Common Reasons for Psychiatric Consultation

4

Hoyle Leigh

Contents

4.1 **Depression** 28
4.1.1 Suicidal Behavior 28
4.1.2 Suicide Attempt 29

4.2 **Altered States of Consciousness/ Delirium/Cognitive Impairment** 31

4.3 **Anxiety and Agitated Behavior** 32
4.3.1 Situational Factors 32
4.3.2 Psychiatric Syndromes and Anxiety 32
4.3.3 Intoxication and Withdrawal 33
4.3.4 Immediate Management of Agitation 33

4.4 **Psychotic Symptoms: Delusions, Suspiciousness, Hallucinations, and Disturbances with Reality** 34

4.5 **Suspected Psychogenic Symptoms** 35
4.5.1 Evaluation of Suspected Psychogenic Symptom 35

4.6 **Patient Behavior Generating Strong Feelings in Staff or Splitting Staff** 36

4.7 **Addiction and Pain Problems** 36

Appendix 1: Glasgow Coma Scale (GCS) 36

Appendix 2: Mini-Mental State Examination (MMSE) 37

Appendix 3: Montreal Cognitive Assessment (MOCA) 37

References 37

Bibliography 38

H. Leigh, MD, DLFAPA, FACP, FAPM (✉)
Professor of Psychiatry, Department of Psychiatry, University of California, San Francisco, CA, USA

Director, Psychosomatic Medicine Program & Psychiatric Consultation-Liaison Service, UCSF-Fresno, 155N. Fresno St., Fresno, CA 93701, USA
e-mail: hoyle.leigh@ucsf.edu

H. Leigh and J. Streltzer (eds.), *Handbook of Consultation-Liaison Psychiatry*, DOI 10.1007/978-3-319-11005-9_4, © Hoyle Leigh & Jon Streltzer 2015

The most frequent emotions, behaviors, and symptoms that patients exhibit that draw the attention of the health care professional and result in a psychiatric consultation request are the following:

1. Depression and Suicidal Behavior
2. Altered states of consciousness/delirium
3. Anxiety and agitated behavior
4. Psychotic symptoms
5. Suspected psychogenic physical symptoms
6. Patient behavior generating strong feelings in staff or splitting staff
7. Addiction and pain problems

This chapter discusses the immediate evaluation of these common reasons for consultation request, their immediate management, and how to proceed from there (Table 4.1).

4.1 Depression

The term, depression, is commonly used to denote both simple depressed affect as well as the depressive syndrome, which is a clinical significant psychiatric condition that requires careful evaluation and treatment. *Depressed affect* refers to subjective feelings of sadness, feeling blue, feeling like crying, or being "down in the dumps," which may be accompanied by a sad expression, tearfulness, and either psychomotor retardation or psychomotor agitation. Depressed affect is a normal response to loss and threatened loss. When such feelings persist, often without any obvious cause, and are accompanied by physiologic signs such as sleep disturbance (insomnia or hypersomnia), anorexia, fatigue, constipation, loss of libido, cognitive symptoms such as inability to concentrate or memory disturbance, low self-esteem, guilt feelings, hopelessness, helplessness, and suicidal ideations, then the depressive syndrome should be suspected, for which definitive treatment may be imperative (see Chap. 15). Suspected depression and/or suicidal ideation is the most common reason for psychiatric consultation request in a general hospital, followed by altered mental status (delirium).

Table 4.1 Common reasons for psychiatric consultation request in a general hospital

Year	2012	2011
Suspected Depression and/or suicidal ideation	356 (28 %)	325 (27 %)
Depression	176 (14 %)	166 (14 %)
Suicide attempt or ideation	80 (14 %)	159 (13 %)
Delirium	255 (20 %)	259 (22 %)
Diagnosis by Consultant		
Mood disorder	335 (26 %)	245 (20 %)
Delirium:	238 (19 %)	231 (19 %)
Total:	1,275 (100 %)	1,197 (100 %)

From CL Database, UCSF Fresno/Community Regional Medical Center

4.1.1 Suicidal Behavior

A common reason for psychiatric consultation is suicidal behavior—either suicidal ideation or suicidal attempt. *Suicidal ideation* refers to thoughts about suicide that a patient expresses spontaneously or upon questioning. Such thoughts may be active ("I want to kill myself") or passive ("I wish I were dead," "I wouldn't mind if I died"), and may be vague thoughts or actual plans.

Suicide is the 10th leading cause of death in the USA, resulting in 36,909 lives lost in 2009. The top three methods used in completed suicides were firearm (51 %), suffocation (24 %), and poisoning (17 %) (CDC). Approximately 3 % of the general population has suicidal ideation each year, and about 0.4 % attempt suicide. About 20–30 % of people who have suicidal ideation make plans, and about 30 % of those who plan make a suicide attempt (Kessler et al. 2005).

Actual plans usually require an immediate involuntary psychiatric hospitalization (see Sect. 4.1.2.8). The underlying, potentially treatable psychiatric conditions should be evaluated as discussed below (see Sect. 4.1.2.1).

There are several quantitative scales to assess the seriousness of suicidal ideation and suicidal attempt, which may be helpful in evaluating and documenting the evaluation of suicidality. They include Columbia Suicide Severity Rating Scale (C-SSRS), Harkavy–Asnis Suicide Survey (HASS), InterSePT Scale for Suicidal Thinking (ISST), Scale for Suicide Ideation (SSI), Sheehan

Suicidality Tracking Scale (STS), Suicidal Behaviors Questionnaire-Revised (SBQ-R), and Beck Suicide Ideation Scale (BSI). Among the more commonly used scales which may be downloaded below, C-SSRS has been endorsed by the FDA for tracking suicidality in pharmaceutical trials (Gassmann-Mayer et al. (2011)).

Columbia Suicide Severity Rating Scale (C-SSRS) (Posner et al. 2011): http://cssrs.columbia.edu/docs/C-SSRS_1_14_09_Baseline.pdf

Sheehan Suicidality Tracking Scale (Coric et al. 2009): http://emmlprofessionals.com.au/images/resources/Mental%20Health/7_Sheehan_Suicidality_Tracking_Scale_(STS).pdf

Modified SSI (Miller et al. 1991): http://160.40.50.57/EXPO/images/5/50/MSSI.pdf

4.1.2 Suicide Attempt

Psychiatric consultation is often automatic in patients admitted because of a suicide attempt. The mode of attempt may range from a mild overdose (e.g., 10 aspirin tablets) to stabbing or gunshot. An immediate consideration in evaluating a suicide attempt is whether the patient is able to provide information or is delirious or comatose. If the patient has an altered state of consciousness, treatment and management of that condition takes first priority. Collateral information from relatives, friends, or a suicide note may be invaluable in determining the patient's preattempt state of mind, seriousness of intent, and stressors. Unless the consultant is convinced that the patient is no longer suicidal, post-attempt patients should be placed on suicide precautions, which would include close observation by a sitter. An emergency involuntary hold may be necessary if the patient is unwilling to stay in the hospital for necessary treatment.

4.1.2.1 Evaluation of the Attempt

1. Demographics of the patient
   (a) Single, divorced, widowed, or living alone are risk factors.
   (b) Caucasian, older males are more at risk of completed suicide, and females are at higher risk of a suicide attempt.
   (c) Are there supportive persons—significant others relatives, friends, community, church?
   (d) Are there ethnic/cultural factors in the suicide attempt (e.g., social alienation, ostracism, shame)?
2. Seriousness of attempt
   (a) How lethal was the mode? Gunshot, stabbing, hanging, and drowning are in general more serious than a drug overdose, but even in an overdose, taking a whole bottle of pills (empty bottle found nearby) is more serious than taking half or less. A bizarre mode points to a psychotic diagnosis (e.g., setting fire to self, drinking Drano).
   (b) What was the likelihood of help from others? Was the patient alone? Did the patient inform anyone about the attempt? Where was the attempt made? When was it made?
   (c) What did the patient have in mind—to die or to escape? What ideas did the patient have about what would happen after he/she died? Is there a psychotic quality, for example, delusional or bizarre quality to the ideas, or any evidence of hallucinations, for example, commanding voices? Did the patient wish to be relieved of physical pain (more serious)?
   (d) Was it planned? If so, how long, how thoroughly? Was there an obsessive-compulsive quality (more serious)?
3. Medical and psychiatric history of the patient
   (a) Presence of a chronic (especially painful) medical condition (increases risk)
   (b) Past history of suicide attempt (increases risk, also helpful in diagnosis)
   (c) History of psychiatric illness, especially depression, mania, psychosis, schizophrenia, substance use including alcohol, PTSD, anxiety and panic, borderline personality, antisocial personality

Table 4.2 Lifetime mortality from suicide in discharged hospital patients

Bipolar disorder	20 %
Unipolar depression	15 %
Schizophrenia	10 %
Alcoholism	18 %
Borderline personality	10 %
Antisocial personality	10 %

From Mann 2002

4. Family history
   (a) Any psychiatric disorder, especially bipolar disorder, depression, schizophrenia?
   (b) Any suicide?
5. Current Mental State

4.1.2.2 Determination of Underlying Condition

On the basis of the evaluation of the above factors, the consultant should be able to determine tentatively the underlying condition(s) for the suicidal behavior/ideation. It should be recognized that suicide per se is not a psychiatric condition; however, it is often associated with underlying psychiatric conditions that may be amenable to treatment (Table 4.2).

4.1.2.3 Situational Precipitating Factors

These factors include interpersonal/family conflict, occupational stress, occupational loss or failure, anomie, and altruistic motive. *Anomie*, first described by the French sociologist, Emile Durkheim, refers to a sense of loss of definition when something that provided an anchor or purpose in life has disappeared, either through successful attainment (e.g., passing an examination) or loss (e.g., someone the patient cared for, or a cause with which the patient was passionately involved). A more common situational factor for suicide is a personal failure, either to achieve a goal or to maintain a status, which Durkheim named "egoistic suicide." Durkheim also described suicides with an altruistic motive, such as an elderly person contemplating suicide so as not to be a burden to his family. A situation of special concern is a patient with a serious medical condition, such as Alzheimer's disease or Huntington's disease, who may choose suicide. If situational factors are present, they should be carefully evaluated. How are the factors affected by the suicide attempt? Are they resolved, the same, or worse? What are the possible avenues of resolution?

4.1.2.4 Intoxication and Altered State of Consciousness

Such states increase the impulsiveness and acting out behavior, and up to 50 % of successful suicides are intoxicated at the time of death (Moscicki 2001).

4.1.2.5 Depressive Syndrome

Depressive syndrome is suspected when depressive affect (sadness, feeling blue or down in the dumps) or, in more severe cases, apathy is associated with other symptoms, such as sleep disturbance, anhedonia, inability to concentrate, anorexia or overeating, guilt feelings, recurring suicidal ideation, hopelessness, helplessness, lowered self-esteem, and social withdrawal, especially if there is a history of previous such episodes or a family history of depression (See the first section of this chapter and Chap. 15).

If a depressive syndrome has been diagnosed, one has to determine whether it is unipolar or bipolar. A history of manic or hypomanic symptoms in the absence of substance use, including feeling full of energy and not needing sleep for nights, feeling "on top of the world," getting involved in many projects at once, and going on spending sprees, point to bipolar illness, as well as atypical depression (hypersomnia, eating more). Suicidality may come without any prodrome in bipolar illness and may be extremely severe. A family history of bipolar illness and suicide should increase the index of suspicion for bipolar illness. (See the first section of this chapter for more on suicidality).

4.1.2.6 Psychosis

When suicidal behavior is particularly bizarre, or accompanied by psychotic symptoms (see

above), then psychosis may be suspected as an underlying condition (see Chap. 19). Examples of bizarre suicidal behavior include embracing a hot stove or setting oneself on fire.

4.1.2.7 Borderline Syndrome or Borderline Personality Disorder

Borderline personality patients show a pattern of stormy interpersonal relationships and a tendency to see others as all good or all bad (*splitting*), which assessment may change suddenly without apparent reason, often accompanied by substance abuse problems, feelings of emptiness, and previous suicide attempts and self-cutting behavior. Sometimes the cutting behavior of borderline patients is not with the intention of dying, but rather to relieve tension (see Chap. 25).

At least 75 % of patients with borderline personality engage in suicidal behaviors, particularly, wrist cutting and overdose of medications. About 10 % eventually commit suicide, representing up to one third of completed suicides (Black et al. 2004; Pompili et al. 2004). Borderline patients who also have major depression, substance abuse, and previous history of suicide attempts are at particular risk for suicide.

4.1.2.8 Management of Suicide Attempt/Ideation

Managing a patient with suicide attempt/ideation involves two considerations:

1. determination of the need for immediate measures to protect the patient, and
2. treatment/resolution of the underlying condition. If the patient is considered to be actively suicidal, he or she may need constant observation and psychiatric hospitalization when medically stabilized, under involuntary emergency certificate if necessary. Treatment of the underlying conditions, in such cases, would be implemented in the psychiatric inpatient setting.

If the patient is not actively suicidal, then treatment of the underlying conditions should be planned, either on an outpatient or inpatient basis, depending on the severity of the underlying condition and the availability of resources (Table 4.3).

Table 4.3 Psychiatric disorders underlying suicide attempts

Disorder	Percent
All disorders	90
Major Psychiatric Disorders	
Anxiety disorders	70–74
Affective disorders	60–74
Major depression	40
Bipolar disorder	20–30
Alcohol abuse	20–45
Other drugs	4–15
Stress-related and somatoform disorders	26
Eating disorders	13
Schizophrenia and nonaffective psychosis	5
Impulse control disorder including conduct disorder	5–33
Personality Disorders	46
Anxious	21
Anancastic (obsessive-compulsive)	19
Paranoid	15
Histrionic	13
Dependent	13
Emotionally unstable	11
Dissocial	5
Schizoid	5
Borderline	55
Co-existing Medical Diseases	45
Presence of Major Stressors	62

4.2 Altered States of Consciousness/Delirium/ Cognitive Impairment

Clouding of consciousness is characterized by impaired ability to think clearly and to perceive, respond to, and remember stimuli. *Delirium* is a state of disturbed and fluctuating consciousness with psychomotor changes, usually restlessness or drowsiness, and transient psychotic symptoms. *Obtundation* is a state in which patients are awake but not alert and exhibit psychomotor retardation. *Stupor* is the state in which the patient, although conscious, exhibits little or no spontaneous activity. Stuporous patients may be awakened with stimuli but have little motor or verbal activity once aroused. *Coma* is the state of unarousable unresponsiveness. A comatose patient does not exhibit purposeful movements.

In light coma, patients may respond to noxious stimuli reflexively, but in deep coma, there is no response even to strongly noxious stimuli. The Glasgow Coma Scale (GCS) is commonly used in identifying the degree of impairment. A GCS score of 8 or below indicates coma (see Appendix 1 at the end of chapter).

Psychiatric consultation is often requested to evaluate altered mental states (AMS). As comatose and stuporous patients do not respond verbally, the immediate approach to such patients is to recognize and treat the underlying medical condition, and to provide physical protection and supportive measures. When the patient presents with delirium or improves to a delirious state, the psychiatric consultant may be of great service in evaluating and managing the condition (see Chap. 12).

Cognitive impairment may be seen in both delirium and dementia (See Chaps. 12, 13, and 33). It is often useful to document the cognitive impairment serially to determine whether the impairment is improving, declining, or stable. Mini-Mental Status Examination (MMSE) and the Montreal Cognitive Assessment are two commonly used tests to document the current cognitive state of the patient (see Appendices 2 and 3).

4.3 Anxiety and Agitated Behavior

Anxiety refers to an emotional state of dread and apprehension, with or without an easily identifiable stressful situation (see Chap. 13). *Fear* refers to anxiety specifically tied to an object or situation, for example, fear of hospitalization. A *phobia* is an irrational fear of a usually harmless object or situation, such as cats (ailurophobia) or open spaces (agoraphobia). *Panic* refers to the intense anxiety experienced when one finds oneself suddenly thrust into a severely feared or dangerous situation, for example, waking up in a room engulfed in fire. Autonomic (usually sympathetic) arousal is usually associated with anxiety spectrum syndromes. Thus, there is often tachycardia, increased blood pressure, rapid breathing, sweating, dry mouth, gastrointestinal disturbance (diarrhea or constipation), and urinary frequency.

As a phenomenon, agitated behavior indicates increased restless motor activity, usually accompanied by hyperarousal and an internal sense of anxiety. When agitated behavior is accompanied with confusion, hallucinations, or delusions, delirium or psychosis should be suspected.

4.3.1 Situational Factors

Mild degrees of anxiety and agitation are commonly seen in stressful situations such as hospitalization and as a result of an internal psychological conflict. Such conflict may be conscious, as in feeling ambivalent about making a decision, or unconscious, as when some trigger awakens a repressed painful memory or an unconscious conflict. An example may be the approaching of the anniversary date of a significant loss.

A common trigger for anxiety and agitation in the health care setting is inadequate communication between the patient and health care team, especially when patients feel they are not listened to or when they misunderstand the diagnosis and treatment.

4.3.2 Psychiatric Syndromes and Anxiety

Anxiety and agitation are common symptoms of almost all psychiatric syndromes. They are very commonly seen in depression, in which patients may alternate between psychomotor agitation and retardation, as well as in bipolar disorders, both in the manic and the depressive phases. Anxiety disorders, including posttraumatic stress disorder, are usually accompanied by agitation during some phase of the illness. Both anxiety and agitation are commonly seen in psychosis including schizophrenia, schizoaffective disorder, delusional disorder, and others. Certain personalities and personality disorders are prone to

Table 4.4 Causes of anxiety/agitation

Symptom	Stress	Cause
Anxiety/agitation	Stress identifiable	Adjustment Disorder/PTSD
		Specific object/situation: phobia social anxiety, performance anxiety
		No specific object/situation
	Stress not identifiable	Panic present: panic disorder
		No panic: generalized anxiety disorder
		Substances (side effect, intoxication, withdrawal)
		Prescribed
		Recreational
		Medical disease present
		R/o secondary to medical condition
		Another major psychiatric syndrome present (e.g., schizophrenia)

anxiety/agitation. Patents with borderline personality syndrome may become anxious and agitated when they feel mistreated by staff; patients with an obsessive-compulsive personality are often agitated when the staff is not as exacting and orderly as they expect the staff to be; patients with a narcissistic personality may be particularly sensitive to any evidence of slight or lack of respect, and histrionic and dependent patients may be sensitive to any perceived lack of attention and caring (see Chap. 25 for more on patients' personalities.)

4.3.3 Intoxication and Withdrawal

Intoxication and withdrawal from both prescribed and recreational drugs often cause anxiety, agitation, and delirium, as do various medical/surgical conditions. Thus, an important part of the diagnostic workup of severe anxiety and agitation is a urine and blood drug screen and blood levels of suspected substances including alcohol. Of particular importance in the consultation-liaison setting is patients who had been dependent on alcohol who find themselves acutely hospitalized. Such patients may develop delirium tremens within days of hospitalization unless a benzodiazepine detoxification schedule or other measures to prevent/treat alcohol withdrawal are implemented upon ascertaining the alcohol history (see Chap. 20 on Substance Use Problems).

4.3.4 Immediate Management of Agitation

Acute agitation is often a medical-psychiatric emergency requiring immediate treatment to reduce the potential for harm both to the patient and to the staff. An acutely agitated patient may need to be physically restrained. If an intravenous (IV) line is not already in place, an intramuscular injection of haloperidol 1–2 mg may be given stat, and an additional lorazepam 1–2 mg IM may be needed. Once an IV line is in place, lorazepam 1–5 mg may be given for immediate management of agitation. At this point, the clinician should assess the patient's medical condition to determine whether there are risk factors for torsades de pointes due to haloperidol's QTc interval$_c$ prolongation effect. The risk factors include female gender, cardiac disease, hypokalemia, concomitant medications that may prolong QTc (almost all psychotropic drugs prolong QTc, especially thioridazine, ziprasidone, and citalopram as well as methadone), and familial long QT syndrome (Justo et al. 2005). In general, if the QTc is below 450 ms, any antipsychotic including haloperidol can be safely used; if QTc is between 450 and499 ms, antipsychotics should be used with

caution, and if QTc is above 500 ms, then they should be avoided. In using haloperidol, the major risk factor, however, is use of exceedingly high doses. There is rarely a problem when normal doses are used. If such risk factors are present, continuing use of lorazepam IV may be indicated (1–5 mg q 2–4 h). Lorazepam, however, is highly likely to increase confusion in a medically ill patient who has any degree of cognitive dysfunction (Breitbart et al. 1996) and may also depress respiration. In addition to lorazepam IV, immediately dissolving olanzapine (Zydis) 5–10 mg may be given if the patient is willing, or olanzapine 5–10 mg may be given IM, to be repeated every 2–4 h up to 20–30 mg per day (Table 4.4).

If risk factors for torsades de pointes are not present, haloperidol 1–5 mg IV (depending on the degree of agitation and the size of the patient) every 1–4 h may be needed until the patient is reasonably calm. Then, the patient may be given the effective dose of haloperidol every 4–6 h. In severe agitation associated with delirium, large doses of haloperidol may be used without significant extrapyramidal side effects as long as it is given intravenously. For most delirium, keeping the dose low, in the range of 1–6 mg per day, leads to rapid improvement if medical causes of the delirium are not ongoing. Haloperidol IV at high doses, however, may lower the seizure threshold and may also cause QT prolongation in some patients, and if other risk factors are present, it may lead to torsades de pointes. Electrocardiogram monitoring should be done on high-dose IV haloperidol patients. In contrast to IV, oral and IM doses of haloperidol exceeding 1–2 mg may be associated with extrapyramidal side effects, requiring the use of benztropine or diphenhydramine.

If the patient is willing to take oral medication, immediately dissolving forms of second-generation psychotics may gradually be substituted for IV haloperidol, for example, Zyprexa Zydis 5 or 10 mg po hs, plus IV haloperidol 1–2 mg q 4 h prn for agitation. Lorazepam 1–2 mg IV may be added to the haloperidol if the patient is so agitated that inducing sleep might be desirable, but in patients with delirium and dementia, benzodiazepines may cause paradoxical agitation due to suppression of the frontal lobe function and are well known to increase cognitive dysfunction (Kraemer et al. 1999).

If the presumptive reason for the agitation is alcohol withdrawal, lorazepam (intermittent lorazepam may increase the chances of developing delirium tremens; see Chap. 20) rather than haloperidol may be used, followed by instituting an alcohol withdrawal schedule (See Chaps. 12 and 20). If the presumptive underlying cause is phencyclidine (PCP) intoxication, haloperidol and phenothiazines should be avoided and the agitation should be controlled with lorazepam.

Psychologically, the staff should approach a delirious patient calmly, and avoid any behaviors that might be interpreted as being threatening, including standing or sitting too close to the patient. The patient should be oriented each time the staff approaches, for example, "I am your nurse, Susan, and you are in University Hospital. I am here to take your temperature and give you an injection for your infection."

Agitated patients should be in a quiet room if possible, and there should be someone to observe the patient at all times.

4.4 Psychotic Symptoms: Delusions, Suspiciousness, Hallucinations, and Disturbances with Reality

Delusion refers to an irrational and persistent conviction or belief that is not shared by the community, which considers it to be not based on reality. Delusions may be, among others, persecutory, grandiose, pessimistic, simple, complex, or bizarre. Delusions or excessive suspiciousness may be symptoms of psychosis, delirium, dementia, or personality disorders. *Hallucination* refers to an internally generated perception, that is, a perception without external sensory input. Hallucinations may be visual, auditory, tactile, olfactory, gustatory, or kinesthetic. Visual hallucinations, especially in the absence of auditory

hallucinations, should be considered to be organic (delirium, dementia, substance-induced, secondary to a medical disease including neurologic disease, such as Charles Bonnet syndrome) unless organic causes are completely ruled out. Auditory hallucinations of voices coming from outside the head, two voices conversing with each other, giving a running commentary on the patient, or giving orders to patients (command hallucinations) are more likely to be symptoms of schizophrenia. Olfactory and gustatory hallucinations are often associated with the aura of seizure disorder, and tactile and kinesthetic hallucinations may be associated with substance use (e.g., cocaine bug). *Illusions*, in contrast with *delusions*, refer to misidentifying sensory input, for example, seeing a gallows instead of an intravenous pole. Illusions are common in delirium. Derealization, where reality does not feel real, and depersonalization, where the person does not feel real, are dissociative symptoms that may be normal under stressful conditions, substance-induced, part of borderline personality syndrome, posttraumatic stress disorder (PTSD), or psychosis.

In general, any of the psychotic symptoms above calls for the ruling out of delirium, drug intoxication/withdrawal states (including prescribed medications), and medical conditions causing psychiatric symptoms (see Table 7.1 in Chap. 7). See Chap. 19 for further discussion of psychosis.

4.5 Suspected Psychogenic Symptoms

Psychiatric consultation may be requested when a patient's physical symptoms are suspected of being psychogenic. Such suspicions are aroused when no organic pathology underlying the symptoms is found, or when the symptoms are considered to be out of proportion to the pathology. When the symptoms involve the somatosensory nervous system, such as blindness, aphonia, "glove-like" anesthesia, convulsions, or paralysis of a limb, conversion disorder is suspected. When the symptom is primarily pain, chronic pain syndrome is suspected. When the patient is preoccupied with symptoms that might point to a disease, for example, heart disease, hypochondriasis may be suspected.

Since Slater's (1965) landmark 10-year follow-up study of patients diagnosed with hysteria (conversion disorder) in which over 50 % were found to have clear neurologic or psychiatric conditions, it is generally recognized that a large percentage of patients diagnosed with conversion or psychogenic physical symptoms have serious neurologic or psychiatric illnesses. However, there has been a steady decline in misdiagnosis of conversion disorder since the 1970s (29 % in the 1950s; 17 % in the 1960s; 4 % in the 1970s–1990s), which may be attributed to both better diagnosis due to the development of better diagnostic tools such as brain imaging (Stone et al. 2005).

4.5.1 Evaluation of Suspected Psychogenic Symptom

A thorough medical and neurologic workup including laboratory testing and imaging studies is a must. Especially of note is that multiple sclerosis is the most common neurologic condition misdiagnosed as conversion disorder. Many physical symptoms that may have an organic basis may be exaggerated or precipitated by psychological factors ("psychological overlay"). Stresses, interpersonal relationships, and psychological conflicts may contribute to the amplitude of distress associated with a physical symptom.

Thus, whether or not tissue pathology is present, a careful psychiatric examination is also warranted to identify environmental stressors, interpersonal relationships, personality style and psychological conflicts, as well as the patient's relationship with the health care system.

Specialized techniques such as hypnosis and lorazepam interview may be conducted to further elucidate unconscious factors that may underlie the symptom (see Chap. 34).

The following is an algorithmic approach for further evaluation:

4.5.1.1 Suspected Psychogenic Symptom After Complete Medical/Neurologic Workup

1. One or several somatosensory symptoms: conversion (functional neurologic symptom) disorder
2. Many symptoms in many organ systems: somatic symptom (somatization) disorder
3. Chronic pain disproportionate to tissue pathology: Somatic symptom disorder with predominant pain (chronic pain syndrome)
4. Preoccupation with a disease: Illness anxiety disorder (hypochondriasis)
5. Preoccupation with a body part: body dysmorphic disorder

4.6 Patient Behavior Generating Strong Feelings in Staff or Splitting Staff

The consultation request arising for this reason is often not explicit, or may sound like something else entirely, for example, "Pt refuses meds; please evaluate" or "Pt disruptive; please evaluate." It is only when the consultant actually speaks with the requesting physician that the reason becomes clearer. The physician may indicate that the patient is difficult, refuses to have a particular nurse attend to him/her, or is inconsistent in complying with simple requests such as allowing blood to be drawn. One finds that the staff members taking care of the patient are often divided; some are more sympathetic to the patient while others are angry with the patient. Such patients are often seen by staff to be demanding, entitled, and unstable. The consultant may notice nonverbal cues from the consultee that he/she dislikes the patient.

The most important consideration in dealing with such patients is that the goal of psychiatric consultation is to allow optimal medical care. Patients with this type of behavior and problems often have borderline personality disorder or traits (see Chap. 25). Though others see such patients as being unstable, for the patients it is others and the external world that is inconsistent and constantly changing. For the patients, people whom they believed loved them suddenly turn against them and behave hatefully. Such patients also have the predisposition to see neutral reality as being hostile. Educating the staff that the patient has a personality trait/disorder that cannot be resolved during an acute medical hospitalization is an important first step. An even-handed, objective, explicit, and firm expectations agreed upon by everyone concerned can be helpful.

4.7 Addiction and Pain Problems

Patients who are suspected of having chronic pain and addiction to pain/prescription drugs (see Chap. 22) often generate frequent consultation requests, especially if the referring physicians believe the psychiatric consultant is skilled in these areas.

Appendix 1: Glasgow Coma Scale (GCS)

The GCS results in a score between 3 and 15, with 3 being the worst and 15 the best. It is composed of three parameters—best eye response, best verbal response, best motor response—as given below:

Best eye response (1–4)

1. No eye opening
2. Eye opening to pain
3. Eye opening to verbal command
4. Eyes open spontaneously

Best verbal response (1–5)

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Orientated Best motor response (1–6)

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obeys commands

Note that the phrase "GCS of 11" is essentially meaningless, and it is important to break the fig-

ure down into its three components, such as "E3V3M5 = GCS 11." A GCS of 13 or higher correlates with a mild brain injury, 9–12 is a moderate injury, and 8 or less a severe brain injury. (From Teasdale G, Jennett B, Murray L, Murray G. Glasgow coma scale: to sum or not to sum. Lancet 1983 Sep 17;2(8351):67 8, and available at http://www.trauma.org/scores/gcs.html).

Appendix 2: Mini-Mental State Examination (MMSE)

Orientation	Score to be added up
What is the year, month, date, day of week, season?	5
Where are we? Country, State, City, Hospital, Floor	5
Registration	
Give the names of 3 objects, then have pt repeat all 3	3
Attention, Concentration, Calculation	
Serial 7 s for 5 answers	5
Recall	
After 5 min, ask for the 3 names of objects	3
Language	
Name two objects shown (e.g., watch, pen)	2
Repeat "No Ands Ifs or Buts"	1
3 Stage command "Take this paper in your right hand, fold it in half, and put it on the bed next to you" 1 point for each done correctly	3
Write on paper "Close your eyes," give it to pt, ask pt to do what it says	1
Please write a sentence on this paper (must have subject and a verb)	1
Visuomotor Function	
Copy two intersecting shapes(e.g., two pentagons, a hexagon and a pentagon)	
The total number of angles should be correct and they must intersect	1
	30

Adapted from:

Folstein MF, Folstein SE, McHugh PR. A practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res. 1975 Nov;12(3):189–98.

Appendix 3: Montreal Cognitive Assessment (MOCA)

This test and instructions may be downloaded from http://www.mocatest.org/

References

Black, D. W., Blum, N., Pfohl, B., & Hale, N. (2004). Suicidal behavior in borderline personality disorder: prevalence, risk factors, prediction, and prevention. *Journal of Personality Disorders, 18*(3), 226–239.

Breitbart, W., Marotta, R., Platt, M. M., et al. (1996). A double-blind trial of haloperidol, chlorpromazine, and lorazepam in the treatment of delirium in hospitalized AIDS patients. *The American Journal of Psychiatry, 153*, 231–237.

CDC Preventing suicide. http://www.cdc.gov/Features/preventingsuicide/

Coric, V., Stock, E. G., Pultz, J., et al. (2009). Sheehan Suicidality Tracking Scale (Sheehan-STS): Preliminary Results from a Multicenter Clinical Trial in Generalized Anxiety Disorder. *Psychiatry (Edgmont), 6*, 26–31.

Gassmann-Mayer, C., Jiang, K., McSorley, P., et al. (2011). Clinical and statistical assessment of suicidal ideation and behavior in pharmaceutical trials. *Clinical Pharmacology and Therapeutics, 90*, 554–560.

Justo, D., Prokhorov, V., Heller, K., & Zeltser, D. (2005). Torsade de pointes induced by psychotropic drugs and the prevalence of its risk factors. *Acta Psychiatrica Scandinavica, 111*(3), 171–176.

Kraemer, K. L., Conigliaro, J., & Saitz, R. (1999). Managing alcohol withdrawal in the elderly. *Drugs & Aging, 14*, 409–425.

Miller IW, Norman WH, Bishop SB, Dow MG. The Modified Scale for Suicidal Ideation: reliability and validity. J Consult Clin Psychol. 1986 Oct;54(5): 724–725.

Moscicki, E. (2001). Epidemiology of suicide. In S. Goldsmith (Ed.), *Risk factors for suicide* (pp. 1–4). Washington, DC: National Academy Press.

Pompili, M., Amadeo, R., Paolo, G., & Tatareli, R. (2004). Suicidality in DSM IV cluster B personality disorders. *Annali dell'Istituto Superiore di Sanità, 40*(4), 475–483.

Posner, K., Brown, G. K., Stanley, B., et al. (2011). The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *The American Journal of Psychiatry, 168*, 1266–1277.

Slater, E. (1965). Diagnosis of hysteria. *British Medical Journal, 1*, 1395–1399.

Stone, J., Smyth, R., Carson, A., et al. (2005). Systematic review of misdiagnosis of conversion symptoms and "hysteria". *British Medical Journal, 331*, 989.

Bibliography

Bostwick, J. M., & Pankratz, V. S. (2000). Affective disorders and suicide risk: a reexamination. *The American Journal of Psychiatry, 157*, 1925–1932.

Crimlisk, H. L., Bhatia, K., Cope, H., David, A., Marsden, C. D., & Ron, M. A. (1998). Slater revisited: 6 year follow up study of patients with medically unexplained motor symptoms. *BMJ, 316*(7131), 582–586.

Couprie, W., Widjdicks, E. F. M., & van Gijn, R. J. (1995). Outcome in conversion disorder: a follow up study. *Journal of Neurology, Neurosurgery, and Psychiatry, 58*, 750–752.

Frances, A., Fyer, M., & Clarkin, J. (1986). Personality and suicide. *Annals of the New York Academy of Sciences, 487*, 281–293.

Gatfield, P. D., & Guze, S. B. G. (1962). Prognosis and differential diagnosis of conversion reactions. *Diseases of the Nervous System, 23*, 623–631.

Hawton, K., Houston, K., Haw, C., Townsend, E., & Harriss, L. (2003). Comorbidity of Axis I and Axis II disorders in patients who attempted suicide. *The American Journal of Psychiatry, 160*(8), 1494–1500.

Jamison, K. R. (1986). Suicide and bipolar disorders. *Annals of the New York Academy of Sciences, 487*, 301–315.

Johns, C. A., Stanley, M., & Stanley, B. (1986). Suicide in schizophrenia. *Annals of the New York Academy of Sciences, 487*, 294–300.

Kessler, R. C., Berglund, P., Borges, G., Nock, M., & Wang, P. S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990–1992 to 2001–2003. *Journal of the American Medical Association, 293*, 2487–2495.

Mace, C. J., & Trimble, M. R. (1991). "Hysteria", "functional" or "psychogenic"? A survey of British neurologists' preferences. *Journal of the Royal Society of Medicine, 84*, 471–475.

Mace, C. J., & Trimble, M. R. (1996). Ten year prognosis of conversion disorder. *The British Journal of Psychiatry, 169*, 282–288.

Mann, J. J. (2002). A current perspective of suicide and attempted suicide. *Annals of Internal Medicine, 136*(4), 302–311.

Maris, R. W. (2002). Suicide. *Lancet, 360*, 319–326.

Marttunen, M. J., Aro, H. M., Henriksson, M. M., & Lonnqvist, J. K. (1991). Mental disorders in adolescent suicide. DSM-III-R axes I and II diagnoses in suicides among 13- to 19-year-olds in Finland. *Archives of General Psychiatry, 48*, 834–839.

Murphy, G. E., & Wetzel, R. D. (1990). The lifetime risk of suicide in alcoholism. *Archives of General Psychiatry, 47*, 383–392.

Paris, J. (2002). Chronic suicidality among patients with borderline personality disorder [review]. *Psychiatric Services, 53*(6), 738–742.

Paris, J., & Zweig-Frank, H. (2001). A 27-year follow-up of patients with borderline personality disorder. *Comprehensive Psychiatry, 42*, 482–487.

Persson, M. L., Runeson, B. S., & Wasserman, D. (1999). Diagnoses, psychosocial stressors and adaptive functioning in attempted suicide. *Annals of Clinical Psychiatry, 11*(3), 119–128.

Raskin, M., Talbott, J. A., & Meyerson, A. T. (1966). Diagnosed conversion reactions: predicative value of psychiatric criteria. *Journal of the American Medical Association, 197*, 530–534.

Roy, A., Lamparski, D., DeJong, J., Moore, V., & Linnoila, M. (1990). Characteristics of alcoholics who attempt suicide. *The American Journal of Psychiatry, 147*, 761–765.

Roy, A., & Linnoila, M. (1986). Alcoholism and suicide. *Suicide & Life-Threatening Behavior, 16*, 244–273.

Slater, E., & Glithero, E. (1965). A follow up of patients diagnosed as suffering from "hysteria.". *Journal of Psychosomatic Research, 9*, 9–13.

Soderberg, S. (2001). Personality disorders in parasuicide. *Nordic Journal of Psychiatry, 55*(3), 163–167.

Stephansson, J. G., Messina, J. A., & Meyerowitz, S. (1976). Hysterical neurosis, conversion type: clinical and epidemiological considerations. *Acta Psychiatrica Scandinavica, 53*, 119–138.

Watson, C. G., & Buranen, C. (1979). The frequency and identification of false positive conversion reactions. *The Journal of Nervous and Mental Disease, 167*, 243–247.