
GENERAL HOSPITAL PSYCHIATRY

MICHAEL ALAN TAYLOR, M.D.

FREDERICK S. SIERLES, M.D.

RICHARD ABRAMS, M.D.

GENERAL HOSPITAL PSYCHIATRY

Michael Alan Taylor, M.D.

Professor and Chairman

Frederick S. Sierles, M.D.

Associate Professor and Director of Undergraduate Medical Education

Richard Abrams, M.D.

Professor and Vice-Chairman

Department of Psychiatry and Behavioral Sciences

University of Health Sciences/The Chicago Medical School



THE FREE PRESS

A Division of Macmillan, Inc.

NEW YORK

Collier Macmillan Publishers

LONDON

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The Free Press
A Division of Macmillan, Inc.
866 Third Avenue, New York, N. Y. 10022
Collier Macmillan Canada, Inc.

Printed in the United States of America

printing number

1 2 3 4 5 6 7 8 9 10

Library of Congress Cataloging in Publication Data

Taylor, Michael Alan
General hospital psychiatry.

Includes index.

1. Psychiatric hospital care. I. Sierles, Frederick S.
II. Abrams, Richard III. Title. [DNLM: 1. Mental
Disorders. 2. Psychiatric Department, Hospital.

WM 27.1 T244g]

RC439.T39 1985 616.89 84-25873

ISBN 0-02-932980-9

FOREWORD

This is an unusual and important book. With clarity and detail it guides the reader through the diagnosis and treatment of the severely mentally ill. Its organization and illustrative case examples make it an essential textbook for medical students, residents, and others in psychiatric training programs. It will also be of significant practical value to neurologists, other physicians who consult regarding psychiatric inpatients, psychologists, social workers, nurses, hospital administrators, and anyone who deals with the inpatient care of the mentally ill.

This unique contribution to psychiatry derives much of its strength from the authors' long-standing research program. Since 1971, Drs. Taylor and Abrams have collected data on a sample of inpatients. Drawing on this rich data and on their examination of other diagnostic criteria, such as psychological testing, EEG, and neurologic examination, they have defined and explored the borders between schizophrenia and manic depressive illness.

Following an original approach, Taylor, Sierles, and Abrams cross the borders between psychiatry and neurology and treat psychiatric patients as sufferers of specific brain disorders. They are neuropsychiatrists in the oldest and best tradition. Thus, they highlight the value of neuropsychological and behavioral neurologic examination, and in descriptions of patients they in-

clude a section on behavioral neurologic diseases: epilepsy, delirium, dementia, and headaches, among others.

Part I, entitled Patient Evaluation, discusses the importance of making the correct diagnosis and demonstrates how to confirm the diagnosis by appropriate mental status and neurologic examination. While emphasizing history taking as "gathering data," the authors also delineate an approach to patient care when information is incomplete. The reader is immediately engaged by the case histories used to illustrate specific points.

Part II deals with Patient Management. Not only does it cover the usual principles of treatment with drugs, and the use of specific drugs for specific diagnoses, but, in addition, this section includes a long discussion on the use of ECT, an area in which the authors have done significant research. Here, they review the efficacy of the treatment and provide instructions on how to do it, including pre-ECT tests and orders, equipment, and post-ECT advice. The authors also cover verbal intervention and behavioral techniques.

The final three chapters of this section (psychiatric emergencies, the inpatient unit, and consultation/liason psychiatry) are especially noteworthy. The inpatient chapter must be read. It is a guide for all psychiatry departments trying to develop short-stay inpatient psychiatric units consistent with the knowledge and advancement of therapies today. The acute inpatient unit, with its emphasis on diagnosis, specific and timely interventions, and short-term stay, becoming *the* model of general hospital patient care, is very different from the standard long-term inpatient facility. When the new short-stay unit is developed, the orientation of the entire staff must be redirected so that the physician/psychiatrist, the psychologist, and social worker, nurses, and activity therapists take on new roles and responsibilities. To aid all concerned in making this transition, the authors describe in detail an inpatient unit and outline the roles and responsibilities of each of the mental health professionals working there.

In part III the authors explain how to treat specific diagnostic disorders such as affective disorder, schizophrenia, delusional disorder, behavioral neurologic disease, substance abuse, anorexia nervosa, anxiety disorder, somatization disorder, conversion disorder, and sociopathy; and specific patient problems such as malingering, suicidal or violent tendencies, catatonia, postpartum disorders, and symptoms associated with old age. This section, which does not always follow *DSM-III*, is, like the others, a joy to read. Throughout, the authors reemphasize a modern, straightforward approach to psychiatric patients, stressing the need for sensitivity, awareness, and practicality in handling both the patient and his or her family and friends. This commonsense, direct approach to the staff's dealing with patients has been all too rare in psychiatric textbooks.

General Hospital Psychiatry is a guide for psychiatric inpatient care, full

of general and specific information. The advice is priceless. With unmatched thoroughness and clarity, all the essential elements for providing this care are reviewed. This volume sets a new standard by which all similar texts must be judged.

DR. PAULA CLAYTON
Professor and Head
Department of Psychiatry
University of Minnesota



PREFACE

In the present renaissance of biological psychiatry, increasing numbers of psychiatrists are practicing in general hospitals and treating an increasingly diverse patient population with a variety of pharmacologic agents. In concert with this developing general hospital practice style, the stereotype of the psychiatric inpatient has metamorphosed from the permanently impaired, edentulous, baggy-clothed, dyskinetic state hospital schizophrenic into a pleasant-looking but depressed individual spending a few weeks in the living room atmosphere of a general hospital psychiatric unit while receiving the latest miracle from an elaborate pharmacopoeia. In fact, neither stereotype reflects the reality of modern hospital psychiatry, in which today's psychiatrist, like his colleagues in internal medicine and surgery, faces complex clinical problems requiring expertise about behavior, neuroscience, pharmacology and laboratory assessment and a better than passing knowledge of general medicine. The stethoscope and reflex hammer are, once again, tools of his trade, and electrophysiologic monitoring, computerized brain tomography and cognitive testing are his standard diagnostic tools. Today's hospital-based psychiatrist is called upon to treat deliria, dementias and psychomotor states as well as psychoses, anxiety disorders and dysthymias of traditional practice. Anticonvulsants, monoamine oxidase inhibitors, B-adrenergic and calcium channel blockers are his to use

along with neuroleptics and cyclic antidepressants, and his day-to-day activities are much like those of a busy internist.

Most psychiatrists approach this modern practice armed solely with a brief experience based primarily on the role modeling gained during residency training. Although there are books galore on psychopharmacology and the various psychiatric syndromes and a few texts dealing with the treatments of hospitalized psychiatric patients, there is little practical help for the psychiatrist in the form of a book that presents the principles and strategies of hospital psychiatry.

As practitioners and teachers of biologic psychiatry and researchers of the more severe mental disorders often requiring hospitalization, we have been fascinated and frustrated by the vicissitudes of hospital psychiatric practice and have long felt a practical guide to the diagnosis and treatment of psychiatric patients within a general hospital to be sorely needed. We believe this book, in part, fills that need for the practitioner, for the psychiatrist-in-training, and for all physicians and students concerned with the modern treatment of the patient with serious mental illness.

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CONTENTS

Foreword by Dr. Paula Clayton	<i>vii</i>
Preface	<i>xi</i>

Part I Patient Evaluation

1. Principles of Diagnosis	3
2. The Neuropsychiatric Examination	14
3. The Behavioral Neurologic Examination	35

Part II Patient Management

4. Principles of Psychopharmacology	83
5. Psychopharmacology	91
6. Electroconvulsive Therapy	119
7. Verbal Interventions and Behavioral Techniques	137
8. Psychiatric Emergencies	148

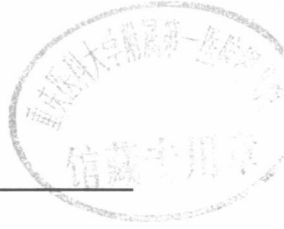
9. The Inpatient Unit	166
10. Consultation/Liaison Psychiatry	190
Part III Clinical Groups	
11. Affective Disorders	213
12. The Suicidal Patient	241
13. The Violent Patient	259
14. The Catatonic Patient	279
15. Schizophrenia	284
16. Delusional Disorder	310
17. Puerperal Psychoses	314
18. Behavioral Neurologic Disease	316
19. Substance Abuse	346
20. The Elderly Patient	366
21. Anorexia Nervosa	391
22. Anxiety Disorder, Obsessional Disorder	406
23. Somatization Disorder (Briquet's Syndrome)	410
24. Conversion Disorder, Psychogenic Pain Disorder, and Hypochondriasis	422
25. Sociopathy	431
26. Malingering	435
Index	445

PART I

PATIENT EVALUATION



Principles of Diagnosis



Introduction

Prior to the 1970s reliable psychiatric diagnosis was often a hit-or-miss affair leading to the standard joke, particularly in the United States, that where there were three psychiatrists, there would be four different diagnoses. Studies correlating changes in patterns of diagnoses with the availability of novel treatments (1,2), cross-national studies comparing diagnosis in Europe and the United States (3–5), and investigations of the diagnostic decision-making process provided overwhelming evidence of the capricious and unreliable nature of how individuals with mental illness were classified (6–8).

The 1970s witnessed a recrudescence of research and clinical interest in psychiatric diagnosis, and from that interest developed several sets of reliable research criteria for psychiatric disorders. *DSM-III*, the first official diagnostic system in the United States with known reliability and operationally defined criteria (9), is the clinical counterpart of that process.

No matter how carefully diagnostic criteria are defined, however, they are useless unless properly implemented. Experience and skill are required to use the criteria and to relate dry definitions to flesh-and-blood patients. The clinician also must have a command of the relevant data base and a clear understanding of the clinical principles of diagnosis.

The Diagnostic Process

Until reliable, specific, sensitive diagnostic laboratory tests for psychiatric illness are developed, diagnosis will remain a probabilistic process of exclusion and inclusion. Each diagnosis derives from many possibilities. Initially all diagnoses are equally probable. As the clinician collects data, the probability of any one diagnosis changes. For example, patient A is referred for evaluation. Without the additional information of age, sex, and chief complaint every diagnosis is equally probable. As the clinician collects more information, however, the probability that patient A is suffering from some disorders diminishes, eventually reaching zero, while the probability favoring other diagnoses increases. This continuing process of exclusion and inclusion eventually leaves the clinician with the most likely diagnosis. Using this model again, patient A is referred for evaluation. If patient A is male, the possibility of obstetrical/gynecological conditions is zero. If patient A is a male who has trouble walking, slurs his speech, and smells of alcohol, the probability of an acute intoxication increases and the probability of other conditions decreases. More information of the right sort is essential for furthering the process of exclusion/inclusion by probability, until the most likely diagnosis is reached. This is as true for the psychiatrist as for any other clinician.

Diagnostic success derives from the clinician's ability to collect accurate information and to relate this information to specific disorders. In the example of patient A, the diagnosis would have been wrong if the clinician failed to detect slurred speech or the smell of alcohol or if he did not know that these signs correlated with an acute alcoholic state.

The integration of accurate data with the process of exclusion/inclusion by probability is a powerful diagnostic tool. One of the earliest clinical axioms taught in medical school is that a woman of childbearing age who has missed two consecutive menstrual periods is considered pregnant until proved otherwise. Virtually every physician will diagnose "possible pregnancy" based solely upon the information: female, age twenty-five, two missed menstrual periods. Psychiatric phenomena can be equally suggestive. For example, a forty-three-year-old woman, who has never been ill before and whose physical examination and laboratory tests are normal, states that for the past three months she has felt "anxious, mildly irritable, and out of sorts." Her age, sex, general good health, and late onset episode of dysphoria strongly suggest depression. Should one hundred such patients all be diagnosed "depressed" solely upon the above information, diagnostic validity would exceed 90 percent (10). Other diagnostically powerful data patterns are displayed in Table 1-1.

TABLE 1-1 Some Examples of Diagnostic Patterns

SYMPTOM PATTERN	MOST LIKELY DIAGNOSIS(ES)
1. Typical depressive features (insomnia, anorexia, psychomotor retardation), but without the profound unremitting sadness of depression	a. Coarse brain disease b. Systemic illness c. Bipolar patient switching from depression to mania or euthymia
2. Typical and constant anxiety features (anxious mood, air hunger, tachycardia) beginning after age thirty-five in a male patient	Systemic illness (e.g. endocrinopathy, hypertension)
3. Irritability, broad affect, rapid/pressured speech, no coarse brain disease	Mania
4. Transient and episodic visual hallucinations and first-rank symptoms, but no thought disorder or affective blunting	Seizure disorder
5. Diffuse cognitive impairment, ataxia, urinary incontinence	Normal pressure hydrocephaly

Principles of Clinical Diagnosis

The proper collection of data and the bits of information that most influence diagnostic probabilities are discussed in detail elsewhere in the text. However, to diagnose the patient's illness correctly so that definitive treatment can be administered requires the clinician to adhere to the principles of clinical diagnosis. The simplicity of these "rules of thumb" belies the extraordinary difficulty most clinicians have in adhering to them in actual practice.

The fundamental principle of clinical diagnosis is *to observe the patient prior to instituting treatment*. Observing behavior and obtaining laboratory results uncontaminated by psychotropic medication is critical for valid diagnosis. Except for certain emergency situations or a patient who is well known to the clinician, this rule should never be violated. Unfortunately, it almost always is—in the irrational rush to treatment so much a part of our culture. This need not be the case despite our indoctrination to the immediate purchase of remedies for each new ache or discomfort (e.g. "Headache? Take aspirin. Nervous? Take Compoz"). Most patients are reassured by a clinician who conducts a careful, thorough examination and diagnostic evaluation, explains the rationale for each procedure to be administered, empathizes with the patient and his family, and educates them about the patient's illness. The few days taken to evaluate the patient properly may prevent years of suffering and minimize the risk of iatrogenic

disorder, such as tardive dyskinesia often induced by needless or prolonged neuroleptic administration. The following vignette illustrates the point:

A thirty-year-old-man, without prior psychiatric history, suddenly became violent at home, destroying several pieces of furniture. One month later he again became violent and destroyed more furniture. He was hospitalized and, although calm, was immediately given chlorpromazine 400 mg. daily. During the next seventy-two hours he became increasingly agitated and irritable and often spoke in a loud and stilted manner as if he were "an angry robot." His frightening behavior resulted in his transfer to a locked unit, where chlorpromazine was discontinued and sodium amobarbital ordered if he became agitated or destructive. His frightening behavior quickly resolved, and he was subsequently observed to have transient episodes of automatic behavior, forced speech, and right-sided hypertonicity during a period of altered consciousness, for which he was amnesic. An EEG confirmed a seizure disorder. Anticonvulsant medication was administered, and he remained well for the next two years.

The initial failure to observe the patient before definitive treatment was administered could have had tragic consequences. The hasty administration of chlorpromazine lowered the patient's seizure threshold resulting in paradoxically increased pathological behaviors, which could have resulted in serious injury to the patient and staff. The chlorpromazine also masked his transient seizure phenomena, particularly the hypertonicity (which could have been misinterpreted as an extrapyramidal drug side effect), preventing an accurate diagnosis. Ultimately he might have been labeled "psychotic" and treated with high and prolonged doses of neuroleptics, with minimal therapeutic effects, prolonging hospitalization and increasing his risk for tardive dyskinesia. On the other hand, the neuroleptic-free observation period permitted adequate observation, accurate diagnosis, and specific, effective treatment.

The appropriate delay in starting definitive treatment optimizes the evaluation process. The phenomenological clinical method (11,12) is best utilized during this observation period. It incorporates the basic diagnostic principles of *objective observation* without interpretation; description using *precise terminology* and consideration of the *form* of behavior separately from its *content*. This approach forms the basis of modern research criteria and *DSM-III*.

Objective observation without interpretation is essential to the diagnostic process. Clinicians too frequently make interpretations rather than observations and undermine the reliability and validity of their diagnoses. For example:

A forty-six-year-old man sits on the floor of a hospital day room. He masturbates publicly and repeatedly places nonedible objects in his mouth. He is said to "chew on