeks to study both the impact of cancer on psychological functioning and the role that psychological and behavioral variables may play in cancer risk and survival. A hallmark of psycho-oncology research has been intervention studies that attempt to influence the course of illness in patients with cancer. A landmark study by David Spiegel found that women with metastatic breast cancer who received weekly group psychotherapy survived an average of 18 months longer than control patients randomly assigned to routine care. In another study, patients with malignant melanoma

who received structured group intervention exhibited a statistically significant lower recurrence of cancer and a lower mortality rate than patients who did not receive such therapy. Patients with malignant melanoma who received the group intervention also exhibited significantly more large granular lymphocytes and natural killer (NK) cells as well as indications of increased NK cell activity, suggesting an increased immune response. Another study used a group behavioral intervention (relaxation, guided imagery, and biofeedback training) for patients with breast cancer, who demonstrated higher NK cell activity and lymphocyte mitogen responses than the controls. Because new treatment protocols, in many cases, have transformed cancer from an incurable to

frequently chronic and often curable disease, the psychiatric aspects of cancer—the reactions to both the diagnosis and the treatment—are increasingly important. At least half of the persons who contract cancer in the United States each year are alive 5 years later. Currently, an estimated 3 million cancer survivors have no evidence of the disease. About half of all cancer patients have mental disorders. The largest groups are those with adjustment disorder (68 percent), and major depressive disorder (13 percent) and delirium (8 percent) are the next most common diagnoses. Most of these disorders are thought to be reactive to the knowledge of having cancer. When persons learn that they have cancer, their psychological reactions include fear of death, disfigurement, and disability; fear of abandonment and loss of independence; fear of disruption in relationships, role functioning, and financial standings; and denial, anxiety, anger, and guilt. Although suicidal thoughts and wishes are frequent in persons with cancer, the actual incidence of suicide is only slightly higher than that in the general population. Psychiatrists should make a careful assessment of psychiatric and medical issues in every patient. Special attention should be given to family factors, in particular, preexisting intrafamily conflicts, family abandonment, and family exhaustion. REFERENCES Copello A, Walsh K, Graham H, Tobin D, Griffith E, Day E, Birchwood M. A consultation-liaison service on integrated treatment: A program description. J Dual Diagn. 2013;9(2):149–157. Dew MA, DiMartini AD, De Vito Dabbs A, Myaskovsky L, Steel J. Rates and risk factors for nonadherence to the medical regimen after adult solid organ transplantation. Transplantation. 2007;83(7):858–873. DiMartini A, Crone C, Fireman M, Dew MA. Psychiatric aspects of organ transplantation in critical care. Crit Care Clin. 2008;24:949–981. Dobbels F, Verleden G, Dupont L, Vanhaecke J, De Geest S. To transplant or not? The importance of psychosocial and behavioural factors before lung transplantation. Chronic Respir Dis. 2006;3(1):39–47. Grover S, Kate N. Somatic symptoms in consultation-liaison psychiatry. Int Rev Psychiatry. 2013;25(1):52–64. Jorsh MS. Somatoform disorders: The role of consultation liaison psychiatry. Int Rev Psychiatry. 2006;18:61–65. Laugharne R, Flynn A. Personality disorders in consultation-liaison psychiatry. Curr Opin Psychiatry. 2013;26(1):84–89. Lipowski ZJ. Review of consultation psychiatry and psychosomatic medicine: I. General principles. Psychosom Med. 1967;29:153–171. Lipsitt DR. Consultation-liaison psychiatry and psychosomatic medicine: The company they keep. Psychosom Med.

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