Psychiatry in the general hospital: hints from the shop floor

Introduction

With the advent of the foundation programme, junior doctors will hopefully find themselves with many more opportunities for exposure to aspects of medicine that previously were not so readily accessible. The art of psychiatry is one such important aspect, and one that is intricately linked to the care of patients in the general hospital setting.

Psychiatric morbidity is present in between 25 and 45% of medical and surgical inpatients, irrespective of the diagnosis that originally brought them into hospital. This morbidity mainly comprises organic disorders, depression and anxiety. This article will re-acquaint foundation doctors with some of the more common psychiatric conditions likely to be encountered on the wards. In addition it will provide some useful tips for the first-line management of these complex cases.

Low mood

The realization that a part of one's body doesn't work the way it should can be experienced as a significant loss, in some akin to bereavement. It takes time to adjust to a new way of life, and in addition, life in hospital is nothing like that outside. Adjustment reactions to illness are an extremely common occurrence in hospital and can be misdiagnosed as clinical depression.

It should also be noted that patients in hospital are often denied, however unintentionally, the means to control what happens to them. Short of complaining, patients have little say in when they will be woken up in the morning, when they eat or when they might be suddenly whisked off for surgery or a scan. After initial anger at this, patients can give up trying to control what happens to them and enter a state of 'learned helplessness'. In this state, a patient's motivation reduces and may even progress to profound apathy. The most important thing for a junior doctor to do in these situations is to recognize that these problems can happen and attempt to elicit patients' beliefs about their illness using some of the questions listed below:

- 'What would you like to know about your illness?'
- 'What are your main worries at the moment, either about your illness or anything in general?'

Finding out about the person behind the illness is also very important and can be done simply by asking the question:

- 'How would you describe yourself before this illness?

By asking these questions, the patient is given a chance to express his/her concerns, be given specific information and develop a rapport with the doctor, all of which may help to give him/her a sense of empowerment in addition to providing useful information for the notes. It may seem to be a waste of precious time in the busy schedule of a ward doctor, but it will certainly be time well spent.

This is not to say that clinical depression and anxiety does not occur in general hospitals, as it certainly does. The assessment and management of depression is detailed in another article in this series. In a general hospital environment, however, the detection of specific organic causes for depression should be of particular concern to the junior doctor. Vigilance to the detection of these causes is necessary as many of them are potentially reversible. Some of the organic causes for depression and anxiety are detailed in *Table 1*.

This is by no means an exhaustive list of causes, which indeed seems almost infinite at times. The moral of the story is simple, however – check the bloods, the drug chart, and use a good drug formulary.

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Deliberate self harm

Approximately 140 000 cases per year are admitted to hospital in England and Wales following deliberate self harm (DSH). In addition, unrecognized psychiatric illness in general hospital patients can occasionally lead to DSH or a suicide attempt. Such action should prompt an immediate referral to the psychiatric liaison team or on-call psychiatrist. In the mean time, however, a basic risk assessment is essential. This covers three areas and can be done using four questions as listed below:

1. 'Did you actually intend to die?' This question assesses the motivation behind the attempt.
2. 'How do you feel now that you have survived?' This assesses the patient's current feelings about the attempt.
3. 'Are you still having thoughts of suicide?'
4. If the answer to question 3 is 'yes', then ask 'how likely is it that you will act on them?' These questions can be used to assess immediate future risk.

It is important not to be fearful that, in asking these questions, the patient will somehow be provoked into harming him-/herself. Research suggests that this is not the case. While waiting for a psychiatric assessment, if any significant concerns remain, ask a member of staff to sit with the patient until he/she has been properly assessed.

Strange behaviour

The behaviour of some patients can seem odd at the best of times but truly bizarre behaviour, often occurring late at night during the 'on-call' hours, is often attributable to a condition called delirium. Prevalence rates of up to 60% have been reported in general hospital populations. Delirium is often compared to and contrasted with dementia, and those working with the elderly will be exposed to dementing illnesses. However, it should be noted that dementia itself is a significant risk factor for delirium.

Table 1. Organic causes of depression and anxiety

	Drugs	Physical conditions
Depression	Antihypertensives (especially beta-blockers)	Hypothyroidism
	Digoxin	Malignancy
	Steroids	Hypercalcaemia
	Benzodiazepines (e.g. diazepam)	Hypokalaemia
	NSAIDs (especially indomethacin)	Addison's disease
	Methyldopa	Cushing's syndrome
	Drug interactions	Parkinson's disease
	Polypharmacy	Multiple sclerosis
	Alcohol	Brain injury (including stroke)
Anxiety	Some antidepressants (e.g. fluoxetine)	Hyperthyroidism
	Withdrawal from benzodiazepines	Hypokalaemia
	Caffeine	Phaeochromocytoma
	Nicotine	
	Steroids	

NSAID = Non-steroidal anti-inflammatory drug

Delirium is an acute confusional state of rapid onset, sometimes over mere hours. In delirium, the patient's level of consciousness is fluctuant, often becoming worse at night, a term known by some as 'sun downing'. Sleep is markedly affected by bizarre and often frightening nightmares. When awake, hallucinations of a predominantly visual nature combined with reduced conscious level can lead to delirious patients misinterpreting their surrounding environment and developing transient delusional ideas. These are often of a paranoid flavour and are extremely distressing for the patient, resulting in agitation and sometimes aggressive behaviour. The easiest way to identify delirium is by using the confusion assessment method (*Table 2*). The criteria for diagnosis are A and B combined with either C or D.

Once delirium has been diagnosed, the cause must be identified. The causes of delirium are organic and potentially reversible. They are listed in *Table 3*.

As with the assessment of organic mood disorder, a set of blood tests and an assessment of the drug chart can be invaluable in establishing causes of delirium. Once this has been identified and is being treated there are some simple management strategies as described below to make life easier for both the staff and the patient:

- Nurse in a well-lit side room
- Keep the environment consistent. Avoid moving the patient around the ward
- Reduce or stop any non-essential medication
- Make sure that the patient's glasses are within reach and any hearing aids are switched on
- Keep any personal belongings within the patient's sight
- For delirium tremens, institute a reducing regimen of chlordiazepoxide according to the protocol of the local hospital
- Consider one-to-one nursing.

Ill-fitting symptoms

It can be frustrating for doctors when, after rigorous investigation, a specific organic cause cannot be found for a patient's symptoms. Some symptoms may indeed seem not to fit with any recognized medical or surgical condition, and this may raise questions as to whether the patient is being entirely honest. In these situations doctors should remind themselves of the concepts of somatization and conversion disorders.

Somatization

This is a psychiatric condition, the principal symptom of which is a preoccupation with one or more physical symptoms. It is these physical symptoms that are the patient's primary concern, and any possibility of underlying systemic illness is usually of secondary importance, if requiring attention at all. Attempts to reassure or explain things to the patient rarely receive positive feedback. Somatization often represents a mask behind which further psychiatric symptoms lie, and patients will often fight to keep this mask on, whether consciously or not.

Conversion

In such a condition the patient has developed a way in which to 'convert' intense psychic anxiety and pain into physical symptoms. It is important to appreciate that this process is not conscious. Such a conversion leaves the patient relatively free of anxiety and seemingly indifferent to sometimes significant disability.

When attempting to manage these complex cases it is useful to remember that the patient is still feeling pain and discomfort somewhere, regardless of whether a cause can be found. Advice will need to be sought from the psychiatric department, but it is important to try to avoid giving the patient the idea that his/her problems are 'all in the mind', as this is likely to provoke hostility from the patient that will be difficult to reverse. Discussions should be matter-of-fact, but also empathic, providing the patient with as much information as is available, and including the possibility that there may be a psychological component to their illness. As in the case of low mood, the doctor should try to find out what the patient thinks about his/her illness and what other worries he/she may have.

Conclusions

The above review does not cover all the psychiatric conditions that may be encountered on the wards during a foundation post. However, doctors should realize that

Table 2. The confusion assessment method

A	Acute onset with fluctuating course
B	Inattention, being easily distracted
C	Disorganized thinking, wandering thoughts
D	Fluctuating level of consciousness with hallucinations/nightmares. May seem drowsy or overactive

Table 3. Organic causes of delirium

Cause	Specific details
Infection	Usually accompanied by high fever but even a mild urinary tract infection in an elderly person with dementia can cause acute delirium
Metabolic disturbance	Hepatic failure can result in a build up of waste products normally cleared by the liver, causing an encephalopathy Renal failure can again result in accumulation of waste products and electrolyte imbalances Hypoxia of any cause resulting in lack of oxygen to the brain and subsequent confusion
Vitamin deficiency	Vitamin B12 and thiamine deficiencies. Alcohol doesn't contain thiamine and some of those consuming it at the expense of anything else tend to become thiamine deficient
Endocrine diseases	Hypoglycaemia in diabetes The increased steroids produced in Cushing's syndrome can induce a psychotic state
Intracranial	Trauma, space-occupying lesions. In epilepsy, ictal or post-ictal states can present as confusion
Drug intoxication and withdrawal	Prescribed medication, e.g. anticonvulsants Hypnotics such as diazepam although given to relax the patient, can cause increased confusion Anticholinergic effect of some antidepressants Opiates for pain relief Illegal substances, e.g. cannabis, cocaine, hallucinogenic drugs
Alcohol withdrawal	So-called delirium tremens. May occur suddenly after the patient has been in hospital for a day or so. Visual hallucinations of insects or 'little-men' common
Postoperative	Confusional state when recovering from general anaesthetic

psychiatry is simply another part of medicine and doctors who appreciate this are much more willing to have input from a 'psychiatry colleague' working for the hospital's liaison psychiatry team. **BJHM**

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Further reading

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KEY POINTS

- There is significant psychiatric morbidity present in general hospital inpatients.
- It is important to exclude organic causes of psychiatric illness in general hospital inpatients.
- Taking time to listen to the patient's worries can be of immeasurable benefit to them.
- Basic risk assessments of patients are essential and do not increase the risk of subsequent self harm or suicide.