Psychiatric Consultation-Liaison in the Acute Physical Disabilities Setting

(depression; professional-patient relations; psychosocial aspects of illness; services, occupational therapy)

Linda J. Watson

This paper provides an overview of psychiatric consultation-liaison services in a general hospital setting. The patient most frequently referred for consultation-liaison services is the individual experiencing depression secondary to physical illness. The dimensions of occupational therapy intervention with this population is featured, including assessment, intervention strategies, and documentation guidelines useful in the treatment planning.

Consultation-liaison psychiatry can be defined simply as the delivery of psychiatric care to the physically ill. In particular, it is concerned with the psychological problems that interfere with or jeopardize the patient's medical treatment.

This paper describes the psychiatric consultation-liaison service within Rush-Presbyterian-St. Luke's Medical Center in Chicago. Occupational therapy is an integral part of the team providing the services. The occupational therapist uses functional activities to promote the patient's psychosocial and physical independence and competence. The occupational therapy intervention strategies that were developed at this center and which may serve as guidelines for therapists working with physically ill individuals with psychological or emotional complications are described. The paper also contains information on depressed patients, the population most frequently referred for consultation-liaison psychiatric services.

Consultation-Liaison Psychiatry

Consultation-liaison psychiatry has existed as a subspecialty of medicine for approximately 50 years (1). Throughout its history, it has served as a link between the fields of psychiatry and traditional medicine.

The theoretical roots of this type of service are diverse. It has been influenced by concepts of personality or psychological conflict, illness behavior, and stress response, as well as general systems theory, psychodynamic formulations, and existential thought. These concepts continue to contribute to the understanding of the effects of the mind on the body in illness and disability. The primary purpose of

Linda J. Watson, OTR, is Assistant Director, Psychiatric Occupational Therapy Department, Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL 60612, and an instructor, Rush University, also Chicago, IL 60612.
consultation-liaison psychiatry is to facilitate the patients' adjustment to a life-style compatible with their value system and their illness or prognosis (2).

The use of psychiatric consultation-liaison services can be beneficial not only for the patient but also for the hospital (3). Yet psychosocial intervention is not likely to change an individual's chronically unpleasant personality. Intervention may, however, decrease the frequency of a patient's complaints or inappropriate requests for nursing assistance. Treatment can provide emotional relief for the hospitalized, physically ill patient and facilitate adaptive coping (4). Hales (5) indicated that these liaison services may reduce the mortality of medical patients, increase compliance, and decrease the patients' length of stay and use of medical services.

The incidence of emotional and cognitive problems in the general hospital population is high. Cavanaugh (6) indicates that 71% of hospital patients have evidence of emotional or cognitive dysfunction. Approximately 25% to 33% of all hospitalized, physically ill patients were found to manifest some symptoms of depression (6). While most depression is mild to moderate, severe depression was experienced by approximately 14% (7). Psychiatric consultation-liaison utilization studies confirm that depression is the most common reason for referral, constituting 60% to 70% of services (8).

The psychiatric consultation-liaison service at Rush-Presbyterian-St. Luke's serves a diverse population within a 1,100 bed tertiary care center. The major sources for our referrals are oncology, neurology, cardiology, renal, and respiratory patient groups. We have observed that patients who are severely ill, in pain, bedridden over a long period, or who have had repeated or long hospitalizations are more frequently referred.

The Team Approach

This psychiatric consultation-liaison service uses a multidisciplinary team approach. The team consists of psychiatrists, psychiatric nurses, and occupational therapists. Social workers and psychologists, although not regular members of the service, participate often as resources to the team. For example, the social worker is contacted when family conflicts and/or financial and legal problems contribute to the patient's state of dysfunction. The psychologist is contacted to assist in making a differential diagnosis through psychological testing or to provide individual psychotherapy, self-regulatory modification techniques, or behavior modification techniques.

The psychiatrist's role on the liaison team is to make a differential diagnosis. This can be difficult because presenting signs and symptoms in the hospitalized physically ill may indicate a biomedical and/or psychiatric disorder. Additionally, the psychiatrist manages the provision of psychotherapeutic services and medication.

The psychiatric nurse's role is to help develop the referring unit's nursing intervention strategies. The psychiatric nurse shares with the unit nurses a working knowledge of the complexity of nursing duties and therefore can evaluate prevailing nursing attitudes that contribute to the patient's care and the unit's environment.

It is the occupational therapist's role to promote, through the use of functional activities, performance and explore with the patient the meaning of his or her illness or disability. This approach has both positive and negative aspects. Gans (9) describes the hate that patients direct toward the therapist as they confront their deficits. However, participation in activity and the discussion that ensues can have a positive, productive outcome. Occupational therapy provides a less formal route than does psychotherapy to talk about fears, anxieties, and feelings of helplessness and vulnerability. Treatment also provides an opportunity to redefine problems and patient assets.

The Depressed Patient

Depression is a common reaction that often accompanies the anxiety associated with hospitalization, illness, or disability. Depression is also a necessary part of the bereavement or grieving process that helps patients adjust to chronic illness and disability.

The depressed, physically ill patient may manifest the typical emotional, cognitive, and vegetative features of classic depression. However, the most significant indicators of depression in the medically ill are the following: loss of interest and ability to experience pleasure, social withdrawal, feelings of worthlessness and helplessness, feelings of failure and punishment, and marked indecisiveness (9). In severe depression these characteristics are persistent and pervasive and interfere with the patient's ability to participate in treatment (10). In fact, the depressed patient frequently refuses treatment and resists the efforts of the family and medical team.

Most hospitalized individuals cope adequately with the regression imposed by hospitalization. As they recuperate, they participate in rehabilitative efforts and are able
to manipulate the hospital environment productively.

By contrast, depressed, physically ill persons feel incompetent and helpless, often harboring unrealistic fears of prolonged uselessness. They are unresponsive to traditional treatment planning. Personal hygiene and grooming are of minimal concern to them. Exercise regimens fail to motivate or sustain the patients' interest in treatment. To facilitate the return of function, patients must view themselves as potentially healthy; however, these patients are emotionally unable to view themselves in this way (11). Moreover, these patients are unable to use available resources to reduce their tension and subsequent depression.

The psychosocial goals for occupational therapy treatment within the context of the psychiatric consultation-liaison team are as follows:

- provide opportunities for mastery and control;
- reduce emotional distress;
- promote psychological competence; and
- help maintain or reestablish an active support network.

**Occupational Therapy Intervention**

**Assessment**

Assessment is an ongoing process from initial contacts through discharge. Formal assessment and evaluation often remain secondary to the development of rapport with the depressed physically ill. This patient's psychosocial status is determined by the following:

- premorbid competencies and level of functioning;
- previous methods of coping with stress;
- important roles, responsibilities, values, and previously held goals;
- past history of interests and preferred activity involvement;
- available support network; and
- beliefs and plans related to discharge.

In our setting, this information is ascertained through semistructured interviews and observations during participation in activity. Figure 1 provides guidelines for recognizing and understanding the patient's perceptions and behaviors.

During initial sessions, open-ended questions are used to encourage patients to talk and to help them evaluate their own situation at this time. The following questions form the core of our assessment:

- Tell me how it was for you before you came to the hospital.
- How is it going for you here in the hospital?
- What problems, if any, do you see your illness or disability creating?
- How do you plan to deal with them?
- How have you coped with problems in the past?
- How does it usually work out?
- How do you think it will be when you leave the hospital?

**Common areas of psychosocial conflict and/or dysfunction in the depressed physically ill patient**

<table>
<thead>
<tr>
<th>Psychological/Emotional Daily Living Skills</th>
<th>Cognitive Components</th>
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</thead>
<tbody>
<tr>
<td>Self-concept/identity</td>
<td>Conceptualization/comprehension</td>
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<tr>
<td>feeling vulnerable, helpless, hopeless</td>
<td>concrete</td>
</tr>
<tr>
<td>loss of interest and pleasure</td>
<td>concentration poor, easily distracted</td>
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<tr>
<td>sense of responsibility, guilt, and punish-</td>
<td>attention span below normal limits</td>
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<td>ment</td>
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<tr>
<td>disrupted competence in roles</td>
<td>Cognitive integration</td>
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<tr>
<td>loss sense of efficacy and self-worth</td>
<td>unable to make decisions</td>
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<tr>
<td>shift in level of dependence/independence</td>
<td>lacks motivation to problem-solve</td>
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<tr>
<td>feeling and/or looking different, disfig-</td>
<td>inflexible, rigid</td>
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<tr>
<td>ured, incomplete</td>
<td>ability to synthesize impaired</td>
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<tr>
<td>lack of continuity between past, present,</td>
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<tr>
<td>and future goals</td>
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<tr>
<td>interpersonal relationships feel unsatis-</td>
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<td>fying</td>
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<tr>
<td>Situational coping</td>
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<td>recollects memories of past feelings of</td>
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<tr>
<td>helplessness, hopelessness</td>
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<tr>
<td>loss of control in usual daily schedule</td>
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<tr>
<td>previous methods of coping not adequate</td>
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<td>due to compromised medical status and/or</td>
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<td>institutional constraints</td>
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<tr>
<td>misperceptions of information, people,</td>
<td></td>
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<tr>
<td>situations in an attempt to connect the</td>
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<tr>
<td>unfamiliar with something familiar</td>
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<tr>
<td>frustration tolerance poor</td>
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<td>personal support system strained</td>
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<tr>
<td>conflict between desired goals and skills</td>
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<tr>
<td>Work/play/leisure</td>
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<tr>
<td>imbalance created by hospitalization and/or compromised medical status</td>
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<tr>
<td>temporary or permanent role change</td>
<td></td>
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<tr>
<td>loss of skills</td>
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</table>

Figure 1
Throughout the interview process additional clarifying questions are asked to assist the patient in exploring his or her feelings (i.e., Tell me more about that. . . . How did you feel about that . . . . I'm not sure I understand . . . .).

The occupational therapist listens as the patient identifies with skills and significant roles, relationships, and life events. The patient's current situation may evoke old conflicts and problems with his or her self-worth and family relationships. Memories involved in these situations may be painful and contribute to the patient's feelings of uncertainty and bleakness about the future. This type of discussion allows the patient and therapist to redefine a problem so that its positive aspects can be seen and solutions can be found.

**Therapist-Patient Rapport**

During initial contacts, the primary concern of the therapist is to engage the patient in treatment by showing an understanding of the patient's emotional distress and by structuring the environment to promote psychological competence in the patient.

While rapport is an important part of engaging any patient in treatment, it is crucial and difficult for this patient population. Developing rapport requires that the therapist meet the patient at his or her level. With the depressed patient, this requires that the therapist resist the expectation that treatment must be physically or verbally active (12). Initially, engagement may take the form of short, frequent contacts, particularly with the highly resistant patient.

Another way to foster the development of rapport is to review with the patient the circumstances that led to the hospitalization. This strategy is particularly useful with the tearful, agitated patient because it provides a sense of relief and control (13). Accepting the patient's perspective of these events supports the evolving alliance. The therapist tries to discern the patient's values and beliefs in this description and points out the patient's strengths and the potentially positive aspects of the events. Throughout treatment it is important to listen for themes in the comments the patient makes, such as concern about changes in physical appearance or loss of the spouse's affection. The content of discussions provides the therapist with the patient's perception of the meaning of his or her illness and prognosis (14). How this perception relates to the patient's anticipated level of functioning, his or her values and goals, and changes in usual roles and habits forms the basis for the selection of therapeutic media and intervention strategies.

**Selection of Therapeutic Activities**

Therapeutic activity holds a different meaning when treating the depressed medically ill. Activities related directly to interest, values, roles, and responsibilities are required to promote psychological competence. In my experience, the use of homemaking, cooking, crafts, games, leisure arts, and work simulations serve as inherently gratifying and motivating media. Early in treatment, the focus is on ability rather than disability, which supports mastery, control, and a view of the patient as being effective. This strategy requires that the therapist select and adapt the activity or environment that will ensure success.

Activity can serve as a precursor to verbalization. For example, during activity involvement patients often discuss concerns about the potential loss of skills and fears about adjusting to being different. The therapist provides both support for expressing concerns and an educated, informed perspective to foster hope and help develop a reality-based future perspective.

Depressed patients have difficulty feeling motivated to take care of themselves. They are more easily mobilized to do things for others, particularly for family members or for significant others. Making useful objects or gifts for others reestablishes the patient as a valuable contributor. Making and doing for others symbolically represents wishes and intent when communication is difficult.

The patient's loss of energy, interest, and withdrawal often exhausts the interpersonal resources of family and friends. A focus on doing and giving rather than on symptoms and complaints begins to reengage the patient in meaningful activities and restore significant relationships.

Throughout these interactions, the therapist elicits as much help as possible from the patient while acknowledging the emotional and physical struggles. Doing provides the structure for identifying strengths and gently challenging depressive cognitions.

The therapist-patient relationship provides a forum for the patient to negotiate the resumption of responsibilities. The therapist gradually plans treatment sessions that foster mutual interchanges through increasing choice and control.

Pleasant, familiar activity is used to energize and motivate the patient over a period of sessions. As the emotional distress diminishes, the therapist slowly introduces physical rehabilitative activity. Treatment requires a continuing
awareness of the patient’s emotional status and responsiveness to changing psychosocial needs.

**Documentation**

The occupational therapist who participates in the psychiatric consultation-liaison service must adequately document the psychosocial dysfunction as well as prepare a related treatment plan and recommendations for the management and future disposition of the patient (15). Progress is measured through observations and behaviors associated with the classic signs and symptoms of the psychiatric disorder (16). For the depressed, physically ill patient, examples of observations and behaviors include the following: amount of eye contact, sad affect and mood, tearfulness, psychomotor retardation, loss of interest in activity, social withdrawal from family and friends, frequency and amount of self-deprecatory comments, reports of hopelessness, and expression of the wish not to live anymore.

The assessment section identifies conflict and/or dysfunction, particularly in the areas of psychological/emotional daily living skills, and cognitive and psychosocial components. Documentation should reflect changes in the patient’s psychological status, even if change is seemingly minimal. This focus in documentation supports the use and reimbursement of the psychiatric consultation-liaison team have been appropriately reimbursed.

**Conclusion**

The occupational therapist’s role within a psychiatric consultation-liaison team is challenging and rewarding, both professionally and personally. Because they are depressed, these patients test the therapist’s patience, perseverance, and creative caring. Working with them requires an understanding of the dynamics of regression and a view of the patient-therapist relationship as a primary mode of treatment (17). The therapist must evaluate his or her own values and attitudes regarding the quality of life, the prolongation of life, and death and dying to contribute objectively to the assessment and treatment of noncompliance, depression, and denial (18).

**ACKNOWLEDGMENTS**

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**REFERENCES**


**RELATED READINGS**