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Developing Empathy for Patients with Mental Illnesses

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Developing Empathy for Patients with Mental Illnesses

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Introduction

In an era where burnout is common, it can be difficult to provide empathic care to patients. There may be a tendency to resort to pharmacotherapy as a replacement to psychodynamic or empathic approaches. This may be appealing as an easy fix, especially in the primary care setting where most non-acute psychiatric care is administered. Throughout their medical education, students are taught methods to narrow differential diagnoses to direct appropriate medical therapy. In addition to the science of medicine, students are often instructed to practice the art of medicine, which can be summarized with the quote, “cure sometimes, relieve often, comfort always.”

When tasked with growing patient censuses and increasingly complex demands, it is often more efficient to operate on heuristic diagnostic principles. In the case of physical illnesses, where diagnostic findings and historical contexts are often manifest in undeniable objective criteria, the decisions for specific treatment approaches are more easily communicated to and understood by patients. Similarly, physical sensations such as chest pain or nausea are readily understood and thus empathized with. In contrast, many mental illnesses have subtle and usually intangible qualities. Can you truly empathize with patients that possess sensations and realities which are different from that of your own?

Part of establishing empathy is noticing one's biases towards patients. As often as patients come into healthcare practices bearing their own biases towards physicians and the healthcare system, providers also label patients well before understanding the full spectrum of their story. This naturally stems from the desire of physicians to classify patients through symptom association. For example, we are taught that cardiac patients often present with exertional, crushing chest pain just as we learn by association that borderline patients often employ splitting as a defense mechanism. By consciously recognizing our biases during patient encounters, we can more avidly develop therapeutic alliances and avoid barriers to treatment.

This brief primer will impart students a set of empathic approaches for psychiatric patients. Students will understand how poignant symptoms manifest in the context of DSM-V diagnoses. Broadly, this primer is split into two convergent approaches: 1) recognition of transference-countertransference responses with concrete examples of facilitating positive transference reactions, and 2) reconciliation of patient and provider goals for therapy. Through these examples, students will be able to go beyond a formal diagnosis and gain deeper insight into how a patient's mental health impacts and is impacted by their current situation.

To achieve that end, students will be taught to recognize key features of the interview from a holistic point of view. After the initial presentation, we will be addressing a patient's medical, psychiatric, and psychosocial circumstances. Students are encouraged to actively reflect on their own implicit biases and reactions to the initial and subsequent presentations of the patient. Appropriate DSM-V diagnostic criteria have been provided for reference within each case. Treatment options and differential diagnoses are not covered in this primer, but students are encouraged to read further. Finally, after the patient is presented, key notes on empathic approaches or goal reconciliation will be addressed.

Information and Introduction: Empathic Approach

In the following cases, students will be instructed on approaches to establish a therapeutic alliance primarily through awareness of transference and countertransference. **Transference** is defined as directed emotions or feelings of the patient towards the therapist, whereas **counter-transference** is defined as emotions or feelings which the therapist directs towards the patient.

In a historical context, Freudian **psychodynamic psychotherapy** evolved as a sort of “transference-only” approach. A relatively emotionless psychiatrist acts as an interpreter, encouraging a patient, largely by free association and flow of consciousness, to draw out repressed emotions. The psychiatrist’s role is to help link a patient’s current maladaptive behavior to a series of unconscious anxieties within the patient. With minimal intervention, a patient’s expression of emotions and conflicts are essentially self-processed to reach a resolution. Traditional psychotherapy requires frequent, intimate sessions which may have use for advanced providers but are impractical for students to learn within a rotation.

Actively incorporating countertransference in a patient interview can be achieved through a variety of therapeutic approaches. In **accelerated empathic therapy**, the therapist and patient work together to achieve the patient’s own goals. As opposed to the unidirectional Freudian approach, empathic therapy encourages open discussion as an expression of compassion. By openly examining both patient’s and therapist’s conflicts and anxieties, the patient’s maladaptive psychiatric manifestations can be processed and ameliorated. Empathic approaches can even be employed in adjunct with cognitive behavioral therapy to reinforce positive changes.

The following cases will end with a series of key notes on how interviews can be conducted in a manner as to garner empathy. Included below are a variety of topics which will be covered in the following section. It may be helpful to refer back to here if terms are unfamiliar when encountered again in context.

Locus of control. The locus of control reflects an individual’s perceived degree of influence over matters at hand. More specifically, it represents a spectrum ranging from entirely external to entirely internal loci of control. An individual with an **external locus of control** believes that he or she has no individual influence on the outcome of events and is therefore entirely at the whims of external or non-self factors. Contrast that with an entirely **internal locus of control**, where one believes that his or her actions are the sole determinant of his or her success or failure. Though the locus of control within individuals varies between specific events, it may be useful to broadly classify patients with pathologically extreme loci of control.

Defense mechanisms and coping behaviors. Broadly speaking, these are characterizations of patterns of behaviors which individuals use when faced with adverse situations (i.e. anxiety). For most successful individuals, medical students included, it is generally simpler to relate to and therefore empathize with adaptive (i.e. higher-functioning) behaviors. Understanding and subsequently correcting these behaviors is often the center point of cognitive behavioral therapy (direct behavior change) and psychodynamic therapy (releasing historical subconscious anxieties). For the purposes of empathic therapy, maladaptive responses should be recognized in the context of the patient holistically. That is, students should seek to avoid quick judgment

Note on the Empathic Approach

based off of seemingly illogical or incongruent reactions during patient interactions. A limited list is provided at the end of this section is provided for reference (source: uptodate).

List of defense mechanisms

Splitting	Compartmentalizing internal representations of self and others so that conflict is avoided and integration of these representations is not possible
Projective identification	A defense involving subtle interpersonal pressure so that the target of a projection takes on characteristics of either an aspect of the self or the internal object that is being projected
Projection	Externalizing unacceptable inner impulses and their derivatives by attributing them to someone else
Denial	Avoiding awareness of aspects of external realities that are difficult to face by dismissing perceptions that are obvious to everyone else in the environment. What is not perceived is not real, and thus cannot cause pain. The unpleasant aspects that are denied may be replaced by a more pleasant internal fantasy.
Disavowal	Dismissing or failing to acknowledge thoughts or feelings that are uncomfortable
Schizoid fantasy	Retreating into one's private, internal world to avoid anxiety about interpersonal situations
Regression	A partial or total return to earlier patterns of adaptation or behavior
Conversion	Development of symbolic physical symptoms and distortions involving the voluntary muscles or special sense organs; symptoms are not under voluntary control and cannot be explained by any physical disorder
Undoing	Symbolically acting out in reverse something unacceptable that has already been done or against an impulse which the ego must defend itself
Rationalization	Justifying irrational or unacceptable behavior, motives, or feelings by making them appear rational and reasonable through belief in plausible explanations that are false
Displacement	Shifting unacceptable feelings associated with one idea or object to another that resembles the original in some way
Intellectualization	Using excessive and abstract rational and logical reasoning to avoid difficult feelings
Isolation of affect	Separating an idea or impulse from its associated feeling or affect to avoid emotional turmoil
Sexualization	Endowing an object or behavior with sexual significance to turn a negative experience into an exciting and stimulating one
Reaction formation	Transforming an unacceptable wish or impulse into its opposite
Sublimation	Energy associated with unacceptable impulses or wishes is diverted into personally and socially acceptable channels
Humor	Finding comic and/or ironic elements in difficult situations to reduce unpleasant affect and personal discomfort
Anticipation	Committing oneself to the needs of others over and above one's own needs
Suppression	Consciously deciding not to attend to a particular feeling, state, or impulse
Repression	Expelling unacceptable ideas or impulses, thus blocking them from entering consciousness (repression is more closely linked with inner states, whereas denial involves external sensory data)

Case 1

Learning Objectives

1. Recognize the criteria for need for acute inpatient hospitalization and psychiatric holds
2. List DSM-V criteria for major depressive episode
3. Recognize physical and psychiatric cues to patient responses

Initial presentation

A 63 year-old homeless, unemployed, widowed Caucasian male is brought in by an ambulance after endorsing suicidal ideation at his clinic. He stated that he wished to hang himself or jump off a bridge given that he had nothing to live for. Chart review prior to initial intake reveals that the patient has a history of multiple incarcerations, a history of multiple substance use disorders (methamphetamine, heroin, alcohol), and has failed multiple medication trials in the past.

He states that he has had depression which started when his girlfriend died four years ago. He has coped with depression by returning to active substance use, leading to incarceration and subsequent homelessness. In addition to current active suicidal ideation, he endorses occasional auditory and visual hallucinations as well as severe lower back and knee pain. He has been on trials of a few anti-depressants and anti-psychotics in the past, was unable to tolerate them. His only medication is methadone for arthritic pain and prior heroin use. He has had three prior suicide attempts where he attempted to overdose on drugs and/or benzodiazepines; he was brought to the emergency department but was not admitted on these occasions.

Mental status exam

Appearance: cachectic male, appears older than stated age, sitting in hospital bed; fair eye contact

Behavior: calm, cooperative, appropriate

Motor: fine tremor, no significant psychomotor agitation or retardation

Gait: slow and unsteady

Speech: soft speech, regular rate and rhythm

Mood: "hazy"

Affect: dysthymic, constricted

Thought process: coherent, logical

Associations: linear

Thought content: endorses active suicidal ideation, no harmful ideation

Perceptions: no current abnormal perceptions. No command auditory hallucinations.

Insight / judgment: limited/limited

Sensorium / orientation / intellectual functions: Alert and oriented to person, place, time.

Physical exam remarkable for poor dentition, dry oral mucosa, bilateral knee pain, lower back pain. Otherwise unremarkable.

What are your first thoughts regarding this patient? Did the chart review influence your initial impressions?

Diagnostic criteria

-Criteria for major depressive episode are at least 5/9 of the following for a period of >2 weeks with significant impairment to a patient.

- 1. Depressed mood or irritable most of the day**
2. Decreased interest or pleasure in most activities
- 3. >5% weight change or change in appetite**
- 4. Sleep disturbances**
- 5. Psychomotor agitation or retardation**
- 6. Fatigue**
- 7. Guilt or worthlessness**
8. Decreased concentration
- 9. Suicidality**

Psychosocial review

During his inpatient psychiatric stay, he reveals significant anxiety regarding his social situation. His age and medical conditions make ambulating difficult; he is often unable to walk the three miles to his methadone clinic. His immobility on many days leads to an inability to gather recyclables to provide for basic food or water. He wakes up at dawn generally due to sleeping in an alley, and his “associates” provide drugs to him for free, which he describes as a mental escape. Unfortunately, these “associates” are physically aggressive with him on a weekly basis, exacerbating his chronic pain.

He thinks that his depression and substance use have resulted in hearing voices and seeing oddities. He has tried haloperidol and olanzapine, but due to increased tremors and sluggishness respectively, had to stop. Currently, he states that he feels better on the escitalopram he has been taking in the hospital. When asked about his plans for the future, the patient tears up, stating that ideally he would function as a contributing member of society but is held back by his lack of skills and age. He has never been employed for long given his multiple incarcerations and long-standing homelessness. His main goal is to stop taking drugs, which he thinks may be accomplished by leaving his current situation on the streets.

How has your perception of this patient changed?

Empathic Approaches to Interview

1. Patient expressed significant anxiety reflected through tremulousness. This is a physical manifestation of his internalized conflict, likely exacerbated by his medical conditions (i.e. chronic substance use disorder).
 - In this case, a calm and spacious interview environment, where the patient was encouraged to participate together, allowed the patient’s external anxiety to calm down.
2. Patient with elements of restrictive emotion, dysphoria, and difficulty with coming up with concrete future plans. This patient has a generalized external locus of control given that many of his governing factors of lifestyle stem from external sources, e.g. his multiple incarcerations, the passing of his girlfriend, homelessness.
 - Actively involving the patient in his own care can help restore a sense of control in this patient, which would aid in reducing dysphoria.

3. Patient endorsed extraneous psychiatric symptoms (intermittent audio and visual hallucinations) and with transient suicidality. This patient has difficulty admitting to needing help, likely stemming from an ingrained expression of machismo learned from having to fend for himself.
 - Reassuring the patient that his problems are reasonable and educating him may provide a foundation for improved communication in the future.
4. Patient with poor initial trust in the medical system. This patient has difficulty building stable relationships, as manifested by his choosing of the word “associates” and general lack of social support. This may have roots in his upbringing, with a lack of stable parent figures.
 - These types of patients often respond well to positivity and affirmation. Delving into his prior parental relationships is more appropriate after a significant level of trust is attained in an outpatient setting.

Case 2

Learning objectives

1. DSM-V criteria for substance use disorders, and specifically cannabis use disorder
2. Recognize a variety of patient defense mechanisms. It is often much easier to identify with more mature or higher level defense mechanisms and coping mechanisms.
3. Know how the role of frequent provider follow up as an irreplaceable “placebo effect” and milieu effect to patients where pharmacotherapy and psychotherapy have failed.

Initial presentation

48 year-old Caucasian male veteran self-presents to the emergency department with complaint of continued vomiting, abdominal pain, and diarrhea. The patient has been hospitalized multiple times for cyclical vomiting syndrome and has received extensive GI workup over the past three years which has been unremarkable. Of note, his last urine toxicology screen from less than a week ago was positive for cannabis.

On interview, patient is retching loudly without any vomitus and clutching his stomach. After receiving intravenous ondansetron, hydromorphone, and saline, patient becomes much more amenable to discussion. He states that his cyclical vomiting is because of his involvement in the Gulf War, with worsening symptoms over a period of years. His first few episodes were manageable at home and lasted a day or so every half a year; in the last two years he has had protracted vomiting and diarrhea with severe 10/10 abdominal pain for multiple days every four to six weeks. He also endorses chronic lower back pain, intermittent paresthesias throughout his body, and headaches. The patient wants to be admitted so that he can receive his normal regimen of IV ondansetron, IV hydromorphone, and IV pantoprazole.

Mental status exam

Appearance: well-dressed male, appears stated age, sitting in gurney

Behavior: anxious, cooperative, appropriate; good eye contact

Motor: occasionally makes retching motions and sounds throughout conversation, no psychomotor agitation or retardation, no abnormal involuntary movements

Gait: normal

Speech: regular rate, rhythm, prosody

Mood: “okay”

Affect: anxious, restricted

Thought process: coherent, logical

Associations: linear

Thought content: perseverates on his vomiting and diarrhea (despite no episodes of diarrhea witnessed from patient presentation to admission to floor), no SI or HI

Perceptions: no abnormal perceptions, does not seem to be responding to internal stimuli

Insight / judgment: limited / fair

Sensorium / orientation / intellectual functions: Alert and oriented to person, place, time.

What are your first thoughts regarding this patient? Did the chart review and lab results influence your initial impressions?

Diagnostic criteria

-Cannabis use disorder per DSM-V is defined as satisfying 2 (mild), 4 (moderate), or 6 (severe) of the following symptoms:

1. Cannabis is often taken in larger amounts or over a longer period than was intended
2. Persistent desire or unsuccessful efforts to cut down or control cannabis use
3. A great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects
4. Strong desire or urge to use cannabis
5. Recurrent cannabis use resulting in a failure to fulfill major role obligations
6. Continued cannabis use despite persistent social or interpersonal problems caused or worsened by the effects
7. Important social, occupational, or recreational activities lost or reduced due to use
8. Recurrent use in situations in which it is physically hazardous
9. Continued cannabis use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by cannabis
10. Tolerance
11. Withdrawal, which is defined as
 - a. Cessation which has been heavy or prolonged
 - b. 3+ of following signs within a week of cessation: irritability, anxiety, sleep disturbances, decreased appetite, restlessness, depressed mood, physical discomfort
 - c. Functional impairment due to the above

-Somatic Symptom Disorder is defined as satisfying all of the following:

1. One or more somatic symptoms that cause distress or impairment
2. Excessive, persistent thoughts, anxiety, or time spent regarding the above somatic symptoms
3. Somatic symptoms (which may change) are present for 6+ months

Follow up and psychosocial review

You admit the patient to the medicine floor for continued management of symptoms with IV ondansetron, IV hydromorphone, and IV pantoprazole as he requests (and found in his previous chart history). He feels much better with these infusions. His pain is now down to a manageable level of 3/10 and he is just hoping that he can return home where he can manage without these infusions. He expresses frustration at the puzzling increase in his symptoms as of late. He cannot hold a job because of his frequent hospitalizations and though he has a place to stay, he is forced to be frugal with his limited disability funds. "I don't like taking medications, but I know when I have to come in because it just won't stop," he sighs. He does not want to seek additional psychiatric help for his pain and other symptoms because he feels that his PTSD-related symptoms are relatively well-controlled with medications alone.

When asked by one of your colleagues to provide a urine sample, the patient angrily refuses, stating that he is "being accused of doing drugs." He refuses to talk to your colleague again, citing other incidences where he has been insulted by staff in this particular hospital. When you approach him, he says, "Thank goodness you're here. Someone who actually listens to what I say. You're a good doctor." He follows up by explaining to you that he knows he will be

cannabis positive because he has been using cannabis oils on his feet for his paresthesias and joint pains. He denies smoking it and dismisses the possibility that he could be having cannabis-induced hyperemesis.

Have you encountered patients which treat you and your colleagues or the staff differently? How did you react to the patients / your peers?

Empathic Approaches to Interview

1. Patient is focused overwhelmingly on his constellation of symptoms, and the benefit he reports is much faster than the time to drug effect possible even for IV medications. The patient's symptoms likely have or have had a physical pathological cause, but the power of placebo for treating anxiety-related physical manifestations is very noticeable.
 - Validating the patient's symptoms and compromising with non-escalating doses of treatments helped to establish an alliance with the patient.
 - Purely giving placebo medications might be a working alternative (to avoid potential drug side effects), but this would be highly unethical. This patient would benefit from frequent outpatient follow-up with a primary care provider for examinations to re-assure his well-being.
2. The patient had multiple complaints against other unnamed doctors, including your colleague, but was very warm towards you. This is evidence of splitting behavior, an immature defense mechanism where an individual or act is viewed as all good or all bad.
 - Being split "positively" allows you to have a better patient-provider relationship. Wording therapies as concessions which align with the patient's beliefs can help strengthen this relationship (e.g. in this case, providing multiple anti-nausea medications "just in case").
 - Though it is appropriate to acknowledge the patient's frustration, it is inappropriate to fuel the fire by tacitly or overtly agreeing with patient's complaints about others. You should instead try to point out the underlying emotional state of both parties. This is important for the eventual resolution of splitting behavior, as the patient will have to realize that both he himself and others are capable of embodying both positive and negative traits.
 - An example of a standard approach to a patient: "It sounds like you are/were frustrated by that. In order to help us help you provide the care that would help you the best, I would like you to communicate your frustrations to us. In addition, though I do not anticipate this, at some point in your treatment you and I might have differing goals which could lead to frustration on your part. If such a situation were to arise, I ask that you be willing to approach me before it escalates."

Case 3

Learning objectives

1. DSM-V criteria for schizophrenia
2. Validation of patient concerns goes a long way towards furthering the patient-physician relationship
3. Recognize that psychotic patients have a fundamentally altered sense of reality which may be illogical to providers

Initial presentation

61 year-old Caucasian female self-presented to hospital with a chief complaint of “I need treatment to get all these bugs out of my body.” Patient was recently evaluated in the emergency department two days ago for a similar problem but left before evaluation. She has not been seen previously in this hospital.

On initial exam, patient is seen with visible excoriations and burn marks scattered over her face and bilateral wrists. She states that she has had a problem with insects infecting her body. She would like procedures or medications because her home remedies have failed in reducing her “bug burden.” This issue started about three years ago, when an assortment of ticks, beetles, worms, and more started to infest her skin and intestinal tract. She feels itchy all the time and sick. She has never been able to get any help from “professionals” but has been trying various home remedies. Most recently, she burned her face and wrists to extract bugs. She has also mixed bleach with milk and wine, which helped her vomit up “jars of bugs.”

Mental status exam

Appearance: thin white female, with multiple burn marks and excoriations of various age across face and anterior wrists; good eye contact

Behavior: anxious, cooperative, appropriate

Motor: repeatedly dabs face during conversation

Gait: normal

Speech: regular rate and rhythm

Mood: “fine”

Affect: anxious, restricted

Thought process: coherent, illogical

Associations: circumstantial

Thought content: continued delusions of multiple insects; incorrectly states parents have been in military for a long time and that she is only 32

Perceptions: active tactile hallucinations; no present audio or visual hallucinations; not responding to internal stimuli

Insight / judgment: poor / poor

Sensorium / orientation / intellectual functions: Alert and oriented to person, place, time.

Physical exam remarkable for skin findings as described in appearance.

Do physical manifestations of mental illness mean they are more pressing to treat, or are they merely more visible to the untrained observer? Based on her description of events, is the diagnosis clear to you?

Diagnostic criteria

-DSM-V criteria for delusional parasitosis; note that delusional parasitosis can be a primary manifestation or secondary to another psychiatric disorder

1. The presence of a delusion with a duration of one month or longer.
2. Primary criteria for schizophrenia has never been met. Hallucinations are generally non-prominent and are related to the delusion of being infected.
3. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.
4. If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.
5. The disturbance is not attributable to the physiological effects of a substance or another medical condition, and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

-DSM-V criteria for schizophrenia

1. The presence of two or more of the characteristic symptoms below are present for a significant portion of time during a one-month period (or less if successfully treated):
 - a. **Delusions**
 - b. **Hallucinations**
 - c. Disorganized speech
 - d. **Grossly disorganized** or catatonic behavior
 - e. Negative symptoms
2. **Significant barrier to functioning (compared with previous) in one or more major areas: work, interpersonal relations, or self-care**
3. **Continuous signs of the disturbance persist for at least six months. The six-month period must include at least one month of characteristic symptoms as above**
4. Schizoaffective disorder and mood disorder with psychotic features have been ruled out
5. Not due to a substance or medical condition

Psychosocial review

The patient is admitted to a psychiatric unit after her skin wounds are treated. There is no sign of infection and she is medically stable. On further interaction, she divulges that she has been unable to work for over two years due to her condition. She currently lives alone in a small apartment that “must be crawling with fleas [...] I think I’ve seen somebody bringing a dog around that has fleas.” When asked whether she knew this person, or whether she thought that this person or others were out to get her, she states, “No, stuff like that was in the past. I’m safe where I live now.”

She spends most of her days obsessed with various remedies on removing these bugs. She can only vaguely describe these bugs in shape and color. She lives alone in her apartment and has had very little contact outside of acquaintances at her women’s health clinic. She has shunned her prior coworkers for “accusing” her of hallucinating when she knows she has a very real infestation. Because of her lack of employment, she has been unable to put together the funds to find different housing. She also thinks her lack of funding is preventing her access to “the right medication” and “expert consultants.” She is restless all the time and cannot sleep well, and has a singular goal of being rid of her infestation.

What emotions were elicited after you listened to her story? Has it changed your perception of her?

Empathic Approaches to Interview

1. This patient's conversational topics tended to re-converge back onto her infestation at all times. This is likely a long-standing acquired obsession. Her perceptions of parasitosis have resulted in social alienation and unemployment. In her mind, fixing her physical manifestations of this issue is a logical step in recovering her functionality. At the point of intervention, this has become her only concern.
 - a. In this case, validating the patient's concerns, however preposterous they may be from a logical standpoint, helped to gain the patient's trust for continued therapeutic intervention.
2. In the initial interview, the patient repeatedly obsessed with scars on face and hands, picking at them. This, along with her multiple acts of self-treatment and restlessness at home, are physical manifestations of her frustration and anxiety towards her condition.
 - a. Providing adequate topical care in addition to a neutral interview environment reduced her anxious behavior in future encounters.
 - b. Education on what is appropriate self-therapy may prevent this patient from developing further traumatic skin injuries.
3. The patient had severely rigid beliefs, rejecting psychiatric help directly. She explicitly states that she knows she cannot be hallucinating despite contradictory evidence and lack of substantial descriptors on her end. This may be typical for many psychotic patients as part of their "poor insight." They often have a firm grasp on their altered sense of reality, which poses a barrier to their initial treatment.
 - a. Directly challenging the patient's belief system is unlikely to provide any substantial benefit and may alienate her. However, given her trust of "experts," framing her psychiatric disease in terms that are not "hallucinations" or "delusions" may eventually lead to a situation where a combination of trust and pharmacotherapy can result in gradual shifts in her perspective.

Information and Introduction: Goal Reconciliation

In the following cases, students will be instructed on methods to establish a common therapeutic alliance through awareness of the potential differences in patient and provider goals. By examining the priorities of both patient and provider goals in conjunction, it is possible to then restructure treatment plans agreeable to both parties. Given that most psychiatric treatment modalities require patient cooperation and buy-in, this would likely result in better long-term follow up and patient outcomes.

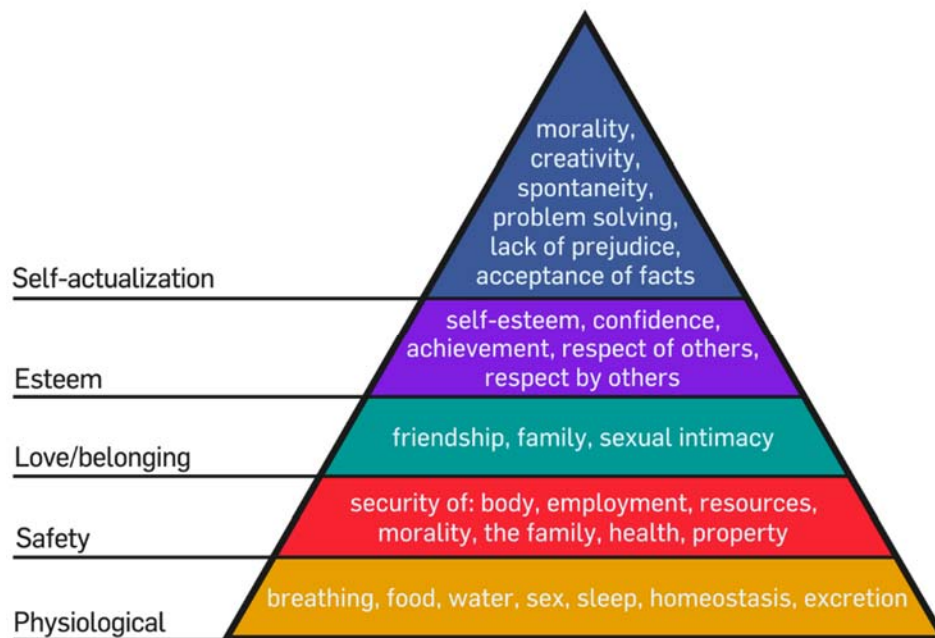
In medical school, students are taught primarily how to recognize, diagnose, and treat medical conditions. Combined with most medical students' predilections towards helping others, this largely leads to **rescue fantasy**, in which treatments are often pushed to "fix" the condition without other considerations. Besides, who wouldn't want to recover from their disease, or at least have symptomatic relief? Instead of discussing risks, benefits, and alternatives for treatment modalities as soon as possible, this writer encourages medical students to inquire about the unique individual goals of each patient.

In general, patients present to physicians largely of their own volition. By directly asking the patient about his or her agenda early in the encounter, students can then tailor the approach accordingly. For example, in the outpatient setting, it is often useful to preface the history and intake with overarching questions such as, "Is there anything in specific that you want to achieve during this visit?" In the case of patients with multiple goals, it may be helpful to follow up with, "What would you say your primary or most important objective is?" or "If you had to rank these goals in order of preference, where would you place each?" In the inpatient setting, especially for patients without clear goal-directed thinking or future orientation, one may have to be more creative in eliciting concrete goals. One could try asking in the following way, "If we had a magic wand and could fix any one problem right now, what would you want?"

Likewise, throughout the patient interview and interaction process, students learn to adjust their internal priorities for treatment goals. In general, this is in concordance to the acuity and severity of the underlying problem and balanced by prognostic factors and complications. One powerful tool to help convince patients to adhere to our provider priorities is **concessions**. By "giving in" to patient desires, especially ones that are relatively simple to accommodate, one can garner patient trust and buy-in.

A provider's professional knowledge allows for an accurate assessment of the plausibility of a patient's goals in the patient's psychosocial context. As a part of patient education, we should strive to counsel patients on the reality of the situation and reframe their improbable or impossible self-stated goals into more feasible gradations. At the same time, research has demonstrated that patients prefer physicians who are more optimistic and rate bearers of good news as more compassionate (<http://oncology.jamanetwork.com/article.aspx?articleid=2120917>). Thus, imparting appropriate hope for manageable, stepwise goals is likely to be most beneficial. Set up realistic probabilities framed between optimistic outcomes and the possibility of failure or therapeutic intolerance; offer encouragement and periodic reassessment as reassurance.

Maslow's Hierarchy of Needs can help organize overarching themes to the priorities of patient goals. Often represented as a pyramid, the basic premise is that needs or goals from each level must be largely satisfied before the next level can be considered. As the diagram below shows, these needs are in the order of: basic physiological needs, needs for short-term and long-term security, the need to feel a sense of belonging, the need for validation from self and others (esteem), and finally self-actualization. Achieving actualization as a topic is beyond the scope of this primer. Through this paradigm, we can also understand how physical medicine often aligns with patient goals, given that disruptions in physiological processes are at the base of the triangle. Similarly, it can be seen that for patients without reliable access to food or shelter, further social support (belonging in the third tier) or self-confidence (in the fourth tier) may not be feasible suggestions in the short term. Though the precise order of these needs will vary depending on personal circumstances, including ethnic, cultural, and societal factors, it useful as a basis to order priorities in patient aid.



Source: https://commons.wikimedia.org/wiki/File:Maslow's_Hierarchy_of_Needs.svg

Case 4

Learning Objectives

1. DSM-V criteria for PTSD
2. In the context of Maslow's Hierarchy of Needs, understand how basic needs often supersede medical and psychiatric management
3. A basic understanding of social work involvement in the care of psychiatric patients

Initial presentation

67 year-old homeless Caucasian male is brought in by an ambulance after being found down on the side of the street. Toxicology is positive for alcohol, opioids, and benzodiazepines. After being resuscitated and roused, the patient is somewhat surprised at his location, stating that he had hoped this would be his final escape.

Patient is a veteran of the Vietnam war with multiple previous hospitalizations for suicidal ideation in the context of polysubstance use (including alcohol with a history of delirium tremens), long-standing major depression, and PTSD. He was last discharged with escitalopram about six months ago but has not filled any refills because "what's the point?" Patient states that he has had worsening depressive mood symptoms for many years. He expresses frustration at the government, stating that his prolonged lack of income and shelter is a result of service related injuries and poor social skills due to his PTSD. He endorses drinking at least a handle of schnapps a day, which has gotten worse because he has recently started "hanging out with the wrong crowd."

Mental status exam

Appearance: cachectic male, appears older than stated age, poor eye contact

Behavior: calm, cooperative

Motor: faint tremor, mild asterixis appreciated

Gait: unable to evaluate

Speech: soft speech, poverty of speech

Mood: "depressed"

Affect: dysthymic, constricted

Thought process: coherent, illogical

Associations: linear

Thought content: endorses active suicidal ideation, no harmful ideation

Perceptions: no current abnormal perceptions. No command auditory hallucinations.

Insight / judgment: poor / poor

Sensorium / orientation / intellectual functions: somnolent but arousable, and oriented to person only.

What are your first thoughts regarding this patient? How does this compare with other suicidal patients?

Diagnostic criteria

-Diagnosis of Post-Traumatic Stress Disorder when all the following criteria are met for a duration of more than 1 month and are causing impairment of function:

1. **Exposure (whether directly experiencing or witnessing) to event(s) which include threat of death, violence, or other traumatic incidence**
2. At least one of the following disruptive symptoms associated with the aforementioned event which started after exposure:
 - a. **Recurrent, intrusive distressing memories of the event(s)**
 - b. Recurrent distressing dreams relating to the event(s)
 - c. **Flashbacks to the event(s)**
 - d. Intense distress when internal or external cues related to the inciting event(s) occur
 - e. Marked physiological reaction when internal or external cues related to the inciting event(s) occur
3. **Active avoidance of stimuli (e.g. thoughts, emotions, people, places) associated with the traumatic event(s)**
4. Worsened mood/cognition associated with the event(s), with two or more of the following:
 - a. Inability to recall key details of the event(s)
 - b. **Persistent, exaggerated negative outlook of self, others, world, etc.**
 - c. **Persistent, distorted cognitive association with the event(s) leading to blaming self or others**
 - d. **Persistent negative emotional state**
 - e. **Diminished interest in significant activities**
 - f. Feelings of detachment or estrangement
 - g. Persistent inability to experience positive emotions
5. Altered perceptions, arousal, or reactions associated with the event(s), with two or more of the following:
 - a. **Irritable behavior or anger outbursts**
 - b. Reckless behavior
 - c. Hypervigilance
 - d. Ease of startling
 - e. **Inability to concentrate**
 - f. **Sleep disturbance**
6. The above cannot be explained by another medical condition or substance effect

Psychosocial review

The patient is admitted to the hospital for control of alcohol withdrawal and possible delirium tremens. During his stay, he expresses gratitude towards the staff and physicians for being so helpful to him during each hospitalization. He laments his current situation, reiterating his feelings of worthlessness. He moved to California many years ago because his sister was in the area, but he cannot recall the last time he talked to her. In fact, he feels that he has no meaningful connections at all.

On his good days, he knows of a few organizations or churches which provide meals or shelter, but those are far and few between prolonged episodes of “drunken stupor.” Originally, he started

drinking to help him sleep through his nightmares, but with time it started to overtake his life. He has never been successful with Alcoholics Anonymous, admitting that group meetings are strongly anxiety-provoking for him. When asked about the patient's goals, he states that he really wants to be able to stop drinking and to not have to worry about where he can sleep safely at night.

How has your perception of this patient changed?

Goal Reconciliation

Physician goals: evaluate for suicidal ideation, management of potentially life-threatening withdrawal, alcohol and substance cessation

Patient goals: alcohol and substance cessation, housing, safety

After detoxification, the patient has intact insight, judgment, and capacity, though he has limited future direction. He is limited primarily by functional hierarchical needs, i.e. reliable access to food, clean water, and housing. Essentially, his chronic homelessness is his most significant barrier to reliable psychiatric and medical healthcare. His primary psychiatric complications are exacerbated by multiple substance use disorders; cessation and counseling would need to be co-managed with appropriate pharmacotherapy.

Ideally, the patient could be placed in a crisis home or temporary shelter for abstinence purposes (e.g. VVSD) whilst simultaneously resolving his shelter and safety issues. Involvement of social work or other peripheral services would have the most impact on this patient's outcome.

Case 5

Learning objectives

1. DSM-V criteria for anxiety disorders
2. Limitations of pharmacotherapy for chronic pain and how to tailor realistic expectations of patients
3. Treatment modalities for nociceptive versus neuropathic pain in brief

Initial presentation

56 year-old male is seen at an outpatient family medicine clinic regarding his persistent, severe lower back pain. He complains of constant 9/10 sharp, burning, electrical, and crushing pain starting in his lower back and radiating to his bilateral legs and worsened by any motion. He states that it started about ten years ago when he was working as a firefighter and fell off a ladder. Two years ago, he saw a surgeon for an L4/L5 discectomy, which paradoxically worsened his pain shortly after his recovery. Since that time, he has had to take increasingly larger doses of medications. He is currently taking carisoprodol (muscle relaxant) 350 mg bid, hydrocodone-acetaminophen 10-325 4/d, diazepam 10mg bid, gabapentin 100mg qhs, and temazepam 15mg qhs for his pain and anxiety. He is here to establish care because his previous providers have failed to provide him any relief. A CURES reports shows that he has had three providers in the past two years, though there is minimal overlap in prescription doses and dates.

He has associated weakness, numbness, and tingling of his lower extremities without changes in bowel or bladder. He also endorses depressed mood, difficulty with sleep, and difficulty concentrating. His pain affects his everyday activities of living, though he still remains independent. He is in agreement with a multi-modal therapeutic approach with psychotherapy and procedures and is willing to consolidate his medication therapy.

Mental status exam

Appearance: well-dressed male, appears stated age, sitting somewhat uncomfortably and crookedly

Behavior: anxious, cooperative, appropriate; good eye contact

Motor: no psychomotor agitation or retardation, no abnormal involuntary movements

Gait: uneven and favoring the left, slow

Speech: slow rate, regular rhythm and prosody

Mood: “my back hurts”

Affect: dysthymic, congruent

Thought process: coherent, logical

Associations: linear

Thought content: no suicidal or harmful ideation

Perceptions: no abnormal perceptions, does not seem to be responding to internal stimuli

Insight / judgment: fair / fair

Sensorium / orientation / intellectual functions: alert and oriented to person, place, time

What is your initial reaction to this patient’s medication regimen? If you have a suspicion that this patient may be “doctor shopping,” how does that affect your willingness to treat him?

Follow up and psychosocial review

The patient is evaluated in pain clinic and by a psychiatrist. Notes reveal that he has had a long history of social anxiety along with depressive and possible hypomanic episodes, likely stemming from a rough childhood and strained parental relationships. The patient expresses frustration with his current status, stating that his pain severely limits his physical functioning and worsens his anxiety. In the past, he used to enjoy surfing and hiking, but due to his chronic pain, he cannot pursue these activities. Most of his time is spent dealing with and worrying about whether he can make it through the day, and as a result he feels depressed.

He currently copes with his pain through guarding behaviors, asking for assistance, stretching, and self-motivation. He receives disability but states that he would very much like to return to volunteering or EMT work, which he enjoys. Ideally he would like to be 100% pain free. He acknowledges that anxiety is a large component of his problem and knows it must be addressed.

Knowing these events, how does that effect your treatment options?

Diagnostic criteria

Social Anxiety Disorder diagnosis:

1. Marked fear or anxiety regarding social situations where the patient is subject to scrutiny
2. Fear that actions will result in negative evaluations
3. Social situations almost always provoke fear or anxiety
4. Avoidance of social situations or endured with fear/anxiety
5. Fear or anxiety out of proportion to actual threat in context
6. Persistent fear/anxiety with duration >6 months.
7. Causing significant distress
8. Not better explained by substances, another mental disorder, or another medical condition

Reconciliation

Physician goals: increase patient functionality, decrease overall opioid and benzodiazepine use, treatment of concomitant psychiatric illnesses

Patient goals: zero pain, returning to work or volunteering, decrease anxiety

This patient exhibits great insight, judgement, and motivation in the context of positive and future-oriented thinking. He also appears to have a great deal of social support (despite strained parental relationships), which would aid in non-pharmacologic management. Unfortunately, the goal of being 100% pain free is unrealistic and needs to be restructured; the patient is educated on the reality of pain control, i.e. single agent pharmacotherapy can realistically result in at most 30% improvement of pain symptoms and that there will likely be residual pain even with multi-modal therapy. He is encouraged to re-evaluate what level of pain is acceptable for quality of life in light of balancing treatment side effects.

We can address his anxiety through pharmacotherapy, relaxation techniques, and psychotherapy (e.g. cognitive behavioral therapy). These same techniques can also be applied specifically for pain. He already exhibits many high level coping mechanisms, which would facilitate these processes. He would likely benefit strongly from physical therapy and additional exercise and active relaxation.

He is taught on the gate control theory of pain. This theory states that there is a gate between the peripheral nervous system, where nociception or other painful stimuli are perceived, and the central nervous system. In chronic pain states, this gate can be over-stimulated and thus open more often to result in increased pain perception. Conversely, it is also possible to close the gate with co-existing non-painful stimuli. He is instructed to keep a pain diary so that he can identify stressors and alleviators to his condition.

In terms of his pharmacotherapy, the most beneficial course of action is a slow taper of his benzodiazepines (for which he is on inappropriate dual therapy) and opioid therapy, given the prevalence of tolerance to both these medications. This would likely also improve his mental status, given that all of his medications lead to decreased mentation (note: for gabapentin, it is often reported that the decreased mentation lasts only for the initial duration of the therapy). For his anxiety, initiation of SSRI or SNRI therapy would be appropriate, with SNRIs have additional benefit of efficacy for neuropathic pain. For his pain, increasing his gabapentin dosage slowly would likely provide adjunctive benefit in the interim before procedures or relaxation techniques take their effect.

Case 6

Learning objectives

1. DSM-V criteria for cluster B personality traits (borderline, antisocial, histrionic, narcissistic)
2. Adjusting the degree of control or autonomy in the patient-physician relationship is often appropriate for patients without motivation, for those who display child-like qualities, or those with poor understanding / insight / judgment.
3. Offer concessions to patients which can be secondary or tertiary to your goals but may satisfy their larger self-goals.

Initial presentation

21 year-old Asian right-handed female is brought to emergency department by her friend after being found in her room with a self-inflicted left wrist laceration. Her wound is repaired by primary closure with four sutures in the emergency department and you are consulted to evaluate her. She has no past medical or psychiatric history.

On evaluation, she reports having struggled with ongoing wavering depressive mood due to poor self-image and lack of current meaningful relationships. She states that her friends and family seem to have unrealistically high expectations of her, which lead to anxiety, restlessness, and overall anhedonia. Leading up to her hospitalization, she states that her day was uneventful until she was suddenly gripped by thoughts of emptiness and hopelessness. She has had these thoughts before, usually about once a month around the time of her menstrual cycle, but has never acted upon them because she would “look ugly and terrible” while dying. She states that she has made threats of self-harm in the past but has never acted on them before.

When re-evaluated by your attending, she tells him, “I’m tired of repeating the same things. Can’t you just ask the others?” To him, she endorses ongoing academic pressure, as she has had difficulty with keeping good grades. She doesn’t feel as if she has anyone here or at her home in China where she can confide in her problems because nobody understands her. Currently, she denies active suicidal ideation, but states that she would be fine if she were to die right now.

Mental status exam

Appearance: well appearing female, in designer clothing and make up, appears stated age,

Behavior: cooperative and pleasant; minimal eye contact

Motor: no abnormal involuntary movements

Gait: normal

Speech: regular in the setting of having English as a second language

Mood: “bored”

Affect: constricted, mildly dysphoric

Thought process: coherent, logical, inconsistent at times

Associations: linear

Thought content: preoccupied with school work and repeatedly asks to stop interview so she can study. No suicidal or harmful ideation

Perceptions: no abnormal perceptions; not responding to internal stimuli

Insight/Judgment: fair / poor

Sensorium / orientation / intellectual functions: Alert and oriented to person, place, time.

What are your first impressions of this patient? If the wound did not require sutures or was otherwise highly superficial, would she qualify for a psychiatric hold?

Psychosocial review

The patient is admitted to a psychiatric unit on a hold. She is a current sophomore studying economics. She is studying economics because her parents, who reside abroad, instructed her to do so for her future. When questioned if she has any aspirations, she responds with, “Why are you like my parents? [...] I ... don’t know. Just to make money or something.” She reiterates that her parents have always exerted pressure on her, constantly comparing her to her classmates and pushing her to do better. She feels as if her parents do not love her at all. When asked if she was grateful to her parents for giving her the opportunity to study abroad and have luxuries such as her designer purse and convertible car, she avoids providing a direct answer. She instead laments that she cannot compare herself to the “many nerds” here in US, and she continues to hide her grades from her parents.

She states that she cannot relate to many of her friends here or back at home. Reflecting on her relationships, she thinks that many of them were just using her for her wealth. She reveals that she is easily annoyed and will not hesitate to tell anyone off directly. Although she has never actually hurt herself in the past, she endorses using verbal threats of self-harm to garner attention at home. She divulges an incidence in high school where she was being bullied and resorted to pulling out a knife, wildly exclaiming that she would kill everyone.

Throughout her stay, she repeatedly asks to be released early, because she does not want to miss her mid-term exam. After discussion, she does think that maybe psychiatric counseling would help but is hesitant to begin pharmacotherapy. She also repeatedly asks to leave to smoke but refuses nicotine replacement or cessation counseling. Although her mood was dysphoric on presentation, the patient denies any such feelings on repeat encounters.

How has her story affected your judgment of this patient? What kind of coping skills does this patient exhibit (or lack)?

Diagnostic criteria

-Pre-menstrual dysphoric disorder criteria by DSM-V with five or more total symptoms from below which must be present in the week prior to menses and resolving shortly after menses:

1. One or more of the following must be present:
 - a. **Mood swings or increased sensitivity to rejection**
 - b. **Anger or irritability**
 - c. **Sense of hopelessness or depressed mood**
 - d. **Tension or anxiety**
2. Total of five or more symptoms total including:
 - a. **Difficulty concentrating**
 - b. **Increase or decrease in appetite**
 - c. Anhedonia
 - d. **Fatigue**
 - e. **Feeling overwhelmed or out of control**
 - f. Breast tenderness, bloating, weight gain, joint or muscle aches
 - g. **Sleep disturbances**
3. Can be superimposed with another psychiatric disorder but cannot be purely an exacerbation of said disorder

-Borderline personality disorder criteria by DSM-V requires 5/9 of the following:

1. **Affective instability with reactive moods**
2. **Inappropriate anger or difficulty controlling anger**
3. **Impulsivity in at least 2 areas which are potentially self-damaging**
4. **Unstable relationships altering between extremes of idealization and devaluation**
5. **Feelings of emptiness**
6. Paranoia or dissociative symptoms
7. **Persistently unstable self-image or sense of self**
8. Abandonment fears
9. **Recurrent suicidal behavior, gestures, threats, or self-mutilation**

Goal Reconciliation

Physician goals: monitor patient for continued suicidal ideation, establish psychiatric follow up for patient (ideally with joint psychodynamic and pharmacotherapy), smoking cessation

Patient goals: to leave the hospital, to smoke, minimize pharmacotherapy

This patient, after her burst of impulsivity, demonstrates fair insight and judgment but lacked motivation or concrete future plans. Attempting to engage the patient via a traditional patient autonomy approach yielded minimal benefits. Given her psychosocial history and suspected personality disorder or traits, it is likely a more paternalistic approach can result in better alignment of physician and patient goals. To minimize conflict, adequate intermediate concessions can be offered. For example, starting the patient on a low dose anti-depressant and scheduling follow up with an outpatient psychiatrist being contingent on her could facilitate further treatment.

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