Massachusetts General Hospital

HANDBOOK OF GENERAL HOSPITAL PSYCHIATRY

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EDITION 6

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Massachusetts General Hospital

Handbook of General Hospital Psychiatry

SIXTH EDITION

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To our patients, our students, our colleagues,
and our mentors . . .

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Preface

This sixth edition, revised and substantially expanded, was put together by a stalwart group of general hospital psychiatrists. It was designed to help busy practitioners care for patients on medical and surgical floors and in outpatient practices filled by co-morbid medical and psychiatric illness. The chapters, which cover specific illnesses and care settings, were crafted for readability. Moreover, clinical vignettes strategically placed throughout the book were meant to act as a nidus upon which clinical pearls would grow.

Consultation psychiatry, recently minted as a new subspecialty called *psychosomatic medicine*, involves the rapid recognition, evaluation, and treatment of psychiatric problems in the medical setting. Practitioners of psychosomatic medicine must also manage psychiatric reactions to medical illness, psychiatric complications of medical illness and its treatment, and psychiatric illness in those who suffer from medical or surgical illness. Because problems related to the affective, behavioral, and cognitive (the "ABCs") realms of dementia, depression, anxiety, substance abuse, disruptive personalities, and critical illness are faced on a daily basis, emphasis has been placed on successful strategies for their management by the consultant and by the physician of record.

Eight new chapters were added to this edition, and previously written chapters were revised and updated. Additions include discussions of the doctor–patient relationship, the psychiatric interview, sexual disorders and sexual dysfunction, emergency consultations, caring for children when a parent is ill, the rigors of psychiatric practice, quality assurance and quality improvement, and psychiatric research in the general hospital.

This book would not have been possible were it not for the steady hands of our acquisitions editor at Elsevier, Adrianne Brigido, and senior project manager, Cheryl Abbott. At the Massachusetts General Hospital, Judy Byford and Elena Muenzen helped shepherd us through thousands of emails, voice mails, FAXes, and photocopies associated with 54 chapters and scores of authors.

On behalf of the patients who suffer, we hope this edition improves the detection and treatment of psychiatric problems and brings much needed relief.

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Massachusetts General Hospital

Handbook of General Hospital Psychiatry

SIXTH EDITION

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PSYCHOSOMATIC MEDICINE

A keen interest in the relationship between the psyche and the soma has been maintained in medicine since early times, and certain ancient physicians (such as Hippocrates) have been eloquent on the subject. A search for the precise origins of *psychosomatic medicine* is, however, a difficult undertaking unless one chooses to focus on the first use of the term itself. Johann Heinroth appears to have coined the term *psychosomatic* in reference to certain causes of insomnia in 1818.[1] The word *medicine* was added to *psychosomatic* first by the psychoanalyst Felix Deutsch in the early 1920s.[2] Deutsch later emigrated to the United States with his wife Helene, and both worked at Massachusetts General Hospital (MGH) for a time in the 1930s and 1940s.

Three streams of thought flowed into the area of psychosomatic medicine, providing fertile ground for the growth of general hospital and consultation psychiatry.[3,4] The psychophysiologic school, perhaps represented by the Harvard physiologist Walter B. Cannon, emphasized the effects of stress on the body.[5] The psychoanalytic school, best personified by the psychoanalyst Franz Alexander, focused on the effects that psychodynamic conflicts had on the body.[6] The organic synthesis point of view, ambitiously pursued by Helen Flanders Dunbar, tried with limited success to unify the physiologic and psychoanalytic approaches.[7]

HISTORY

The history of general hospital psychiatry in the United States in general,[8] and consultation–liaison (C-L) psychiatry in particular,[9] has been extensively reviewed elsewhere. For those interested in a more detailed account of both historic trends and conceptual issues of C-L psychiatry, the writings of Lipowski[10–15] are highly recommended.

In years gone by, controversy surrounded the use of the term *liaison* in C-L psychiatry. We believed that using the term *liaison* was confusing and unnecessary. It was confusing because no other service in the practice of medicine employed the term for its consultation activities. In addition, the activity it referred to—to teach nonpsychiatrists psychiatric and interpersonal skills—is done as a matter of course during the routine consultation. The term *liaison*, although still used, has to some extent fallen out of fashion.

In March 2003, the American Board of Medical Specialties unanimously approved the American Board of Psychiatry and Neurology's (ABPN's) issuance of subspecialty certification in psychosomatic medicine. The first certifying examinations were administered in 2005. As of 2009, the completion of an American Board of Medical Specialties–certified fellowship in psychosomatic medicine became mandatory for all who wish to sit for that examination. The achievement of subspecialty status for psychosomatic medicine is the product of nearly 75 years of clinical work by psychiatrists on medical–surgical units, an impressive accumulation of scholarly work contributing to the psychiatric care of general medical patients, and determined intellectual and organizational efforts by the Academy of Psychosomatic Medicine (APM). The latter's efforts included settling on the name *psychosomatic medicine* after *C-L psychiatry* met with resistance from the ABPN during the first application for subspecialty status in 1992.[16] *Psychosomatic medicine* was ultimately felt to best capture the field's heritage and work on mind–body relationships, though there remains controversy over the nebulous boundaries this name implies.[17]

When the history of consultation psychiatry is examined, 1975 seems to be the watershed year. Before 1975, scant attention was given to the work of psychiatrists in medicine. Consultation topics were seldom presented at the national meetings of the American Psychiatric Association. Even the American Psychosomatic Society, which has many

strong links to consultation work, rarely gave more than a nod of acknowledgment to presentations or panels discussing this aspect of psychiatry. Residency training programs on the whole were no better. In 1966, Mendel[18] surveyed training programs in the United States to determine the extent to which residents were exposed to a training experience in consultation psychiatry. He found that 75% of the 202 programs surveyed offered some training in consultation psychiatry, but most of it was informal and poorly organized. Ten years later, Schubert and McKegney[19] found only "a slight increase" in the amount of time devoted to C-L training in residency programs. Today, C-L training is mandated by the ABPN as part of general adult psychiatry training.

Several factors account for the growth of C-L psychiatry in the last quarter of the 20th century. One was the leadership of Dr. James Eaton, former director of the Psychiatric Education Branch of the National Institute of Mental Health (NIMH). Eaton provided the support and encouragement that enabled the creation of C-L programs throughout the United States. Another reason for this growth was the burgeoning interest in the primary care specialties, which required skills in psychiatric diagnosis and treatment. Finally, parallel yet related threats to the viability of the psychiatric profession from third-party payers and nonphysician providers were an incentive to (re-)medicalize the field. Although creation of the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (DSM-III), and increased pharmacotherapy are the two most obvious upshots of this trend,[20,21] an elevated profile for C-L psychiatry also emerged as uniquely tailored to the psychiatrist's skill set. For these reasons, and because of expanding knowledge in neuropsychiatry, consultation work has enjoyed a renaissance.

The origins of organized interest in the mental life of patients at the MGH dates back to 1873, when James Jackson Putnam, a young Harvard neurologist, returned from his grand tour of German departments of medicine to practice his specialty. He was awarded a small office under the arch of one of the famous twin flying staircases of the Bulfinch building. The office was the size of a cupboard and was designed to house electrical equipment. Putnam was given the title of "electrician." One of his duties was to ensure the proper function of various galvanic and faradic devices then used to treat nervous and muscular disorders. It is no coincidence that his office came to be called the "cloaca maxima" by Professor of Medicine George Shattuck. This designation stemmed from the fact that patients whose maladies defied diagnosis and treatment—in short, the "crocks"—were referred to young Putnam. With such a beginning, it is not difficult for today's consultation psychiatrist to relate to Putnam's experience and mission. Putnam eventually became a professor of neuropathology and practiced both neurology and psychiatry, treating medical and surgical patients who developed mental disorders. Putnam's distinguished career, interwoven with the acceptance of Freudian psychology in the United States, is chronicled elsewhere.[22]

In the late 1920s, Dr. Howard Means, chief of medicine, appointed Boston psychiatrist William Herman to study patients who developed mental disturbances in conjunction with endocrine disorders. Herman's studies are hardly remembered today, although he was honored by having a conference room at the MGH named after him.

In 1934, a department of psychiatry took shape when Stanley Cobb was given the Bullard Chair of Neuropathology and granted sufficient money by the Rockefeller Foundation to establish a ward for the study of psychosomatic conditions. Under Cobb's tutelage, the department expanded and became known for its eclecticism and for its interest in the mind–brain relationship. A number of European emigrants fled Nazi tyranny and were welcomed to the department by Cobb. Felix and Helene Deutsch, Edward and Grete Bibring, and Hans Sachs were early arrivals from the continent. Erich Lindemann came in the mid-1930s and worked with Cobb on a series of projects, the most notable being his study of grief, which came as a result of his work with victims of the 1942 Coconut Grove fire.

When Lindemann became chief of the Psychiatric Service in 1954, the Consultation Service had not yet been established. Customarily, the resident assigned to night call in the emergency department saw all medical and surgical patients in need of psychiatric evaluation. This was regarded as an onerous task, and such calls were often set aside until after supper in the hope that the disturbance might quiet in the intervening hours. Notes in the chart were terse and often impractical. Seldom was there any follow-up. As a result, animosity toward psychiatry grew. To remedy this, Lindemann officially established the Psychiatric Consultation Service under the leadership of Avery Weisman in 1956. Weisman's resident, Thomas Hackett, divided his time between doing consultations and learning outpatient psychotherapy. During the first year of the consultation service, 130 consultations were performed. In 1958, the number of consultations increased to 370, and an active research program was organized that later became one of the cornerstones of the overall operation.

By 1960, a rotation through the Consultation Service had become a mandatory part of the MGH residency in psychiatry. Second-year residents were each assigned two wards. Each resident spent 20 to 30 hours a week on the Consultation Service for 6 months. Between 1956 and 1960, the service attracted the interest of fellowship students, who contributed postgraduate work on psychosomatic topics. Medical students also began to choose the Consultation Service as part of their elective in psychiatry during this period. From our work with these fellows and medical students, collaborative research studies were initiated with other services. Examples of these early studies are the surgical treatment of intractable pain,[23,24] the compliance of duodenal ulcer patients with their medical regimen,[25] post-amputation depression in the elderly patient,[15] emotional maladaptation in the surgical patient,[26–30] and the psychological aspects of acute myocardial infarction.[31,32]

By 1970, Hackett, then chief of the Consultation Service, had one full-time (postgraduate year [PGY]-IV) chief resident and six half-time (PGY-III) residents to see consultations from the approximately 400 house beds. A private Psychiatric Consultation Service was begun, to systematize consultations for the 600 private beds of the hospital. A Somatic Therapies Service began and offered electroconvulsive therapy to treat refractory conditions. Three fellows and a full-time faculty member were added to the roster in 1976. Edwin (Ned) Cassem became chief of the

Consultation Service, and George Murray was appointed director of a new fellowship program in psychosomatic medicine and consultation psychiatry. In 1995, Theodore Stern was named chief of the Avery Weisman Psychiatric Consultation Service. Now both fellows and residents take consultations in rotation from throughout the hospital. Our Child Psychiatry Division, composed of residents, fellows, and attending physicians, provides full consultation to the 40 beds of the MGH Hospital for Children.

In July 2002, Gregory Fricchione was appointed director of the new Division of Psychiatry and Medicine, with a mission to integrate the various inpatient and outpatient medical–psychiatry services at the MGH and its affiliates while maintaining the diverse characteristics and strengths of each unit. The division includes the Avery D. Weisman Psychiatry Consultation Service, the MGH Cancer Center, the Psychosocial Oncology Disease Center, the Transplant Consultation Service, the Trauma and Burns Psychiatry Service, the Women's Consultation Service, the Cardiovascular Health Center Service, the Behavioral Medicine Service, and the Spaulding Rehabilitation Hospital's Behavioral and Mental Health Service. Psychiatrists from this division also attend in the human immunodeficiency virus (HIV) outpatient unit and the gastroenterology clinic.

PATIENT CARE, TEACHING, AND RESEARCH

The three functions provided by any consultation service are patient care, teaching, and research.

Patient Care

At the MGH, between 10% and 13% of all admitted patients are followed by a psychiatrist; roughly 3500 initial consultations are performed each year. The problems discovered reflect the gamut of conditions listed in the DSM-IV[33]; however, the most common reasons for consultation are related to depression, delirium, anxiety, substance abuse, character pathology, dementia, somatoform disorders or medically unexplained symptoms, and the evaluation of capacity.

Patients are seen in consultation only at the request of another physician, who must write a specific order for the consultation. When performing a consultation, the psychiatrist, like any other physician, is expected to provide diagnosis and treatment. This includes defining the reason for the consultation; reading the chart; gathering information from nurses and family members when indicated; interviewing the patient; performing the appropriate physical and neurologic examinations; writing a clear clinical impression and treatment plan; ordering or suggesting laboratory tests, procedures, and medications; speaking with the referring physician when indicated; and making follow-up visits until the patient's problems are resolved, the patient is discharged, or the patient dies.

Interviewing style, individual to begin with, is further challenged and refined in the consultation arena, where the psychiatrist is presented with a patient who typically did not ask to be seen and who is often put off by the very idea that a psychiatrist has been called. In addition, the hospital room setting and the threat of acute illness might cause the patient to be either more or less forthcoming than under usual circumstances. The stigma of mental illness and the fear of any illness are universal; they are part of every physician's territory, and each psychiatrist learns to deal with them in a unique way. Residents learn to coax cooperation from such patients by trial and error, by self-understanding, and by observing role models rather than by observing formulas. Essential, however, are interest in the patient's medical situation and an approach that is comparable to that used by a rigorous and caring physician in any specialty. Each consultation can thus be viewed as an opportunity to provide care, to de-stigmatize mental illness, and to de-stigmatize psychiatry by personally representing it, via manner, tone, and examination, as a proper medical specialty.

Teaching

Many consultation psychiatrists believe that teaching psychiatry to medical and surgical house officers cannot be done on a formal basis. When teaching is formalized in weekly lectures or discussion groups, attendance invariably lags. More than 30 years ago, Lindemann, in an attempt to educate medical house officers about the emotional problems of their patients, enlisted the help of several psychiatric luminaries from the Boston area. A series of biweekly lectures was announced, in which Edward and Grete Bibring, Felix and Helene Deutsch, Stanley Cobb, and Carl Binger, among others, shared their knowledge and skills. In the beginning, approximately a fifth of the medical house officers attended. Attendance steadily dwindled in subsequent sessions until finally the psychiatry residents had to be required to attend so as to infuse the lecturers with enough spirit to continue. This might be alleged to illustrate disinterest or intimidation on the part of the nonpsychiatric staff, but we think that such didactics are simply too far removed (geographically and philosophically) from their day-to-day work.

We believe that teaching, to be most effective and reliable, is best done at the bedside on a case-by-case basis. Each resident is paired with an attending physician for bedside supervision, and all new patients are interviewed by our C-L attending staff. Residents teach as well. Medical students, neurology residents, and other visiting trainees are supervised by PGY-III residents, the chief resident, the fellows, and our attending staff. Twice weekly, rounds are held with Stern, the chief resident, and the rest of the service. In 90 to 120 minutes, follow-ups on current cases are presented and discussed, and new cases are presented by the consulting resident.

Before each group of residents begin their 4-month half-time rotation (in July, November, and March), they receive 25 introductory 45-minute lectures on practical topics in consultation (e.g., how to write the note, how to perform the neurologic or neuropsychological examination, the nature of psychotherapy in consultation, ruling out organic causes of psychiatric symptoms, diagnosing delirium and dementia, using psychotropic medications [e.g., psychostimulants, intravenous haloperidol] in the medically ill, assessing decisional capacity, performing hypnosis, and managing functional somatic symptoms). In concert with the orientation lecture series, we provide residents with relevant articles and with an annotated bibliography.[34] The overall curriculum we provide is quite