

## THE PSYCHIATRIST'S TOOLBOX

# Consulting With Medical Patients

Some years ago, an elderly gentleman began to experience hiccups after eye surgery. He also had a history of cardiovascular disease. After 5 days of medical intervention, such as breathing into a paper (not plastic) bag, using vagal stimulation, drinking glasses of water rapidly, swallowing ice, and putting pressure on his eyeballs, nothing worked.

The patient took phenobarbital and chlorpromazine in moderation, but both medications proved equally ineffective. Finally, a medical attending asked me what I could do to help stop these uncontrolled hiccups, which at this point were becoming detrimental to the patient's well-being.

As we know, hiccups originate most often from irritation of afferent or efferent nerves that control respiratory muscles, especially the diaphragm. Before I was consulted on this case, both a psychiatrist and a psychologist had seen the patient and had tried to explore some of the stresses and anxieties in his life, and nothing was working. Both of them failed. In fact, they caused the patient more distress, anger, and irritation with their questions.

I explained to the internist that I would gladly see the patient but had no intention of discussing psychological issues. I also said I would like two of my residents in the short-term therapy program I ran to accompany me. He agreed. My plan was to develop a simple behavior program aimed at getting him to relax and alter what had become his endless and obsessive focus on the hiccups.

When I saw the patient, he was unhappy, irritable, and in no mood to hear the word psychiatrist. Besides, he was not "nuts," he said. I was there only to offer him a technique to "maybe" stop the hiccups, I explained. The word "maybe" worked, because it implied no promises.

I had little interest in knowing where the patient had gone to school or the nature of his work or family relationships. I did, however, ask the patient what he had done

for a living. His response: "Okay, show me the technique."

I asked the patient to close his eyes and imagine seeing the ocean. "Why?" he asked. I encouraged him to get prepared for the technique I was going to teach him. All this time, the patient was hiccupping, and remained unhappy and distressed.

He was able to imagine the ocean, and said, "So what now?" What now was to distract him with an imagined movie screen, because at this point, I knew that he had the capacity for imagination based on his success in seeing the ocean.

With the screen, my suggestion was for him to imagine or see an ocean scene and try to see himself at the beach. He was able to do this. I made it clear this was now *his* movie screen and he could go wherever he wanted on that screen of *his*. The

next step was for me to help him see himself hiccupping on that big movie screen.

I emphasized the importance of the patient seeing himself hiccupping on the screen. One of the residents was on the far side of the chair in which the patient was sitting, and I encouraged the patient to see himself hiccupping on the screen while the resident and I took turns speaking repetitively. My goal was to create a homemade stereo effect for better concept.

The purpose was to capture the patient's imagination and obsessive thinking about the ever-present hiccups by reciprocal inhibition, leading to distraction and subsequent cessation of the hiccups. The outcome was a slowing down of the hiccups, and after about 20 minutes, they stopped altogether. I was a hero for the day.

Because of my experience with behavior modification techniques, hypnosis, and cognitive therapy, I often have been called over the years to do medical/surgical consultations to offer something different from the more traditional kind of psychiatric interview/formulation. The strategy I used not only was successful, it was straightforward.



BY ROBERT T. LONDON, M.D.

The need is great for psychiatric services and care on medical and surgical units today. Recently, I discussed some of these issues with Dr. Yelena Davydov, an expert in consultation-liaison psychiatry who sees thousands of hospital patients yearly and is affiliated with Lutheran Medical Center, New York.

According to Dr. Davydov, 30%-60% of hospitalized patients have psychiatric problems, and contemporary hospitalists or hospital house staff have little understanding of the issues, nuances, and treatments that go into psychiatric care. From the issues of suicide assessment and prevention (a priority of the Joint Commission) to the care of the suicidal patient, more than just a checklist of 9 or 15 questions is needed. In the case of suicidal ideation, patients need psychiatric physicians with experiential skills to offer an in-depth assessment of possible suicidality.

When a patient is hospitalized, she said, it is imperative that overdoses and the physical harm people do to themselves be addressed by a psychiatrist. In addition, many medical patients suffer from psychiatric illnesses such as anxiety disorders, mood disorders, schizophrenia, and dementia—coupled with personal stressful situations involving financial and domestic problems. All of these challenges can occur while in a hospital and they require immediate care. Simply being a hospital patient is stressful.

Dr. Davydov was quick to point out that the number of psychiatric beds in state and county hospitals in the United States dropped 52% between 1986 and 2004. Furthermore, she said, fewer and fewer psychiatrists are doing inpatient care, including consultations on hospital patients. The time involved in addressing these problems and a lack of fair reimbursement have infringed on the ability of psychiatrists to do their jobs effectively.

At least some hospitalists are doing the job Dr. Davydov said, but they are a stop-gap solution. It's hard to imagine, with all they have to do in a day's work, that they are able to factor in the complexity of psychiatric problems.

After talking with Dr. Davydov, I understood that the need for psychiatric consul-

tations in hospitals is critical. After all, hospitalists who care for seriously medically ill patients should not have the burden of acting on behalf of psychiatrists, just as they would not be expected to act on behalf of orthopedic or cardiovascular surgeons.

Under current systems, when hospitalists are used, psychiatric care is provided on the cheap by nonpsychiatrists. When you consider the training involved in becoming a consultation-liaison psychiatrist—a 4-year residency program plus fellowship year—how can we justify having nonpsychiatrists practice psychiatry?

Considering the overwhelming need for psychiatric consultations on medical/surgical hospital units, we need to make this specialty a national priority. How about this approach: If a psychiatrist is 100 or 1,000 miles away from a patient, why not give him or her direct contact for assessment or treatment by providing a webcam or other telecommunications device? Included in this model would be the ability to do follow-ups when necessary.

If patients can buy pharmaceuticals online, why can't we make greater use of telepsychiatry—just as surgeons are using superior technology to aid and direct care where skills are lacking?

Deciding on care from a distance is nothing new. After all, psychiatrists who rule on managed care patients on psychiatric or nonpsychiatric units based on financial concerns have no problem making psychiatric decisions, and they never see the patient. Under the model I'm proposing, the psychiatrist and patient would be in real visual and auditory contact.

Ensuring that patients receive good psychiatric care is well within our grasp—with a little creativity. Patients deserve this care. Hospitalists, who never chose to be psychiatrists, should not have to act as such.

Let me know your thoughts on this most important topic facing our profession and our patients, and I'll try to pass them along to my readers. ■

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## Psychiatric Diagnoses Common in Chronic Idiopathic Urticaria

BY ROBERT FINN  
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Nearly half of all patients with chronic idiopathic urticaria have Axis I psychiatric diagnoses and 45% have Axis II diagnoses, a new study shows.

Obsessive-compulsive disorder (OCD) and major depression were the most common Axis I diagnoses among 89 consecutive patients with chronic idiopathic urticaria (CIU), and both psychiatric illnesses were significantly more common in the patients than in a control group.

Among the patients, 26% had OCD, compared with 2% of the controls, and 13% had major depression, compared with 3% of the controls, reported Dr. Faruk Uguz and his colleagues at Selcuk University, Konya, Turkey (*J. Psychosom. Res.* 2008;64:225-9).

Obsessive-compulsive personality disorder and avoidant

personality disorder were the most common Axis II diagnoses among the CIU patients, and both were significantly more prevalent in the patients than in the controls. Thirty percent of the patients had obsessive-compulsive personality disorder, compared with 3% of the controls, and 18% of the patients had avoidant personality disorder, compared with 5% of the controls.

Characterized by the rapid appearance of itchy wheals, urticaria is considered chronic when it is recurrent for at least 6 weeks. Few cases have identifiable physical causes, such as infections, reactions to drugs or foods, or vasculitic diseases. But 75% of all cases have no known cause, and these are referred to as chronic idiopathic urticaria.

The study involved 89 consecutive patients with CIU who were seen at an outpatient clinic in Turkey and a control group of 64 hospital employees and their relatives who were matched to the patients' sociodemographic charac-

teristics. The investigators excluded from both groups individuals who were illiterate, and those who had accompanying severe medical illnesses, or had used corticosteroid or psychotropic medications within the prior 4 weeks.

Psychiatrists made Axis I diagnoses using the Structured Clinical Interview for DSM-IV and the Structured Clinical Interview for DSM, Revised Third Edition, Personality Disorders.

In all, 44 of the CIU patients (49%) and 8 of the individuals in the control group (12%) had an Axis I disorder. Forty of the CIU patients (45%) and nine of the controls (14%) had Axis II disorders. Both differences were statistically significant.

The investigators acknowledged that their study could not establish a causal relationship between psychiatric disorders and CIU. Psychiatric disorders could either be a cause or a consequence of CIU. ■