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Inside

In This Issue

This month's issue of the *Residents' Journal* features a section theme on geriatric psychiatry. The section begins with an article by Brian E. McKinney, M.D., on psychiatrists' role in collaborative and integrated care models, particularly with regard to geriatric populations. Kristina Zdanys, M.D., provides a review of globus in the elderly. Tamela D. McClam, M.D., presents a case report of dementia with associated behavioral disturbances in an elderly patient. Last, Kristopher Keith Klem, B.A., and David Chih-dah Hsu, M.D., present a case report of a serious suicide attempt in a 75-year-old woman.

Editorial

From Strength to Strength

Arshya Vahabzadeh, M.D.
Editor-In-Chief

The new academic year brings with it a time to explore new opportunities, tackle fresh challenges, and reflect on past achievements.

This year I begin my fellowship in child and adolescent psychiatry at Massachusetts General Hospital/McLean/Harvard. I am particularly interested in the diagnosis and treatment of autism spectrum disorder, with a focus on social cognition, psychopharmacology, and public education.

As of this month, I am also the Editor-in-Chief of the *American Journal of Psychiatry Residents' Journal*, the largest and most robust resident-led journal in the house of medicine. In keeping with the theme of transitions, I am pleased to welcome our new editorial team.

Misty Richards, M.D., M.S., a resident psychiatrist at UCLA, will be joining our team as Deputy Editor. She has previously received a Fulbright scholarship in medicine, has served on several editorial boards, and discovered her passion for writing while spending time as a research fellow at the National Institute of Mental Health. She plans to pursue a career in child and adolescent psychiatry.

David Hsu, M.D., a fellow in geriatric psychiatry at the Massachusetts General Hospital/McLean/Harvard program, will join the team as Associate Editor. He has a passion for the medical-psychiatric interface and geriatrics, as well as the philosophy and history of psychiatry. Dr. Hsu is also a trained internist, so he is especially interested in the literature on integrated care.

The *Residents' Journal* continues to flourish; every year, the quality and number of the manuscripts we receive continue to increase. We are privileged at the Journal to have the support of both the editorial and administrative staff of the *American Journal of Psychiatry*, who continue to do a phenomenal job of keeping the Journal on track.

Whether you are a seasoned resident or an intern looking to become involved, we would like to see your submissions and your feedback about the Journal. Your contributions, thoughts, and suggestions have been essential for our continuing success.

Beyond Collaboration: The Psychiatrist and the Medical Home

Brian E. McKinney, M.D.

The disparities in health care outcomes for patients with psychiatric disorders have been well documented, including a two- to three-fold increased risk of cardiovascular death and increased risk of developing metabolic syndrome, diabetes, hypertension, and hyperlipidemia (1). This should be especially concerning in geriatric patients who are already more likely to have a greater number of medical problems associated with advancing age (2–4). These patients frequently have high health care utilization in the form of emergency department visits and hospitalizations, and health care inequalities abound even more for older adults with mental illness, such as inferior medical care and a 19% increase in 1-year postmyocardial infarction mortality, compared with older adults without mental illness (2, 5). In an era in which cost-effective allocation of resources has become an important part of medical ethics and the Affordable Care Act has begun to incentivize outcome-based health care (6), various collaborative and integrative models have been proposed to bring mental health care into the medical home and to focus on patients who are most at risk for inadequate care, high utilization, and poor outcomes.

Hypothetical Case

To begin, let us look at a hypothetical case that highlights a common clinical scenario germane to this discussion.

A man in his late 60s with poorly controlled hypertension, type 2 diabetes, and hyperlipidemia begins presenting to his primary care provider with concerns that "something isn't right." The patient, whose chronic medical problems had previously been under good control, begins to come to the clinic three to four times a month with complaints of fatigue, vague body pains, and gastrointestinal symptoms that change weekly, as well as low mood. Cognitive testing performed in the clinic shows normal results, and a thorough medical work-up reveals no direct cause for the patient's symptoms. The patient's frequent visits continue, and he begins to appear more depressed. He is eventually started on an antidepressant but discontinues after 1 week because of side effects that he is unable to characterize. Other medication trials are attempted with similar results. The patient is resistant to the idea that he has a "mental disorder" and believes that his depression must be caused by some underlying undiagnosed medical problem.

Mental Health and Primary Care

In the traditional consult-liaison model of mental health care, the above patient would likely be referred at this point to a psychiatrist for further care. This traditional model, however, has had a number of inherent problems, including long waiting periods to establish care, minimal communication with the primary care provider who follows the patient most frequently, and increased stigma of mental illness and obtaining mental health treatment outside of the primary care setting (7, 8). To address the limitations of the traditional consult-liaison model, a continuum of alternative models have been suggested, spanning from offsite, mostly consultative models within a medical neighborhood to more intricate networks of collaborative and integrated care at the primary care level (9).

One model developed specifically for treatment of depression in older adults is the collaborative care model seen in the IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) trial (10–12). In IMPACT, older adult patients (age ≥60) received either usual primary care or the intervention protocol in which a co-located nurse or psychologist (known as a "depression care manager") interviewed patients, oversaw follow-up, and provided brief psychotherapy when indicated (10, 11). These care managers also worked under weekly supervision of a psychiatrist to discuss new recommendations for the primary care provider. Specialist referral could occur within the model's three-step algorithm if the patient did not respond after the first 3 to 5 months. The results were significant, showing that older adult patients in the intervention group were more than twice as likely as patients in usual care to have sustained treatment response (45% compared with 19%) and were three times as likely to have complete remission of depressive symptoms at 12 months (25% compared with 8.3%) (11).

Other studies have examined similar collaborative care models. The PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) study demonstrated improved outcomes with the use of care managers to help identify geriatric patients with depression and to offer evidence-based treatment recommendations (13). Patients in the intervention condition, compared with those in usual care, showed not only improvement in depressive symptoms but also had greater and more rapid declines in suicidal ideation, with resolution rates of 71% (compared with 44%) at 8 months (13). Another collaborative model, by Dietrich et al. (14), included care managers whose role was primarily to monitor treatment response in depressed patients through the use of monthly and as-needed telephone interviews. A supervising psychiatrist could then communicate any new recommendations through the care manager to the primary care provider. This model revealed a smaller effect size than that found in either IMPACT or PROSPECT—remission rates of 37% in the treatment arm compared with 27% with usual care at 6 months—possibly related to a lower level of fidelity within the collaborative model (14, 15). Its lower complexity, however, suggested a more sustainable model outside of research funding and oversight.

Although primarily used to target depressive symptoms, collaborative care models have also been used to improve management of dementia, as well as chronic medical illness. A collaborative care model implemented by Katon et al. (4) showed significant decreases in low-density lipo-

protein levels, glycated hemoglobin levels, and systolic blood pressures at 12-months in patients with depression and diabetes, coronary heart disease, or both. In a study conducted by Callahan et al. (16), collaborative care teams significantly reduced behavioral and psychological symptoms in patients with dementia without increased use of antipsychotics while also reducing caregivers' depressive symptoms. The teams included the patients' primary care providers and an advanced practiced nurse, who provided patient-caregiver training, monitored treatment progress by telephone, and communicated recommendations to primary care providers in weekly meetings with an oversight team of a geriatrician, geriatric psychiatrist, and psychologist. This need for a greater collaborative network in the Callahan et al. model likely reflected the more complex physical and mental health needs of the targeted patients with dementia.

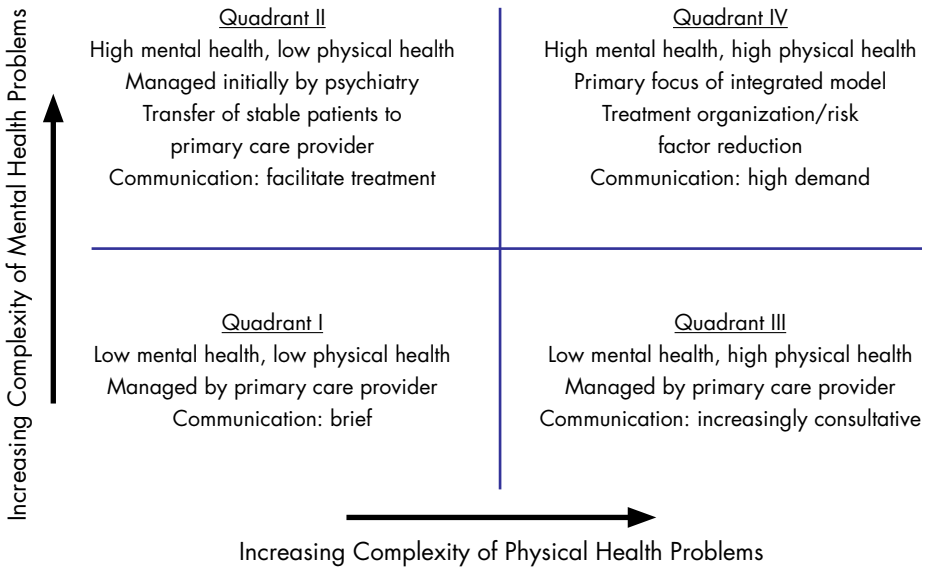
Integration and the Four Quadrant Model

Outside of collaborative care models, another model gaining attention in the medical literature is the integrated care model, in which psychiatric care and primary care are co-located and functionally united (3, 7, 9, 17). In an earlier study by Druss et al. (17), an integrated model in a Veterans Affairs mental health clinic with co-located primary care providers demonstrated a greater than 50% reduction in emergency department visits for medical services over 1 year among patients in the intervention arm. Patients were also more likely to attend follow-up appointments with their primary care providers and receive recommended preventative health measures. The PRISM-E (Primary Care Research in Substance Abuse and Mental Health for the Elderly) trial also examined clinical integration, comparing it with traditional consult-liaison models (3). The study, however, frequently used mental health providers other than psychiatrists within the medical home, which may explain its findings that more severely depressed geriatric patients benefited more from specialist consultation than from colocation services. Like the Callahan study, PRISM-E suggested that patients with more complicated health problems benefit from more specialized care. Placement of an additional provider within the medical home, however, understandably brings additional questions regarding how to best allocate this specialized resource. In addressing this concern, a key concept known as the four quadrant model can be applied to integrated care models to understand expectations for patient management and provider communication (2, 9, 18).

In the four quadrant model, patients are categorized by their complexity of mental and physical health problems (Figure 1). In quadrant I (low mental health, low physical health), patients are managed by their primary care providers, with limited communication with an integrated psychiatrist. In quadrant II (high mental health, low physical health), the psychiatrist initially serves as the primary provider. The goal, however, is to eventually transfer appropriately stable patients to the primary care provider, with an expectation of increased need for communication between providers. Quadrant III (low mental health, high physical health) is primarily managed by the primary care provider, but now the psychiatrist may serve a more consultative role (9, 18). This is also the quadrant likely addressed by many collaborative care models, in which case managers are integrated into the medical home.

The bulk of the integrated model, then, focuses on quadrant IV (high mental health, high physical health), which frequently includes geriatric patients with complex physical and mental illnesses (2, 18). The patient in the above vignette can help further illustrate this category of care. First, his diagnosis remains unclear, and a thorough psychiatric evaluation may require additional laboratory tests or imaging, making direct communication with the primary care provider beneficial. Regarding physical complexity, the patient has already shown destabilization of multiple comorbid health problems. Using the four quadrant model, an integrated care model would facilitate a high degree of communication between providers, allowing for optimization of chronic disease management while synchronously addressing mental health concerns. Finally, psychiatric care would be accessible within the patient's medical home, improving continuity of care and helping to alleviate the patient's own expressed stigma concerning mental illness.

Figure 1. Adaptation of the Four Quadrant Model to Integrated Psychiatric Care[a]



[a] Graphical representation of the Four Quadrant Model as adapted for specifically integrating psychiatric care into the medical home model (9, 18)

Conclusions

Whether through collaborative or integrated care models, a growing amount of evidence shows that bringing mental health care to the medical home improves outcomes in both mental health and chronic disease management. While collaborative care models have shown success in treating depression and other chronic medical problems, integrated care models provide psychiatrists with a unique opportunity to work alongside primary care providers in managing patients with highly complex physical and mental health problems. For geriatric patients, both models suggest solutions for individuals who are already at increased risk of comorbid illness, inadequate care, and poor outcomes.

Dr. McKinney is a second-year resident at the Naval Medical Center San Diego. He is also an active-duty Lieutenant in the United States Navy.

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The views expressed in this article are solely those of the author and do not necessarily reflect the official policy or position of the U.S. Government, Department of the Navy, or Department of Defense.

For further information on psychiatrists' roles in medical homes and integrated/collaborative care models, see the recently published essay by Shim et al. in Psychiatric Services.

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Globus in the Elderly

Kristina Zdanys, M.D.

"Globus" is the subjective sensation of a lump in one's throat without any apparent medical cause. Historically, globus was known as "globus hystericus." Descriptions of a disorder similar to globus date back to Hippocrates, who wrote that the movement of the womb in a woman's body was the cause of many somatic symptoms, including suffocation and choking (1). Plato wrote that a woman's womb that has not borne children may suffocate her because it is "discontented and angry" (1).

Psychoanalytically, globus has been considered to be a manifestation of repressed, prohibited fantasies, including oral sex and coprophagia (2). Diagnostic criteria for globus include persistent or intermittent sensation of a lump in the throat, occurrence of the sensation between meals, absence of dysphagia or odynophagia, absence of evidence that the symptom is attributable to gastroesophageal reflux, and absence of histopathology-based esophageal motility disorders (3). The onset of symptoms must be greater than 6 months before the time of diagnosis, and the patient must have met criteria for the 3 months prior to diagnosis (3). In the elderly, investigation and diagnosis of globus may be complicated because dysphagia is a common symptom of many age-related diseases, and presenting complaints may be similar. The purpose of the present review is to describe the symptoms, work-up, and differential diagnosis of globus in the elderly in order to provide appropriate treatment.

Presenting Symptoms

Patients experiencing globus may describe this symptom in a variety of ways. Although traditionally considered to feel like a lump in the throat, patients may describe an inability to swallow; a choking sensation; a foreign body stuck in the throat; throat tightness, burning, or irritation; or "insects moving inside the throat" (4). The sensation is more frequently experienced between meals and rarely while eating (4).

Epidemiology

Although globus historically was thought to be a symptom seen only among young women, it has now been demonstrated to affect both genders and all ages. Thompson and Heaton (5) estimated that 45% of the healthy adult population has experienced the feeling of a lump in the throat at least once. Moloy and Charter (6) found that of 4,330 patients presenting to an otolaryngology clinic for their first evaluation, 4.1% reported globus symptoms as a chief complaint, and these findings were similar to those of another study in which 3% of patients seen in an otolaryngology clinic were evaluated for globus (4). Globus has been demonstrated to affect women under age 50 as much as three times more often than men under age 50. This distinction no longer holds true for patients over age 50, among whom globus affects as many men as women, although this appears to be related to a decrease in the number of women reporting globus as opposed to an increase in the number of men with the symptoms (6).

Evaluation

There are no standard recommendations for the evaluation of globus. Early literature suggested that barium swallow was a necessary radiologic assessment for all patients who present with globus (4). Although many physicians seek a barium swallow study as a first step in evaluation, a study conducted by Hajioff and Lowe (7) found that among 2,011 patients with globus evaluated by barium swallow, there were no major radiological abnormalities, and the authors estimated that no more than one in 700 patients with globus may have a serious lesion. Protective factors that would lower suspicion of mass lesion include female gender, <40 years old, and no history of tobacco or alcohol misuse (7). Weighed against the risks of barium swallow, which include death, Hajioff and Lowe recommended only performing barium swallow in patients for whom there are atypical features, such as pain or true dysphagia.

Beyond barium swallow, there are several other types of otolaryngological examinations that may be useful in the evaluation of globus. Moser et al. (8) suggested that if the patient's history and otolaryngological examination are inconclusive, the otolaryngologist may perform radiologic, manometric, and video cinematographic motility evaluations in addition to pH monitoring of possible reflux (8).

Psychiatric Classification

The psychiatric classification of globus is a source of debate. Initially classified as a symptom of hysteria, globus is now widely considered to be a symptom of conversion disorder (9). Globus meets criteria for conversion disorder as defined by DSM-IV-TR: the symptom affects voluntary motor function suggestive of a neurologic condition; the symptom is frequently preceded by a stressor; the symptom is not intentionally produced; the symptom is not attributable to a general medical condition, cultural behavior, or effects of a substance; the symptom causes clinically significant distress; and the symptom is not limited to pain, sexual dysfunction, or during the course of somatization disorder (10). There is debate regarding whether globus meets the final criterion of conversion disorder, namely, whether the symptom may be attributable to another mental disorder. Additionally, although research indicates that globus often is preceded by a stressor (2, 11, 12), this may not be true in all cases (2). Of note, in DSM-5, conversion disorder has been renamed conversion disorder (functional neurological symptom disorder) and has been modified to emphasize the importance of the neurological examination and de-emphasize the necessity for a psychological stressor at the time of diagnosis (13).

Of the population who reported a history of globus in the Thompson and Heaton study (5), 95.5% indicated that the sensation was associated with a strong

emotion. Globus has been associated with depressive symptoms in a number of investigations. A 1992 study of patients who presented to an otolaryngology clinic found that patients of both genders with globus were significantly more likely to be depressed than clinic patients without globus (11). A study of male veterans experiencing globus found an association between globus and depression, as well as somatization disorder (14). Another study of over 1,000 middle-aged women approached on the street found that those who reported globus also had higher levels of "psychological distress" as manifested by anxiety, depression, and somatic concerns (15).

There is also evidence that globus may be related to underlying personality structure and not "hysterical" personality. Lehtinen and Puhakka (2) found a higher incidence of neurotic, especially obsessional personality features, in patients with globus, particularly among females (2). Similarly, other studies have found that female patients who reported globus had significantly higher scores of neuroticism and introversion on measures of personality in otolaryngology clinics (16) and in street surveys (15).

Differential Diagnosis

It is important to consider the multiple medical causes of dysphagia during the work-up of globus, since many diseases affecting the elderly may contribute to this sensation. Areas of consideration include neurologic etiologies (dementia, Parkinson's disease, stroke, Huntington's disease, traumatic brain injury, myasthenia gravis, Guillain-Barré syndrome, and myopathy), rheumatologic etiologies (progressive systemic sclerosis, polydermatomyositis, Sjögren's syndrome), tumor, chemotherapy, and radiation therapy (17). Thyroiditis and gastric reflux may also contribute to a globus sensation (6).

The elderly are also susceptible to medication side effects that affect swallowing. For example, anticholinergic and antihistaminergic effects of many medications may contribute to dry mouth, which can in turn affect swallow function. In reviewing medications, it is important to note all medications that potentially cause dry mouth, including many antihypertensives, antiarrhythmics, analgesics, antispasmodics, diuretics, antineoplastics, antiulcer treatments, cough and cold medicines, and particularly psychotropics (antidepressants, especially tricyclics, antipsychotics, and some mood stabilizers) (18).

Age-related changes in swallowing function may also contribute to dysphagia, including a slowing of the swallowing process (17), and thus even if no overt etiology of dysphagia is determined, there may be a physiological explanation for subjective difficulty in swallowing.

Treatment

As with any psychiatric symptom, identified medical abnormalities should be treated first in patients who present with globus. Differences in the approach to psychiatric treatment of globus reflect differences in opinion regarding underlying etiology. Among those who view globus as a symptom of conversion disorder, recommended treatments include reassurance and psychotherapy, although no one particular form of psychotherapy has been found to be the most effective (9). Among those who view globus as a manifestation of depression, antidepressants and ECT have been recommended (19). Data are limited regarding the best choice of antidepressants, although benefits of tricyclic antidepressants and monoamine oxidase inhibitors have been reported (19, 20).

Conclusions

Globus is a symptom that has been documented for thousands of years and is found among patients of all ages and both genders. In the elderly, globus is equally common among men and women and can be difficult to diagnose given the wide differential diagnosis of swallowing disorders in this population. Within the psychiatric differential diagnosis, there is debate as to whether to classify globus as a symptom of conversion disorder, anxiety and depression, or neurotic personality. It is possible that globus may be a symptom of each of these and should be considered in the context of other symptoms to narrow psychiatric diagnosis. There is no standard work-up for globus, although depending on the patient's risk factors, an otolaryngological evaluation may be appropriate. Once medical etiologies of globus have been ruled out, psychiatric treatment approaches may include reassurance, psychotherapy, antidepressant treatment, and ECT, depending on the patient's other symptoms.

Dr. Zdanys is a fifth-year geriatric psychiatry fellow in the Department of Psychiatry, Yale University School of Medicine, New Haven, Conn.

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Case Report

Interdisciplinary Treatment of Dementia With Associated Behavioral Disturbances

Tamela D. McClam, M.D.

Alzheimer's disease is the most common cause of dementia in the United States (1). Advancing age is the primary risk factor (1), and given the anticipated population increase of those 65 years of age or older, an estimated 14 million Americans will meet diagnostic criteria by 2050 (2). The National Institute of Aging defines dementia associated with Alzheimer's disease as a progressive decline in at least two cognitive areas that is a decline from baseline functioning such that it interferes with daily living (3). Frequently co-occurring with dementia are neuropsychiatric symptoms, such as apathy, psychosis, mood symptoms, agitation, and aggression (4). These symptoms are prevalent in approximately 60% of dementia patients, with varying etiologies, including delirium and progression of dementing disease (4). Given the shortage of clinicians specializing in treating all aspects of dementia care, the majority of patients must rely on their primary provider for diagnosis and treatment (5, 6). Hinton et al. (7) interviewed 40 physicians about the difficulty of treating dementia in primary care. Areas of concern included limited access to dementia specialists and community social services, limited time for appointments, limited or no training in treating neuropsychiatric symptoms, and difficulty coordinating longitudinal care with specialists (5, 7).

In *Practical Dementia Care,* Rabins et al. (8) established a dementia treatment plan based upon four treatment "pillars": treat the disease, treat the symptoms, support the patient, and support the caregiver. The following case describes an interdisciplinary approach to treating patients with dementia based upon these pillars.

Case

"Mrs. E" is a 76-year-old Caucasian woman with a 6-year history of dementia, who was admitted to the dementia unit because of a 2-week history of an acute change in behavior. The patient lives with her daughter, who is her primary caregiver. For the past 2 weeks, the patient experienced significant insomnia, exhibited a decline in functioning, and no longer performed her baseline functions, including basic personal hygiene and taking daily walks. Her daughter was extremely distressed by her aggressive behavior. She was easily agitated and refused assistance with personal hygiene by yelling, kicking, and striking when others approached. On admission, her daughter inquired about long-term placement because of her acute change in behavior; the daughter did not believe that she could provide adequate care at home.

Once admitted, Mrs. E was assigned to an interdisciplinary treatment team consisting of a geriatrician and geriatric nurse practitioner, a geriatric psychiatrist, an occupational therapist, a physical therapist, and a social worker. The interdisciplinary team met twice a week to discuss the patient's progress and treatment goals. On medical evaluation, she was diagnosed with acute cystitis and started on antibiotic treatment. To manage her behavior, she was started on a low-dose selective serotonin reuptake inhibitor (SSRI) with an antipsychotic as needed for aggression. Her functional abilities were assessed by an occupational therapist, and activities that she could safely perform independently were established. With physical therapy, she started a daily exercise routine, focusing on improving gait. During the patient's hospitalization, her daughter attended psychoeducation classes recommended by the team social worker, who also provided the daughter with information on community resources. On the day of the patient's discharge, her behavior improved, and she no longer required antipsychotic medication (as needed). Her cystitis was successfully treated, and she was adequately tending to personal hygiene and walking independently. Because her behavior had returned to what it was at baseline, her daughter felt comfortable taking her back home. The treatment team discussed their findings with the daughter and provided recommendations for outpatient treatment.

Discussion

Providing adequate care for patients with dementia involves treating the patient and frequently assessing the well-being of the caregiver. In the above case, the patient presented with an acute behavior change and a delirium that was most likely a result of untreated cystitis. The treatment plan based upon the above pillars involved treating the patient's infection and associated symptoms. As her acute symptoms improved, she accepted and actively engaged in the nonpharmacological treatments. Lastly, the patient's primary caretaker received support and reassurance; she felt comfortable having the patient return to the home.

Recognizing and treating psychosocial symptoms in the caregiver is associated with better outcomes for the patient. A study assessing caregiver well-being found that both depression and burden in caregivers were associated with increased neuropsychiatric symptoms and aggression in those with dementia (9). Poorly managed neuropsychiatric symptoms in dementia patients are frequent causes of caregiver distress, leading to frequent hospitalizations, increased financial costs, and earlier placement in long-term care facilities (10).

Various studies assessing the effect of interdisciplinary treatment for dementia care have shown positive results. A quality of care study found improvements after primary care physicians implemented dementia-specific interventions into routine practice, including increased referrals

to Alzheimer's Association chapters (11). In a randomized trial, patients in a collaborative care plan for dementia treatment reported fewer neuropsychiatric symptoms compared with patients receiving augmented routine dementia care (12). In both studies, the interventions occurred over a predefined time period. Longer trials comparing intervention outcomes are needed to determine the long-term outcomes of interdisciplinary care models.

Conclusions

The interdisciplinary treatment team approach for treating dementia is the optimal treatment plan for patients with dementia. While ideal, this model of treatment is not feasible in many locations. Barriers to establishing interdisciplinary teams include limited dementia care specialists, limited finances, and lack of community resources. A practical solution, as mentioned above, is educating primary care providers about dementia treatment, caregiver support, and available community resources. Ultimately, more providers comfortable with dementia care are needed, given the anticipated increase in both incidence and prevalence of this disease.

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Case Report

A Serious Suicide Attempt in An Elderly Woman

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Suicide among the elderly differs in many ways from suicide in younger individuals (1). The elderly generally attempt suicide with much higher lethality than younger persons, and the ratio of completed and attempted suicides increases substantially with age (2, 3). Elderly patients are also less likely to discuss plans of suicide beforehand (4). Retirement, loss of a loved one, and increased burden of disability are all risk factors for suicide, and all of these stressors are disproportionately present among geriatric patients (5, 6). Despite these worrisome statistics, geriatric suicide receives less attention in the medical literature and the news media than suicide in younger adults (7). In almost all countries, elderly men have the highest rates of suicide, and white men over 85 years old are at highest risk. The rate of suicide and the lethality of suicide attempts both decrease after age 60 in women (8). We report the case of a suicide attempt of unusually high lethality in an elderly female patient.

Case

"Ms. A" is a 75-year-old Caucasian woman who was found unresponsive in her bathtub with a severe neck laceration and an empty bottle of methadone. Examination of the patient revealed a Glasgow Coma Scale score of 3 and hypotension. After intubation, she was taken by ambulance to a nearby emergency department. Her ECG revealed marked bradycardia and a prolonged QTc interval. On physical examination, her pupils were noted to be pinpoint and unreactive to light. The patient was given naloxone but had only moderate improvement in her vital signs, and she remained obtunded. Her toxicology screen was notable for elevated acetaminophen, opiate, and benzodiazepine levels. Emergent surgical repair of the neck laceration was performed, and psychiatry was consulted following medical stabilization.

On examination, the patient looked younger than her stated age. Her speech was hoarse, soft, and slow, as she explained that she was "in the lobby of a hotel." Her affect was despondent and at times nearly flat. She was unable to cogently explain why she was in the hospital. Her delirium persisted for over a week, and after it cleared, she was largely dismissive of any attempt to elicit a psychiatric history. It took 2 weeks for her to acknowledge her suicide attempt and longer still for her to divulge a history of depression.

Several friends came to visit Ms. A. They relayed that in her youth she was an accomplished athlete and scholar. However, severe back pain had restricted her ability to participate in her favorite recreational pastimes. She was taking a number of narcotic medications for pain relief and had recently undergone an unsuccessful laminectomy. Her friends noticed that she had become progressively withdrawn, and her attendance at her usual social gatherings had waned. Her closest friend had become concerned after she stopped answering her telephone. It was later learned that the patient was seeing a therapist. Both the friend and the therapist foresaw that a suicide attempt was probable.

Discussion

While a number of factors portended a risk of suicide in our patient, several findings are distinctive in this case. First, the method and lethality of the suicide attempt were striking, particularly given the gender of the patient. It has been well established that men, particularly elderly men, have higher rates of completed suicides and suicide attempts by more lethal means than women. Second, the age of the patient in the above case is uncharacteristic. In the United States, the suicide rate among women peaks in the 40s and 50s and declines afterward. Furthermore, women between the ages of 50 and 69 are more likely to attempt suicide by lethal means than women over age 70 (8). Less clear is the association between the level of educational and financial attainment and suicide risk among the elderly. While it has been shown that suicide attempts in patients over age 70 are associated with lower education levels, data for elderly individuals with high levels of education are lacking (9). Although our patient had begun to withdraw from her social support network prior to her attempt, her level of involvement in social and volunteer activities would be considered a protective factor against suicide. Geriatric persons who attempt suicide often have constricted social networks (10).

Although the demographic characteristics and lethality of the suicide attempt in this case were somewhat unusual, it was instructive for the psychiatry team to reflect on the characteristics of this patient for which predictive models held true. Notably, the patient was widowed and did not have any children, both of which are associated with increased suicide risk. The loss of autonomy from chronic pain was particularly devastating to this patient, since she was accustomed to a high level of functioning. Polypharmacy and opioid dependence are known suicide risk factors and may have contributed to impulsivity in this case. Perhaps most importantly, progressive social withdrawal was evident weeks before the attempt. Many in the patient's social network admitted that they had dismissed these warning signs and commented that the patient's age and well-groomed outward appearance quickly supplanted any thought that she would actually harm herself. Debriefing with the surgical team revealed a similar sentiment, and for many, the patient brought up memories of their own loved ones and feelings of disbelief. Members of the psychiatry team were not immune to this tendency, underscoring the inherent difficulty in predicting suicide in this population.

Because of these challenges, we recommend performing a thorough suicide risk assessment, obtaining detailed collateral

information, and having a low threshold for inpatient hospitalization for geriatric patients contemplating suicide.

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The Standard of Care in Suicide Risk Assessment: A Review for Psychiatry Residents

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Suicide is one of the most frequent emergencies encountered by mental health professionals. According to the Centers for Disease Control and Prevention, in 2009, suicide was ranked as the tenth leading cause of death in the United States, accounting for over 36,000 deaths (1). Thus, it comes as no surprise that according to the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology, the assessment and management of suicide risk is a core competency for psychiatrists (2). The present article provides a review of the standard of care and the necessary components in completing an adequate suicide risk assessment.

Standard of Care

The standard of care used to review the behavior of psychiatrists in malpractice litigation is a reflection of the law's expectations in professional practice (3). Each state defines the legal criteria for determining the standard of care required of physicians (4). The laws articulating the standard of care range from the standard of customary practice to the standard of the "reasonable, prudent psychiatrist" (3, 5). The 1976 California case *Landeros v. Flood* determined that "a physician is required to exercise, in both diagnosis and treatment, that reasonable degree of knowledge and skill which is ordinarily possessed and exercised by other members of his profession in similar circumstances" (6). In the suicide case of *Stepakoff v. Kantar* (1985), the court applied the customary practice standard and determined the standard to be "the duty to exercise that degree of skill and care ordinarily employed in similar circumstances by other psychiatrists" (4). The customary practice standard has been the most frequent legal standard employed by the states in malpractice cases. This legal standard permits psychiatrists to set the standard of care without legal intrusion. However, an increasing number of states are rejecting the standard of customary practice. These states are adopting the "reasonable, prudent psychiatrist" standard that calls for a critical examination of customary practices by the profession and the courts (3, 7). Under the latter standard, courts have imposed their own standards onto the medical profession (8).

The legal standard must not be confused with professional "best practice" (7). The legal standard does not require the psychiatrist to provide "perfect care." Legal standards are set at the acceptable minimum level of care that adequately addresses a patient's clinical needs. Unlike legal standards, professional "best practice" strives for "optimum" treatment through evidence-based medicine and research findings (7).

In cases of alleged malpractice after a patient suicide, the courts evaluate the psychiatrist's assessment and management of the patient to determine whether the patient's suicide was foreseeable (4). Psychiatrists are not expected to predict suicide attempts or completions, for which no professional standard exists. Such predictions lead to many false-positive and false-negative results (9). However, predictability should not be confused with foreseeability, which is defined as the reasonable anticipation that harm or injury is likely to result from certain acts or omissions (10).

Importance of Collateral Information

The standard of care requires psychiatrists and other mental health professionals to adequately assess suicide risk when indicated. To achieve this, the psychiatrist must gather sufficient information about the patient to perform an adequate suicide risk assessment (4). A patient's declaration that he or she is not suicidal may require further examination because true intention is not always disclosed. In some cases, patients may even view the psychiatrist as an adversary (11).

Likewise, studies have shown that "no-harm contracts" do not prevent suicide (12). Obtaining a written or an oral contract against suicide can be useful in assessing the therapeutic alliance between the psychiatrist and the patient. However, such a measure alone does not mitigate suicide risk (13). No-harm contracts are not a substitute for the systematic assessment of suicide risk and modification of risk factors. They are not legal documents that exonerate the psychiatrist from liability if the patient commits suicide (13).

If possible, collateral information should be obtained from family members or others who know the patient. Patients at risk for suicide may complete a no-harm contract or deny having suicidal ideation to the clinician but report suicidal ideation to their families (14). In addition, family members may have observed suicidal behaviors or rehearsals, presumptive evidence that the patient is at acute, high risk for suicide (15). Hence, management of patients at high risk for suicide may require breaking patient confidence and involving the family or significant others (4).

Documentation

Suicide risk assessment is an integral part of the psychiatric examination. High-risk patients are not uncommon in psychiatric practice, and thorough documentation is helpful for improving treatment and mitigating liability for the treating clinician (16). Nevertheless, the risk assessment is rarely performed systematically, or when it is performed, it is not contemporaneously documented (4). Simon (4) identified multiple reasons for clinical failure to perform and document an adequate suicide risk assessment. They include clinician lack of knowledge of how to perform a systematic suicide risk assessment, delegation of the task to others, clinician fears that documenting the risk assessment process creates legal exposure, and clinician completion of systematic risk assessments but not documenting them.

It is imperative to clearly document a systematic suicide risk assessment that identifies pertinent static and dynamic risk factors along with protective factors.

In cases of alleged malpractice, what is not recorded by a physician may be considered not to have been performed (5). In *Abille v. United States,* a psychiatrist failed to maintain medical records that adequately explained the decision making for a patient who committed suicide. Even though the clinical decision to transfer the patient from suicide status to a status appropriate for less dangerous patients was found to be within the standard of care, the physician was found liable for his failure "to describe accurately and fully in his report of the events and medical orders everything of consequence that he did and which his trained eye observed during the inpatient stay" (17). Documentation of a suicide risk assessment informs patient treatment and allows the court to evaluate the complexities inherent in the assessment and management of patients at risk of suicide (5).

To assist with the identification of individuals at increased risk for suicide, a psychiatrist may consider complementing the suicide risk assessment with suicide risk assessment measures and scales. A prime example includes the Columbia Suicide Severity Rating Scale, which has been found to be suitable for assessment of suicide ideation and behavior in clinical and research settings (18). Other research scales with psychometric properties include the Columbia Suicide History Form, which determines lifetime suicide attempts; the Beck Scale for Suicide Ideation, based on characteristics of suicide ideation; the Suicide Intent Scale, which identifies the wish to die; and the Beck Hopelessness Scale, which reveals negative attitudes about the future (19). Reportedly, patients often disclose more information regarding suicidal thoughts and behaviors on self-report measures than during clinical interviews, further supporting the use of scales that estimate suicide risk (20). Nevertheless, the standard of care does not require psychiatrists to use psychological tests or scales as part of the systematic assessment of suicide risk (19).

Although clinical and research scales standardize suicide risk factors central to assessing a patient's risk of suicide, it is inadequate to base a patient's risk for suicide solely on the results of a scale without any clinical judgment (19). No single scale or measure can encompass all pertinent risk and protective factors or how such factors affect a patient's risk for suicide. Simon (19) noted that the variety of general and individual suicide risk factors cannot be captured by any form, even if all scales were combined into a single risk assessment form.

Conclusions

The standard of care calls for psychiatrists to perform an adequate suicide risk assessment when indicated. This entails identifying and prioritizing evidence-based risk and protective factors. To ensure thorough data gathering on which to base an adequate suicide risk assessment, collateral information from family members may have to be obtained and completion of suicide risk measure scales should be considered. Finally, clinicians should make every effort to clearly and thoroughly document their suicide risk assessment.

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For further information related to suicide risk assessment, see the recent article by Teo et al. in Psychiatric Services.

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Rethinking Our Approach: A Cry Against Gun Violence

Lama Bazzi, M.D.

Today's media is riddled with stories of gun violence, regulation, and implications on civil liberties. The Sandy Hook shootings in Newton, Connecticut sparked heated debates and had our entire country up in arms over gun control.

On December 14, 2012, 20-year-old Adam Lanza shot 20 young children and six adults at Sandy Hook Elementary School. His mother was found dead in the home they shared, having sustained four gunshot wounds to the head. Lanza committed homicide with his mother's semi-automatic Bushmaster rifle and committed suicide with a handgun. He clearly came from a financially stable home, was fairly intelligent, and had no criminal history (1, 2).

With 300 million registered privately owned firearms, anywhere between 39% and 50% of U.S. households have at least one gun (3). Almost 67% of homicides and homicide-suicides are committed using firearms (4). Lanza's mother owned several guns and taught him how to shoot them. Having access to handguns has been linked to increased mortality(3). Studies confirming that stricter gun control laws lead to less suicides and homicides have been conducted in Canada and Australia. Implementation of U.S. laws allowing concealed weapons transportation was associated with increased homicides (5).

Mental illness and violence are often erroneously thought to be related. In reality, psychiatrically ill patients commit less than 5% of all violent crimes. Mental illness alone (without comorbid substance abuse) has not been shown to be significantly associated with violence (6, 7). Furthermore, psychiatric patients are 2.5 times more likely to be victims of violent crimes (6). In retrospect, many violent criminals who were mentally ill exhibited critical signs of psychiatric decompensation before committing crimes. Psychological autopsies in many cases revealed interpersonal difficulties, treatment-seeking behavior, and threats of violence or suicide, but these "red flags" did not lead to timely interventions (7).

The politically powerful National Rifle Association (NRA) has asserted that arming the "good" citizens protects us from murderers. The NRA officials have staunchly protected the Second Amendment, stating that had people been armed against assailants, many mass murders would have been prevented. Furthermore, the NRA's lobbyists have blocked research on gun violence prevention, legislation on ownership, registration, and tracking guns (8).

Gun ownership has been linked to a higher risk of death (9). Gun violence often occurs in homes of gun owners and by people with access to legal personal firearms. Lanza used his mother's weapons to commit his crimes (2). Furthermore, 40% lower gun-related murders and 37% less gun suicides occur in states with more comprehensive gun laws (10). Massachusetts, a state with a high number of gun laws, has a suicide rate that is three times less than that of Louisiana, a state where gun culture is considerably more lenient (10).

Following the Newton, Connecticut massacre, Americans called for legislative action. In addition to calling for revisiting gun laws, citizens have called for the mental health field to take responsibility for the violent mentally ill (5). Those opposed to gun registries and enforcing gun control insist that the failure of the mental health system has led to more gun deaths (11). NRA officials call for increased access to mental health care instead of limiting access to weapons (11).

Lanza was never diagnosed with a psychiatric illness by a mental health practitioner. After his death, some reports included "a personality disorder…or Asperger's syndrome"(1). Personality disorders and Asperger's syndrome are not independently linked with a propensity to violence. Furthermore, neither diagnosis was ever made by a treatment provider, and no records of Lanza being in psychiatric care have ever surfaced (1, 2).

Nevertheless, legislation has moved forward in many states, including New York, mandating physicians to report patients who may be dangerous to the Office of Mental Health. The haste with which legislation passed left little room for negotiation. The SAFE Act (New York Secure Ammunition and Firearms Enforcement Act of 2013), which went into effect on March 16, 2013, has left many mental health practitioners feeling bound by the constraints of an unclear law (12). Mental health practitioners and physicians must report potentially dangerous patients to government bodies (13). Professionals worry about the therapeutic alliance, the practitioners' safety, and the future of the mental health field. Additionally, the law serves to widen the rift between opposing sides of the gun control debate, since violating the civil rights of citizens by using governmental databases to track and potentially remove weapons from the homes of psychiatric patients is a contentious issue (11).

Although universal access to mental health services is critical, the issue at hand remains gun control. The mental illness most associated with violence or the risk thereof is substance abuse, which was not implicated in the Connecticut massacre. Lanza did not have a history of mental illness and had never been evaluated formally by a psychiatrist (1, 4, 8, 11). Increasing the control over gun sales, curtailing access to semiautomatic weapons, and limiting the number of bullets in magazines could decrease the risk of weapons ending up in the wrong hands, including the hands of the few violent mentally ill citizens (5, 10, 12).

On the other hand, simply implementing stricter gun control alone may not suffice. Research suggests that an unaddressed issue remains the breakdown of societal networking and relationships. We prioritize protecting political and fiscal interests, which supersede the interests of society. The fear of malpractice and litigation pushes psychiatrists to practice their craft defensively, and schools do the same. By charging society to care for its members, we would shift the mentality from

one of scapegoating blame to one of taking responsibility and action.

Open communication between teachers, parents, school counselors, psychologists, social workers, and psychiatrists begets identifying students at risk for violence or victimization. Support for students needs to be available in the form of counseling, group therapy, and integration into school activities. A focus on avoiding stigma and a strong "it takes a village to raise a child" approach to teaching must be fostered. Instead of isolation and fear and marginalization and individuality, we must advocate that citizens be responsible for the integration of their own peers. Federal funding should be allocated to programs that encourage socialization, positive mentorship, and involvement in activities (14).

There are many programs targeting violence among youths, and they have been shown to work. In Chicago, the University of Chicago Urban Crime Lab collaborated with Chicago Public Schools, World Sport Chicago, and Youth Guidance to conduct a randomized controlled study of youth violence. Chicago is notorious for violent crimes, and gun deaths are responsible for the deaths of most youths. Additionally, among black males, gun deaths are responsible for more deaths than the next nine causes of death combined (15). In the 1-year program, about 800 boys between the seventh and tenth grades were randomly assigned to either an intervention group or a comparison group. The intervention group received a cognitive- and behavioral model-based therapy, including nontraditional sports and group therapy, targeting social integration, impulse control, social information processing, and conflict resolution. The intervention group exhibited a 44% decrease in violent arrests, a 36% decrease in arrests for vandalism, trespassing, and weapons possession, and a 53% decrease in the risk of attending a juvenile court school. The program was demonstrated to be highly cost effective, costing about 11 times less than the amount it saved (15).

Other research has shown that strong social bonds decrease the risk of arrest, especially among children in foster care, who have a 46% risk of arrest as adults (14). Preventive methods included solidifying social bonds and connecting with mentors and adults as the children transitioned out of the foster care system. Adults transitioning out of foster care have a four times higher risk of being arrested compared with low-income adults. Foster children are the best example of children of society, and communities need to care for all children at risk for violence. By improving opportunities available to our youths, using violence prevention methods, and moving toward a social ecology of taking responsibility for our youths, we can build necessary community protections that last (14, 15).

The U.S. government spends over 500 billion dollars on public school education, yet very little focus is placed on funding social cognitive skill development and identifying interpersonal communication deficits (14, 15). Instead of waiting for events to occur and wondering what precipitated the tragedy, we must take control and intervene. Educating all childcare providers of the early signs of abuse and propensity to violence will invoke responsibility. Parents must communicate openly and directly with involved teachers and counselors and be open to seeking the help of professionals when needed. The risk of stigmatization of mentally ill children and teens must be attenuated, and societal education on mental illness, violence, and gun safety must be made a priority.

All of us must lend a hand in the cry against gun violence. By accepting our role in rearing and nurturing every member of a community, along with better legislative control of deadly weapons, we can take a multimodal view of gun ownership and come to a solution where all of us put down our weapons and learn to trust one another.

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For further information related to the topic of gun violence and policy, see the recently published literature review by McGinty et al. in Psychiatric Services.

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TEST YOUR KNOWLEDGE

In preparation for the PRITE and ABPN Board examinations, test your knowledge with the following questions. (answers will appear in the next issue)

This month's questions are courtesy of David Hsu, M.D., a fellow in geriatric psychiatry at Massachusetts General Hospital/McLean/Harvard, Boston, and Associate Editor of the Residents Journal.

Question 1

In which stage of Margaret Mahler's separation-individuation paradigm do children willingly separate from their mothers but then return for comfort?

A. Normal autism
B. Differentiation
C. Symbiosis
D. Rapprochement
E. Object constancy

Question 2

Which biological change is associated with normal aging?

A. Maintenance of IQ until age 80
B. Increase of glomerular filtration rate
C. Enhanced sense of touch, taste, and smell
D. Production of testosterone in men is increased
E. Reduction of cardiac output

ANSWERS TO JUNE QUESTIONS

Question #1

Answer: A. Antidepressant-induced apathy

Apathy is defined as a loss of motivation, with cognitive emotional and behavioral components, and is increasingly recognized with the use of selective serotonin reuptake inhibitors (SSRIs). Treatment of SSRI-induced apathy includes reducing the SSRI dosage, augmentation, or switching to a prodopaminergic agent or to a non-SSRI class of antidepressants (1, 2).

References

1. Marin RS: Differential diagnosis and classification of apathy. Am J Psychiatry 1990; 147:22–30
2. Padala PR, Padala KP, Monga V, Ramirez DA, Sullivan DH: Reversal of SSRI-associated apathy syndrome by discontinuation of therapy. Ann Pharmacother 2012; 46:e8

Question #2

Answer: C. Mirtazapine

Antidepressants can cause hyperprolactinemia, and patients taking antidepressants can present with sexual problems, breast growth, and galactorrhea. The precise mechanism of action is not known; stimulation of GABAergic neurons proximal to the tubero-infundibular dopamine cells and central 5-$HT_{1C/2}$ receptors are thought to play a role in antidepressant-induced hyperprolactinemia. Citalopram, clomipramine, and venlafaxine have all been implicated in this adverse effect. Mirtazapine and bupropion have fewer propensities to cause this side effect (1, 2).

References

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We are currently seeking residents who are interested in submitting Board-style questions to appear in the Test Your Knowledge feature. Selected residents will receive acknowledgment in the issue in which their questions are featured.
Submissions should include the following:
1. Two to three Board review-style questions with four to five answer choices.
2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.
***Please direct all inquiries and submissions to Dr. Hsu: davidhsu222@gmail.com.**

Author Information for *The Residents' Journal* Submissions

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted. To submit a manuscript, please visit http://mc.manuscriptcentral.com/appi-ajp, and select "Residents" in the manuscript type field.

1. **Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
2. **Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure.
3. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.
4. **Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.
5. **Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.
6. **Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
7. **Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

Upcoming Issue Themes

Please note that we will consider articles outside of the theme.

Global Psychiatry

If you have a submission related to this theme, contact the Section Editor, Misty Richards, M.D., M.S. (mcrichards@mednet.ucla.edu).

Adolescent Psychiatry

If you have a submission related to this theme, contact the Section Editor, Justine Wittenauer (jwittenauer@challiance.org).

Mental Health Disparities

If you have a submission related to this theme, contact the Section Editor, Ijeoma Chukwu, M.D. (ichukwu@uci.edu).