Consultation-Liaison Psychiatry for Medical Students: Common Presentations and Management Strategies

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Consultation-Liaison Psychiatry – The Basics

Consult/Liaison Psychiatry	
What is C/L?	Subspecialty service for diagnosis/treatment of psychiatric disorders comorbid with medical or surgical illness. **Consult (C):** Provide expertise on medical conditions and medications which cause/exacerbate psychiatric symptoms and psychiatric aspects of medical illness **Liaison (L):** Collaborate with primary medical and surgical teams to facilitate proper and effective medical care for patients with psychiatric conditions
Why is C/L Psych important?	Psychiatric disorders commonly exacerbate the course of medical illness, cause significant distress, prolong hospital length of stay, and increase costs of care. C/L can help optimize patient care by facilitating communication and collaboration between the patient and medical team(s)
Example Consult Workflow	Speak directly with referring clinician regarding question for team→ review current records and pertinent past records → review patient's meds → gather collateral data → interview and examine the pt → formulate diagnostic and therapeutic strategies → write note → speak directly with the referring clinician → provide periodic f/u
Tips	• Confirm with primary team that patient is aware psychiatry is coming • Optimize privacy in pt's room • Try to stay at pt's eye level in comfortable position (and don't sit on pt's bed) • Clarify role. Pts may fear that primary team/psychiatry think they are "crazy" • Medically ill / hospitalized pts may need more focused interview • Patients may need to utilize alternative/non-verbal communication tools

Adapted from: Stern, Theodore A., Oliver Freudenreich, Felicia A. Smith, Gregory Fricchione, J. F. Rosenbaum, and J. F. (Jerrold F.) Rosenbaum. Massachusetts General Hospital Handbook of General Hospital Psychiatry. Seventh edition. Edinburgh: Elsevier, 2018.

Mental Status Exam (MSE)	
Consciousness	Alert, drowsy, somnolent, stuporous, +/- fluctuations
Appearance	Grooming, hygiene, dress
Behavioral	Cooperation, eye contact, psychomotor activity, abnormal movements (tics, tremors, chorea, posturing)
Attention	Vigilance, concentration, focus; test by reciting months backward, spelling "world" forwards then backwards, or serial 7s
Orientation	Person, place, time, situation
Language/Speech	Rate, volume, fluency, rhythm; comprehension & naming ability; describe observed abnormalities
Memory	3-word recall; general knowledge questions, naming and visual recognition tasks (naming various objects)
Mood	Pt's reported emotional state (happy, sad, anxious, worried, depressed, etc)
Affect	Interviewer's perception of patient's emotional state—quality (euthymic, dysthymic, irritable, labile), range (expansive, full, restricted, blunted, flat), appropriateness (reactivity, mood congruency)
Thought Form	Nature/structure (linear, circumstantial, tangential, disorganized, blocked)
Thought Content	SI, HI, delusions, paranoia, ideas of reference
Perception	Hallucinations, illusions
Judgment	Act according to values/desires; appreciate alternatives
Insight	Pt's understanding of their illness, situation, treatment, life circumstances
Reasoning	Logical vs illogical; ability to make consistent decisions reflecting values

Pharmacology on the Consultation-Liaison Psychiatry Service

Psychopharmacology in Medical Illness	
• Can treat symptoms impeding medical care or functioning that do not fulfill criteria for a psychiatric disorder • Common Target Symptoms: depression, anxiety, fatigue, insomnia, pain, agitation, psychosis, withdrawal	
Pharmacokinetics & Pharmacodynamics	*Absorption:* how a drug moves from administered route (e.g., oral, IM) to systemic circulation *Bioavailability:* fraction of drug available in systemic circulation *Distribution:* how a drug spreads and disseminates throughout the body *Metabolism:* processing of drug into subsequent compounds (metabolites) for activation/inactivation or clearance for excretion; most commonly occurs in the liver (specifically hepatic cytochrome P450) *Excretion:* elimination of drug or drug metabolites; most commonly by kidneys • Medical illness can affect a drug's kinetic and dynamic properties. • Most psychotropics are tightly protein bound (exceptions: lithium, venlafaxine, methylphenidate, gabapentin, topiramate). • Protein loss can increase amount of unbound active drug. • Dose adjustments in renal/liver disease are needed to prevent toxicity. • Some medications (including valproic acid for agitation) benefit from a loading dose to help rapidly achieve effective serum concentrations. • Body's biological response to a medication may change due to drug-drug interactions.

Medication Onset of Action	
PO	20 – 30 minutes; max effect at ~1 hr
IM	10 – 15 minutes; max effect at ~30 min
IV	Effective in minutes

Systems-Based Psychopharmacologic Considerations for Medically Ill Patients	
Cardiac	• Common cardiovascular side effects of psychotropics: orthostatic hypotension, conduction disturbances, arrhythmias • Cardiovascular disease can affect kidney and liver perfusion by impacting drug metabolism and clearance • CHF: fluid retention can alter a drug's volume of distribution • Psychotropics can prolong QTc interval, especially with underlying cardiac disease; consider changing medications or reducing dose for QTc > 500 msec in adults or > 440 msec in children Considerations for specific medications: • Citalopram: not recommended in cardiac disease due to risk of conduction disturbances (but may make sense to continue for a patient with psychiatric illness that has responded well to this medication) • Tricyclic antidepressants: may prolong QTc and increase risk of arrhythmias; may cause ventricular fibrillation in overdose • Lithium: can increase risk for sinus node dysfunction, first degree AV block • Carbamazepine: can increase risk for AV conduction abnormalities • Lamotrigine: associated with QTc prolongation • Antipsychotics: can increase risk of orthostatic hypotension due to alpha-adrenergic blockade and can prolong QTc interval • Haloperidol: high-dose parenteral administration associated with QTc prolongation, torsades des pointes, and multifocal ventricular tachycardia • Clozapine: can cause myocarditis, rare instances of cardiomyopathy • Psychostimulants: use with caution in structural or severe cardiac disease • Clonidine: can decrease systolic blood pressure and heart rate
Epilepsy	• Bupropion: contraindicated at higher doses given potential to lower seizure threshold • TCAs: greater epileptogenic risk than other antidepressants • Lithium: pro-convulsant but can be used judiciously • Clozapine: more likely to lower seizure threshold than other antipsychotics (low dose antipsychotics do not significantly affect seizure threshold if on stable anti-seizure regimen) • Psychostimulants: no evidence for increased seizure risk
Gastrointestinal	• Common GI side effects of psychotropics: slowed motility and impaired absorption (drugs with anticholinergic properties); increased motility and diarrhea (SSRIs); GI bleeding (SSRIs with co-administered NSAIDs) • Extended-release preparations: less GI upset, slower increase in plasma levels • Most drugs are absorbed in the proximal > distal GI tract • GI disease can impact drug absorption by impairments in mucosal integrity (gastroparesis, Crohn's disease), motility (diabetes, gastritis, pyloric stenosis), or diversion of blood away from GI tract (CHF, shock)
Hematologic	• Clozapine: risk of agranulocytosis • SSRIs: can cause platelet dysfunction (platelets require serotonin for aggregation)
Hepatic	• Affects first-pass metabolism and distribution through reduced bioavailability, changes in serum drug levels • Moderate to severe liver disease: may need to reduce medication doses • Antidepressants with greater risk of hepatotoxicity: nefazodone, imipramine, amitriptyline, duloxetine, trazodone, bupropion • Antidepressants with less risk of hepatotoxicity: citalopram, escitalopram, paroxetine, fluvoxamine • Avoid carbamazepine, valproate, chlorpromazine, fluphenazine • Benzodiazepines: lorazepam, oxazepam, temazepam may be used with liver disease (undergoes conjugation only; not oxidation)

Renal	• For renally excreted medications, general dose adjustment is decreased by one third • Many psychotropics (except for lithium and gabapentin) do not require dosing adjustments but caution should be used • Hemodialysis: drug redistribution after dialysis leads to transient increase in plasma concentration; most protein-bound medications are not cleared by dialysis
Pulmonary	• Benzodiazepines: increased risk for respiratory depression; contraindicated in respiratory disease with comorbid sleep apnea; intermediate acting agents (lorazepam, oxazepam, temazepam) have less respiratory depression; can improve respiratory status in asthma with comorbid anxiety • Diphenhydramine, hydroxyzine: can exacerbate asthma symptoms given anticholinergic properties • Beta blockers: contraindicated in asthma due to bronchoconstriction

Reference: Levenson. (2019). The American Psychiatric Association Publishing textbook of psychosomatic medicine and consultation-liaison psychiatry (Levenson, Ed.; Third edition). American Psychiatric Association Publishing.

Commonly Prescribed Psychotropics		
Selective Serotonin Reuptake Inhibitors (SSRI): Citalopram (Celexa) Escitalopram (Lexapro) Fluoxetine (Prozac) Fluvoxamine (Luvox) Paroxetine (Paxil) Sertraline (Zoloft)	**Serotonin-Norepinephrine Reuptake Inhibitors (SNRI):** Desvenlafaxine (Pristiq) Duloxetine (Cymbalta) Milnacipran (Savella) Venlafaxine (Effexor)	**Atypical Antidepressants:** Bupropion (Wellbutrin) Mirtazapine (Remeron)
Serotonin Modulators: Nefazodone (Serzone) Trazodone (Desyrel) Vilazodone (Viibryd) Vortioxetine (Trintellix)	**Tricyclics and Tetracyclics:** Amitriptyline (Elavil) Clomipramine (Anafranil) Desipramine (Norpramin) Doxepin (Silenor, SINEquan) Imipramine (Tofranil) Nortriptyline (Pamelor)	**Monoamine Oxidase Inhibitors:** Isocarboxazid (Marplan) Phenelzine (Nardil) Selegiline transdermal patch (Emsam, Eldepryl, Zelapar)
Mood Stabilizers: Anticonvulsants: Carbamazepine (Tegretol, Curadil) Lamotrigine (Lamictal) Topiramate (Topamax) Valproate/Valproic Acid (Depakote, Divalproex) **Mood Stabilizers: Other** Lithium	**Typical (1st Generation) Antipsychotics (* has LAI):** Chlorpromazine (Thorazine) Droperidol (Inapsine) Fluphenazine* (Prolixin) Perphenazine (Trilafon) Haloperidol* (Haldol) Thioridazine (Mellaril, Melleril)	**Atypical (2nd Generation) Antipsychotics (*has LAI):** Aripiprazole* (Abilify) Asenapine (Saphris) Brexpiprazole (Rexulti) Cariprazine (Vraylar) Lurasidone (Latuda) Olanzapine* (Zyprexa) Paliperidone* (Invega) Quetiapine (Seroquel) Risperidone* (Risperdal) Ziprasidone (Geodon) Clozapine (Clozaril)

Psychosis and Agitation

Acute Psychosis	
Common Etiologies	1° psychiatric illness, 2° to medical condition--systemic or brain based: brain tumor, infection (CNS or other), stroke, delirium, dementia, temporal lobe epilepsy, metabolic derangements; substance use, meds
Initial Evaluation	CBC, Electrolytes (w/ Ca, Phosphorus), BUN/Crt, Glucose, TSH, LFTs, ESR, ANA, HIV test, FTA-ABS for syphilis, Vit B12 and folate, serum cortisol, ceruloplasmin, UA, serum tox screen, serum Rx drug levels, blood cx, urine cx, MRI brain, +/- EEG, +/- LP
Treatment	Treat underlying cause Antipsychotics, benzodiazepines
Other	Tolerability of antipsychotics is important in medically ill pts (use with caution in dementia) Psychosis can greatly impair pt cooperation/flow of medical care

Acute Agitation	
Types	Impulsive: typically reactive, emotionally laden, sometimes explosive; not always unintentional (+/- cognitive deficits, psychosis, high emotional sensitivity, autonomic arousal) Instrumental: premeditated, purposeful controlled behavior; can be predatory or pathological
Common Causes	Pain, Fear, Confusion, Distress, Inability to Communicate
1st Line Treatment: Behavioral	Nonverbal: safe distance, non-threatening posture and position, good eye contact (don't stare), respect patient's personal space, stay at same height as pt Verbal: calm & clear tone; personalize yourself; express empathy to pt's situation; don't insist on having last word Tactics: find common goals; don't challenge/argue; establish boundaries; acknowledge patient's autonomy
1st Line Treatment: Environmental	Remove dangerous objects from the room; decrease external stimuli; bring in additional help (1:1, security); utilize distractions
2nd Line Treatment: Pharmacologic	Acute goal: calm patient and ensure safety of pt & staff • Benzodiazepines (preferred given more AE w/ antipsychotics, unless agitation is due to delirium) • Antipsychotics (can utilize sedating effects of certain agents; common agents include haloperidol, risperidone, olanzapine) +/- benzodiazepine
3rd Line Treatment:	Seclusion, physical restraints. These interventions should be used for the shortest amount of time possible and should be used only if other interventions are insufficient to keep individuals safe. Individuals in seclusion or restraints should receive concomitant medication and should have a sitter present for monitoring.

Catatonia

Catatonia: syndrome of **abnormal movement and behavior** (look for an **underlying cause**)	
Common Features	Hyperactive vs hypoactive Immobility/stupor Staring Mutism/Withdrawal Echolalia/Echopraxia Stereotypy Malignant features: autonomic instability, rigidity, coma *See Bush-Francis Catatonia Rating Scale (BFCRS) for additional features/criteria*
Common Etiologies	Neurologic/medical illness: toxic-metabolic disease, infections, CNS diseases, medication side effects, poisoning Psychiatric illness: most common – bipolar disorder; mood disorders, schizophrenia, acute psychosis, conversion disorder
Treatment	Lorazepam challenge + scheduled lorazepam Track sx with BFCRS Dx and treat underlying etiology Closely monitor vitals & supportive care D/c antipsychotics or other antidopaminergics and restart recently d/c'd dopamine agonists, benzodiazepines ECT if unresponsive to pharmacologic treatment

Reference: Bush G, Fink M, Petrides G, Dowling F, Francis A. Catatonia. I. Rating scale and standardized examination. Acta Psychiatr Scand. 1996;93(2):129–136.

Pharmacologic Emergencies

	Serotonin Syndrome	***Neuroleptic Malignant Syndrome***
Precipitant	Serotonin agonist	Dopamine antagonist
Onset	Within 24 hours of exposure	Days to weeks after exposure
Vitals	Hypertension, tachycardia, tachypnea, hyperthermia (>40° C)	
Skin	Diaphoretic	
Neuromus cular	Increased tone, tremor, choreoathetoid movements	Diffuse rigidity, "lead pipe"
Reflexes	Hyperreflexia, clonus	Hyporeflexia
Pupils	Mydriasis	Normal
Bowel Sounds	Hyperactivity	Normal
Treatment	Benzodiazepine, cyproheptadine	Benzodiazepines; dantrolene, bromocriptine, ECT
Resolution	Within 24 hours	Days to weeks

Capacity and Safety Assessments

Capacity: a person's ability to make a decision regarding their health and care; fluid; situation specific and NOT global; can be assessed by any provider, four primary components
(1) Communicate a clear choice
(2) Understand the relevant information
(3) Appreciate the situation and its consequences
(4) Reason about treatment options through rational processing of relevant information

Suicide: Risk & Protective Factors	
Risk Factors	**Protective Factors**
History of prior attempts (recent > remote) Family history of suicide Access to firearms/lethal means Male sex: more likely to complete Female sex: more likely to attempt White/Caucasian race Indigenous/Native heritage Irritability/anger/impulsivity/insomnia Intoxication Change in providers or treatment (inpatient teams, outpatient, recent discharge) Reluctance to accept help General psychosocial stressors	Feelings of obligation to family, friends, kids Sense of community (incl. social support system) Ego dystonic thoughts re:self-harm Strong spiritual or religious beliefs Robust/developing coping skills Positive therapeutic relationships Help-seeking behaviors Engagement in (mental) health treatment Lack of prior attempts

Depression and Anxiety in the Medically Ill

Depression in Medically Ill Patients	
● Frequently underdiagnosed/untreated (symptoms may be attributed to physical source) ● Bidirectional/reciprocal comorbidity with medical illness (esp. chronic illness) ● Differentiate from adjustment disorder secondary to new medical illness ● Can screen with the Hospital Anxiety and Depression Scale (HADS)	
Risks if Untreated:	Increased somatic symptom burden, worse quality of life, higher rates of health care utilization, decreased adherence to medical treatment, lower functional capacity, less occupational productivity
Confounding Symptom Overlaps:	● Fatigue, anorexia, weight loss, insomnia, psychomotor retardation, diminished concentration; apathy in hypoactive delirium or dementia; akinesia and masked facies in Parkinson's ● Post-stroke or MS patients: "emotionalism" (pathological crying, apathy, or fatigue)
Treatment	● Address underlying medical illness if physiologic contributor ● SSRIs first line (consider comorbidities + safety profile) ● Severe/refractory cases—ECT, rTMS

Acute Anxiety in the Hospital Setting	
● Common in medically ill pts ● Can impede planned/recommended treatment course (e.g., ventilator wean) ● Can impair overall functioning / status of pts with chronic illnesses ● Can screen with the Hospital Anxiety and Depression Scale (HADS)	
Four Main Etiologies:	1. Primary psychiatric disorder (GAD, panic d/o, phobias; PTSD, OCD) 2. Effects of medical illness: medical conditions commonly a/w anxiety include hyperthyroidism, cardiovascular d/o (CAD, CHF, arrythmias), respiratory illness (asthma, COPD exacerbation, pulmonary embolism), neurologic (insular seizure), malignancies 3. Effects of substance/medication: caffeine, OTC sympathomimetics (e.g. decongestants), withdrawal 4. Secondary to psychologic reaction to experience of illness
Treatment	● Psychotherapy: supportive therapy at bedside, CBT ● Pharmacotherapy: 1. Acute/severely impairing/time-limited sx:antihistamines (hydroxyzine), gabapentin/pregabalin, benzodiazepines, low dose antipsychotic 2. Chronic/long-standing sx: antidepressants, buspirone, beta-blockers, antihistamines (hydroxyzine), gabapentin/pregabalin

Delirium and Dementia: Features and Differentiation

Delirium: syndrome marked by disturbance of consciousness with **impaired attention** and **awareness (always** has an **underlying cause)**				
Features	Abrupt onset w/ waxing/waning course (tangentiality to incoherence)		Disorganized thought process	
	Impaired attention		Disturbed sleep/wake cycle	
	Memory deficits (registration)		Emotional disturbances and labile affect	
	Altered psychomotor activity (hyper- or hypoactive)			
Predisposing Factors	Older age	Neurocognitive d/o	Prior brain injury	Sleep Deprivation
	H/o delirium	Depressive d/o	H/o EtOH use d/o	Malnutrition
	Sensory deficits (visual/hearing)		Impaired functional status	Polypharmacy
	Malnutrition	Dehydration	ICU or post-op admission	Bone Fracture(s)

Precipitants	"END ACUTE BRAIN FAILURE" **E**lectrolyte and fluid imbalance **N**eurological disorders and injuries **D**eficiencies (nutritional/vitamins) **A**ge Baseline **C**ognitive function **U**-tox or acute substance intoxication and withdrawal states Bodily **T**rauma and surgery **E**ndocrinopathies **B**aseline psychiatric disorders **R**x or medications and various toxidromes **A**noxia or decreased oxygenation states **I**nfection **N**oxious stimuli Organ **F**ailure **A**pache score (severity of medical illness process) **I**solation and sensory deprivation **L**ight exposure, sleep disturbances and alterations of the circadian rhythm **U**remia and other metabolic disorders Physical **R**estraints and immobility **E**mergence from sedation
Prevention & Treatment	Treat underlying cause Minimize polypharmacy Early Identification (CAM/CAM-ICU) Avoid deliriogenic meds Reorientation Family at bedside Adequate pain control Treat constipation Minimize napping Glasses/hearing aids Lights on/blinds open during day Early mobilization/ROM exercises Adequate nutrition/hydration Tx agitation with antipsychotics
Common Deliriogenic Meds	Hypnotics (ex: zolpidem), benzodiazepines, antihistamines, anticholinergics (ex: diphenhydramine), opioids

Adapted from Maldonado, José R. "Acute Brain Failure." *Critical care clinics* 33.3 (2017): 461–519.

Common Dementia Syndromes

- Older patients with depression can present with dementia-like syndrome (usually severe depressive sx + mild dementia sx)
- Cholinesterase inhibitors; SSRIs for chronic agitation; judicious antipsychotics given association with increased mortality

Type	Onset	Features	Course	Motor	Imaging	Pathology
Alzheimer's Disease	>65	Most common cause of dementia, progressive memory decline, executive function difficulty, amnesia, word fluency loss; aphasia, agnosia	Insidious onset & gradual decline	Apraxia (unable to perform tasks/ movements even though they are 'second nature')	Hippocampal & generalized cortical atrophy; temporal and parietal hypometabolism	Neurofibrillary tangles (hyperphosphory-lated tau protein) and amyloid plaques
Frontotemporal	<65	Behavioral change: apathy, disinhibition, overeating, loss of executive control; behavioral and language variants	Insidious onset & gradual decline	Frontal release signs (pathologic reflexes incl. grasp, snout, rooting and palmomental and glabellar)	Frontal/temporal atrophy and hypometabolism	Tau, transactive response DNA binding protein (TDP-43), Pick cells and Pick bodies in cortex
Lewy Body and Parkinson Disease	>65	Cognitive dysfunction (often fluctuant), visual	Insidious onset, gradual with	Parkinsonism	Generalized cortical atrophy, occipital	Alpha-synuclein+ Lewy bodies in cortex,

		hallucinations (well formed, detailed), REM-sleep behavior d/o	fluctuations (LB: dementia before motor & PD: motor before dementia)		hypometabolism	midbrain
Vascular	>65	Second most common cause of dementia, variable presentation depending on location of lesion and type of vasculature affected	Abrupt or gradual; stepwise decline	Focal weakness	Strokes, lacunar infarcts, cerebral hemorrhages	Arterioles with thickened vessel walls

Differentiating Delirium vs Dementia		
Feature	**Delirium**	**Dementia (Major Neurocognitive Disorder)**
Usual Onset	Sudden / Acute	Gradual
Course	Fluctuating, usually reversible	Progressive deterioration
Duration	Hours-weeks	Months-years
Consciousness	Impaired/Altered	Clear until late stages
Attention	Impaired	Intact until late stages
Memory	Deficits in working memory (registration) and recall	Short-term memory deficits > remote memory loss
Speech	Incoherent; can be fast/slow	Word-finding difficulty
Affect	Can be labile	Variable; can be blunted
Psychotic Features	Fluid, short-lived delusions; misperceptions; illusions	Delusions of theft/persecution/imposters; hallucinations per subtype (LBD)
Sleep/Wake	Fragmented, Reversal	Often normal
Psychomotor	Increased or decreased	Often normal; may wander or become agitated
EEG Findings	Abnormal (findings specific to underlying cause)	Generally normal (except for certain early-onset causes, eg CJD or prion dz)

Personality Disorders

Personality D/o Cluster	**Presenting Characteristics**	**Comorbidity Associations**	**Common Defense Mechanisms**
Cluster A (Paranoid, Schizotypal, Schizoid)	Odd, eccentric, withdrawn, distrusting	Psychotic d/o	Intellectualization, projection, magical thinking, avoidance
Cluster B (Borderline, Narcissistic, Antisocial, Histrionic)	Dramatic, emotional, impulsive, inconsistent, sensitive to perceived abandonment/criticism, difficulty w/ relationships, can be hostile or erratic	Mood d/o	Denial, acting out, regression (histrionic), splitting (borderline), projective identification, idealization, devaluation
Cluster C (Avoidant, Obsessive-Compulsive, Dependent)	Anxious, fearful, preoccupied, not easily reassured	Anxiety d/o	Isolation, avoidance, hypochondriasis

Personality Type	Characteristics	Meaning of Illness	Management Tips
Paranoid	Guarded, distrustful	Proof world is against patient	Avoid confrontation while trying to acknowledge concerns/feelings
Schizoid	Remote, inhibited	Fear of intrusion	Balance respecting privacy with preventing patient withdrawal
Masochistic	"Perpetual victim"	Conscious or unconscious punishment	Suggest treatment as another burden to be endured
Narcissistic	Demanding, devaluing	Threat to self-concept of perfection/invulnerability	Be humble, reframe entitlement to foster treatment adherence
Histrionic	Melodramatic, flirtatious	Loss of love/attractiveness	Balance warmth/formality and maintain clear boundaries
Obsessional	Orderly, likes control	Loss of control over body/emotions/impulses	Set routine and foster patient input to improved sense of control
Dependent	Needy, demanding	Threat of abandonment	Schedule visits, avoid withdrawing from patient, reward independence

Adapted from Groves MS and Muskin PR, Psychological Responses to Illness from The American Psychiatric Association Publishing Textbook of Psychosomatic Medicine and Consultation-Liaison Psychiatry

Somatic Symptom Disorders and Deception Syndromes

Somatic Symptom and Related Disorders, Factitious Disorder, & Malingering	
Somatic Symptom Disorder	• 1+ physical sxs that are distressing or functionally impairing • Excessive and disproportionate thoughts, feelings, and/or behaviors about symptoms • Essential feature: somatic symptom burden • May be present with or without medical illness
Functional Neurological Symptom Disorder	• Syndrome of neurological sxs (weakness, abnormal movements, nonepileptic seizures) involving abnormal functioning rather than structural disease • Essential feature: functional pattern of sensory/motor symptoms that are incompatible with recognized neurologic disorders • May co-occur with neurological illness
Illness Anxiety Disorder	• Persistent, excessive thoughts and feelings about having a serious physical illness; not reassured by normal tests • Essential feature: preoccupation with being ill • May be present with or without medical illness
Factitious Disorder	• Falsification of or self-induced signs/symptoms of injury or disease in the absence of personal gain • Primarily to attain/identify with sick role • Can be imposed on self or another person • Essential feature: falsification or medical or psychological signs/symptoms for deception
Malingering (not a psychiatric disorder)	• Feigns/reports symptoms for personal gain

Substance-Related Presentations

Substance	Intoxication	Tx of Intoxication	Withdrawal	Tx of withdrawal
Alcohol	Change in speech (more talkative, slurred) Change in mood (gregarious or sullen, irritable) Poor coordination, unsteady gait	Supportive care Food Hydration Sleep Mechanical ventilation if severe	Tremor Hallucinations Seizures Anxiety Headache Nausea/vomiting Autonomic Hyperactivity * Can be fatal	Benzodiazepine (CIWA protocol) Phenobarbital Gabapentin Thiamine to prevent Wernicke's (give before glucose) and Folic Acid
Amphetamines	Euphoria Hypervigilance Autonomic hyperactivity Pupillary dilatation Weight loss Hallucinations	Antipsychotics for psychosis Benzodiazepines Propranolol Monitor hypertension	Anxiety Tremulousness Headache Increased appetite Depression Elevated risk of suicide	None
Cannabis	Impaired motor coordination Slowed sense of time Social withdrawal Euphoria Conjunctival injection Dry mouth Increased appetite Tachycardia Hyperemesis	None	Irritability Insomnia Restlessness Depressed mood	None
Hallucinogens	Ideas of reference Hallucinations Dissociation Papillary dilatation Tremor incoordination	Reassurance Anti-psychotics Benzodiazepines	None	None
Inhalants	Belligerence Apathy Assertiveness Blurred vision	Antipsychotics if delirious or agitated	None	None
Opioids	Respiratory depression Pinpoint pupils CNS depression (stupor, coma) Hypotension Hypothermia Constipation	Naloxone (Narcan)	Nausea/vomiting Diarrhea Muscle spasms Joint pains Abdominal cramps Rhinorrhea Lacrimation Sweating Autonomic instability	Agonist Tx: Methadone Buprenorphine/ Naloxone Symptomatic Tx: Clonidine Dicyclomine Hydroxyzine Ondansetron Acetaminophen NSAIDS
Benzodiazepine	Disinhibition Impairment in memory and concentration CNS depression	Flumazenil	Autonomic hyperactivity Tremors Insomnia Anxiety	Benzodiazepines

			Seizures * Can be fatal	

Organ Transplantation

Transplant Evaluation Components (Based off SIPAT)	
Readiness Level	Knowledge/understanding of medical illness, transplant process; willingness/desire for treatment; h/o past/present medical treatment; lifestyle factors (diet, exercise, fluid restrictions, habits related to specific organ)
Social Support System (SSS)	Availability and functionality of SSS, appropriateness of physical living space and home environment
Psychopathology	History of or current organic psychiatric disorder or neurocognitive impairment, depression & anxiety assessments, coping styles/strategies, current cognitive functioning, influence of personality traits/disorder, truthfulness vs deceptive behaviors, overall risk
Lifestyle & Substance Use	Establish Use/Abuse/Dependence/Risk for relapse for: ● Alcohol, nicotine, other substances

Adapted from: Maldonado JR et al. The Stanford Integrated Psychosocial Assessment for Transplantation (SIPAT): a new tool for the psychosocial evaluation of pre-transplant candidates. Psychosomatics 2012; 53: 123–32.

General References

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