Models and Process of Psychosomatic Medicine

Psychosomatic Medicine
- Subspecialty at the interface of Medicine and Psychiatry
  - Clinical Service
  - Research
  - Training
- Psychosomatic Medicine is the name of the accredited subspecialty

Models of Psychosomatic Medicine

Psychiatry
- Traditional/Conventional
  - Hospital or Ambulatory Based
  - Consultation Upon Request (reactive)
  - Liaison Psychiatry
- Mental Health Integration
  - Hospital or Ambulatory Based
  - Case Finding/Screening
  - Proactive/Systemic Mental Health Involvement
  - Population Based Programs
  - Disorder Specific Programs
- Hybrid Models

Types of Patients
- Complex, co-morbid psychiatric and medical conditions
- Neurocognitive disorders
- Somatic symptom and functional disorders
- Psychiatric disorders secondary to medical conditions or treatments

Distinction from Office Based Psychiatry
- Services requested by consultee
  - No “self referral”
- Obligations to consultee as well as patient
- Patient often unaware of referral
  - Usually ill, uncomfortable or in pain
- Patient motivation often compromised
- Limited privacy
- Visits not scheduled nor time based

NOTE: There are 24 more slides in this lecture. The complete set is available to APM members in the Members' Corner.
The Medical Management of Acute Agitation

Objectives
- Identify the principles of the “cycle of violence.”
- Describe the broad differential diagnosis behind the symptoms of agitation and aggression.
- Apply nonpharmacologic and pharmacologic approaches to management of the agitated patient in the general medical setting.

The Case
- A 47-year-old male with a history of substance abuse and bipolar disorder along with morbid obesity, DM and COPD presents to the ED at 0200 after calling 911 and reporting chest pain.
- Initially cooperative in the ED, but the staff indicate that he has been mumbling to himself and staring at them suspiciously. They gave him some lorazepam to “calm” him.
- Since arrival to the floor to r/o MI he has become increasingly irritable, confrontational and restless. Eventually he starts to become uncooperative with care and then verbally and physically threatening to the staff.
- They call a psychiatry consult for “HELP!!!”

Definitions
- Agitation– Excessive motor or verbal activity
- Aggression– Actual noxious behavior that can be verbal, physical against objects, or physical against people
- Violence– Denotes physical aggression by people against other people

(Citrome and Volavka, 2002)

Component Behaviors
- Aggressive behaviors
  - Physical
    - Fighting
    - Throwing things
    - Grabbing objects
    - Destroying items
  - Verbal
    - Cursing
    - Screaming
- Nonaggressive behaviors
  - Restlessness (akathisia, restlessness)
  - Wandering
  - Inappropriate behavior (disrobing, intrusive, repetitive questioning)

NOTE: There are 60 more slides in this lecture. The complete set is available to APM members in the Members’ Corner.
Delirium

(When things really do go bump in the night!)

APM Resident Education Curriculum

Thomas W. Heinrich, M.D.
Associate Professor of Psychiatry & Family Medicine
Chief, Psychiatric Consult Service at Froedtert Hospital
Department of Psychiatry & Behavioral Medicine
Medical College of Wisconsin

Delirium

DSM 5 Criteria

- Disturbance in attention
- Disturbance develops over a short period of time, is distinctly different from baseline and tends to fluctuate
- Has an additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception)
- Not accounted for by dementia
- Caused by a general medical condition

DSM 5 Criteria

- Classification of delirium
  - Delirium due to another medical condition
  - Substance intoxication delirium
  - Substance withdrawal delirium
  - Delirium due to multiple etiologies
  - Medication induced delirium
  - Delirium not otherwise specified

DSM 5 Criteria

- Further Specifiers
  - Time
    - Acute: Hours/Days
    - Persistent: Weeks/Months
  - Level of activity
    - Hyperactive
    - Hypoactive
    - Mixed level of activity

Synonyms for Delirium

- Acute confusional state
- Encephalopathy
- Acute brain failure
- ICU psychosis
- Altered mental status
- Acute reversible psychosis

Motoric Subtypes of Delirium

- Hypoactive
  - Decreased activity
  - Lethargy
  - Apathy
- Hyperactive
  - Increased activity
  - Delusions
  - Hyperalert
- Mixed

NOTE: There are 50 more slides in this lecture. The complete set is available to APM members in the Members' Corner.
Depression in Medical Settings

Learning Objectives

By the end of the lecture, the viewer will be able to:

1. Describe the types and characteristics of depression in a variety of medical settings
2. Appreciate the diverse medical conditions, medication therapies and psychiatric conditions that contribute to depressive symptoms
3. List the evidence-based therapies for depression in the medically ill

Overview

- Classification of depression
- Prevalence in medical Settings
- Evaluation
- Time course and associations
- Treatment

Depression in medical illness

- Coexistence
- Induced by illness or medications
- Cause or exacerbate somatic symptoms

Classification of Depression

- Major depression
- Persistent Depressive Disorder (DSM5)
- Adjustment disorder
- Mood disorder due to general medical condition, with depressive features
- Substance-induced mood disorder
- Mixed anxiety depression (moved to Section III in DSM5)

Some Medical Conditions Closely Associated with Depressive Symptoms

- Stroke
- Parkinson’s disease
- Multiple sclerosis
- Huntington’s disease
- Pancreatic cancer
- Diabetes
- Heart disease
- Hypothyroidism
- Hepatitis C
- HIV/AIDS

NOTE: There are 45 more slides in this lecture. The complete set is available to APM members in the Members' Corner.
The “Difficult” Patient

APM Resident Education Curriculum

Mary Jo Fitz-Gerald, MD
Professor of Clinical Psychiatry
La. State University Health Sciences Center
Shreveport, LA

Objective

- Discuss characteristics of difficult patients
- Develop a differential diagnosis for the difficult patient
- Describe the effect of medical illness on normal personality styles and defense mechanisms
- Discuss behavioral strategies for managing the difficult patient.

The Consult

- 53 year old male, self-employed business owner, history of cocaine and alcohol abuse, hospitalized with osteomyelitis. Assess capacity to leave AMA.
- 25 year old female with sickle cell anemia and longstanding opiate dependence becomes agitated after medical team refuses to give her IV Dilaudid. Need recommendations for med-seeking behavior.
- 40 year old male admitted with myocardial infarction calls office of the hospital CEO to complain about his care. Assess for psychiatric disorder.

What Makes a Patient Difficult?

- Multiple somatic complaints
- Anger or irritability
- Frequent doctor visits/calls
- Noncompliance
- Depression
- Anxiety
- Agitation
- Drug-seeking behavior
- Excessive requests for attention
- Physically or verbally aggressive behavior
- Sabotaging care
- Wandering/pulling out lines

Approach to the Difficult Patient

- Step 1: Initial diagnosis
- Step 2: Gauge distress of the treating team
- Step 3: Develop a management plan

NOTE: There are 36 more slides in this lecture. The complete set is available to APM members in the Members’ Corner.
HIV/AIDS Psychiatric Illness & Treatment

HIV Milestones
- Early 1980s – first cases
- Mid 1980s – HIV test available
- Late 1980s to Early 1990s – minimal benefit from antiretroviral therapy
  - Time from AIDS diagnosis to death = 2 years
  - PCP prophylaxis reduces mortality
- Mid 1990s – Highly Active Antiretroviral Therapy (HAART)
  - HIV/AIDS became a chronic illness

Epidemiology
- 1.1 million people in the US living with HIV
  - ~18% unaware of being infected
  - Males who have sex with males (MSM) still most affected
  - Blacks face the most severe burden
- Vulnerable populations
  - Individuals with substance use disorders
  - Individuals with chronic mental illness

Antiretroviral Therapy
- Primary goal of viral suppression, <50 cells/mL.
- Secondary goal of immunologic restoration and prevention of HIV-related complications
- Treatment naive: one non-nucleoside reverse transcriptase inhibitors (NNRTI) or protease inhibitor (PI) + two nucleoside reverse transcriptase inhibitor (NRTI)

Diagnoses of HIV Infection by Transmission Category, 2011 - United States and 6 Dependent Areas;

Estimated New HIV Infections in the United States for the Most Affected Subpopulations, 2010

NOTE: There are 43 more slides in this lecture. The complete set is available to APM members in the Members' Corner.
Informed Consent and Capacity

Informed Consent

• Case I (Part 1)
  – Ms. W an 83 year old female with a history of cognitive impairment and known CAD was admitted with chest pain. EKGs and enzymes are abnormal and a cardiac catheterization is recommended. You are asked to see if you think the patient can consent to the procedure...
  – What do you do now?

Informed Consent

• Purpose of informed consent
  – To promote individual autonomy
  – To foster rational decision-making
  – Informed consent is founded on two distinct legal principles
  – The right of self-determination
  – The physician's fiduciary responsibility to the patient

Informed Consent

• Exceptions to informed consent
  – Emergency
    • Time required to obtain consent is not available without threatening the patient’s life
  – Therapeutic privilege
    • In some circumstances, in which disclosure itself may be harmful to the patient, physicians may withhold certain information
  – Waiver
    • Patients waive their rights to consent
  – Incompetence

NOTE: There are 34 more slides in this lecture. The complete set is available to APM members in the Members' Corner.
Neuroleptic Malignant Syndrome & Serotonin Syndrome

ACADEMY OF PSYCHOSOMATIC MEDICINE
Psychiatrists Providing Collaborative Care for Physical and Mental Health

Neuroleptic Malignant Syndrome and Serotonin Syndrome
APM Resident Education Curriculum

Thomas W. Heinrich, M.D.
Associate Professor of Psychiatry & Family Medicine
Director of Psychiatric Consult Service
Froedtert Hospital
Medical College of Wisconsin

Historical Background

- Syndrome malin des neuroleptiques
  - Rapidly progressive neurovegetative state
  - Observed during early clinical trials of haloperidol
  - 1960
- Neuroleptic Malignant Syndrome
  - First appeared in English literature in 1967
  - Belated recognition in the U.S.

Incidence

- Typical antipsychotics
  - Best estimate 0.1-0.2% (Caroff and Mann, 1996)
  - Wide variance in estimates 0.1-3.0%
- Atypical antipsychotics
  - It remains unclear whether atypical antipsychotics are less likely to cause NMS compared to typical antipsychotics (Troller, et al., 2009)

Pathogenesis

- Central dopamine hypoactivity
  - Theory (Strawn et al, 2007, Fricchione 1985)
    - Patients susceptible to developing NMS may have a baseline central hypodopaminergic state
      - Trait vulnerability
    - The hypodopaminergic state is further stressed with pharmacologic or stress-induced reductions in dopamine activity
      - State vulnerability

Clinical Characteristics

- Early signs
  - Change in mental status
  - Extrapyramidal symptoms unresponsive to antiparkinsonian agents
  - Autonomic dysfunction

There are 47 more slides in this lecture. The complete set is available to APM members in the Members' Corner.
Psycho-Oncology and Palliative Care

Palliative Care and Psychosomatics

- Hospice began in France in 1840s
- Involves all stages of life-threatening illness
- Includes psychological, social, spiritual, and cultural issues
- Palliative care ....
  - Affirms life and regards dying as normal
  - Neither hastens nor postpones death
  - Provides relief from pain and other symptoms
  - Integrates the psychological and spiritual
  - Offers support system to help patient live life actively
  - Helps family cope
  - Utilizes a multidisciplinary approach

Common Psychiatric Issues in the Palliative Care Population

- Anxiety
- Bereavement
- Depression
- Delirium

Anxiety in Palliative Care

- Ranges from 15-28% and is most often comorbid with depression
- Prevalence increases with advanced disease and decline in physical status
- Includes fears of clinical course, treatment outcomes, death, social stigma, and/or physical symptoms (such as dyspnea or pain)

Causes of Anxiety in Palliative Care

- Anxiety symptoms can be caused by various medical complications
  - Hypoxia,
  - Pain
  - Drug side effects (akathisia)
  - Substance withdrawal
  - Pulmonary embolism (PE)
  - Electrolyte imbalance,
  - Dehydration
- Fear of isolation and separation of death

NOTE: There are 34 more slides in this lecture. The complete set is available to APM members in the Members’ Corner.
Psychopharmacology in the Medically Ill

ACADEMY OF PSYCHOSOMATIC MEDICINE
Psychiatrists Providing Collaborative Care for Physical and Mental Health

Psychopharmacology in the Medically Ill
APM Resident Education Curriculum
Paula Zimbren, M.D.
Assistant Professor of Psychiatry
Yale University School of Medicine
Reviewer: Ryan Kimmel, MD
Assistant Professor of Psychiatry
University of Washington School of Medicine

ACADEMY OF PSYCHOSOMATIC MEDICINE

Outline
1. Psychopharmacology of organ insufficiency
2. Special populations (Neurological disorders, Transplantation, OBGYN)
3. Special topics
   1. Non psychiatric use of psychotropic medications
   2. Major drug to drug interactions
   3. Alternate routes of administration
   4. Other agents used in the CL setting

A. PSYCHOPHARMACOLOGY OF ORGAN INSUFFICIENCY

Cardiovascular Disease
Liver Disease
Renal Insufficiency/Dialysis
Respiratory Disease

Case no 1.

55y/o m with CAD, s/p MI 2 months ago, admitted with CP, MI ruled out. History reveals a recurrence of panic attacks since he returned to work after his MI, as well as mild depressive symptoms. He is a busy professional with no time for psychotherapy but would take a medication for his symptoms.

NOTE: There are 41 more slides in this lecture. The complete set is available to APM members in the Members' Corner.
Somatoform Disorders, Factitious Disorder, & Malingering

**Disclaimer**

- The ABPN, however, will continue to test on DSM-IV criteria until 2015-16
- Therefore, the talk will focus on the DSM-IV disorders and conclude with a brief summary of the changes inherent in this group of disorders in DSM-5
  - Rationale for changes
  - Disorders

**Somatoform Disorders**

- Medically unexplained physical symptoms (MUPS)
  - Physical symptoms that prompt the sufferer to seek health care but remain unexplained after an appropriate evaluation (Richardson and Engel, 2004)

- **MUPS – One syndrome or many?**
  - Internal Medicine
  - Gynecology
  - ENT
  - Dentistry
  - Temporomandibular dysfunction
  - Rheumatology
  - Fibromyalgia
  - GI
  - Irritable bowel syndrome
  - Neurology
  - Nonepileptic seizures

**Somatoform Disorders**

- **MUPS – Consequences**
  - Impaired physician-patient relationship
    - Physician frustration
      - 2% primary care visits are considered “difficult”
    - Hahn, 2001
    - “Dose-response” relationship between symptoms and physician frustration
      - 0-3 symptoms ⇒ 5% difficult
      - 4-6 symptoms ⇒ 15% difficult
      - 7-9 symptoms ⇒ 25% difficult
      - 10 or more symptoms ⇒ 30% difficult
    - Patient dissatisfaction

**Somatoform Disorders**

- **One syndrome or many?**
  - Some authors have suggested that the precise diagnosis given depends more on the diagnosing physician’s specialty than on any actual differences between the syndromes
  - Categorization
    - Psychiatric
    - Hypothetical syndromes based on diagnostic criteria

**Somatoform Disorders**

- Medically unexplained physical symptoms (MUPS)
  - Physical symptoms that prompt the sufferer to seek health care but remain unexplained after an appropriate evaluation (Richardson and Engel, 2004)

NOTE: There are 91 more slides in this lecture. The complete set is available to APM members in the Members’ Corner.
Suicide Risk Assessment & Management

Suicide Risk Assessment and Management in the Medical Hospital
APM Resident Education Curriculum

Ann Schwartz, MD, FAPM
Academic Associate Professor
Chief, Consultation Liaison Service, Grady Memorial Hospital
Department of Psychiatry and Behavioral Sciences
Emory University School of Medicine

ACADEMY OF PSYCHOSOMATIC MEDICINE
Psychiatrists Providing Collaborative Care for Physical and Mental Health

Suicide Risk Assessment & Management

Suicide

• Definitions
• Epidemiology
• Clinical assessment of suicide risk
• Suicide risk assessment / documentation
• Challenges

Epidemiology

• Suicide is the 11th leading cause of death in the US
  • 30,000 deaths/year
  • Accounts for 1 – 2% of all deaths
• Known suicide rate is nearly identical to rate in 1900
  • 10-12/100,000/year
  • Firearms most common method (60-65%)
    • Regional variation
  • Hanging second most common for men, drug overdose second most common for women
• For each person that completes suicide, ~8-10 people attempt
• For every completed suicide, ~18-20 attempts are made

Suicide-Related Behaviors

• Potentially self injurious behaviors
  • Suicide
  • Instrumental suicide-related behaviors
• Focus on intent to die
  • “The person intended at some (non-zero) level to kill self...”
  • “The person wished to use the appearance of intending to kill self in order to obtain some other end...”

“The person intended at some (non-zero) level to kill self....”

• Suicide, completed suicide
• Suicide attempt with injuries
• Suicide attempt
• Suicidal act

NOTE: There are 48 more slides in this lecture. The complete set is available to APM members in the Members' Corner.
Informed Consent Discussion

- Risks of psychiatric illness in pregnancy and postpartum
- Non-pharmacological treatment options
- Risks of psychotropic exposure to developing fetus/breastfeeding infant
- Potential adverse effects to mother
- Benefits of psychotropic use in treatment of psychiatric illness

Risk-Benefit Analysis

"Parenthood is a journey into the unknown, but together we can try to make decisions which reduce the overall risk."
- Accepting risk is part of the process
- Think of assessing risk above baseline risks
  - 1-3% of pregnancies which have some type of congenital malformation
- Think in terms of absolute risk
  - Example: One retrospective study demonstrated 6x increase in omphalocele w/ use of SSRIs in early pregnancy (NOTE: didn't control for other exposures)
  - BUT absolute risk is less than 3/1000

Antenatal Depression

- 12-20% of women will have depression at some point during pregnancy or the post-partum period
- Prevalence is similar for pregnant and non-pregnant women
- 2nd and 3rd trimester seem to be higher risk than 1st trimester
- Prevalence of SI similar to rates of non-pregnant patients
  - Pregnancy is NOT protective!

Depression and Pregnancy

NOTE: There are 109 more slides in this lecture. The complete set is available to APM members in the Members' Corner.