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Quote of the month:

Your time is limited, so don't waste it living someone else's life. Don't be trapped by dogma - which is living with the results of other people's thinking. Don't let the noise of others' opinions drown out your own inner voice. And most important, have the courage to follow your heart and intuition.

Steve Jobs, Apple co-founder.

1901 N DUPONT HIGHWAY NEW CASTLE DE 19720

IN THIS ISSUE

Our Noisy World
By: Saleem Khan M.D.
"Board Certified Child and Adolescent Psychiatry"

Our day to day world has become very loud and distracting. Living in this kind of environment is not good for our health. According to world health organization, noise pollution is a serious problem. There are so many noise producing gadgets that are all around us all the time. As such we hardly get any chance to enjoy total silence.

Loud noise increases our stress level by activating amygdala in the brain and causes the release of cortisol (stress hormone) that is responsible for increase blood pressure and heart attacks. High-level of noise also impair our hearing and has overall negative effect on our health. Just a few minutes of silence, in our busy lives can be very relaxing. It can bring blood pressure down and improve brain circulation. Silence helps replenish our mental resources too.

When the brain is disengaged from external stimuli (noises), we can tap into our innermost memories, ideas, emotions and thoughts. When that happens, we are better able to empathize with others and do soul searching in a meaningful way.

A 2013 study which was published in a prestigious scientific journal suggests that two hours of silence daily, in rodents led to development of new cells in the hippocampus (involved in memory, emotions and learning).

We all have been given one tongue to speak and two ears to listen.
It suggests that we should listen more and speak less, but most of us do just the opposite. We listen less and speak more. Many successful individuals try their best to listen to others carefully and only speak when it is necessary.

The idea that silence is good for us is gradually becoming more and more popular in many parts of the word including the U.S. Eastern Philosophers and famous practitioners of different religions were not only aware of virtue of silence, but they also taught the same to their followers.

More quiet and peace, we have, more creative we become. In such an environment, we feel less stressed and more able to focus on the tasks that we want to perform. In some parts of the globe, retreats are being offered, where people learn to relax and appreciate the virtues of silence. It is a much-needed service for our fast paced life, where we feel deprived of silence.

Saleem A. Khan, M.D.

Abnormal Illness Behavior-The Missing Link in DSM 5

Neil S. Kaye, MD

Every branch of medicine encounters patients with unexplainable symptoms. Somatization, first introduced by Stekel in 1924 (Woolfolk, R. and Allen, L.: *Treating Somatization* (2006) p. 5) is the propensity of certain people to experience and to communicate their psychological and emotional distress in the form of somatic or physiologic symptoms. These patients require unusually large amounts of resources while simultaneously frustrating doctors. This is not a new problem. Galen noted that "people pretend to be ill for many reasons, and it would seem a physician's business to discover the truth in all such cases." In the past, diagnoses such as Railroad Worker's Spine, Shell-Shock, Battle Fatigue, Hysteria/Mass Hysteria, and psychosomatic were used to categorize groups of people with similarly unexplained symptoms.

Today, these syndromes have multiple names including but not limited to: Sick Building Syndrome (SBS), Multiple Chemical Sensitivity (MVS), Idiopathic Environmental Intolerance (IEI), and Gulf War Syndrome (GWS).

The common factor in these cases is that the person believes and behaves as though she/he has a symptom or an impairment that despite appropriate/adequate medical/scientific investigation has no apparent medical cause. The absence of a true diagnosis, based on concrete findings/test results or agreed upon diagnostic medical criteria, means either that 1) the doctor has not yet discovered the true etiology or 2) there is no real physiologic disturbance.

Commonly, treating and forensic doctors use terms such as "embellished, somatic overlay, functional, or exaggerated" when describing how these individuals present during evaluation. Medicine has long operated under the construct that when there is no physiologic explanation than the explanation must be psychological in nature and a psychiatric referral is often pursued. Psychiatry in turn has used terms and diagnoses including Hysteria, Conversion, Dissociation, Somatization, Briquet's Syndrome, Munchausen's, Hypochondriasis, and Malingering to categorize these individuals.

Internationally, data is consistent. 60-70% of patients with depression present with somatic/physical symptoms while only 30-40% present with psychological symptoms. In a typical primary care office, depression presents with multiple physical/pain complaints, fatigue, moodiness, migraine headaches, IBS, weight changes and/or sleep disturbance. (Wittchen, H.: Comorbidity in Primary Care. J. Clin Psychairty 1999; 60 [suppl 7]: 29-36.) Historically, common psychosomatic illnesses included pseudo-MI, migraine headaches, pseudoseizures, asthma, IBS, sexual dysfunction and pelvic pain complaints and combined system illness such as CFS/CFIDS and FMS. The more symptoms a person has, the more likely it is that the person has depression, particularly when symptoms represent

involvement of multiple organ systems. If a person has two pain complaints, the likelihood of a comorbid mood disorder is increased six-fold, and with three pain complaints the likelihood is increased eight-fold. 60% of women evaluated for pelvic pain at a GYN clinic were also diagnosed with depression. However, symptoms generated by psychological factors, are often unrecognized or unacknowledged by both the patient and clinician.

Since 1994, we have operated under various versions of DSM-IV, which used the concept of Somatoform Disorders and then focused on whether or not the person was conscious regarding the production of the symptoms or if the symptoms were an unconscious manifestation of underlying conflict. Truly feigned pathology for the purpose of secondary gain was diagnosed as Malingering. Things such as self-injurious behavior as part of another diagnosis (eg: personality disorder) was subsumed on the primary diagnosis and not separately diagnosed.

With the release of DSM 5 (2013) the Somatoform Disorder section has undergone a major revision (Somatic Symptom Disorder (SSD),) garnered significant criticism and received less than an enthusiastic acceptance by many practicing clinicians. In particular, the issues of chronic pain and PTSD have received substantial press after having been changed substantially, and caution in its use in forensic settings has been recommend (Young, G.: Ill-Treatment of Pain in the DSM-5. Psychol. Inj. and Law (2013) 6:307-313.)

As ICD -10 is operationalized in medicine, a psychiatrist needs to be familiar with its criteria:

2014 ICD-10-CM Diagnosis Code F45.9

Somatoform disorder, unspecified

- F45.9 is a billable ICD-10-CM code that can be used to specify a diagnosis.
- On October 1, 2015 ICD-10-CM will replace ICD-9-CM in the United States, therefore, F45.9 and all other ICD-10-CM codes should only be used for training or planning purposes until then.

Clinical Information

- A category of psychiatric disorders which are characterized by the presence of physical symptoms that suggest a medical condition but are not fully explained by any known medical reasons.
- A group of disorders characterized by physical symptoms that are affected by emotional factors and involve a single organ system, usually under autonomic nervous system control. (american psychiatric glossary, 1988)

- Characterized by physical symptoms and demonstrable structural or physiological changes in which emotional factors are believed to play a major etiologic role.
- Disorders characterized by bodily symptoms caused by psychological factors.
- Disorders having the presence of physical symptoms that suggest a general medical condition but that are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder. The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning. In contrast to factitious disorders and malingering, the physical symptoms are not under voluntary control. (apa, dsm-iv)

Applicable To

- Psychosomatic disorder NOS

Description Synonyms

- Psychophysiologic disorder
- Psychosomatic disorder
- Somatoform disorder

The most challenging cases for both clinicians and forensic experts involve people with limited pre-incident documented psychopathology, who then experience a rather mild exposure/traumatic event, yet develop extreme somatic complaints, usually spanning multiple organ systems, and without any sound medical explanation, despite a conscientious and thorough medical work-up. Often, reassurance is of little value, doctor shopping becomes common, and litigation may well follow.

DSM 5 does not provide a good framework for diagnosing such a person who has what can be best described as abnormal illness behaviors (AIB's.) DSM has lost the concept of learned psychological dysfunction due to re-enforcers of illness behavior that are non physiologic. Illness Anxiety Disorder perhaps best categorizes these individuals, but it is not an ideal fit. An inherent problem in the DSM approach is that it requires an assessment of and an opinion about the person's feelings, emotional state, motivation, and honesty. This clearly introduces subjectivity and a serious risk of bias.

Instead, I propose that understanding these people requires incorporating a behavioral model. A behavioral analysis approach obviates the need for the subjective opinions from the evaluator and fosters a therapeutic alliance between the doctor and patient.

Cognitive theory explains SSD as arising from negative, distorted, and catastrophic thoughts and reinforcement of these cognitions. This causes a person to misinterpret mild symptoms as evidence of a serious illness. These thoughts/beliefs are then reinforced by supportive social connections. A spouse who responds more to his or her partner's pain cues makes it more likely that he or she will express greater pain (Williamson, D., Robinson, M. E., & Melamed, B. (1997). "Patient behavior, spouse responsiveness, and marital satisfaction in patients with rheumatoid arthritis". *Behavior Modification* (21): 97–106.)

Children of parents who are preoccupied or overly attentive to the somatic complaints of their children are more likely to develop somatic symptoms (Watt, M. C., O'Connor, R. M., Stewart, S. H., Moon, E. C., & Terry, L. (2008). "Specificity of childhood learning experiences in relation to anxiety sensitivity and illness/injury sensitivity: Implications for health anxiety and pain". *Journal of Cognitive Psychotherapy: An International Quarterly* (22): 128–143. These cognitive distortions can make a person with SSD limit her/his behavior he and cause increased disability and impaired functioning.

Most behaviors are accomplished in pursuit of a clear goal; a purposeful action or activity is undertaken with an associated expected outcome. Three drivers of behavior have been described: 1) operant and classical conditioning; 2) appetite and internal drives; and 3) social pressure and modeling. All three of these share the idea that behavior is learned and shaped via reinforcement. Often forgotten however, is that the influence in a doctor-patient relationship is bidirectional: patients condition us while we condition them.

Issy Pilowsky, an Australian psychiatrist introduced the concept of Abnormal Illness Behavior (AIB) (Pilowsky I. (1969). "Abnormal illness behaviour." *Br J Med Psychol* 42 (4): 347–351.) A person becomes unwell and takes on the sick role. This illness behavior becomes “proof” of an actual illness. AIB is when the patient is not entitled to the sick role she/he expects yet the patient continues her/his expectation despite being told it is inappropriate.

Reenforcers of healing include social, occupational, romantic, sexual, financial and self-image. Reinforcers of AIB include positive reinforcers (disability payments, attention from others such as partner, family, lawyer, doctor), the ability to express prohibited feelings, and in some cases, lump sum payments. Negative reinforcers of AIB include relief from stress, expectations and criticism, and relief from pain and discomfort.

Physicians can easily and unwittingly get caught in reinforcing AIB by looking at a specific symptom or symptoms to be relieved rather than seeing the whole case/person; rewarding unhealthy behavior (with a particular risk when using benzodiazepenes or opiates,) allowing the patient to run her/his own treatment, and by fractionating care among too many specialists which makes communication and delivery of integrated care essentially impossible. Changes

in health care delivery have exacerbated this by emphasizing efficiency (short visits,) problem focused care (to reduce cost,) by using pain as a vital sign, through the use of algorithmic medicine dictated by a fear of malpractice litigation, by focusing on patient satisfaction rather than outcomes, and by pushing doctors to improve compliance and patient retention.

Treatment Issues:

Treating the person with AIB requires a basic message that people heal. The patient must be told that she/he has been sensitized and will be desensitized with appropriate treatment.

The clinician must be prepared for the “what if” argument and should acknowledge that while medicine doesn’t know everything, together with the patient vigilance for new ideas and reasonable explanations will be maintained.

Somatization is a remarkably common presentation in the medical world. A compassionate physician can effectively treat a patient with this disorder while not promoting illness behavior. We must all be aware of the risk of conditioning patients to assume the sick role.

A Psychiatric Residency Coordinator

The first year…

I have been an administrative assistant for most of my career. I have worked in a governor's office, the Delaware State Senate and for the CEO of the Delaware Psychiatric Center. Although I enjoyed working in all those different capacities, I believe those experiences led me to the position of Residency Coordinator for the Delaware Psychiatric Center.

A year ago I was aware of this position, but had no idea what my predecessor really did…I should have paid more attention, because when the CEO asked me to take over as the coordinator for the DPC Residency Program it felt like I was thrown in the deep end of the pool March 2015. Luckily for me, the program director, Imran Trimzi, M.D. was very patient and knowledgeable and would always take the time to explain how things work in the program. The great thing about residency programs across the country is that they are *all* doing the same activities around the same time weekly, monthly and yearly. When I started March of 2015 there were about 10 major things going on at the same time. Four new residents needed to be hired and credentialed, five residents needed a graduation planned, a retreat for all the residents that needed to confirmed and countless other tasks including updating various websites with information I had to gather from several different resources; all of which was brand new to me, it was a whirlwind of activity and hard work, but somehow I got through it. I agree with former president Clinton when he said *"Work is about more than making a living, as vital as that is. It's fundamental to human dignity, to our sense of self-worth as useful, independent, free people." William J. Clinton.* I found this position is a lot of hard work, but it rewarding and although this is how I make my living, my sense of self/team-worth has skyrocketed.

This March, a year later, I had the opportunity to travel to Austin, Texas to attend the American Association of Directors of Psychiatric Residency Training (AADPRT) conference. It was a wonderful experience for me since I am the only Psychiatric Residency Program Coordinator in the entire state of Delaware and have no immediate peers to communicate with on a regular basis. The most important thing I learned at the conference was that I am on the right track with most of AADPRT's mission purposes including, assisting Dr. Trimzi to provide a nurturing learning environment for the residents and encouraging individuals to grow professionally in the program. I thought I was just making up "my way" of doing things, like navigating through the endless applications to our program in September and finally hiring four strong candidates. But after speaking to other coordinators with larger programs and support staff, I was not

only doing things “correctly”, I had come up with a good way to filter candidates that I had an opportunity to share with my colleges at the conference.

Another valuable lesson I learned was the definition of all those acronyms: ABPN, ACGME, APA, ERAS, GMEC, PRITE, CCC, FREIDA, and NPI, how they work together and why they do not share information (I couldn’t figure out why I had to keep imputing the same information into different databases that I thought were the same database for a while) Suddenly, the light bulb went off and I was excited that after a year of experience and a two day conference I had gained new confidence in my abilities as a coordinator ready to take on the challenges that 2016 and beyond will bring.

It's like Forrest Gump said, 'Life is like a box of chocolates.' Your career is like a box of chocolates - you never know what you're going to get. But everything you get is going to teach you something along the way and make you the person you are today. That's the exciting part - it's an adventure in itself. Nick Carter

I am glad I finally got to the piece of chocolate I really like…Residency Program Coordinator for the Delaware Psychiatric Center.

Respectfully submitted,

Ms. Terry Ravi Young

JOURNAL CLUB

Antidepressant medication use and its association with cardiovascular disease and all-cause mortality in the Reasons for Geographic and Racial Differences in Stroke (REGARDS) study

Annals of Pharmacotherapy, 03/16/2016Hansen RA, et al.

The authors aimed to assess whether antidepressant use is associated with acute coronary heart disease (CHD), stroke, cardiovascular disease (CVD) death, and all–cause mortality. In fully adjusted models, antidepressant use was associated with a small increase in all–cause mortality.

Methods

- Secondary analyses of the Reasons for Geographic and Racial Differences in Stroke (REGARDS) longitudinal cohort study were conducted.
- Use of selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, bupropion, nefazodone, and trazodone was measured during the baseline (2003–2007) in–home visit.
- Outcomes of CHD, stroke, CVD death, and all–cause mortality were assessed every 6 months and adjudicated by medical record review.
- Cox proportional hazards time–to–event analysis followed patients until their first event on or before December 31, 2011, iteratively adjusting for covariates.

Results

- Among 29 616 participants, 3458 (11.7%) used an antidepressant of interest.
- Intermediate models adjusting for everything but physical and mental health found an increased risk of acute CHD (hazard ratio [HR] = 1.21; 95% CI = 1.04–1.41), stroke (HR = 1.28; 95% CI = 1.02–1.60), CVD death (HR = 1.29; 95% CI = 1.09–1.53), and all–cause mortality (HR = 1.27; 95% CI = 1.15–1.41) for antidepressant users.
- Risk estimates trended in this direction for all outcomes in the fully adjusted model but only remained statistically associated with increased risk of all–cause mortality (HR = 1.12; 95% CI = 1.01–1.24).
- This risk was attenuated in sensitivity analyses censoring follow–up time at 2 years (HR = 1.37; 95% CI = 1.11–1.68).

Psychiatric Symptoms Caused by Medical Illness Can Be Easily Confused for Psychiatric Illness

Lee Berman M.D.

It is a very common occurrence that patients present in the emergency room or other settings and appear to have psychiatric illnesses. These symptoms can be upsetting for many people and might cause medical staff to behave differently towards these patients as they can become uncomfortable around those in mental distress. This could cause patients to receive substandard care as many people are uncomfortable working with those with mental illness. There are also many medical illnesses that often present with psychiatric symptoms, and can be easily confused with mental illness. The combination of these issues might make it more likely for patients with psychiatric symptoms to be misdiagnosed. Psychiatric symptoms can be very upsetting to most people, and I have seen that many times people want to avoid anyone who might appear to be mentally ill. I am unsure of the exact reasons for this, but it seems to be a common phenomenon all over the country. If a medical practitioner starts to feel a certain way about a patient, and starts to not want to talk or work with them, it is certainly possible that some details might be missed and mistakes can be made. The important question to know is whether or not having psychiatric symptoms makes it more likely to be misdiagnosed. This is necessary to understand because there is the possibility of improvement in the area of medical care if this is shown to be true. Medical staff can be trained to respond more appropriately towards those who appear to have mental illness so that the proper screenings are not missed. While I understand that it is difficult to work with people who have mental illness it is not fair to

patients that are not being treated properly. By answering this question those in the medical field might gain a better understanding of the severity of this problem and those in administration might be able to make suitable changes.

This problem is stated several times in many different medical journals. Because of the upsetting nature of many psychiatric symptoms many treatment providers might miss symptoms that can be caused by medical conditions, and end up misdiagnosing the patient. This can even result in patients being admitted to psychiatric hospitals due to medical conditions which can be very harmful to the patient and can cause significant harm from the delay in correct diagnosis. Acute change in mental status is an example of a group of symptoms that are many times caused by medical problems such as infections, dehydration, electrolyte imbalances, or drug overdoses or intoxications. This is mentioned in the annals of Clinical Psychiatry which states, “Acute change in mental status has been referred to in the literature by a number of terms, including altered mental status, delirium, encephalopathy, and acute confused state. Studies have shown that alteration of mental status secondary to medical illness may occasionally be incorrectly attributed to a psychiatric disorder.”[2] This can be very dangerous because patients having these symptoms can be extremely ill physically, and need medical attention quickly or they can die. There is a great deal of data to show how often specifically this happens and there are many studies which document exactly how broad of a problem that this can be.

This is further substantiated by a series of investigations demonstrating the incidence of medical illnesses in patients with altered mental status. The studies were performed by Henneman and colleagues. They evaluated 100 consecutive patients

ages 16 to 65, with new psychiatric symptoms and found that 63 of the patients had an organic or medical etiology for their symptoms, including 3 who were ultimately found to have cerebrospinal fluid abnormalities following lumbar puncture.[2] I have personally witnessed patients with altered mental status coming from delirium which is a condition caused by a serious medical condition that affects the mentation of an individual. They can present with confusion, and even have hallucinations or delusions which can easily appear as psychiatric illness. When this is diagnosed correctly, physicians treat the underlying medical problem which quickly resolves the psychiatric symptoms.

Delirium can frequently occur in elderly patients as they are fragile medically and even something as simple as a urinary infection can cause a great deal of symptoms that appear psychiatric. It is very important in these patients to figure out what is causing the delirium and this is clearly shown by a quote in an article specifically about delirium in the elderly. Dr. Cole states in this article, “The medical assessment of delirium is not evidenced-based. At present, it involves a careful history and physical examination to search for conditions predisposing to, precipitating, or perpetuating the delirium (putative causes)” (Cole, 12). ‘The most important problems are medication toxicity, cardiorespiratory and neurologic disorders, and infections” (Cole, 12). This statement was important because it showed that the diagnosis is subjective and requires an expert evaluation to reduce the chances that mistakes are made.

The misdiagnosis of psychiatric illness would certainly be improved by increasing the access of psychiatric staff in the hospital. A consensus study was published in the Journal of Psychosomatic Research which made these conclusions. These conclusions were based on a list of recommendations which were derived from qualitative interviews

conducted with 39 doctors and nurses working in EDs in four general hospitals in England.[4] They recommended that a psychiatric liaison staff be available 24 hours a day in the emergency room to help with the proper diagnosis of patients where there was a question if the symptoms were caused by medical or psychiatric issues. One possible problem with this study was that it was concluded in only one city, but in general there are similarities between patient populations in England and in the USA. I agree that psychiatric staffs are extremely important to have even on a medical unit to help with patients that present with difficult psychiatric symptoms. Psychiatrically trained staff is much better equipped to handle these kinds of patients and can help reduce the amount of errors that are being made. This happens is many hospitals and there are psychiatrists trained in a consult and liaison specialty which can help to serve teams with advice and expert opinions.

There was one article that I looked at that criticized the DSM which is the diagnostic manual for Psychiatry. The authors stated that, "Incautious, inept misapplication of these highly subjective and catch-all criteria will likely result in frequent inappropriate psychiatric diagnosis with far-reaching implications for both the health care industry and diverse patient populations." [1] This can be especially true when dealing with somatic symptoms. The authors clearly show how the DSM can be easily misinterpreted by those that are not experts in the field. He states many times that he feels that somatic symptoms should not so easily be diagnosed as psychiatric and warrant a careful examination to rule out medical causes (Frances 1). This problem can occur in many settings such as the emergency room and many patients needing medical attention will end up going to a psychiatric unit because of their symptoms. I do

agree that the DSM can be confusing to many people because of the subjective criteria so it highlights the importance of having trained psychiatric staff to diagnose psychiatric illness before patients with medical illnesses slip through the cracks.

There are additional costs beyond the cost of a patient's health for being misdiagnosed. In addition to adverse health events there are financial costs to the healthcare system as well as risks to other patients who were exposed to those patients being misdiagnosed. The reason for this is some health problems that manifest psychiatric illnesses can be contagious. An example of this would be in patients with infections. Diagnosing them faster can reduce mortality as well as decreasing the cost of treating these patients in the long-term after they have serious adverse events. Not only that, it can also decrease the likelihood that contagious illness can be spread. Treating patients earlier often results in increased savings to the healthcare system as illnesses are treated before they become chronic and increase in severity.[3]

It is clear to me that the misdiagnosis of psychiatric symptoms caused by medical illness is a big problem, and that many medical professionals would agree. There is a great deal of documentation and studies which show this problem clearly and hopefully changes can be made in the near future to reduce the incidence of this issue. There are many medical illnesses such as delirium which can be easily confused for psychiatric illness by those who are untrained in how to deal with these patients, or fail to perform full workups because they are working with a difficult patient. The addition of psychiatric staff in medical hospitals was shown to be a clear benefit which can increase the quality of care for patients and help to reduce errors in misdiagnosis. These psychiatric staff can serve in the role of consult and liaison and help to serve as experts

and train other medical professionals in how to deal with difficult patients who demonstrate psychiatric symptoms. In the end I feel that this will not only increase the quality of care but help to reduce costs that occur from harm done to patients that are misdiagnosed. This seems to be in tune with the changes being done to the healthcare industry today. Increasing the quality of care, decreasing the cost of care, and increasing access to patients were the main goals of the Health Care Reform Act.

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