HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Mass General Brigham

Best Practices for Inpatient Management of Patients with Psychiatric Illness

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Disclosure

With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship with any for-profit company which could be considered a conflict of interest.

Outline

- Demoralization
- Depression
- Anxiety
- Somatic Symptom Disorder
- Insomnia
- Personality Disorders
- Psychotic Disorders
- Decision-Making Capacity

Fiorillo and Sartorius
Annals of General Psychiatry (2021) 20:52
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Annals of General Psychiatry

COMMENTARY Open Access

Mortality gap and physical comorbidity of people with severe mental disorders: the public health scandal

Andrea Fiorillo[1*] and Norman Sartorius[2]

Conclusion: "Patients suffering from severe mental disorders, including schizophrenia, major depression and bipolar disorders, have a reduced life expectancy compared to the general population of up to 10–25 years."

Case Example

47 yo man with h/o DM2, HTN, hyperlipidemia, asthma and no formal past psychiatric history is admitted to the hospital with acute renal failure. His hospitalization is complicated by PNA followed by sepsis. He is admitted to the ICU, intubated and has a prolonged stay of 1 month. He is extubated and learns that he will need lifelong dialysis as he is not a candidate for renal transplantation. His medical team notes that he sleeps most of the day, does not engage in physical therapy and eats very little. He notes that he has periods of the day when he is in intense pain and does not know how he will learn to live with this new obstacle in his life. He denies depressed mood and his cognitive status remains intact. His mood is visibly bright when his children visit.

Conservation-Withdrawal Versus Depression

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General Hospital Psychiatry

Demoralization

- No Diagnostic Criteria
- Definition: dysphoric state, destruction of confidence/hope, disempowerment
- Contrasted with Depression
- Prevalence: 1/3 of physically ill patients

Management of Demoralization

Encouragement, Enhanced Engagement	Validate, Normalize Experience of Illness	Active Symptom Management	Exploration of Attitudes of Hope and Meaning in Life
Searching for Renewed Purpose and Role in Life	Cognitive Restructuring of Negative Beliefs	Spiritual/Religious Support	Promotion of Social Contact

Case Example

26 yo woman with h/o depression was admitted s/p MVA with resultant concussion, multiple rib fractures and tibia fracture. She is now post-op ORIF of tibia. She reports to you that she has not been taking her antidepressant for many months now and that this accident has led to an overall feeling of hopelessness. She cites that her appetite is low, it's difficult for her to concentrate and "I just don't know if I have the energy to do all this."

Depression Symptoms

5 or More Symptoms During 2-Week Period

- At least 1 of:
  - Depressed Mood
  - Loss of Interest or Pleasure (Anhedonia)
- Other Symptoms:
  - Significant Weight Loss or Decrease or Increase in Appetite Nearly Every Day
  - Thought Slowing/Reduction of Physical Movement
  - Fatigue or Loss of Energy Nearly Every Day
  - Feelings of Worthlessness or Inappropriate Guilt
  - Decreased Ability to Concentrate
  - Recurrent Thoughts of Death/Recurrent Suicidal Ideation

Depression

- Consequences of Depression
  - Poorer Physical Health
  - Worse Functional Outcomes
  - Greater Rates of Rehospitalization
- Prevalence
- Overlap with Demoralization
- Overlap with Delirium

Depression: Initiation of Treatment

- Antidepressant Initiation
  - SSRIs
  - SNRIs
  - NDRI
  - Mood Stabilizers, Antipsychotics
- Previous treatment, Family History
- Contraindications to Initiation
- Outpatient Follow Up

Suicidality

The Joint Commission Journal on Quality and Patient Safety 2018; 44:643–650

Incidence and Method of Suicide in Hospitals in the United States

Scott C. Williams, PsyD; Stephen P. Schmaltz, PhD; Gerard M. Castro, PhD, MPH; David W. Baker, MD, MPH

Psychiatric Safety Risk Assessment

- Active vs Passive Suicidal Ideation
- Risk Factors
- Protective Factors
- Validated Screening Tools
- Collateral Information

Case Example

45 yo man with no previous medical history was hospitalized x 1.5 months s/p fall from ladder leading to SCI. The patient did well during his hospitalization, participating in the treatment plan with motivation. Close to the time of discharge, the patient began to show reticence towards participation in discharge planning and his mood seemed to have shifted towards irritability and extreme worry.

Anxiety Disorders

- Separation Anxiety Disorder
- Specific Phobias
- Social Anxiety Disorder
- Panic Disorder
- Generalized Anxiety Disorder
- Substance/Medication-Induced Anxiety Disorder

Anxiety

- Excessive worry occurring more days than not for at least 6 months about a number of events or activities
- Difficult to control the worry
- 3 or More:
  - Restlessness/Feeling on Edge
  - Easily Fatigued
  - Difficulty Concentrating
  - Irritability
  - Muscle Tension
  - Sleep Disturbance

Anxiety: Barrier to Care

- Previous History of Anxiety?
- Explore Specific Fears
- Transparency of Treatment Plan
  - Loss of Control
- Avoid Reassurance or “Advice Mode”
- Referral to Cognitive Behavioral Therapy (CBT)

Anxiety: Treatment in the Hospital

- Cognitive Behavioral Therapy
- PRN Medications
  - Antihistamines
  - Antipsychotics
- Benzodiazepines
- Antidepressants

Case Example

45 yo woman with h/o anxiety, DM2 was admitted to the hospital with chest and abdominal pain and slightly elevated 1st troponin. Remainder of the cardiac and abdominal workup is unrevealing, but patient remains with pain. She reports that's she is convinced "there's something really wrong" and cannot be reassured. She begins demanding unnecessary studies and discharge planning is difficult.

Somatic Symptom Disorder

- One or more somatic symptoms that are distressing or result in significant disruption of daily life
- Excessive thoughts, feelings or behaviors related to the somatic symptoms or associated health concerns as manifested by:
  - Disproportionate and persistent thoughts about the seriousness of one's symptoms
  - Persistently high level of anxiety about health or symptoms
  - Excessive time and energy devoted to these symptoms or health concerns
- Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)

Somatic Symptom Disorder: Management

- Encourage Stable and Consistent Primary Care
- Support/Understanding
- Validation of Fears
- Suggest Tracking Symptom Information
- Encourage Family/Friend Involvement
- Management of Underlying Psychiatric Disorders

Insomnia

- Behavioral Interventions/Sleep Hygiene
  - Fixed Sleep/Wake Time
    - Minimize Daytime Sleeping
  - Unplug from Electronics
  - Relaxation Techniques
  - Quiet Environment/Minimize Disturbances
- Underlying Conditions
  - Anxiety
  - Depression
  - Delirium
  - Pain
  - Psychosocial Stressors
- Medication Management

Case Example

39 yo woman with h/o borderline personality disorder, depression, HTN, CHF who was admitted for CHF exacerbation. The medical team notes that her chart indicates previous "demanding behaviors." During this admission, the patient is disparaging of staff, demanding in her behaviors and intermittently refuses to participate in care. She makes comments that some providers are "the best" and refuses to work with others.

Personality Disorders
Borderline Personality Disorder

- Efforts to Avoid Real or Imagined Abandonment
- Pattern of Unstable and Intense Interpersonal Relationships
  - Alternates Between Extremes of Idealization and Devaluation
- Identity Disturbance
- Impulsivity in 2 Areas (spending, sex, substance use, reckless driving, binge eating)
- Recurrent Suicidal Behavior, Gestures/Threats, Self-Mutilating Behavior
- Affective Instability
- Chronic Feelings of Emptiness
- Inappropriate, Intense Anger
- Transient, Stress-Related Paranoid Ideation or Severe Dissociative Symptoms

Personality Disorders--Management

Avoid Personalization

- Monitor Countertransference
- Tolerate Intense Anger or Hate

Set Limits

Consistent Messaging to Avoid Splitting

Reinforce Positive Behavior

Medications?

Clinical Review & Education

JAMA | Review

Borderline Personality Disorder
A Review

Falk Leichsenring, DSc; Nikolas Heim, MA, MSc; Frank Leweke, MD; Carsten Spitzer, MD; Christiane Steinert, PhD; Otto F. Kernberg, MD

Leichsenring F, Heim N, Leweke F, Spitzer C, Steinert C, Kernberg OF. Borderline Personality Disorder: A Review. JAMA. 2023 Feb 28;329(8):670-679. PMID: 36853245.

Case Example

54 yo man with h/o schizoaffective disorder-bipolar type, DM, HTN, Crohn's disease presented to the hospital for scheduled bowel resection surgery. Post-surgery, the patient is initially calm but then begins to exhibit paranoia towards staff (worried that nurses are talking about him, refuses to eat hospital food) and intermittent refusal to participate in care. The patient's cognition is intact and delirium is ruled out.

Psychotic Disorders

- Psychotic Disorders
  - Delusional Disorder
  - Schizophrenia
  - Schizoaffective Disorder
  - Substance/Medication-Induced Psychotic Disorder
  - Psychotic Disorder Due to a Medical Condition
- (Bipolar Disorder)
- Hallmark Symptoms
  - Delusions
  - Hallucinations
  - Disorganized Thinking and/or Behavior
  - Negative Symptoms

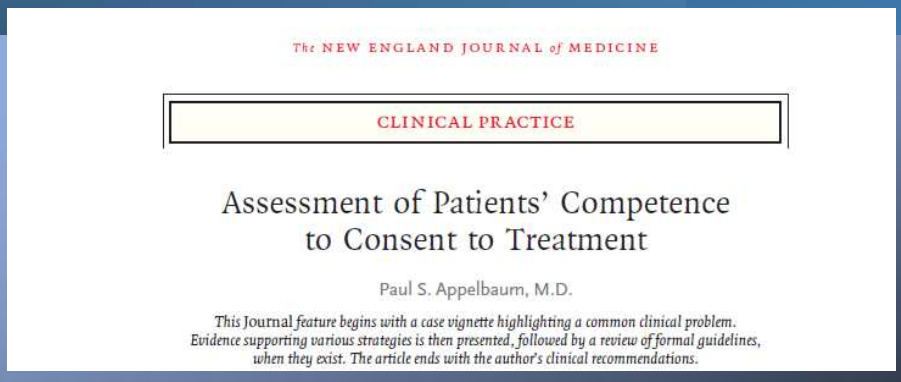
Case Example—Revisited

54 yo man with h/o schizoaffective disorder-bipolar type, DM, HTN, Crohn's disease presented to the hospital for scheduled bowel resection surgery. Post-surgery, the patient is initially calm but then begins to exhibit paranoia towards staff (worried that nurses are talking about him, refuses to eat hospital food) and intermittent refusal to participate in care. The patient's cognition is intact and delirium is ruled out.

- Reassure Safety
- Do Not Challenge Delusions
- Transparency of Interventions and Treatment Plan
- Build Rapport
- Medication Management

Decision-Making Capacity

- Communicate a Choice
- Understand the Relevant Information
- Appreciate the Situation and its Consequences
- Reason about Treatment Options



The NEW ENGLAND JOURNAL of MEDICINE

CLINICAL PRACTICE

Assessment of Patients' Competence to Consent to Treatment

Paul S. Appelbaum, M.D.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author's clinical recommendations.

Appelbaum PS. Clinical practice. Assessment of patients' competence consent to treatment. N Engl J Med. 2007 Nov 1;357(18):1834-40.

Take Home Points

- Demoralization vs Depression
- Recognition of Suicidality
- Consequences of Anxiety
- Reassurance and Validation of Patients with Somatic Symptom Disorder
- Importance of Insomnia Management in the Inpatient Setting
- Management of Personality Disorders
- Psychosis Can Be Managed Effectively in a Hospital Setting
- Decision-Making Capacity Assessments are Nuance but can Follow at Protocolized Methodology