Family Practice Grand Rounds

Six Years of Psychosis

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DR. ROBERT A. FRIED *(Assistant Director, Department of Family Medicine, Mercy Medical Center)*: Long-term continuity of care gives the family physician a unique perspective on the management of patients with complex, interacting medical and psychiatric problems. The case presented in this Family Practice Grand Rounds illustrates the evolving illness of one patient and my efforts as his family physician to periodically revise treatment plans based on new information.

Our purpose today is to discuss a man who has been my patient for more than six years. His history and course represent an interesting confluence of medical, psychiatric, and social problems, and his complex illness illustrates many of the issues a family physician faces in the care of such a patient. Our panel of experts, which includes a social worker, a psychiatrist, an alcoholism counselor, and a family physician, will be adding its insights about the patient.

For the purposes of today's discussion, I will call my patient Frank Turner, although that is not, of course, his real name. I first encountered Frank when I was an intern in 1977. Five years before, he had contracted subacute bacterial endocarditis (SBE) of a congenitally bicuspid aortic valve. Although he had a bacteriologic cure, he underwent valve replacement in 1973 and had a porcine valve when we met. Before his first bout with SBE, he had been a heavy drinker. He had been divorced and had gained sobriety through working with Alcoholics Anonymous (AA). His second wife, whom I shall call Janet, was also an ex-alcoholic whom Frank had met at AA.

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When I met Frank, he was a patient at University Hospital in Denver with prosthetic valve endocarditis. After his release, I followed him in the Family Medicine Center. Several months later, Janet began to experience episodes of transient psychosis and was subsequently given a diagnosis of borderline personality. She complained of marital difficulties but claimed to have worked them out without professional help.

About one year after his hospitalization, Frank became acutely ill, and soon thereafter his failing porcine valve was replaced by a small Bjork-Shiley valve. The replacement valve mandated chronic anticoagulation with warfarin. In the spring of 1978, following his valve replacement, he was chronically ill with malaise, myalgias, and fatigue. No definite organic etiology could be found. At that time he began to discuss with me his perceptions of his marriage. As he put it, his wife frustrated him "to the point of violence." He agreed to counseling but kept appointments erratically over a six-month period, finally telling me in the fall that everything was "rosy." About six months later the marriage deteriorated; again, he was physically abusive to Janet, and he once more agreed to counseling. Again, he participated irregularly and then pronounced himself cured.

I then completed my residency and entered private practice in a Denver suburb. Frank promptly experienced a recurrence of malaise, this time associated with depression and suicidal ideation. He was seen by a resident whom he found unsatisfactory and eventually returned to my care some eight months after I left my residency. He soon became psychotically depressed with depersonalization, derealization, and referential ideas. He refused psychiatric hospitalization and was accordingly treated with imipramine, thioridazine, and counseling. Once more he had a rapid response, pronouncing himself well after a week or two and

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refusing additional counseling or medication.

He dropped out of sight again for about a year, but then began to drink heavily for the first time since 1972 and was admitted at his own request to the Alcohol Care Unit here. By this time I had made the transition from private practitioner to full-time residency faculty at Mercy, and I was not surprised to see Frank on my clinic schedule in early 1982. Soon thereafter he experienced an agitated depression and was briefly treated with imipramine and thioridazine. I sought psychiatric consultation at that time because I was beginning to entertain the diagnosis of bipolar depression or manic-depressive illness. Frank began to drink again, which coincided with his ruminating about his now ex-wife, Janet, and he was once again admitted to the Alcohol Care Unit. After a brief stay, he became "radiantly happy"—to use his words—and remained well through the summer of 1982.

In September, I happened to be inside Mercy's operating suite when I discovered Frank inside the doors of the clean area, talking in a rapid fashion about his campaign to be President of the United States to a group of surprised and very uncomfortable nurses! He refused any intervention, although he was persuaded to leave the operating room. A few days later I saw him in the emergency room with sudden paralysis of all limbs, his neck, and even his eyeballs. Needless to say, this was a conversion hysteria and reversed itself completely in five minutes. He refused psychiatric intervention and soon began to send me clippings describing his campaign from small-town newspapers all over the country as well as letters—which were jovial to say the least—asking for my support. Over the Christmas holidays he was arrested in Fort Collins, a town north of Denver, and claimed to have a serious medical illness that required immediate hospitalization and intravenous heparin. When the jail personnel learned of his history through contact with us and tried to put him on antidepressants, he became agitated, and refused medical care. After his release from jail, he began to write me letters that were much more hostile and threatening. He then arrived at Mercy Medical Center demanding to be hospitalized and placed on heparin. No evidence of pulmonary emboli or deep venous thromboses was found, and he left without further treatment. A month later he was seen at University Hospital, and an alert resident who knew of my interest in Frank managed to get him held involuntarily. While in the psychiatric facility, he developed chest pains in the middle of the night, was taken to another hospital for evaluation, and escaped.

At this point I became concerned about his increasingly erratic behavior and more menacing comments, and I contacted the US Secret Service. They actually did find him and convinced him to complete the remainder of his required psychiatric evaluation. He then persuaded a judge that he was not gravely disabled or a danger to himself and was released. I have not seen him since, but I have continued to receive a number of letters. The most recent one, with a return address of General Delivery in Ames, Iowa, came last week; I would like to share a few excerpts with you:

> My dear Robert—I'm of the mind that you don't want to be my doctor anymore, Bob. Now don't mind me, but don't you think you're being just a little bit snooty? After all, you've coddled my mind for a long time now, and I'm sure you like the money you've gotten from my particular dilemma. I need lots of love, not all that damned mind-bending medicine. After all, I'm going to be President of these United States, and you wouldn't want me to tell my 130 million voters that you're a bad, bad doctor, now would you? . . . Medically, as well as legally, and even morally, you of course will now try to explain to our 130 million voters just why you are in a position to profit from the artificially induced misery of others. . . . My 130 million voters are not playthings, and neither are the 270 poor-man type Congressional candidates I have found in 27 states. . . .

The letter goes on to threaten me with the loss of my medical license and concludes, "Love, and still a little respect from nearly 1,000 miles away, Frank Turner."

I think it's fair to say that I have had an interesting time with this gentleman over the past few years. At this point I would like to ask our psychiatric consultant to comment on what he thinks is the right diagnosis and how one might do a better job in early detection and intervention.

DR. ALAN SHIFFRIN *(Psychiatrist in private practice; faculty, Department of Family Medicine, Mercy Medical Center)*: The differential diagnosis includes two broad categories. The first is an ongoing organic brain syndrome. The likelihood of such a problem is small, although this patient's medical history makes him a candidate for a wide array of disorders associated with organic impairment. A better choice is a functional disturbance. There is a long history of discrete, time-limited depressive episodes; there is also hypomanic behavior as evidenced by hyperactivity, elation, euphoria, pres-

sured speech, and grandiosity. In my opinion, we have hypomanic symptomatology associated with recurrent depressive episodes, which would make bipolar affective disease the most likely psychiatric diagnosis. We should also consider schizoaffective illness, which would require the presence of schizophrenic symptoms and a major affective disorder. We have no evidence for this in the case as presented.

The presence of alcoholism is another interesting facet. Certainly if these symptoms were shown by the patient during periods of acute intoxication or alcohol withdrawal, that would affect our differential diagnosis.

A RESIDENT: How do we as family physicians recognize the early stages of this disorder?

DR. SHIFFRIN: Eliciting a thorough psychosocial history and a family history of psychiatric disease would be of value. One would need to better define and diagnose these dysphoric episodes to determine whether they were indeed discrete depressive events and to better understand any possible bipolar pattern.

DR. FRIED: We do have some additional information. The patient's natural father was in a state hospital for many years with an unknown diagnosis, although the patient told me it was for depression. His mother describes herself as always having been a nervous person, but she carries no formal psychiatric diagnosis and has never been treated.

DR. SHIFFRIN: A lengthy stay at a state hospital usually meant that the patient was suffering from chronic schizophrenia, but often this was a misdiagnosed major affective disturbance. It's interesting how rapidly this patient responded to tricyclic antidepressants. A hypomanic swing, rather than a normalization of mood, during tricyclic treatment supports the diagnosis of bipolar affective illness.

A RESIDENT: Is it reasonable to believe that this patient's alcoholism is a sign of a more basic underlying psychiatric disorder?

DR. SHIFFRIN: As with any case, making the primary diagnosis is important. In this situation, one could reasonably ask whether the underlying problem is alcoholism, depression, or bipolar disease. I think the dramatic symptomatology in this patient's history is fairly characteristic of patients with manic-depressive illness, and I believe that is the primary diagnosis. It is important to note that these patients often self-medicate during their hypomanic swings, often with alcohol.

DR. FRIED: Let me now ask for help from someone who helped to treat Frank when he was a patient at Mercy's Alcohol Care Unit.

MARY COLLINS *(Nurse practitioner, Alcohol Care Unit, Mercy Medical Center)*: When I first saw Frank on the unit, his blood alcohol level was about 300 mg/dL. He was quite hysterical, literally flapping about on the bed and giving the nurses a difficult time. His blood alcohol level was 0 mg/dL when I examined him the next day. My initial impression was not that of a man with a psychiatric disorder other than alcoholism. It's exactly that question that we deal with every day in our unit. Of interest is the history that the patient's grandfather was an alcoholic, and that he told me his father was a schizophrenic.

We can usually sort out the various problems after ten days or so of treatment. The alcoholics start looking better and the schizophrenics get worse. Unfortunately Frank left on the 12th hospital day. His counselors found him to be grandiose, manipulative, and inappropriately smiling throughout his stay. Our experience has been that manic patients become extremely manic after a few days on the Alcohol Care Unit. This patient was not really like that.

DR. FRIED: At some points in my long experience with this patient, I wished I had more experience. I would like to ask a veteran family physician to comment on how we manage the complex interplay of medical, psychiatric, and social factors that go into the care of a patient like Frank. How does our long-term relationship with the patient affect what we do?

DR. R. NEIL CHISHOLM *(Professor and Acting Chairman, Department of Family Medicine, University of Colorado Health Sciences Center)*: Having been in practice for 25 years and in academic work for the last eight years, I can understand why I was asked to comment on the aspects of this case that concern the long-term relationship of physician and patient. While the case presented demonstrates many of the aspects of long-term care, it also highlights the issue of caring for the patient who does not stimulate the physician's ego. Nevertheless, it illustrates the importance of having one person overseeing all aspects of care. The diagnosis here is still in doubt. Regardless of that, if a different physician were seeing this man each time he came in with a new problem, and the patient received no continuity of care, his care would have suffered. The interrelationship between physician and patient would have to be

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started all over again. Here the patient had access to one physician over a long time, and other providers could go to one source for information. Continuity lessens frustration and saves both time and money in terms of not having to repeat tests and long medical histories. My sense is that Bob enjoyed taking care of Frank Turner. That is important; some of these patients can really turn the physician off because of inconvenient calls in the middle of the night from jail or other circumstances. Happily, most patients are different. The continuity you provide is a pleasure, because you can easily see the advantages of progressively accumulating data.

Concerning the therapeutic use of the physician-patient relationship, the work of Michael Balint[1] is an important guide. The physician becomes a more potent "drug" the better he or she knows the patient. Just being able to sit down with the patient and have a calm conversation is probably more effective than any benzodiazepine.

A RESIDENT: How would you respond to the patient's letter?

DR. CHISHOLM: You must first decide whether responding at all will make the problem better or worse. I am still wondering whether Bob responded. Personally I would probably answer the letter. I think it is important to maintain contact. When I first heard that Bob had involved the Secret Service, I was amazed, but it seems to be a good idea because this patient is quite unpredictable and possibly dangerous.

DR. FRIED: I had two reasons for involving the Secret Service. One was the hope that they would find him after his escape from the psychiatric hospital. The other, quite frankly, was self-protective. I felt an obligation to involve the authorities in the unlikely event that this patient would act out his fantasies in some way and become violent.

A RESIDENT: Have you answered the letter?

DR. FRIED: Not yet. I was hoping to get some advice from the group of experts assembled here today.

DR. SHIFFRIN: I think the letter should be answered, but I don't think it matters one way or the other, since this patient will never be lost to this physician. The patient clearly has a relationship with him despite what the physician says or does. As he travelled around the country, he maintained the relationship, although it is an oppositional and negative relationship. When a patient is psychotic, he often must have such a relationship with a physician in order to maintain himself as a discretely defined, functioning psychological entity. Such patients fear that they will somehow dissolve and lose themselves if they submit or agree to get close.

I would respond to the letter, and I would recommend hospitalization and treatment with lithium carbonate. This would help to maintain contact with the patient and would perpetuate the adversarial quality of that relationship that he requires. Involuntary treatment may be required at present.

I really cannot comment on how dangerous he may be. He has no history of violent behaviors aside from those when he was married. His tendency to violent behavior would have to be reevaluated periodically.

DR. FRIED: Because this patient is indigent, getting him hospitalized required us to interact with the community mental health system. I was quite frustrated with the system's apparent lack of interest in the information I had to offer based on my years of experience with this particular patient. I will now turn to our social worker and ask her to discuss how family physicians should relate to the community mental health system.

ELEANOR S. FRAZIER *(Behavioral sciences coordinator, Department of Family Medicine, Mercy Medical Center)*: Every state has a different way to handle psychiatric patients who are not in private treatment and have no insurance. This man was so dysfunctional that he was not able to comply with the government's requirements for certification under Medicare. In the conversations I had with people in the system, the question of who was going to pay recurred continually. The lack of interest on the part of private hospitals was very apparent. The community mental health system is overloaded, and there is a wide variation in people on staff. One of the most important things a family physician can do in this setting is to evaluate who within the system can be trusted. In trying to place Frank Turner, I was constantly frustrated by my lack of a personal relationship with the people at the other end of the telephone. In theory the system in Denver involves calling a central intake facility, being referred from there to a local mental health center, then waiting for a staff member to arrive and evaluate the patient independently. In this case, the patient simply moved too fast for the system to catch up with him.

The other frustrating thing was to learn how much was known about this man by the various

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community agencies and how little communication went on among them. This patient had a police record, was known to some mental health agencies already, and had a long history with Alcoholics Anonymous. If the agencies in question had shared their information, many aspects of the patient's situation would have been more obvious.

There are agencies with programs that could have helped this patient, and in the best of all possible worlds, we would have been able to coordinate things more effectively in his behalf.

DR. FRIED: One of the many double binds we got into occurred when he was temporarily housed in a private hospital early in his brief involuntary commitment. The hospital, which wanted to move him out because he had no insurance, declined to send up a social worker to help him fill out the forms for disability and Medicaid, which would have paid for his care in the hospital.

A RESIDENT: Do you consider yourself this gentleman's family physician?

DR. FRIED: I have a letter from him stating that he never wants to see me again as a patient. Then there is a more recent letter, which states in part: "The bad news of this letter is that I want you for my doctor, and I don't mean maybe, either. If you really believe that I am insane, or sick in any way, you should hang in there and try to make me well, don't you think, Bob?" If I answer his letter—and based on this conversation, I'm now inclined to do so—I may well point out that contradiction and ask him to clarify it.

A RESIDENT: But does your investing in this effort in the first place mean that you feel obligated as a physician, or are you acting on the basis of a personal friendship?

DR. FRIED: I think the honest answer is that it is some of both. I don't count him as a friend, but I do think of him as a very likeable person to whom I have enjoyed talking over the years. If he asked me to resume the physician-patient relationship, I would probably agree.

DR. SHIFFRIN: But that relationship has never ended; it is an ongoing relationship, albeit a crazy one. Any patient who writes frequently to his physician with a request to terminate their relationship is saying unconsciously that he wants the relationship to continue. If somebody doesn't want a relationship anymore, it's not necessary to write a long letter about it.

Reference

1. Balint M: The Doctor, His Patient, and the Illness. New York, International Universities Press, 1964