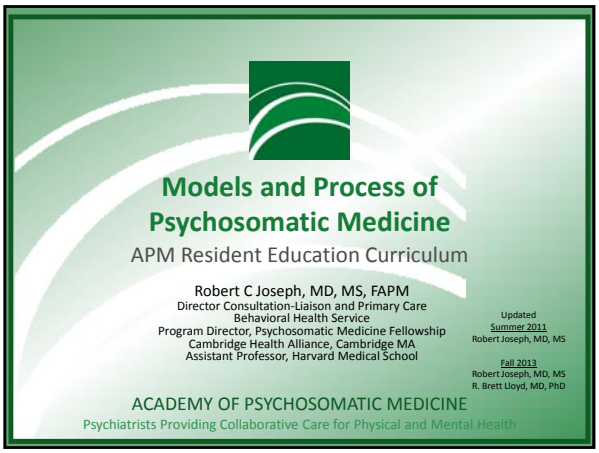

Psychosomatic Medicine

- 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

Traditional Models

- Consultation Upon Request
  - Reactive
  - Patient and consultee specific
  - Primary responsibility for patient remains with consutee
- Liaison Psychiatry Components
  - Education
    - Formal and informal education
  - Support
    - Service, Ward, Nursing Staff
  - Can be Sub-Specialty Specific
    - OB, Oncology, Neurology etc.

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

APM Resident Education Curriculum

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Updated
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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 starring at them suspiciously. They gave him some lorazepam to "calm" him.
- Since arrival to the floor to r/o MI he has been becoming 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

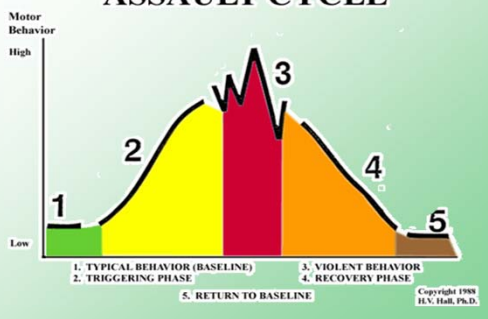
- Agitation
  - Excessive motor or verbal activity
- Aggression
  - Actual noxious behavior that can be verbal, physical against objects, or physical against people
- Violence
  - Denotes physical aggression by people against other people

(*Citrome and Volavka, 2002)*

Component Behaviors

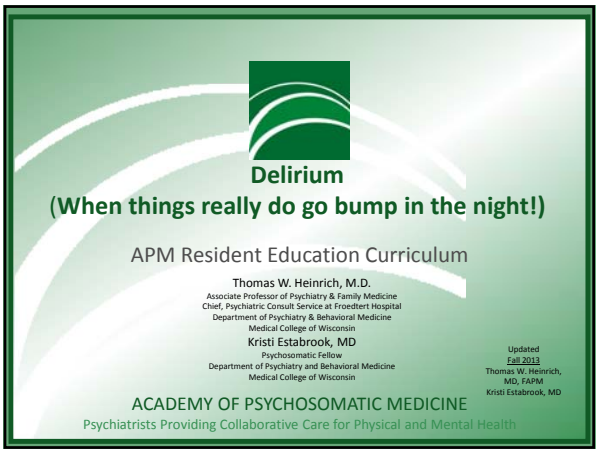
- Aggressive behaviors
  - Physical
    - Fighting
    - Throwing things
    - Grabbing objects
    - Destroying items
  - Verbal
    - Cursing
    - Screaming
- Nonaggressive behaviors
  - Restlessness (akathisia, restlessness)
  - Wandering
  - Inappropriate behavior (disrobing, intrusive, repetitive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

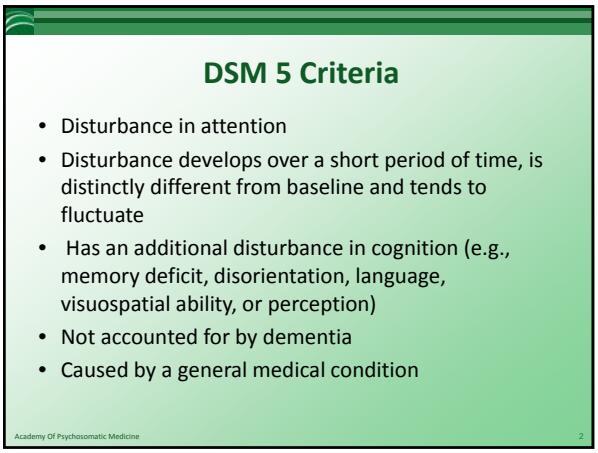
ASSAULT CYCLE

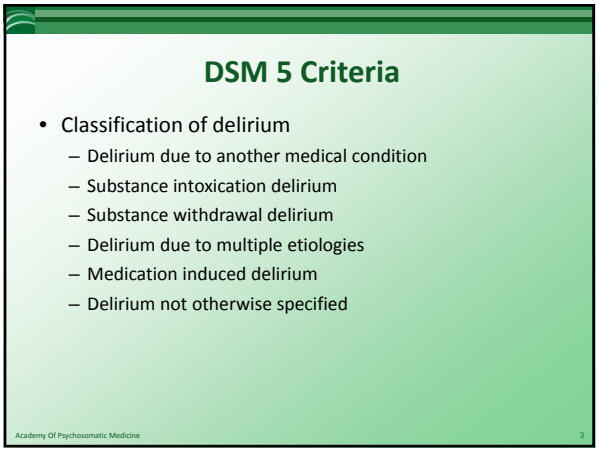


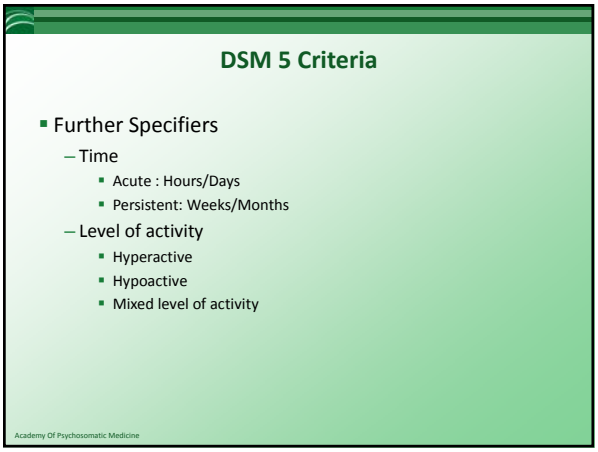
NOTE: There are 60 more slides in this lecture. The complete set is available to APM members in the Members' Corner.

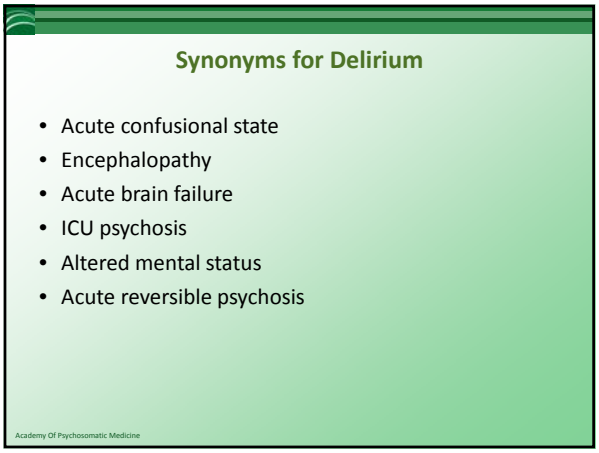
Delirium

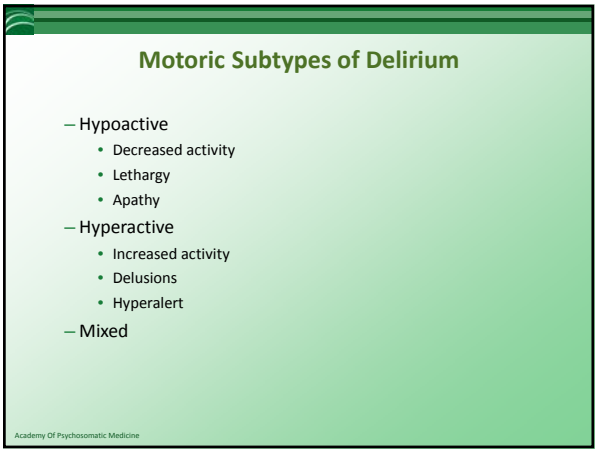




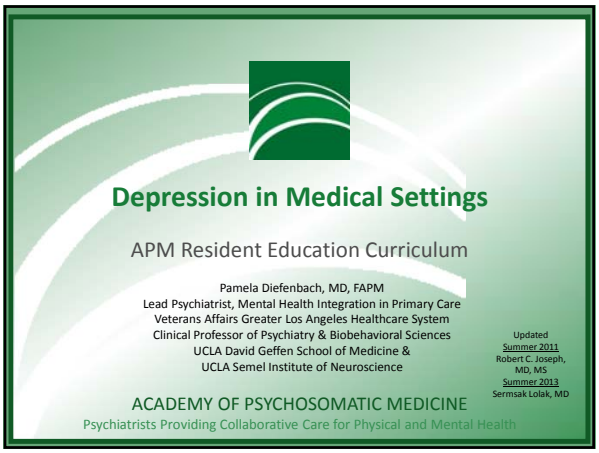








NOTE: There are 50 more slides in this lecture. The complete set is available to APM members in the Members' Corner.



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

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Overview

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

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Depression in medical illness

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

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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)

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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

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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

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Revised
Summer 2011
Ann Schwartz, MD, FAPM
Fall 2013
Carrie Ernst, MD
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Psychiatrists Providing Collaborative Care for Physical and Mental Health

Objectives

- 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

Step 1: Initial Diagnosis

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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

APM Resident Education Curriculum

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Updated
Fall 2013
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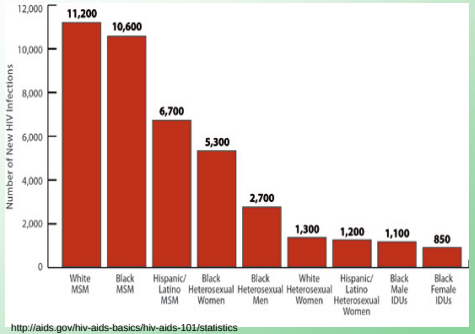
HIV Milestones

- 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

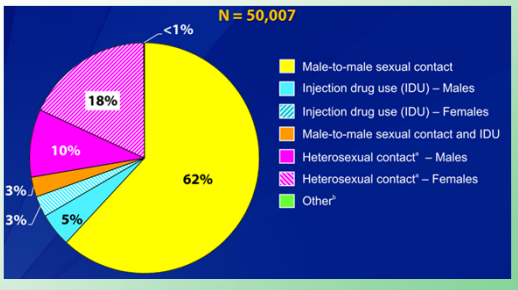
- 1.1 million people in the US living with HIV
  - ~18% unaware of being infected
  - Males who have sex with males (MSM) still most affected
  - Blacks face the most severe burden
- *Vulnerable* populations
  - Individuals with substance use disorders
  - Individuals with chronic mental illness

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



http://aids.gov/hiv-aids-basics/hiv-aids-101/statistics

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



http://www.cdc.gov/hiv/library/reports/surveillance/

Antiretroviral Therapy

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

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

APM Resident Education Curriculum

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Updated
Fall 2013
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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

- A little bit of history…
  - The "era of simple consent"
    - Objection to treatment usually respected
    - However, consent was often inferred or evoked by incomplete or misleading information
  - The "era of informed consent"
    - Goal is to allow a competent individual to exercise effective and informed self-decision-making

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

Informed Consent

- The 3 basic elements of informed consent
  - Disclosure of information
  - Voluntary choice
  - Competence to decide

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

Neuroleptic Malignant Syndrome and Serotonin Syndrome

APM Resident Education Curriculum

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Historical Background

- Syndrome malin des neuroleptiques
  - Rapidly progressive neurovegatative 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

Evidence

- All antipsychotics implicated share dopamine receptor antagonism
- Withdrawal of dopamine agonists or "freezing" episodes in Parkinson's disease have induced NMS-like states
- Dopamine agonists appear beneficial in treatment
- Disruption of dopamine tracts produce NMS-like states
- A case report utilizing SPECT revealed almost complete D2 receptor blockade in a patient with NMS
- Reduction in CSF homovanillic acid (HVA) in NMS
  - Reduction persisted after recovery

Pathogenesis

- Central dopamine hypoactivity (continued)

Theory (Strawn et al, 2007, Fricchione 1985)

- Patients susceptible to developing NMS may have a baseline central hypodopaminergia
  - 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

APM Resident Education Curriculum

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Psychiatrists Providing Collaborative Care for Physical and Mental Health

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

James L Levenson, M.D., 2005.
Academy Of Psychosomatic Medicine 2

Psychiatry and Palliative Care

Working Together Towards a Common Goal

- Palliative care's goal is to relieve symptoms and suffering and improve the patient's quality of life
- Palliative informs psychiatry
  - Assessment and treatment of pain
  - Bereavement
  - Anticipatory loss
- Psychiatry informs palliative care
  - Assessment of psychiatric illness and mental status changes
  - Evaluation of capacity
  - Psychiatric treatment
  - Insight into personality structure and communication issues
  - Conflict resolution

JLSpeiss, 2002
Academy Of Psychosomatic Medicine 3

Common Psychiatric Issues In the Palliative Care Population

- Anxiety
- Bereavement
- Depression
- Delirium

James L Levenson, M.D., 2005, Wyszynski, 2005
Academy Of Psychosomatic Medicine 4

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)

James L Levenson, M.D., 2005, Wyszynski, 2005, LW Roberts 2004
Academy Of Psychosomatic Medicine 5

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

James L Levenson, M.D., 2005,Wyszynski 2005
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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

APM Resident Education Curriculum

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

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

- What is the evidence for **efficacy** of specific agents for psychiatric illness associated with specific medical problem?
- What is the evidence for **safe** us of psychotropics in a specific situation?
- Does the psychiatric treatment need to be **adjusted** due to pharmacokinetics/dynamics?

- Studies, if any, are typically small or open
- Patients with significant medical problems are typically excluded from medication trials

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

Somatoform Disorders, Factitious Disorder and Malingering

APM Resident Education Curriculum

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Psychiatrists Providing Collaborative Care for Physical and Mental Health

Disclaimer

- DSM-5 published in May 2013.
- 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 suffer to seek health care but remain unexplained after an appropriate evaluation (Richardson and Engel, 2004)

Somatoform Disorders

- MUPS – 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

- MUPS – One syndrome or many?
  - Internal Medicine
    - Chronic fatigue
  - Gynecology
    - Chronic pelvic pain
  - ENT
    - Idiopathic tinnitus
  - Dentistry
    - Temporomandibular dysfunction
  - Rheumatology
    - Fibromyalgia
  - GI
    - Irritable bowel syndrome
  - Neurology
    - Nonepileptic seizures

Somatoform Disorders

- MUPS – Consequences
  - Impaired physician-patient relationship
    - Physician frustration
      - 1/6 primary care visits are considered "difficult"
        - Hahn, 2001
      - "Dose-response" relationship between symptoms and physician frustration
        - 0-1 symptom → 6% difficult
        - 2-5 symptoms → 13% difficult
        - 6-9 symptoms → 23% difficult
        - 10 or more symptoms → 36% difficult
    - Patient dissatisfaction

NOTE: There are 91 more slides in this lecture. The complete set is available to APM members in the Members' Corner.

Suicide Risk Assessment and Management in the Medical Hospital

APM Resident Education Curriculum

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Updated
Fall 2013
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Suicide

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

Suicide

"The termination of an individual's life resulting directly or indirectly from a positive or negative act of the victim himself which he knows will produce this fatal result"

– Durkheim 1857

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.

Treatment Considerations in Antenatal and Postpartum Psychiatric Illnesses

APM Resident Education Curriculum

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Updated
Fall 2013
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Psychiatrists Providing Collaborative Care for Physical and Mental Health

Risk-Benefit Analysis

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

Informed Consent Discussion

- "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

Depression and Pregnancy

- 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!

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