21 - 18 Liaison psychiatry

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840 Chapter 18 Liaison psychiatry Introduction Liaison psychiatry1 is concerned with the assessment and management of psychiatric and psychological illnesses in general medical populations. The subspecialty is a relatively recent innovation and has expanded consider ably in both role and practitioner numbers over the last 25yrs. It offers an opportunity for interesting and varied clinical practice and research at the interface between psychiatry and medicine. History The development of a distinct subspecialty of liaison psychiatry arose, in large part, due to the physical separation of psychiatric specialists from their medical and surgical colleagues with the establishment of asylums separate from the general hospitals in the nineteenth century. Following this separation, a number of practitioners remained within the general hospitals with a special interest in 'nervous disorders', working at the boundary be tween neurology and psychiatry. At that time, the distinction between the two specialties was not as clear as it later became. As neurological practice became more scientific, the role of psychological factors became less an object of clinical attention for neurologists. At the same time, psychoanalytic theories were pre-eminent within psychiatry, and interest in, and involvement with, organic illnesses declined. However, by the early twentieth century, there was increasing attention to psycho somatic factors in the aetiology and maintenance of disease and their role in recovery. With the onset of 'biological psychiatry' in the mid-twentieth century, a number of pioneering individuals began psychiatric practice within the general hospitals. They advocated the need for recognition and treatment of psychological factors in physical illness and began the process of establishing links with medical colleagues, identifying appropriate cases for intervention and gaining funding for service development and research. The development of the subspecialty was motivated by the low rate of outside referrals in proportion to the prevalence of the disorders in the medical population and increasing medical specialization, leading to a lack of confidence and competence with psychiatric/psychological prob lems in physicians and surgeons. By the 1970s, a distinct subspecialty was recognized in both the UK and the USA. It was staffed mainly by sole practitioners who were generally confined to the larger hospitals. They developed services and established

models and ways of working and, in particular, developed links with individual departments with particular needs. In the last quarter-century, there has been growth in both role and practitioner numbers. This growth has often been service-led, with de mand, and hence funding, from individual clinical services that see the need for regular psychiatric input. Roles and responsibilities The role of the liaison psychiatrist and the types of referral seen will vary by the hospital type, the population served, and the specialty mix within the hospital. • Direct consultation on the general wards Requests for advice on diagnosis, prognosis, and management of psychiatric disorder. 1 The subspecialty is generally known as ‘liaison psychiatry’ within the UK but is also referred to as ‘psychosomatic medicine’, ‘consultation–liaison psychiatry’, and ‘psychological medicine’.

Introduction • Direct liaison with specialist units A closer relationship with a specialist unit, with involvement in unit planning, staff support, policy development, and training, as well as involvement in individual clinical cases. • Emergency Department Assessment of patients presenting with symptoms suggestive of mental disorder, following deliberate self-harm, and of patients brought in by the police to a ‘place of safety’. • Outpatient referrals Outpatients referred from general medical, surgical, or obstetric clinics. Some services also take GP referrals, particularly of cases with somatization or MUS. • Teaching and training Formal teaching of undergraduate and postgraduate medical trainees and training of paramedical and nursing staff. • Research and audit Particularly research into the psychological and psychiatric effects of medical illness and into deliberate self-harm. Presentations The range of psychiatric presentations and disorders seen in the general hospital is very wide, and liaison psychiatrists can expect to see conditions described in all of the chapters of this handbook. In our clinical practice, we have found the following 12 referral types to be the most common: • Patients presenting after self-harm or with suicidal thoughts or plans (E Assessment after self-harm, p. 848). • Assessment of mood or anxiety symptoms (E Assessment of depressive and anxiety symptoms, p. 844). • Issues of consent, capacity, or detainability (E Capacity and consent, p. 856). • Assessment of confusion or cognitive impairment (E Acute confusional state (delirium), p. 846). • Assessment of psychotic symptoms (E Assessment of psychotic symptoms and confusion, p. 846). • Request for advice in a patient with pre-existing psychiatric problems. • Patients referred during pregnancy or in the puerperium (E Disorders related to childbirth, p. 494). • MUS (E Medically unexplained symptoms 1: introduction, p. 858). • Alcohol or drug problems (E Assessment of the patient with alcohol problems, p. 584; E Assessment of the drug user, p. 630). • Assessment prior to listing for organ transplantation (E Assessment prior to organ transplantation, p. 878). • Psychiatric symptoms secondary to organic illness (E Chapter 4). • Eating disorders (E Chapter 9).

842 Chapter 18 Liaison psychiatry Working in the general hospital While working as a psychiatrist in a medical setting, you are in a sense acting as an ambassador for psychiatry2 in general. You may well be the only psych iatrist whom colleagues in other specialties will regularly meet. You should therefore aim to be available, approachable, considerate, and practical, and strive to be a ‘problem-solver’. In this role as ‘ambassador for psychiatry’, you will have the opportunity to meet and encourage medical students and doctors in training, some of whom may not have previously thought of psychiatry as a career. You will also have the opportunity to teach staff in multiple professions and grades, both on a case-by-case basis and during formal teaching sessions. When you first come to work in the general hospital, you may feel over whelmed. There are many new disorders, altered presentations of familiar disorders, a new tempo of working, and patients suffering from medical conditions about which you may know very little. Additionally, general hos

pital doctors in the various specialties will have their own ideas about psych iatry, as well as about the indicated treatment in each case (which may differ from yours). Nonetheless, it is well to remember that you have a range of skills and knowledge that will be useful and are not shared by other mem bers of staff. You should rely on these and your own judgement, backed up by senior colleagues, in difficult situations. Taking referrals The person receiving the referral should take details of the patient, their GP, their treating team, and the nature of the problem, including its urgency. It is important to clarify what questions the treating team wants addressed. It is vital to clarify that the patient understands that psychiatric referral has been made and agrees to this. Gathering information Where the situation is not an emergency, it is useful to review any departmental or other psychiatric records for previous con tacts, prior to assessing the patient. A discussion with the GP may also be helpful. On arrival on the ward, review the medical record of this and pre vious admissions, and speak to a senior member of the treating team. Clarify the patient's diagnosis and any investigations or treatments planned. Discuss the patient with the nursing staff—they may have useful information regarding the patient's symptoms around the clock and their mood from day to day. Approach to the patient Arrange a private room for the interview, if at all possible. Introduce yourself to the patient as a psychiatrist or a psycho logical medicine specialist. Explain your role, which may be misunderstood by the patient, who may feel you are there to 'see if I'm crazy'. Stating that the medical team is concerned about some of the patient's symptoms and they want a specialist in these symptoms to give them some advice is often an acceptable phrasing for patients. Assessing psychiatric symptoms on the general wards The assessment of psychiatric symptoms in the general hospital is broadly similar to their assessment in psychiatric settings. There are, however, a number of im portant differences: • The patient's medical condition, the clinical urgency of the situation, or the setting (e.g. A&E, ICU) may make full or normal assessment impossible. 2 Masterton G (2003) Liaison psychiatry and general hospital management. Br J Psychiatry 183:366.

Working in the general hospital • The patient's medical symptoms may confuse the issue—symptoms of psychiatric disorders overlap with those of many medical conditions. • The differential diagnosis and relative likelihood of various psychiatric diagnoses are different between the general medical and psychiatric populations. The assessment of depressive, anxiety, and psychotic symptoms and of con fusion on the general wards is described in E Assessment of depressive and anxiety symptoms, p. 844; E Assessment of psychotic symptoms and confusion, p. 846; E Assessment after self-harm, p. 848; E Management after self-harm, p. 850; E Depression in physical illness, p. 852; and E Acute confusional state (delirium), p. 854, as well as the differential diag nosis for these symptoms in the general setting. Management of psychiatric illness on the general wards The pharma cology and psychology of particular psychiatric disorders are broadly similar in the psychiatric and the general hospital settings. The differences relate to factors imposed by the patient's medical condition and the environment. When considering medication, consult E Prescribing in pregnancy, p. 1028; E Prescribing in lactation, p. 1030; E Prescribing for patients with car diovascular disease, p. 1032; E Prescribing for patients with liver disease, p. 1034; E Prescribing for patients with renal impairment, p. 1036; and E Prescribing for patients with epilepsy, p. 1038, which describe the pre scribing of psychotropics in specific medical conditions. Documenting your findings When documenting your findings in the med ical notes, remember that the written record has a dual purpose—it acts both to document the clinical contact and to communicate information about your findings and opinion. In general, the medical team will be more interested in the opinion and any associated management advice than in detailed history or

psychiatric formulation. You should avoid any jargon or acronyms which are specific to psychiatry. Stating your opinion Aim to specifically answer any questions you have been asked. If a definitive psychiatric diagnosis is possible, write this clearly in the notes, along with a provisional management plan and any treat ment recommendations. Clarify in the notes if further psychiatric review is planned and when, and which symptoms should cause them to seek an earlier review. If at all possible, discuss your findings with the medical team face-to-face. Remember that general hospital doctors will have less experi ence than you in psychiatric issues, and it will be necessary to 'spell out' some things, e.g. what the implication of detention is, what side effects they should look out for after antipsychotic prescription.

844 Chapter 18 Liaison psychiatry Assessment of depressive and anxiety symptoms Depressive symptoms One of the most common referrals in liaison psychiatry is of patients with low mood. Apparent low mood is a common presentation of hypoactive delirium (E Acute confusional state (delirium), p. 854), and so assessment of orientation and basic cognitive testing is an important part of the as sessment of mood symptoms in the general setting. If delirium is ruled out, the next step is to assess the nature and severity of the mood disorder and, if depressive illness is present, to make suggestions as to appropriate management. Differential diagnosis Depressive illness (E Depression in physical illness, p. 852; E Differential diagnosis, p. 252), hypoactive delirium (E Acute confusional state (de lirium), p. 854), normal emotional response to illness or loss, adjustment reactions (E Adjustment disorders, p. 398), drug or alcohol misuse, de pression with organic cause. Organic causes of depressive symptoms • Neurological (CVA, epilepsy, Parkinson's disease, brain tumour, dementia, MS, HD, head injury). • Infectious (HIV and related opportunistic infections, EBV/CMV, infectious mononucleosis, Lyme disease). • Endocrine and metabolic (hypothyroidism, hyperprolactinaemia, Cushing's disease, Addison's disease, parathyroid disease). • Cardiac disease (MI, cardiac bypass surgery, heart failure). • Systemic disease (SLE, rheumatoid arthritis, cancer). • Medications (analgesics, antihypertensives, levodopa, anticonvulsants, BDZs, antibiotics, steroids, combined oral contraceptive, cytotoxics, cimetidine). • Substance misuse (alcohol, BDZs, cannabis, cocaine, opioids). Key points in assessment • Is there evidence of confusion? Examine for orientation, and perform a basic test of cognitive function (e.g. AMT, MMSE). Acute onset of confusion (or acute deterioration of existing impairment), together with an apathetic and 'depressed' presentation, is seen in patients with hypoactive delirium (E Acute confusional state (delirium), p. 854). • How does the patient describe their mood? It is vital to gain an understanding of the patient's subjective mood. Often referrals are made without this information because patients 'look depressed'. • Explore cognitive depressive symptoms Biological depressive features may be less useful, as diagnostic features in physically ill patients— impairment of sleep, appetite, energy levels, concentration, and libido— may be due to depression or may be due to the medical condition itself. For this reason, cognitive symptoms are more important diagnostically: • Do they describe hopelessness? How do they view their situation? What do they think the future holds for them? Do they think things will ever improve? Patients with depressive illnesses tend to maintain a gloomy

Assessment of depressive and anxiety symptoms and pessimistic view of the future, while non-depressed patients will often remain optimistic about improvements in their condition and look forward to rehabilitation or discharge. • Anhedonia Are they still doing things they enjoy doing (if they are physically able to)? If not, do they still wish they could do those things or have they lost interest altogether? Do they seem to retain pleasure in family visits? • Lack of reactivity Are they

flat in affect? Emotionless? These are more indicative of clinical depression. • Collateral information Obtain information from close family or others who know the patient well. This can add insight into the severity, duration, and temporal relationship of the symptom course. Anxiety symptoms Anxiety is a common phenomenon in medically ill patients and may often be viewed as appropriate to their current situation. Where it is severe, prolonged, and out of keeping with the current situation or it is interfering with appropriate medical management, it may become a focus of clinical attention. Often medical patients do not meet the full diagnostic criteria for the diagnosis of an anxiety disorder—it is important to make an individual assessment and make a decision, based on symptom severity and impair ment, as to whether treatment would help the anxiety. Differential diagnosis Realistic worry over a medical condition, primary medical condition, alcohol withdrawal, prescribed or illicit drug withdrawal (especially BDZ or opiate), drug intoxication (especially stimulants), GAD or panic disorder (new or exacerbation of pre-existing disorder), anxiety as part of a depressive illness, specific phobia (especially needles). Organic causes of anxiety symptoms • Neurological (epilepsy, dementia, head injury, CVA, brain tumour, MS, Parkinson's disease). • Pulmonary (COPD, asthma, airway-assisted patients on weaning trials). • Cardiac [arrhythmias, heart failure (CHF), angina, mitral valve prolapse]. • Hyperthyroidism, hypoglycaemia, metabolic acidosis/alkalosis, phaeochromocytoma. • Medications (antidepressants, antihypertensives, anti-arrhythmics). • Drugs of abuse (alcohol, BDZs, caffeine, cannabis, cocaine, LSD, ecstasy, amphetamines). Key points in assessment • Medical work-up Assess for medical causes for symptoms first. Has the patient had a complete medical evaluation for the physical complaints? • Consider substance abuse/ingestion Always take a drug/alcohol history, and selected patients should have a urine drug screen. • Past psychiatric history Does the patient have an underlying anxiety disorder that is being made worse by a new medical stressor? • Are there psychological anxiety symptoms? Do the subjective findings match the objective findings? Does the patient feel like, or fear, they are going to die? Have they a sense of doom? Do they fear they are 'going crazy'?

846 Chapter 18 Liaison psychiatry Assessment of psychotic symptoms and confusion Psychotic symptoms While referrals for assessment of apparent psychotic symptoms are common in the general setting, presentations with functional psychoses are rare in comparison with psychiatric hospitals. They are seen in the Emergency Department in patients brought in by the police to a 'place of safety' and after self-harm (especially in those using violent or bizarre methods). However, in the majority of cases in the general hospital, psych otic features represent organic illnesses—commonly delirium, or are part of a withdrawal syndrome. Differential diagnosis Delirium (E Acute confusional state (delirium), p. 854), drug intoxication or withdrawal, alcohol withdrawal, epileptic phenomena (E Psychiatric aspects of epilepsy 1, p. 138), dementia (E Dementia: general overview, p. 152), schizophrenia (E The diagnosis of schizophrenia, p. 184), acute/ transient psychotic disorders (E Acute and transient psychotic disorders, p. 236). Organic causes of psychosis • Neurological (epilepsy, head injury, brain tumour, dementia, encephalitis, e.g. HSV, HIV, neurosyphilis, brain abscess, CVA). • Endocrine (hyper-/hypothyroidism, Cushing's, hyperparathyroidism, Addison's disease). • Metabolic (uraemia, electrolyte disturbance, porphyria). • SLE ('lupus psychosis'). • Medications (steroids, levodopa, interferon, anticholinergics, antihypertensives, anticonvulsants, stimulants). • Drugs of abuse (cocaine, LSD, cannabis, PCP, amphetamines). Key points in assessment • The nature of any hallucinations Auditory hallucinations are characteristic of functional psychoses, while visual hallucinations (and visual illusions and misperceptions) are seen in organic conditions. • Presence of fluctuations Note

whether symptoms are fluctuating in nature or associated with confusion and/or behavioural disturbance. A waxing and waning picture with alterations in attention and alertness suggests delirium, as opposed to a primary psychotic disorder. • Previous history Note any previous history of psychotic illness or previous or current history of drug or alcohol use. • Time course of illness How long have psychotic symptoms been present? Was there a gradual or sudden onset? Have previous similar episodes occurred before? • Vital signs Withdrawal syndromes can present with psychotic symptoms. It is helpful to look for any autonomic instability, vital sign changes, sweating, and tremor, which may suggest an underlying withdrawal from alcohol or other sedatives. Such changes would be less likely in a primary psychotic disorder.

Assessment of psychotic symptoms and confusion Confusion A common referral is the request to assess for the severity and possible cause of confusion. A wide range of disorders and insults to the brain pro duce three common clinical presentations: (1) acute confusional state or delirium, (2) dementia (progressive or non-progressive), and (3) acute or chronic confusion. A common question is the extent to which confusion reflects an acute or a chronic deficit—often linked to requests for opinion about capacity/consent and placement issues. Another key question is whether there is a reversible component to the condition. Differential diagnosis Delirium (E Acute confusional state (delirium), p. 854), dementia (E Dementia: general overview, p. 152), alcohol withdrawal, drug intoxication or withdrawal, Wernicke–Korsakoff syndrome, epileptic phenomena, func tional psychoses. Key points in assessment • Bedside cognitive testing Assess conscious level (via GCS; see Box 2.3) and orientation in time, place, and person, and make an objective measurement of confusion (e.g. AMT, MMSE, ACE-III-R; E Assessing cognitive function 2, p. 86). • Previous history For an accurate account of the previous history in a confused patient, it is vital to have corroboration of the patient’s account—this should ideally be by a live-in or close relative or friend, but in their absence, a neighbour or GP may provide useful information. Note any previous history of cognitive impairment or functional decline; any history of alcohol of drug use; and any history of previous similar episodes. • Previous functional level It is important to consider the degree of cognitive deficit now and the level of cognitive function over the lifespan, reflected in the educational achievement of the patient and their work status, and their recent cognitive function as reflected in their self-care, etc. • Medical status Note the current medical condition, as recorded in the case records and nursing notes/observations. Note recent investigation findings, noting particularly any abnormal results or recent changes. Examine the drug kardex for any medications associated with confusion—have any medications recently been started or stopped? • Consideration of specialist testing In selected cases, specialist neurocognitive assessment may be helpful. • Consideration of imaging In consultation with medical and radiology colleagues, consider whether cerebral imaging (e.g. CT, MRI) is indicated.

848 Chapter 18 Liaison psychiatry Assessment after self-harm Self-harm is ‘self-poisoning or self-injury, irrespective of the apparent pur pose of the act’.3 Psychiatric assessment of such patients is mandatory once their medical condition allows. The involvement of mental health profes sionals in the assessment of patients following self-harm relates to the fol lowing observations: • In this population of patients, roughly 1% will die by completed suicide in the 24mths after the initial act, with the risk highest in the weeks following the original act. This represents a mortality by suicide 50–100 times that of the general population. • The rates of completed suicide are significantly raised in all mental disorders, excepting learning disability and dementia. Studies examining completed suicides in patients with mental illness show inadequate doses of therapeutic drug

treatment, i dropout rate from follow-up, and i presence of untreated comorbidity. • Clear risk factors exist for completed suicide (see Box 18.1), and the closer the self-harming patient approximates to these demographics, the greater the relative risk. However, the absolute risk is low, and estimate of the risk in a particular case relies on assessment of the individual act and the mental state. Assessment The initial management of the patient following an OD or physical self-harm will be by specialist toxicologists or general medical/ surgical specialists. Early psychiatric assessment may be required for advice regarding detainability, behavioural disturbance, drug/alcohol withdrawal, or delirium, but assessment of the self-harm itself should be deferred until the conscious level is full. The history should focus on the act itself, the patient's mental state and recent life events, and the past medical/psychi atric history. It may be easier to assess these in reverse order, moving from the factual history to the emotive descriptions of the self-harming act itself after building rapport. Features of act • Method In the UK, 790% of self-harm is by self-poisoning, with self- cutting making up most of the remainder. Use of method likely to be fatal (e.g. jumping, hanging) is indicative of a clear intent to die. • Patient's belief in the lethality of the method Did the patient believe that that combination of tablets was likely to be fatal? Serious suicidal intent is associated with medically trivial ODs—and vice versa. • Length of planning Was the act impulsive—'on the spur of the moment', or planned in advance—and for how long? • Triggers Was there a clear precipitant (e.g. row with partner)? Were they intoxicated at the time? Was there any direct 'gain' (e.g. patient in custody at the time of the act)? • Final acts Was there a suicide note? Did they make any other 'acts of closure' (e.g. setting the affairs in order, arranging for the care of children)? 3 National Institute for Health and Care Excellence (2004) Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical guideline [CG16]. London: National Institute for Health and Care Excellence.

Assessment after self-harm • Precautions to avoid discovery Where did the act take place? Would they have anticipated being found? Did they signal or tell their intentions to another? Was anyone else actually present at the time? • Previous similar acts Is this act a repeat of a previous non-fatal act? Are there any different features? • Actions after act What did they do after the act? How did they end up coming to hospital? Mental state • Attitude now to survival Are they relieved or disappointed to be alive? Do they have an ongoing wish to die? How do they feel about the future, and what plans (if any) do they have? • Affective symptoms Current affective symptoms. Recent symptoms of low mood, anhedonia, and hopelessness. Biological depressive features. • Substance misuse problems Evidence for current drug or alcohol misuse or dependence. • Other mental disorder Enquire directly about other symptoms of mental disorder, as directed by the history. • Risk to others Is there any evidence of intent to harm anyone else? Did the act put anyone else at risk? Personal and past medical/psychiatric history • Recent life events Describe recent events involving loss or change (e.g. bereavements, job loss, relationship break-up). • Current life situation State of current significant relationships. Type and security of job and accommodation. Presence of legal/criminal problems. • Previous or current psychiatric diagnoses Clarify with hospital records if further details required or if significant history. • Physical health problems Again clarify with records or the GP, if required. Box 18.1 Risk factors for completed suicide Sociodemographic factors • ♂ sex. • Elderly. • Single, divorced, or widowed. • Living alone, poor social support. • Unemployed or low socio-economic class. Personal/mental health factors • Previous self-harm. • Any mental disorder (greatest risk in major depression and anorexia nervosa, then functional psychosis, then neurotic and personality disorders). • Dependence on alcohol

or drugs. • Recent inpatient psychiatric treatment. • Concurrent physical disorder. • Recent bereavement.

850 Chapter 18 Liaison psychiatry Management after self-harm Reasons for act Only a minority of patients presenting after self-harm have evidence of a clear intent to die. Assessment will reveal a mixture of the following types of case: • Those whose intent was unequivocally to die but were prevented by discovery, chance, or overestimation of the lethality of the method. • Those who were ambivalent whether they lived or died, 'letting the chips fall as they may'. • Those whose act was impulsive and 'in the heat of the moment' in response to an immediate stressor. • Those whose actions were designed to communicate distress—the classical 'cry for help'. • Those whose actions were manipulative in nature and designed to provoke changed behaviour from others. • Those attempting to escape from intolerable symptoms or an intolerable situation. • Those whose intent is later unclear, even to themselves. There may initially be diagnostic confusion with the following groups: (1) deliberate ODs of drugs taken for intoxicating effect; (2) deliberate self- injury (e.g. wrist cutting), which is a repetitive, ritualistic action where the in tent is to relieve tension, not to kill or seriously injure; (3) accidental ODs of prescribed or over-the-counter (OTC) medication. (1) and (2) may merit psychiatric evaluation in their own right, and (3) should be examined care fully for evidence of post hoc rationalization of self-harm. Assessment aims By the end of assessment, you should aim to answer the following questions: • Is there ongoing suicidal intent? Evidenced by: continuing stated wish to die; ambivalence about survival; sense of hopelessness towards the future; clear intent to die at the time of the act. • Is there evidence of mental illness? Diagnosed in the normal way. Most common diagnoses are depressive illness and alcohol misuse. Be alert to comorbid substance misuse and to the combination of an acute stressor on the background of a chronic condition. • Are there non-mental health issues which can be addressed? Many patients will reveal stressors such as family or relationship difficulties and emotional problems (particularly relating to previous abuse; school or employment problems; debt; legal problems; problems related to immigration). They can be usefully directed to appropriate local services. Management • Ongoing suicidal intent In many cases, this will be managed by admission to a psychiatric ward, on a compulsory basis if necessary. • Mental illness • Patients already known to mental health services—here close liaison with the usual team is required to agree a joint management plan. • New diagnoses—here the focus should be on integrating with an appropriate service for follow-up, rather than necessarily starting new treatments. The type of appropriate follow-up depends on the

Management after self-harm type of disorder (e.g. GP review for moderate depressive illness, referral to alcohol services for alcohol abuse). Short-term community outreach from liaison psychiatry can 'bridge' the patient to the general services. Try to ensure follow-up is as soon as possible, even if non- urgent, as otherwise non-attendance is very high. • Admission required—for both new and established mental illnesses, admission will sometimes be indicated after self-harm, even where there is no ongoing suicidal intent. This may be due to the seriousness of the condition (e.g. new psychotic illness) or to allow for a period of inpatient assessment of the mental state. It should not simply be in order to defer or devolve the decision about discharge—ask yourself what will have changed to mean discharge in a few days will be safer than now. • Other issues With the patient's permission, discuss the case with an appropriate agency (e.g. abuse counselling service, school counsellor). Clarify the appropriateness of the referral and referral method, and feed these back to the patient. • In all cases Discuss and agree the management plan with the patient. In

most cases, discuss with the GP (mandatory if GP input is required). Consider the provision of an emergency crisis card, giving details of the emergency psychiatric service and telephone contact for emergency counselling/support services. Frequent attenders A small minority of patients attend emergency services repeatedly with self-harm without suicidal intent. A management plan for such patients should be agreed on a case-by-case basis. The aim should be to avoid ‘rewarding’ maladaptive behaviours (e.g. by repeated admissions providing ‘time-out’ from stressful situations), while providing appropriate support and treatment.

852 Chapter 18 Liaison psychiatry Depression in physical illness Depressive illness is more common in those with physical illness than in the healthy population. In primary care, the prevalence of depressive illness is 75%, while in medical outpatients, it is 5–10% and in medical inpatients 10– 20%, with higher rates reported in some studies. The frequency of depres sive illness is raised in those with more severe illnesses, and some conditions (e.g. cardiac and neurological disorders) show very high rates. Occurrence of depression in physically ill patients adds to their morbidity, both due to the depressive symptoms themselves and by hampering the treatment of the underlying medical condition (e.g. by impairing compliance or by diminishing interest in rehabilitation). Additionally, there is i risk of cardiac mortality in depressed patients, which is directly correlated with the severity of the depression. Depression is poorly recognized and undertreated in general patients. In some medical settings, there is a lack of focus on psychiatric symptoms— ‘not willing to ask the question’. There is also often a reluctance to prescribe antidepressants in the context of medical illness. More often, the possibility of treatment is simply overlooked, with the patient assuming that the symp toms are due to their underlying disorder and the treating physician making assumptions (e.g. ‘I’d be depressed in his situation’) and not thinking of offering treatment. Reasons for the association of depression and physical illness • The physical illness causes the depression: • Biological cause, e.g. hypothyroidism, Cushing’s disease, Parkinson’s disease. • Psychological cause—related to loss or change, life events secondary to illness, e.g. amputation, and loss of sexual function. Particularly potent are fatal, or potentially fatal, disfiguring, or disabling diseases. • The depression is a side effect of the treatment for the physical illness: • Drug treatments, e.g. steroids, β-blockers, digoxin, calcium channel blockers, aminophylline, theophylline, NSAIDs, cimetidine, metoclopramide, levodopa, methyldopa, isotretinoin, interferon alfa. • Disfiguring, painful, or prolonged treatments. • The physical illness is a result of the depression, e.g. liver failure after paracetamol OD in the context of depressive relapse. • The physical illness and the depression have a common cause, e.g. stressful life events acting as precipitants to both MI and depression. • Their co-occurrence may be coincidental—depressive illness is common and its co-occurrence with other common illnesses can be expected by chance. Presentations of depression in physical illness Low mood, tearfulness, hopelessness regarding recovery, biological depres sive features (poor sleep, appetite, energy, and concentration)—which may be misinterpreted as symptoms of the physical disorder, poor compliance, increase in somatic complaints or complaints of pain severity, apparent cog nitive impairment (pseudodementia).

Depression in physical illness Diagnosis Nursing staff are often more proficient than medical colleagues at identifying medical inpatients with depressive disorders. While operational diagnostic criteria are the same in physically ill as physically well patients, biological fea tures may be less useful in making the diagnosis. Features include: • Depression of mood (is it pervasive or do some activities, e.g. family visits, still provide pleasure?) • Hopelessness (is the patient’s attitude that

although things are bad now, they can still look forward to, for example, going home or moving to the rehabilitation ward, or are they hopeless about any prospects for recovery?) • Morning depression (do the nurses note a diurnal variation in mood or in other marker symptoms, e.g. interest in rehabilitation, talkativeness?) Screening tools are available (e.g. Geriatric Depression Scale) and are used in some centres. They do not replace individual clinical assessment. Treatment (See also E Treating depressive illness (without psychotic features), p. 266; E Treating depressive illness (with psychotic features), p. 268.) Effective treatment offers the possibility of improvement in mood (which is, of course, valuable in itself) but also improves rehabilitation, with better compliance, d hospital stay, and an overall reduction in morbidity, mortality, and eventual disability. • Practical interventions: e.g. attention to specific worries (e.g. clarification of prognosis, about which the patient may be unduly pessimistic); attempt to improve social contacts; aim to optimize the medical condition, mobility, and pain control. • Psychological support: often the liaison psychiatrist will have a key role here, but you should also attempt to engage the nursing and paramedical staff in supportive psychotherapeutic interventions—often these staff members are enthusiastic about constructive involvement, but fearful of 'doing the wrong thing', and will appreciate your guidance. • Consideration of drug treatment: treatment strategies are similar to those in patients without medical illness, while taking note of the advice given for treatment in specific medical conditions (E Prescribing in pregnancy, p. 1028; E Prescribing in lactation, p. 1030; E Prescribing for patients with cardiovascular disease, p. 1032; E Prescribing for patients with liver disease, p. 1034; E Prescribing for patients with renal impairment, p. 1036; E Prescribing for patients with epilepsy, p. 1038). • Specific psychological treatments: individual psychotherapy is often unavailable in, or unsuited to, the general setting, but some therapies, e.g. CBT, are now incorporated into rehabilitation and pain management programmes.

854 Chapter 18 Liaison psychiatry Acute confusional state (delirium) Essence Stereotyped response of the brain to a variety of insults; commonly seen in inpatients; characterized by acute onset of fluctuating cognitive impairment (or deterioration in pre-existing cognitive impairment), associated with be havioural abnormalities. it is more common in those with chronic impair ment already (e.g. dementia, may be undiagnosed). Epidemiology Incidence 10–20% of medical and surgical inpatients. High risk: elderly; pre- existing dementia; blind or deaf; very young; post-operative (especially car diac); burn victims; alcohol- and BDZ-dependent; serious illness, particularly multiple. Carries significant mortality, as well as morbidity, to the patient and others. Common cause of delayed discharge. Clinical features • Impaired ability to direct, sustain, and shift attention. • Global impairment of cognition with disorientation, and impairment of recent memory and abstract thinking. • Disturbance in sleep–wake cycle, with nocturnal worsening. • Psychomotor agitation. • Emotional lability. • Perceptual distortions, illusions, hallucinations—characteristically visual. • Speech may be rambling, incoherent, and thought-disordered. • There may be poorly developed paranoid delusions. • Onset of clinical features is rapid, with fluctuations in severity over minutes and hours (even back to apparent normality). Three clinical presentations are commonly seen: hyperactive or agitated delirium (psychomotor agitation, i arousal, inappropriate behaviour, de lusions, and hallucinations); hypoactive delirium (psychomotor retardation, lethargy, excess somnolence); and mixed delirium (combination of these fea tures with varying presentation over time). Differential diagnosis Mood disorder; psychotic illness (new mental disorder much less likely than delirium in a hospitalized patient, especially if elderly); post-ictal; dementia (characteristically: insidious onset, stable course, clear consciousness). Aetiology The cause is frequently multifactorial, and the most likely cause varies with the clinical setting in which the

patient presents: • Infective—UTI; chest infection; wound abscess; cellulitis; subacute bacterial endocarditis (SBE). • Metabolic—anaemia; electrolyte disturbance; hepatic encephalopathy; uraemia; cardiac failure; hypothermia. • Intracranial—CVA; head injury; encephalitis; primary or metastatic tumour; raised ICP. • Endocrine—pituitary, thyroid, parathyroid, or adrenal diseases; hypoglycaemia; diabetes mellitus; vitamin deficiencies.

Acute confusional state (delirium) • Substance intoxication or withdrawal—alcohol; BDZs; anticholinergics; psychotropics; lithium; antihypertensives; diuretics; anticonvulsants; digoxin; steroids; NSAIDs. • Hypoxia—secondary to any cause. Course and prognosis Usually has a sudden onset, with a fluctuating clinical course. There is gradual resolution of symptoms, with effective treatment of the underlying cause. Symptom resolution may be much slower in the elderly. There is often patchy amnesia for the period of delirium following recovery. Mortality is high (720% will die during that hospital admission, up to 50% at 1yr). May be a marker for the subsequent development of dementia. Assessment (See also E Assessment of psychotic symptoms and confusion, p. 846.) • Attend promptly (the situation only tends to deteriorate, and behaviourally disturbed patients cause considerable anxiety on medical wards). • Review the time course of the condition via notes and staff report— note recent investigation findings, particularly any abnormal results or recent changes. Examine the patient record for any drugs associated with confusion—have any medications recently been started or stopped? • Establish the premorbid functional level (e.g. from relatives or GP). Management • Identify and treat the precipitating cause and exacerbating factors. • Likely primary cause varies according to setting and examination findings—remember the cause may be multifactorial. • Optimize the patient's condition—attention to hydration, nutrition, elimination, and pain control. • Provide environmental and supportive measures. • Education of those who interact with the patient. • Make the environment safe. • Create an environment which optimizes stimulation, e.g. adequate lighting, reduce unnecessary noise, mobilize the patient when possible, and correct any sensory impairment (e.g. hearing aids, glasses). • Reality orientation. Firm, clear communication, preferably by same staff member (or small group of staff). Use of clocks and calendars. • Avoid sedation, unless severely agitated or necessary to minimize risk to the patient or to facilitate investigation/treatment. • Use single medication; start at a low dose, and titrate to effects. • Give the dose, and reassess in 2–4hrs before prescribing regularly. • Consider oral haloperidol 0.5–1mg (max of 6mg daily), oral lorazepam 0.5–1mg (max of 4mg daily), or oral risperidone 1–4mg (max of 6mg daily)—consider giving preference to antipsychotic management first, as BDZs tend to worsen delirium, with the exception of alcohol withdrawal and gammabutyrolactone (GBL) withdrawal. • If the patient is withdrawing from alcohol, BDZs are first line (E Management of alcohol withdrawal 2, p. 594). • Review the dose regularly, and aim to stop as soon as possible. • Regular clinical review and follow-up (MMSE useful in monitoring cognitive improvement at follow-up).

856 Chapter 18 Liaison psychiatry Capacity and consent A fundamental principle of medical practice is that treatment of a patient should be with their valid consent. Valid consent is that which is informed, freely given, and obtained from a patient with capacity.4 The medical team will often ask for a psychiatric opinion as to a patient's capacity to make treatment decisions. While all doctors should be familiar with the assess ment of capacity and be prepared to make decisions regarding consent, liaison psychiatrists are often consulted on such matters, due to their ex perience in assessing mental disorder and abnormal mental states and their (usually) greater knowledge of applicable law. Incapacity legislation Specific incapacity legislation exists in England

and Wales (the Mental Capacity Act 2005); Scotland (the Adults with Incapacity Act 2000). These Acts and their accompanying codes of practice should direct and guide clinical practice relating to incapacity for doctors working in these jurisdictions. Referral types Occasionally, these referrals will take the form of a spe cific question, e.g. does this patient with dementia have capacity to give consent to a hip operation? More often, they reflect a number of worries about a patient's capacity, ability to care for themselves, and decisions which balance a patient's autonomy against best exercising their duty of care. The two most common referrals ask the following questions: • Does this patient have the capacity to consent to, or refuse consent for, a procedure or treatment? • Does this patient have the capacity to make personal welfare decisions (e.g. to choose to go home, rather than accept residential care)? Occasionally, a referral is phrased as a capacity assessment when the patient is seeking to leave hospital against medical advice, and what is actually re quired is a decision as to the patient's detainability under the MHA. In these cases, the patient should be assessed for the presence of a mental disorder justifying detention in the normal way. In these cases, remember that de tention under the MHA does not allow for the compulsory treatment of medical conditions. Assessment of incapacity

1. Identify the question The question 'Does this patient have capacity?' is essentially meaningless. Incapacity law and common law in the UK presume capacity in adults, and incapacity law explicitly encourages the exercise of residual capacity. Incapacity must therefore be assessed in relation to the particular decision required of the patient, and the nature of this decision should be estab lished prior to the interview. Additionally, you should clarify with the med ical team what treatment is proposed and what information has already been discussed with the patient. 4 This page should be read in conjunction with those pages in E Chapter 20 describing consent (E Consent to treatment, p. 936), treatment without consent (E Treatment without consent, p. 938), common law (E Common law, p. 940), and incapacity legislation (E Mental Capacity Act: England and Wales, p. 942; E Incapacity Act, Scotland, p. 944; E Incapacity Act: Northern Ireland, p. 946; E Incapacity Act: Republic of Ireland, p. 948).

Capacity and consent 2. Consider whether the patient has capacity to make the decision Incapacity cannot be presumed on the basis of any individual patient factors (e.g. diagnosis of dementia, learning disability, brain injury, mental disorder) but must be assessed specifically for each decision. The questions to ask are—for the decision required: does the patient have the ability to: • Make a decision? • Understand the information relevant to the decision? • Use or weigh that information in making the decision? • Retain memory of the decision? • Communicate the decision? For example, in considering whether a patient can refuse an amputation in the setting of osteomyelitis and early gangrene, we need to establish whether the patient is aware of the nature of their illness, the treatment being offered to them, the risks and potential benefits associated with that treatment, and any alternative treatment options, as well as the conse quences of refusing treatment. 3. Evaluate the presence of psychiatric illness, and determine whether it is influencing the patient's decision Even if the patient's decision reflects a fair grasp of the elements of consent, it is necessary to determine whether their judgement is being influenced by mental illness. For example, if the patient with gangrene understands the nature of their infection and the risks of surgery vs delaying treatment, we would not support their making a decision to avoid surgery if the decision was based on auditory hallucinations telling them that they do not deserve to live. Therefore, a comprehensive psychiatric assessment, screening for the presence of mental

disorder, and including an evaluation of how they have made their decision are essential. The psychiatric evaluation for capacity assessment needs to be com prehensive, particularly focusing on cognitive functions, reasoning, and judgement; however, it is otherwise similar to any thorough psychiatric examination. The primary difference lies in the additional examination of how the patient has made similar choices in the past and what role psychi atric symptoms are playing in their current decision. 4. Gather additional information If the opinion is that the patient lacks capacity, then it will be important to establish: (1) what the patient's views on the matter were when greater capacity existed (e.g. did they discuss treatment outcomes with relatives? Is there an advance directive?), (2) what the views of the patient's relatives or carers are, (3) whether there is a relative with surrogate decision-making powers (e.g. attorney, court-appointed deputy in England and Wales, or guardian in Scotland). 5. Report and document opinion You should formally document your opinion and the reasons for it, as well as speak to the treating team directly, if at all possible.

858 Chapter 18 Liaison psychiatry Medically unexplained symptoms 1: introduction A substantial proportion of patients presenting to primary care or to any individual hospital specialty will have symptoms for which, after adequate investigation, no cause can be found. Non-specific symptoms without underlying organic pathology are very common and usually transient. Where they become prolonged enough to merit medical attention, they may present to any specialty, with presentations such as pain, loss/disturb ance of function, and altered sensation. Symptom 'meaning' The 'problem' of MUS arises, in part, from the dif ferent meanings symptoms hold for the patient and doctor. Patients pre sent to doctors with illness (symptoms and behaviours); doctors diagnose and treat disease (pathology and other recognized syndromes). The patient wants explanation and treatment for their symptoms, and the route to this is generally through being given a diagnosis. If there is no recognized diag nosis available, the doctor may respond with 'there's nothing wrong', ex pecting to be met with pleasure. The patient, however, is baffled—there is 'something wrong' and the symptoms are still there. The doctor may then undertake a number of courses of action—continue to investigate in the hope of finding something; treat the patient anyway as a therapeutic trial; refer to another specialty; or dismiss the patient. Psychiatric role The role of psychiatry in the assessment and manage ment of these patients has changed substantially over recent years (hope fully for the better). Formerly, patients were referred 'at the end of the line', often after prolonged, inconclusive tests and unsuccessful interven tions. Patients often misinterpreted (and resented) the referral as sug gesting that symptoms were 'all in your mind' or were feigned. Psychiatrists sometimes took an overly narrow view of their role and responsibility, un helpfully dismissing patients as having 'no psychotic or depressive illness' or colluding with the patient's desire for a 'clean bill of mental health' in order to return to treatment-seeking behaviour. We are currently at an early stage of our understanding of medically unexplained illnesses. While no specialty has all the answers in the management of this patient group, psychiatry can offer: experience of the presentation of MUS across the hospital specialties; the ability to assess and treat the frequently comorbid depressive/anxiety symptoms; and a tolerance for diagnostic uncertainty and the ability to take a long-term view of improvements. Misdiagnosis A frequently expressed concern doctors hold about this group of patients is the risk of 'getting it wrong' (often associated with poorly formed worries about litigation). A long-held belief was that, despite repeated negative findings, all such patients (or a majority) would even tually be found to suffer from an organic disease which would, in retro spect, account for their symptoms. This concern was largely based on older, poorly conducted studies with significant methodological flaws. Recent

follow-up studies suggest that the misdiagnosis rate for functional illness is 75% (e.g. comparable to other medical and psychiatric diagnoses such as idiopathic epilepsy and schizophrenia). This improvement has followed both the development of modern imaging and investigatory techniques, and the use of operational diagnostic criteria for psychiatric diagnosis.

Medically unexplained symptoms 1: introduction Iatrogenic harm A problem common to all members of this group of disorders is the potential for iatrogenic harm. These patients often accrue considerable morbidity, and even mortality, due to excess negative investi gations, irradiation, operative procedures, etc. Those disorders associated with chronic pain carry the risk of iatrogenic opiate dependency. Often at later stages in the patient's illness, this secondary morbidity is more prob lematic than the original symptoms. A major positive intervention in these patients is therefore the avoidance of iatrogenic harm. Classification Patients presenting with somatic symptoms for which no adequate physical cause can be found make up a large and heterogenous group in all clinical settings, from primary to tertiary care. Our lack of full understanding of this group of disorders is reflected in the confusing and disputed classification system adopted. Our modern concepts arose from the concept of 'hysteria'—of repressed emotions being expressed as phys ical symptoms. There are differences between the current and proposed classifications of this group of disorders, and each classification system con tains a number of disputed and unsatisfactory categories. One difficulty has been the residual old labels still in use; another has been the confusion of names indicating the symptom and disorder; a third has been the substantial overlap between the syndromes described. Differential diagnosis The differential diagnosis for relatively acute, iso lated MUS includes: • Symptoms directly related to psychiatric disorders such as depression, anxiety disorders, or psychosis. • Functional somatic illness (E Medically unexplained symptoms 2: clinical presentations, p. 860). • Conversion and dissociative disorders (E Conversion (dissociative disorders), p. 868). • Pain disorders (E Somatoform pain disorder, p. 866). • Somatization disorder (E Somatization disorder, p. 864). • Factitious disorder (E Factitious disorder (Munchausen's syndrome), p. 876). • Malingering. • Uncommon medical syndromes which have not yet been diagnosed. Causative mechanisms These are currently unclear, but the following may play a part: patient psychological factors; patient's health beliefs; affective state; underlying personality; degree of autonomic arousal; i muscle ten sion; effects of hyperventilation; effects of disturbed sleep; effects of pro longed inactivity; impaired ability to filter afferent stimuli.

860 Chapter 18 Liaison psychiatry Medically unexplained symptoms 2: clinical presentations Somatization This is the experience of physical symptoms with no—or no sufficient— physical cause, with presumed psychological causation. Somatization is a symptom of various disorders commonly seen in liaison psychiatry and may occur: (1) as a normal accompaniment of physical illnesses; (2) as a common presentation of depressive illness; (3) as a core component of illness ('functional somatic syndromes'); and (4) as part of a long-standing pattern of behaviour ('somatization disorder').

1. As a normal accompaniment of physical illnesses Complaint of symptoms and help-seeking behaviour is adaptive. All illnesses have emotional components which deserve attention. Both doctor and patient may be more comfortable dealing with specialty-appropriate symptoms (e.g. a patient presenting with pain post-radiotherapy may be ar ticulating a desire for reassurance that the tumour has not recurred). While some doctors may be reluctant to deal with the emotional context of illness, patients may have worries

and express these as somatic complaints. These should often be understood as part of the emotional reaction to illness, not dismissed as ‘functional overlay’. Their appropriate treatment is via consult ation with the responsible clinician. Psychological factors may (positively or negatively) influence outcome in treatment of physical illnesses by their ef fects on advice-seeking, treatment compliance, and perceived quality of life.

2. As a common presentation of depressive illness A frequent cause of MUS is somatized depression and anxiety. Somatic com plaints (e.g. pain, GI complaints, weakness, loss of appetite) are common presentations of depression, with prevalence i in certain subgroups (e.g. elderly, children, certain immigrant populations). Anxiety disorders (e.g. atypical panic attacks) can be the cause of unexplained cases of chest pain and shortness of breath. Conversely, anxiety and depressive symptoms are a common finding in both the physically ill and those with somatization.
3. As a core component of illness (‘functional somatic syndromes’) These conditions are usually reported as individual clinical syndromes; how ever, several factors are common to them all. There is presentation by the patient with symptoms which are suggestive of an underlying organic illness; these symptoms cause distress; there is no identifiable organic illness which is sufficient to explain the symptoms, and the causation is attributed to psy chological factors which may be more or less apparent. A variety of presen tations are seen across the medical and surgical specialties: • Cardiology—atypical chest pain. • Respiratory medicine—HVS (E Hyperventilation syndrome, p. 366). • GI medicine—IBS. • Infectious diseases—CFS. • Rheumatology—fibromyalgia. • Neurology—tension headache. • ENT—globus syndrome.

861 MEDICALLY UNEXPLAINED SYMPTOMS 2: CLINICAL PRESENTATIONS • General surgery—unexplained abdominal pain. • Gynaecology—chronic pelvic pain. • Dentistry—atypical facial pain. 4. As part of a long-standing pattern of behaviour Somatization disorder (E Somatization disorder, p. 864). Hypochondriasis (E Hypochondriasis, p. 870) This is the belief that one has a particular illness, despite evidence to the contrary—usually takes the form of an over-valued idea, although it is more rarely frankly psychotic in nature. A particular form of hypochondriasis is dysmorphophobia (E Body dysmorphic disorder, p. 872)—the belief that one has a significant deformity. Conversion/dissociation (E Conversion (dissociative) disorders, p. 868) ‘Conversion’ or ‘dissociation’ is the theorized process by which thoughts or memories unacceptable to the conscious mind are repressed from con sciousness, and either are ‘converted’ into physical symptoms, sometimes with symbolic meaning to the patient, or result in disruption to the normal integrated functioning of the mind—as evidenced in symptoms such as am nesia, fugue, or stupor. Factitious symptoms Factitious symptoms are those which are intention ally produced or elaborated, with the aim of receiving a medical diagnosis. Where there is secondary gain (e.g. obtaining opiate prescription, obtaining legal compensation), this is referred to as malingering.

862 Chapter 18 Liaison psychiatry Medically unexplained symptoms 3: management principles Accepting cases for assessment Psychiatrists should be reluctant to accept patients for assessment of MUS where significant doubt still exists in the treating doctor’s mind as to the diagnosis (e.g. where significant further investigations are planned). They should also be reluctant to be put in the position of ‘last hurdle’ before an otherwise planned intervention (e.g. ‘I’ll perform your operation if the psychiatrist gives the go-ahead’). Management principles Definitive treatments validated by RCT evidence are not currently available for MUS. In addition, these patients present a

heterogenous group, in terms of presentation, ‘psychological mindedness’, and severity. Nonetheless, the following principles may be helpful. Management should include: (1) thor ough assessment; (2) confident diagnosis; (3) clear explanation; (4) mini mization of iatrogenic harm; (5) empirical use of potentially beneficial treatments; and (6) consideration of involvement in treatment trials. Assessment • Prior to the consultation, obtain the full hospital case records for all specialties. Discuss the case with the GP, and obtain copies of GP records, if available. Clarify whether the patient is seen in other hospitals or healthcare services, and aim to obtain these records. Establish whether there are any pending investigations and what the patient has been told about their presumed diagnosis. • At the interview: establish full details of current symptoms, circumstances of symptom onset, and ‘life context’ of symptom development. • Explore their illness beliefs—specific worries about the cause and possible prognosis; ask the patient to describe their understanding of their symptoms and what they feel they may represent. • Full details of the past medical history (may be reticent—‘no problems before current symptoms’ or overly dramatic); what were they told at the time by the doctors treating them? • Remember to explore possible psychiatric differential diagnoses—full mental state as normal, even if no symptoms spontaneously mentioned. • Observe the patient in the waiting room/onward/entering and leaving the room—be alert to inconsistencies in symptoms. Diagnosis • A positive and confident diagnosis is crucial. • Be willing to make organic and non-organic diagnoses (e.g. where there is undoubted organic disease, but also significant MUS morbidity). • Acknowledge the patient’s distress and disability; a diagnosis of MUS should not mean to the patient that you believe that there is ‘nothing wrong with them’.

Medically unexplained symptoms 3: management principles Explanation • Terminology in this field is variable, imprecise, and potentially offensive (e.g. supratentorial, hysterical). The terms ‘functional illness’ or ‘medically unexplained illness’ are generally acceptable to patients. • Begin with a clear explanation of what is (and what is not) wrong: ‘You are suffering from a functional, not structural, problem of your nervous system. This is a common problem which we have seen in other patients.’ Various analogies may be used as appropriate (e.g. computer hardware vs software problem; piano working, but out of tune). • Emphasize what can and cannot be done: ‘We can help train the body to function normally again’ and ‘We might not be able to pinpoint the exact cause’. • Allow the patient to query what you have said (you should have allowed sufficient time at the end of the interview). Allow carers/relatives to become involved in this exploration of your explanation. • Copy your clinic letter to the GP and hospital professionals caring for patient. Consider, in certain situations, copying the letter to the patient. Minimize iatrogenic harm • In all MUS patients, be aware of the risk of iatrogenic harm and justify any risks taken by benefit to the patient, over and above the gratification of seeming to give the patient ‘what they want’. • Accept that there may be a chronic illness which can be managed, but not ‘cured’. • Appropriately investigate genuinely new symptoms. • In planning further investigations in patients with MUS, greater weight should be placed on objective, rather than subjective, change. • Clear verbal and written (and, in some cases, face-to-face) communication between all involved professionals is especially crucial in this group of patients—everyone should ‘know what is going on’. • Accept that there will be a proportion of severe cases who are unable to leave the sick role and who must be managed by changing how the system responds to them. Empirical use of potentially beneficial treatments • Often there is improvement in patient perception of symptoms following a confident diagnosis and explanation. • All patients with prominent depressive/anxiety symptoms should have these treated in the normal way. • Consider empirical trial of antidepressant medication, even where affective features are not prominent. • Consider use of physiotherapy to aid regaining of functional loss. • Consider

referral for assessment for formal psychotherapy. • Consider referral to other resource (e.g. pain management). Involvement in treatment trials • Little is known about the course of these disorders over time and less about appropriate treatments—consider patients for involvement in research.

864 Chapter 18 Liaison psychiatry Somatization disorder Somatization disorder (ICD-10) is a disorder in which there is repeated presentation with MUS, affecting multiple organ systems, first presenting before the age of 40yrs. It is usually chronic in adults. In children, it usually involves one or a few organ systems, often for shorter periods of time. At all ages, it is associated with significant psychological distress, functional im pairment, and risk of iatrogenic harm. In DSM-5, it has been incorporated, along with DSM-IV 'undifferentiated somatization disorder' and aspects of 'hypochondriasis', into 'somatic symptom disorder', and it is proposed that the condition is called 'bodily distress disorder' in ICD-11 (see Box 18.2 Clinical features Somatization disorder patients have long, complex medical histories ('fat-file' patients), although at interview, they may min imize all but the most recent symptomatology. Symptoms may occur in any system and are, to some extent, suggestible. The most frequent symptoms are non-specific and atypical. There may be discrepancy between the sub jective and objective findings (e.g. reports of intractable pain in a patient observed by nursing staff to be joking with relatives). Symptoms are usually concentrated in one system at a time but may move to another system after exhausting diagnostic possibilities in the previous one. The patient's life re volves around the illness, as does their family life. There is excessive use of both medical services and alternative therapies. Diagnosis is usually only suspected after negative findings begin to emerge, because normal medical practice is to take a patient's complaints at face value. The key diagnostic feature is multiple atypical and inconsistent MUS in a patient under the age of 40yrs. Chronic cases will have had large numbers of diagnostic procedures and surgical or medical treatments. There is a high risk of both iatrogenic harm and iatrogenic substance dependence. Hostility and frustration can be felt on both sides of the doctor–patient relationship, with splitting (E Defence mechanisms, p. 892) between members of the treating team. Psychological approaches to treatment are hampered by on going investigations of ever rarer diagnostic possibilities and by the attribu tion of symptoms to fictitious, but 'named', medical entities. Two-thirds of patients will meet criteria for another psychiatric disorder, most commonly major depressive or anxiety disorders. There is also as sociation with personality disorder and substance abuse. Patients charac teristically deny emotional symptoms or attribute them directly to physical handicaps—'the only reason I'm depressed is this constant pain'. Aetiology Observable clinical association with childhood illnesses in the patient and a history of parental anxiety towards illness. i frequency of somatization disorder in first-degree relatives. Possible neuropsychiatric basis to the disorder with faulty assessment of normal somatic sensory input. Association with childhood sexual abuse. Epidemiology Lifetime prevalence of 70.2%. Markedly higher rate in par ticular populations. ♀:♂ ratio 5:1. Age of onset is childhood to early 30s. Differential diagnosis Undiagnosed physical disorder—particularly those with variable, multisystem presentations (e.g. SLE, AIDS, porphyria, TB, MS). Onset of multiple symptoms for the first time in patients over 40 should be presumed to be due to unexposed physical disease. Psychiatric disorder—major affective and psychotic illnesses may initially present with

Somatization disorder predominantly somatic complaints. Diagnosis is by examination of other psychopathology; however, over half of somatization disorder patients exhibit psychiatric comorbidity. Other somatoform disorders—distinguish from: hypochondriasis (presence of a firm belief in a particular disorder), somatoform pain disorder (pain, rather than other symptoms, is

prom inent), conversion disorder (functional loss without multisystem com plaints), factitious disorder (intentional production or feigning of physical symptoms to assume sick role), and malingering (intentional production of false or grossly exaggerated physical symptoms with external motivation). In practice, the main distinction is between the full and severe somatization disorder and somatization as a symptom in other disorders. Assessment (E Assessment, p. 862) Establish the reasons for referral, experience of illness, attitudes to symptoms, personal and psychiatric his tory, and family perspective. Initial management (E Management principles, p. 862) Make, document, and communicate the diagnosis. Acknowledge symptom severity and ex perience of distress as real, but emphasize negative investigations and lack of structural abnormality. Reassure the patient of continuing care. Attempt to reframe symptoms as emotional. Assess for, and treat, psychiatric comorbidity as appropriate. Reduce and stop unnecessary drugs. Consider a case conference involving the GP and treating physicians. Educate the parents/family. Ongoing management • Regular review by a single, named doctor. • Reviews should be at a planned and agreed frequency, avoiding emergency consultations. • Symptoms should be examined and explored with a view to their emotional 'meaning'. • Avoid tests 'to rule out disease'—investigate objective signs only. • All secondary referrals made through one individual. • Disseminate management plan. • These patients can exhaust a doctor's resources—plan to share the burden over time. Some evidence for the effectiveness of patient education in symptom re-attribution, brief contact psychotherapy, group therapy, or CBT if the pa tient can be engaged in this. Prognosis Poor in the full disorder; tendency is for chronic morbidity, with periods of relative remission. Treatment of psychiatric comorbidity and reduction of iatrogenic harm will reduce overall morbidity. Key for re covery in children and adolescents is rehabilitation and return to usual ac tivities as soon as possible.

866 Chapter 18 Liaison psychiatry Somatoform pain disorder In somatoform pain disorder, there is a complaint of persistent severe and distressing pain, which is not explained or not adequately explained by or ganic pathology. The causation of the symptom is attributed to psycho logical factors. This disorder is diagnosed where the disorder is not better explained by somatization disorder, another psychiatric diagnosis, or psy chological factors in a general medical condition. In ICD-11, it is part of 'bodily distress disorder' (see Box 18.2). All pain is a subjective sensation, and its severity and quality, as experi enced in an individual, are dependent on a complex mix of factors, including the situation, the degree of arousal, the affective state, the beliefs about the source, and 'meaning' of the pain. The experience of pain is modified by its chronicity and associations, and there is a 'two-way' relationship with affective state, with chronic pain predisposing to depressive illness, while depressive illness tends to worsen the subjective experience of pain. Comorbidity In common with the other somatoform disorders, there is substantial overlap with major depression (740% in pain clinic patients) and anxiety disorders. Substance abuse (including iatrogenic opiate depend ency) and personality disorder patients are over-represented. Epidemiology No population data are available. The prevalence of pa tients with medically unexplained pain varies by clinical setting—higher in inpatient settings, particularly surgery, and highest in pain clinic patients. Differential diagnosis Elaboration of organic pain, malingering (e.g. pa tient with opiate dependency seeking opiate prescription), genuine organic cause with absence of other manifestations (e.g. sickle-cell crisis, angina). Assessment History from patient and informants, length of history (may be minimized), relationship to life events, general somatization, experience of illness, family attitude to illness, periods of employment, treatments, be liefs about cause, comorbid psychiatric symptoms. Management (E Management principles,

p. 862) It is important to rec ognize and treat occult comorbid depression. It is often helpful to adopt an atheoretical approach—‘let’s see what works’, and to resist pressure for ‘all-or-nothing’ cure or a move to investigation by another specialty. Opiates are not generally effective in chronic pain of this type and add the risk of dependence. Psychological treatments—these are directed towards enabling the patient to manage and ‘live with’ the pain, rather than aspiring to elim inate it completely; can include relaxation training, biofeedback, hypnosis, group work, and CBT. Pain clinics—these are generally anaesthetist-led, with variable psychiatric provision. They offer a range of physical treat ments such as: antidepressants, transcutaneous electrical nerve stimulation (TENS), anticonvulsants, and local or regional nerve blocks.

Somatoform pain disorder Box 18.2 Disorders of bodily distress or bodily experience (ICD-11) Bodily distress disorder (BDD) This new broad category replaces the ‘Somatoform disorders’ of ICD-10 and will unite a number of previous separate categories like somatization disorder, somatoform autonomic dysfunction, somatoform pain disorder, and neurasthenia. Core features include: • Presence of bodily symptoms that are distressing to the individual: • Usually multiple bodily systems varying over time. • Occasionally a single symptom such as pain or fatigue. • Excessive attention directed towards the symptoms, which may be manifest by repeated contact with healthcare providers and is not alleviated by appropriate clinical examination and investigations and reassurance. Even when another health condition may be causing or contributing to the symptoms, the degree of attention is clearly excessive in relation to its na ture and progression. Mild, moderate, and severe forms are differentiated in ICD-11, but no subtypes are specified. X Body integrity dysphoria (BID) Also called body integrity identity disorder (BIID), this extremely rare phenomenon is characterized by an intense and persistent desire to be come physically disabled in a significant way (e.g. major limb amputee, paraplegic, blind). Onset is by early adolescence and is accompanied by persistent discomfort or intense feelings of inappropriateness concerning current non-disabled body configuration. The desire to become physically disabled results in harmful consequences, as manifested by: • The preoccupation with the desire (including time spent pretending to be disabled) significantly interfering with productivity, leisure activities, or social functioning (e.g. the person is unwilling to have a close relationship because it would make it difficult to pretend). • Attempts to actually become disabled, resulting in the person putting his or her health or life in significant jeopardy (e.g. lying on a railway track to amputate a limb). • Surgical interventions being sought (and even agreed to), e.g. for an amputation or for transection of the spinal cord. The nature of this disorder is disputed, with sufferers of BID explaining the desire for amputation as analogous to the desire of transsexuals for surgical sex reassignment or other more extreme forms of body modi fications. There is some functional brain imaging evidence suggesting it is a disorder of body image, similar to neglect in stroke patients, with loss of insight (hence it is a form of neuropsychiatric disorder). This shadow of doubt over autonomy in BID has fuelled the ethical controversy over elective amputations of healthy limbs, which some BID proponents argue is their right.

868 Chapter 18 Liaison psychiatry Dissociative (conversion) disorders In dissociative disorders (previously conversion disorders), there is a loss or disturbance of normal motor, sensory, or cognitive functions, which initially appears to have a neurological or other physical cause but is later attributed to a psychological cause. These disorders were initially explained by psy chodynamic mechanisms—repression of unacceptable conscious impulses and their ‘conversion’ to physical symptoms, sometimes with symbolic meaning. Any presumed psychodynamic

mechanisms are no longer part of the current diagnostic classification, although the initiation or worsening of the symptom or deficit is often preceded by conflicts or other stressors. Symptoms are not produced intentionally, and the presence of ‘secondary gain’ is not part of the diagnosis. Classification In DSM-5, ‘conversion’ refers to motor or sensory def icit, while ‘dissociation’ refers to disturbance in function of consciousness. Conversion disorders are classified with ‘somatic symptom and related disorders’, while dissociative disorders are classified separately. In ICD- 10, dissociation and conversion are used synonymously, with dissociation preferred as it does not imply a definite psychological explanation. All ex pressions of such disorders are classified together under the heading ‘F44, Dissociative (conversion) disorders’. In ICD-11, they are simply referred to as ‘dissociative disorders’, in a grouping which includes dissociative neuro logical symptom disorder, dissociative amnesia, trance disorder, and dis sociative identity disorder. Clinical features These vary, depending on the area affected, but the fol lowing are commonly seen: • Paralysis One or more limbs or one side of the face or body may be affected. Flaccid paralysis is common initially, but severe, established cases may develop contractures. Often active movement of the limb is impossible during examination, but synergistic movement is observed (e.g. Hoover’s test: the patient is unable to raise the affected limb from the couch but is able to raise the unaffected limb against resistance, with demonstrable pressing down of the heel on the ‘affected’ side). • Loss of speech (aphonia) There may be complete loss of speech or loss of all but whispered speech. There is no defect in comprehension, and writing is unimpaired (and becomes the main method of communication). Laryngeal examination is normal, and the patient’s vocal cords can be fully opposed while coughing. • Sensory loss The area of loss will cover the patient’s beliefs about anatomical structure, rather than reality (e.g. ‘glove’ distribution, marked ‘midline splitting’). • Seizures Non-epileptic seizures are found most commonly in those with genuine epilepsy. Non-epileptic attacks generally occur only in the presence of an audience—no injury is sustained on falling to the ground; tongue biting and incontinence are rare; the ‘seizure’ consists of generalized shaking, rather than regular clonic contractions, and there is no post-ictal confusion or prolactin rise.

Dissociative (conversion) disorders • Amnesia Memory loss, most often for recent events, not attributable to organic mental disorder, and too severe to attribute to ordinary forgetfulness. Usually patchy and selective amnesia—true global amnesia is rare. There is expectation of recovery, and usually a history of recent traumatic event gradually emerges. • Fugue Here there is dissociative amnesia plus a history of travel outside the patient’s normal environs. The patient may ‘come to’ far from home, without memory of how they came to be there, and with variable amnesia for other personal information. Although there is amnesia for the period of the fugue, the patient has apparently functioned normally during this time (e.g. able to buy travel tickets, etc.). Again recovery can be expected in time, and a history of recent traumatic events is commonly found. Diagnosis The diagnosis will usually be suspected due to the nonanatomical or clinically inconsistent nature of the signs. It is established by: (1) excluding an underlying organic disease or demonstrating a minor disorder insufficient to account for the symptoms; (2) finding of ‘positive signs’ (i.e. demon stration of function thought to be absent); and (3) a convincing psycho logical explanation for the deficit. Additionally helpful, though non-specific, is a prior history of conversion symptoms or recurrent somatic complaints or disorder, family or individual stress and psychopathology (recent stress, grief, sexual abuse), or the presence of a symptom model. Treatment Clear presentation of the diagnosis, in collaboration with the treating medical team. Aim to present the diagnosis as positive (emphasizing the likelihood of recovery), rather than negative

(‘we couldn’t find anything; it’s all in your head’). In general, avoid interventions which could maintain the sick role or prolong abnormal function (e.g. provision of crutches to those with dissociative gait disturbance), and instead consider interven tions directed towards graceful resumption of normal function (e.g. physio therapy). Treat psychiatric comorbidity if present. Controlled treatment studies are absent; CBT, IPT, supportive psychotherapy, FT, and biofeed back are all potentially helpful. Prognosis For acute conversion symptoms, especially those with a clear precipitant, the prognosis is good, with an expectation of complete reso lution of symptoms (70–90% resolution at follow-up). Poorer outcomes for longer-lasting and well-established symptoms.

870 Chapter 18 Liaison psychiatry Hypochondriasis Hypochondriasis is the preoccupation with the fear of having a serious disease, which persists despite negative medical investigations and ap propriate reassurance, with subsequent distress and impaired function. In ICD-10, it is classified within ‘Somatoform disorders’, whereas ICD-11 places it in ‘Obsessive–compulsive or related disorders’. DSM-5 has re moved ‘Hypochondriasis’ completely, and the concept is subsumed by two new diagnoses within ‘Somatic symptom and related disorders’: som atic symptom disorder (for those with excessive somatic symptoms) and illness anxiety disorder (for those who are excessively anxious about illness). Clinical features The central and diagnostic clinical feature is the pre occupation with the idea of having a serious medical condition, usually one which would lead to death or serious disability. The patient repeatedly ruminates on this possibility, and insignificant bodily abnormalities, normal variants, normal functions, and minor ailments will be interpreted as signs of serious disease. The patient consequently seeks medical advice and in vestigation but is unable to be reassured in a sustained fashion by negative investigations. The form of the belief is that of an over-valued idea; the patient may be able to accept that their worries are groundless but nonetheless be unable to stop dwelling and acting on them. Where the belief in illness is of de lusional intensity, the patient should be treated as for delusional disorder (E Delusional disorder 1: clinical features, p. 230). Aetiology As in somatization disorder, there may be a history of child hood illness, parental illness, or excess medical attention-seeking in the parents. Childhood sexual abuse and other emotional abuse or neglect are associated. In one aetiological model, individuals with a combination of anx iety symptoms and predisposition to misattribute psychical symptoms seek medical advice. The resulting medical reassurance provides temporary relief of anxiety, which acts as a ‘reward’ and makes further medical attention- seeking more likely. Epidemiology Equal sex incidence. Very variable prevalence, depending on group studied (0.8–10.3%), higher in secondary care. Differential diagnosis The main differentiation is from the feared physical disease. In most cases, this is straightforward, but the possibility of an early, insidious disease with vague physical signs and normal baseline investiga tions should be considered. Comorbidity High (>50%) incidence of GAD. Hypochondriasis may also coexist with major depressive illness, OCD, and panic disorder. Examination of the time course of symptom development and most prominent clinical features helps to distinguish primary hypochondriasis from a secondary clin ical feature of these disorders.

Hypochondriasis Management • Initial—allow the patient time to ventilate their illness anxieties. Clarify that symptoms with no structural basis are real and severe. Aim to plan continuing relationship and review, not contingent upon new symptoms. Explain negative tests, and resist the temptation to be drawn into further exploration. Patients will, in the early stages, often change or expand symptomatology. Emphasize the aim to improve function. Break the cycle of reassurance,

and repeat the presentation—family education may help in this. • Pharmacological—uncontrolled trials demonstrate antidepressant benefit, even in the absence of depressive symptoms. Try fluoxetine 20mg, increasing to 60mg, or imipramine up to 150mg. • Psychotherapy Behavioural therapy (response prevention and exposure to illness cues); CBT (identify and challenge misinterpretations, substitution of realistic interpretation, graded exposure to illness-related situations, and modification of core illness beliefs).

872 Chapter 18 Liaison psychiatry Body dysmorphic disorder The core clinical feature of body dysmorphic disorder is preoccupation with the belief that some aspect of the physical appearance is markedly abnormal, unattractive, or pathological. This preoccupation causes distress and has the characteristics of an over-valued idea; it is not amenable to reassurance. The bodily part is found to be normal or, if abnormal, is only trivially so, compared with the degree of distress. It is an unusual condition which has only relatively recently come promin ently to clinical attention. It rarely presents directly, but such individuals may present requesting plastic surgery or mutilating surgical procedures, and hence come to psychiatric attention. There are many similarities to OCD in terms of clinical features and treatment response, and it is now classified alongside OCD in ICD-11 and is distinguished from ICD-11 ‘Body integrity disorder’ which is characterized by the desire to become significantly phys ically disabled (see Box 18.2). Clinical features There is preoccupation with the idea that some speci fied aspect of their appearance is grossly abnormal, markedly unattractive, or diseased. Any part of the body may be affected, most usually the face, head, and secondary sexual characteristics. Patients believe that the sup posed deficit is noticeable to others and attempt to hide or minimize it. These beliefs may develop delusional intensity. There is associated func tional impairment, agoraphobia, and risk of suicide. Comorbid behaviours, such as skin picking, rubbing, and topical applications, may cause worse secondary problems. Clinically significant disorder causes severe functional impairment, restriction of relationships and employment opportunities, and the risk of iatrogenic morbidity by unwarranted surgical procedures. Aetiology Begins in late childhood or early adolescence, overlap with normal worries at this age. Epidemiology Equal sex incidence. Less than 1% prevalence, but markedly over-represented in some groups [e.g. plastic surgery (10%) and derma tology]; 10% incidence in first-degree family members. Comorbidity 60% risk of major depression. Differential diagnosis There is significant overlap in terms of symptom profile with social phobia, hypochondriasis, OCD, somatic delusions in schizophrenia, and anorexia nervosa. Where the concerns are persistently delusional, ICD-10 reclassifies as delusional disorder, while DSM-5 (which classifies body dysmorphic disorder within ‘Obsessive–compulsive and re lated disorders’) allows the diagnosis of a delusional form. Treatment • Operative—plastic surgery to the affected part is generally not indicated, even successful surgery risks being followed by a new preoccupation or a focus on surgical scarring. • Pharmacological—evidence for clinical effectiveness of SSRI; try fluoxetine 20mg, increasing to 60mg. If ineffective, try clomipramine up to 250mg. If delusional features, add an antipsychotic. • Psychological Evidence for CBT; treatment focused on response prevention, challenging cognitive errors, and behavioural tasks. Prognosis Chronic course with fluctuating symptom severity. Partial, rather than full, remission.

Body dysmorphic disorder 873

874 Chapter 18 Liaison psychiatry Chronic fatigue syndrome CFS is a clinical syndrome, the central feature of which is severe fatigue, unrelated to exertion or triggered by only minimal activity, and

unrelieved by rest. The fatigue is experienced as a subjective feeling of lethargy, lack of energy, exhaustion, and a feeling of ‘i effort to do anything’. Patients also often complain of aching muscles, sleep disturbance, aching joints, headaches, and difficulties with concentration. They may date the onset of symptoms very precisely to an episode of viral infection with sore throat, fever, and tender lymph nodes. The syndrome was previously referred to as neurasthenia (in ICD-10 under ‘Other neurotic disorders’), then as my algic encephalomyelitis (ME). The term CFS was later preferred, as it did not imply knowledge of underlying pathology or aetiology. The condition is referred to as post-viral fatigue syndrome in ICD-11 under ‘Other disorders of the nervous system’. CFS is not a disorder in the conventionally accepted sense, but a characteristic clinical syndrome. It shows diagnostic overlap with major depression, somatization disorder, and hypochondriasis but cannot be subsumed into these diagnoses because of substantial areas of lack of fit. Any operational diagnostic criteria for CFS will be contentious and will include people with chronic organic illnesses. Patients with this syndrome will often have passionately held beliefs about the cause of their symptoms and the appropriate management. A practical and pragmatic approach is advised from treating clinicians. Aetiology Currently, the aetiology of CFS is unknown, with immuno logical, genetic, viral, neuroendocrine, and psychological causes suggested. While a minority of cases have a confirmed onset with viral illness, ongoing viral replication or chronic infection is not the cause. The condition is likely to be heterogenous, without a single or simple aetiology. At the moment, it may be best regarded as a spectrum of illness that is triggered by an acute reaction to stress or minor illness in a vulnerable individual with a persisting clinical syndrome caused by deconditioning and other secondary phenomena. Vulnerable individuals are those with abnormal symptom at tribution, i awareness of normal bodily processes, cognitive errors, and perfectionist personality types. Epidemiology Population prevalence of 0.2–0.4%, with women affected at four times the rate of men. Most common in people in their 40s and 50s. Occasionally occurs in children, particularly during adolescence. Diagnosis CFS should be considered where there is complaint of fatigue, which: (1) is persistent and/or recurrent; (2) is unexplained by organic con ditions or other psychiatric diagnoses; (3) results in substantial reduction in previous activity level; and (4) is characterized by post-exertion malaise and slow recovery after effort, AND one or more of the following symptoms: • Sleep disturbance (e.g. insomnia, hypersomnia, unrefreshing sleep, disturbed sleep–wake cycle). • Muscles and/or joint pain without evidence of inflammation. • Headache. • Painful lymph nodes. • Sore throat. • Minor cognitive dysfunction (e.g. impaired concentration, impairment of STM, word-finding difficulty).

Chronic fatigue syndrome • Worsening of symptoms following mental or physical exertion. • Recurrent flu-like symptoms. • Dizziness, nausea, and palpitations. Comorbidity Many patients with CFS meet the criteria for other psychi atric diagnoses, most commonly major depression. Many patients resist a ‘psychiatric’ diagnosis, attributing mood disturbance to the restriction on activities caused by illness. Despite this, treatment of comorbid depressive or anxiety symptoms can produce clinical improvement. Investigation findings Non-specific subjective cognitive impairment similar to that found in depression. Normal muscle function, with poor per formance on tolerance testing related to deconditioning. No characteristic blood abnormalities or immune system abnormalities. There are no definite and replicable abnormal findings. Do minimum indicated tests. Assessment Establish the diagnosis, and identify comorbid psychiatric disorders. Avoid confrontation with the patient, and attempt to agree a common understanding of the disorder. Acknowledge the severity of the symptoms and the consequent disability. Aim to take the focus of the inter view towards potentially beneficial interventions and away from unwar ranted

investigations. Management There is no specific pharmacological treatment. The best evidence base exists for GET and CBT. • GET—establish via a diary record the patient's daily activity level; establish with them their maximal tolerable level, even on their worst day, and encourage them to perform this level of activity every day, no more and no less, with a gradual negotiated increase over time. The aim is to break the cycle of inactivity, brief excess activity, and consequent exhaustion. • CBT (E Cognitive behavioural therapy 1, p. 910). • Psychotropic medication—consider antidepressant treatment trial, even where no clear-cut evidence of affective symptoms. Try SSRI first (e.g. paroxetine 20mg), as this patient group is intolerant of side effects. • Symptomatic medication—patients may experience greater intolerance and more severe side effects from drug treatment. Where appropriate, drugs used for symptom control should be initiated at a lower dose than in usual clinical practice, and should be i gradually. Prognosis Outcome is difficult to predict, but the severely affected cases and those with very chronic symptoms appear to do worse. Many patients with mild to moderate symptoms do show some degree of improvement over time. A proportion of cases show a fluctuating course, with periods of relative remission, followed by relapse. Of the severe cases, a proportion will remain significantly disabled.

876 Chapter 18 Liaison psychiatry Factitious disorder (Munchausen's syndrome) In factitious disorder, patients intentionally falsify their symptoms and past history and fabricate signs of physical or mental disorder, with the primary aim of obtaining medical attention and treatment. In ICD-10, it is classified in 'Disorders of adult personality and behaviour' [intentional production or feigning of symptoms or disabilities, either physical or psychological (fac titious disorder)], whereas ICD-11 introduces a new separate section for 'Factitious disorders', differentiating those imposed on self from those im posed on others (see further text). DSM-5 has similar subdivisions but in cludes factitious disorders within 'Somatic symptoms and related disorders'. The diagnostic features are the intentional and conscious production of signs, falsification or exaggeration of the history, and the lack of gain be yond medical attention and treatment. Three distinct subgroups are seen: • Wandering—mostly ♂ who move from hospital to hospital, job to job, place to place, producing dramatic and fantastic stories. There may be aggressive personality or dissocial personality disorder and comorbid alcohol or drug problems. • Non-wandering—mostly ♀; more stable lifestyles and less dramatic presentations. Often in paramedical professions; overlap with chronic somatization disorder. Association with borderline personality disorder. • By proxy—mostly ♀. Mothers, carers, or paramedical and nursing staff who simulate or prolong illness in their dependants—here the clinical focus must be on the prevention of further harm to the dependant (ICD-11/DSM-5 'Factitious disorder imposed on another'). The behaviours can mimic any psychical and psychiatric illness. Behaviours include: self-induced infections, simulated illnesses, interference with ex isting lesions, self-medication, altering records, and reporting false physical or psychiatric symptomatology. Early diagnosis reduces iatrogenic morbidity and is facilitated by: awareness of the possibility; a neutral interviewing style using open, rather than closed questions; alertness to insistencies and ab normalities in presentation; use of other available information sources; and careful medical record-keeping. Differential diagnosis Any genuine medical or psychiatric disorder. Somatization disorder (no conscious production of symptoms and no fab rication of history), malingering (secondary gain for the patient, e.g. com pensation, avoiding army service), substance misuse (also gain, i.e. the prescription of the drug), hypochondriasis, psychotic and depressive illness (associated features of the primary mental illness). Aetiology Unknown; there may be a background of CSA or childhood emotional neglect. Probably more common in men and those with a nursing or paramedical background. Association

with personality disorder. Production of psychiatric symptoms associated with borderline personality disorder, CSA, or emotional abuse.

Factitious disorder (Munchausen's syndrome) Management There are no validated treatments. Patients are often reluctant to con sider psychiatric assessment and may leave once their story is questioned. Management in these cases is directed towards reducing iatrogenic harm caused by inappropriate treatments and medications. • Direct challenge—easier if there is direct evidence of feigned illness; the patient is informed that staff is aware of the intent to feign illness and the evidence is produced. This should be in a non-punitive manner, with offer of ongoing support. • Indirect challenge—here the aim is to allow the patient a face-saving 'way out', while preventing further inappropriate investigation and intervention. One example is the 'double bind' 'if this doesn't work, then the illness is factitious'. • Systemic change—here the understanding is that there is no possibility of change in the individual, and the focus is on changing the approach of the healthcare system to assessing them in order to minimize harm. These strategies can include dissemination of the patient's usual presentation and distinguishing marks to regional hospitals, 'blacklisting', 'Munchausen's registers', etc. As these strategies potentially break confidentiality and can decrease the risk of detecting genuine illness, they should be drawn up in a multidisciplinary fashion, involving senior staff.

878 Chapter 18 Liaison psychiatry Assessment prior to organ transplantation For patients with end-stage organ disease (e.g. kidney, liver, heart, lung, bowel, or pancreas), a transplant offers the prospect of significant im provement in their mortality and quality of life. Unfortunately, the supply of donor organs is less than the number of potential recipients. Because of this, patients requiring transplantation will suffer declining health while on the waiting list, and a proportion of listed patients will die while awaiting transplant. This places a responsibility on the assessing team to consider carefully each potential candidate for listing for transplantation, in order to ensure the best use of the donor organs. Psychiatric assessment of patients prior to listing for organ transplantation may be requested in the following situations: • In some patients being considered for liver transplantation: • Fulminant liver failure following OD (usually paracetamol). • Liver disease secondary to ALD. • Patients with a history of mental illness. • Patients with previous or current drug misuse. • Patients with a history of non-compliance. • Living related donors. The involvement of the psychiatrist in the assessment prior to listing for transplantation should, in no sense, be a moral judgement as to the patient's suitability. The issues are whether there are psychiatric factors which would jeopardize the survival of the donor organ. The psychiatric opinion may have the most profound implications for the patient, and so assessment should be as thorough as time allows. In addition to taking a psychiatric his tory and an MSE, family members, the GP, and hospital case records should be consulted. Fulminant liver failure This will often follow on from a late-presenting paracetamol OD. At the point patients are seen, it is often unclear whether they are going to recover or deteriorate to the point of requiring a trans plant. They should be seen as soon as possible after presentation, as en cephalopathy may develop as their condition worsens. The issue is whether there is: an ongoing intent to die or a refusal of transplant (which would normally preclude transplantation); or whether there is a history of re peated ODs in the past, significant psychiatric disorder, or ongoing drug or alcohol misuse (which would be relative contraindications). Liver disease secondary to ALD Suitably selected patients transplanted for ALD have similar outcomes in terms of survival and quality of life to patients transplanted for other indications. Units will have individual policies regarding these patients, which should be consulted, if available. The

issue is whether the patient, who has already damaged one liver, will damage a second. There is a wider issue of maintaining public confidence in the ap propriate use of donated organs. Consider: • How long they have been abstinent (is there independent verification of this?). • Whether they accept alcohol as the cause of liver failure. • Whether they undertake to remain abstinent post-transplant.

Assessment prior to organ transplantation • Whether they have a history of dependence or harmful use. • What their history of involvement is in alcohol treatment services and, in the past, how they have responded to relapse. • When they were told that their drinking was causing liver damage and what their response was. Given these findings and your routine psychiatric assessment, the trans plant team will seek your opinion as to: • The patient's psychiatric diagnosis. • Their risk of relapse. • Their risk of re-establishing harmful/dependent drinking. • The potential for successful intervention, should this occur. History of mental illness/drug misuse Generally speaking, a diagnosis of mental disorder (other than progressive dementia) will not preclude trans plantation. The important issues are whether the mental disorder will affect compliance or longer-term mortality in its own right. Close liaison with the patient's normal psychiatrist is clearly crucial here. Ongoing substance de pendence is generally a contraindication to transplantation and should be addressed before listing. History of non-compliance with treatment Non-compliance with treat ment may be the reason for a patient's need for transplant or place the patient at risk for future morbidity or mortality and the loss of a donated organ if not recognized early in assessment. Past medical records and dis cussions with past treatment teams will provide information regarding this area of risk for a given patient or family. In addition, pre-transplant evaluation by multiple team members, including behavioural health, should identify psychosocial factors that place a patient or family at risk for non- adherence and provide the team an opportunity to be proactive to increase the likelihood of future adherence and transplant success. Living related donors This type of transplant uses organs or tissues from a matched, and usually biologically related, donor. Examples include bone marrow, single kidney, or portion of the liver. In this case, the donor is an additional focus of evaluation, with the goal of establishing that there is valid consent and absence of coercion.