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Liaison Psychiatry

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LIAISON PSYCHIATRY

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Introduction

The thrust for the psychological care of the sick came from psychiatry rather than from medicine. It was part of a strenuous effort by psychiatry to gain a share of the practice of medicine. How this was done and at what expenditure of effort will be described in this presentation. But psychiatry has been so eager to be accepted as a discipline by medicine, that it seems at times to have lost sight of the patient as the primary concern of psychological care. The goal of liaison psychiatry is the biopsychosocial care of the medically ill patient, but so many obstacles to this have arisen that efforts to persuade members of the hospital power base (non-psychiatrist physicians and administrators) to acknowledge the value of psychiatric methods have often taken precedence over patient care itself. This proselytizing effort has been going on since 1929 and has led to the development of a specialty—liaison psychiatry.

Throughout its history, the locus of liaison psychiatry has been the general hospital. Here geographical fact and the presence of the patient in residence facilitates transactions between medical disciplines. There has been relatively little experience with liaison programs for ambulatory or home care

patients. In community hospitals, psychiatric consultation systems alone may be standard; in tertiary hospitals a variety of consultative-liaison programs exist depending on the characteristics of the hospital. Their function, success, or failure depends largely on the liaison psychiatrist, whether he is a consultative psychiatrist in private practice, a full-time hospital physician, or a psychosomatic fellow. His effectiveness depends largely on the strategies he has devised to overcome the obstacles inherent in the health system. For the liaison psychiatrist, these obstacles are legion; in no other area of medicine are there so many. They include functioning in clinical territories over which he has little authority and working with physicians who give little credence to psychosocial issues, have different value systems, are resistant to engaging in psychosocial transactions, and have low expectations of his effectiveness. He may be dependent upon the willingness of one man, such as a chairman of a department of medicine, to establish or maintain a liaison program. He receives little financial support from his own psychiatric department or the department he serves. He deals with patients who often do not want his services and are often not willing to pay for them. He knows that his own department of psychiatry does not place his service high on their list of priorities. He must negotiate with hospital administrators whose lukewarm interest is concerned mainly with protecting the legal and financial position of the institution. Shaping his liaison work is, therefore, a creative task dependent upon the obstacles and assets that confront him in the particular

setting.

Definitions

Liaison psychiatry has come to be the name of choice for identifying the *system* whereby psychiatry and other disciplines of medicine cooperate in clinical activity in order to deal with psychosocial variables in their concerns with health and disease. The liaison program in the field of liaison psychiatry refers to the organizational structure within which the delivery of mental health services to medical and surgical patients takes place. Since there is some lack of clarity in the use of synonymous terms, there is a need for definition. The name "psychosomatic medicine" has been retained over a long period of time and refers to the interrelationship of emotion and disease, or the effects of reaction to stress, life change, illness, and neuroendocrine and other biological influences on disease process. Under its umbrella have been studied the psychological characteristics of medical and surgical disorders, and recently, theories of disease. Another term connected with liaison psychiatry is "psychosocial medicine." This refers to the influence of social factors in disease through epidemiological approaches or with methodologies of psychological care within the hospital and in the wider community in the context of the growing knowledge of the social implications of health care. "General hospital psychiatry" is yet another term that has recently become more prevalent, as general hospitals expand their services in the field of

mental health and as increased recognition has been given to the role of psychiatry in critical care medicine.

In the literature and in the conference rooms of general hospitals, the expression “the psychosomatic approach” is frequently used. By this is meant awareness of psychological-sociological-biological interrelatedness in disease and of readiness to identify psychosocial factors and to deal with them in clinical situations. Finally, a term that tends to be all-encompassing is “psychiatric medicine.” Whether or not this name will find widespread acceptance is problematical, but it indicates the difficulty of crystallizing psychosocial considerations within the field of medicine. Allowing for this difficulty, for the present liaison psychiatry expresses most clearly the working relationship between psychiatry and medicine.

The Nature of Liaison Psychiatry

When all is said and done, the goal of liaison psychiatry is to effect a relationship—a liaison with other departments of medicine to promote the recognition of psychosocial factors in clinical work and to ascertain that the medically ill get the benefit of complete care which requires inclusion of these factors. In order to do this, psychiatry has relied upon medical protocol, or the medical model— that the contract between physician and patient is so strictly private that accountability for decision and result depends upon the judgment

of the physician. In consequence, a resource person cannot approach the situation uninvited. Within liaison psychiatry, this is honored, although it is now thought that since the patient is a member of the hospital system, the psychiatrist may contribute to direction of his care.

But this right has been slow to evolve. Liaison psychiatry began with the psychiatric consultation and was called consultation psychiatry. As interest grew in the psychological and social aspects of medical disorders, psychiatrists sought teaching and case finding opportunities in general medical units of hospitals. To indicate the conjoint clinical and teaching functions of such psychiatric programs, consultative-liaison services were organized. All are now subsumed under the name of liaison psychiatry or liaison program.

In 1959, Beigler and his coworkers had called attention to two major categories of liaison psychiatry:

> 1) the consultation-type functions and 2) the specifically 'liaison' functions. The former comprise the services usually rendered by a psychiatrist summoned as a consultant; the latter constitute . . . functions of the psychiatrist as he works over an extended period of time on the various nonpsychiatric divisions of a general hospital.

Lipowski, in 1973, attempted to refine the meaning of these terms and what they represent when he stated that:

> Psychosomatic medicine as a scientific discipline attempts to collect a body of facts and build a unified theory about the interrelationships between man's psychological and biological attributes and functions on the one hand, and his physical and social environment on the other.

He defined consultation-liaison psychiatry as "the area of clinical psychiatry that encompasses clinical, teaching, and research activities of psychiatrists and allied mental health professionals in the non-psychiatric divisions of a general hospital." He continued:

> The designation "consultation-liaison" reflects two interrelated roles of the consultants. "Consultation" refers to the provision of expert diagnostic opinion and advice on management regarding a patient's mental state and behavior at the request of another health professional. "Liaison" connotes a linking of groups for the purpose of effective collaboration.

In 1976, he included under a definition of psychosomatic medicine, "clinical activities at the interface of medicine and the behavioral sciences subsumed under the term consultation-liaison psychiatry."

Strain, in 1977, described the nature of liaison psychiatry by strictly dividing the functions of liaison and consultation psychiatry:

> Although consultation in the hospital setting provides the cornerstone for the liaison effort, there are major differences between these models. . . . Briefly, in contrast to the psychiatric consultant, whose primary function is to alleviate acute psychiatric symptomatology in the individual patient, the liaison psychiatrist seeks to enhance the psychological status of all medical patients ... In addition, the liaison psychiatrist differs from the psychiatric consultant in that he/she participates in case detection rather than awaiting referral, clarifies the status of the caretaker as well as the patient,

> and provides an educational program that promotes more autonomous functioning by medical, surgical, and nursing personnel with regard to handling their patients' psychological needs.

In this way, he spelled out some of the functions of a liaison program in the delivery of mental health services to the medically ill and offered an overview of the nature of liaison psychiatry. But to most liaison psychiatrists, modern consultation practices and liaison activities are inseparable.

Historical Perspective

Liaison psychiatry was an outgrowth of the psychosomatic movement, which began in Germany and Austria in the second and third decades of this century and reached its apogee in the United States between 1930 and 1950. Many theoretical, research, and clinical studies of the interrelationship of the emotions and bodily functions were conducted under the influence of psychoanalytic investigators, physiologists, and clinical psychiatrists. Methods of application of concepts and vehicles of administration soon developed. Henry, in 1929, published a significant paper in the *American Journal of Psychiatry.* It is noteworthy not only because it was the first exposition of the consultation model of service, but because it described many of the classical obstacles and indicated their solutions.

In 1933, the true development of liaison programs was set in motion. The Medical Sciences Division of the Rockefeller Foundation, under the

leadership of Dr. Alan Gregg, placed major emphasis on the development of psychiatry by providing funding for full-time teachers of psychiatry in selected American medical schools and by establishing departments of psychiatry or extensions of departments within certain university hospitals. Grants were given for these purposes to Harvard (Massachusetts General Hospital) (1934), Tulane University (1936), George Washington University in St. Louis (1938), and Duke University (1940). The foresight of Alan Gregg and his associate, Dr. Robert Lambert, set the course of psychiatry for a generation and placed psychiatry in the general hospital where it could exercise a significant influence on the rest of medicine.

The growth and influence of these new or extended departments developed at different rates but all in the course of time made striking contributions to psychiatry, medicine, and psychosomatic medicine. The first two institutions to influence liaison psychiatry were the University of Colorado Medical Center and Harvard’s Massachusetts General Hospital. At the University of Colorado, the extended department was called “The Psychiatric Liaison Department” or “P.L.D.” As far as can be determined, here was the origin of the term “psychiatric liaison” and it is attributed to Franklin G. Ebaugh and Edward G. Billings who developed the concept there. The model established has been followed by many centers. “The department purposely had no hospital beds assigned to it and no specific niche in the outpatient clinic. Patients were examined, treated, and utilized as the focus for

teaching and research wherever they might be bedded—whether in a pediatric, surgical or medical ward." Billings stated that the liaison department was organized around three aims, which are still, after forty-five years, the objectives of many liaison services:

> 1. To sensitize the physicians and students to the opportunities offered them by every patient, no matter what complaint or ailment was present, for the utilization of a common sense psychiatric approach for the betterment of the patient's condition, and for making that patient better fitted to handle his problems—somatic or personality—determined or both.
>
> 2. To establish psychobiology as an integral working part of the professional thinking of physicians and students of all branches of medicine.
>
> 3. To instill in the minds of physicians and students the need the patient-public has for tangible and practical conceptions of personality and sociological functioning. This was to be not so much in the sense of "prevention" of mental disorders per se, but rather in the sense of preventing false thinking, misconceptions, misunderstanding, folk-lore and taboos which made it difficult for the patient to accept help or to allow the physician to be of help. [p. 30]

In 1948, Kaufman and Margolin offered the following principles:

> The organization of the psychiatric service in a general hospital at any given time depends on the level of sophistication with respect to

> psychology. *Therefore, no blueprint of an organization can be regarded as universally applicable* [author's italics] ... Its structure will be sufficiently dynamic and flexible as to permit revision, in terms of shifts of emphasis and foci of activity as the level of psychological indoctrination changes.

These principles are as effective today as they were in 1948, and have been utilized in the organization of many liaison services. There is no one ideal liaison program; each is shaped to fit the potentials of the institution and its liaison psychiatrists.

Kaufman and Margolin also described the objectives of a liaison program:

> The administrative set up must be built around the professional needs of the institution. The *primary needs* are always:
>
> 1. Psychiatric services: i.e., diagnoses and treatment of the hospital population, both outpatient and inpatient.
>
> 2. Teaching, which involves two aspects— one, the further training of the psychiatric staff, and two, the indoctrination and teaching of every member of the hospital staff from administration through chiefs to house staff.
>
> 3. Research, [p. 612]

A variety of strategies was developed to attain objectives. At the Massachusetts General Hospital the goal was to demonstrate that the scientific method was applicable to psychiatry; at Rochester the operational strategy was to merge with medicine; at Duke the aim was to reach objectives

through concentrated training of the medical house officer; at Johns Hopkins there was refinement of the consultative process; at Washington University emphasis was on the comprehensive approach to clinical problems; at Cincinnati the psychosomatic ward and hospital psychosomatic conferences were emphasized; and at Einstein there was a hospital-consultation service and psychoanalytically oriented teaching. All of these were designed to influence the acculturation of the non-psychiatrist physician toward the acceptance of psychiatry as relevant to the care of the sick and dying.

In the history of liaison psychiatry, six models of consultation liaison programs developed.

The Consultation Model

Patients are referred to the psychiatrist for evaluation and possible treatment, and/or for recommended emotional care by the consul tee and/or caretaker staff. This is basic to all models, whether alone or in combinations with other models. Despite the fact that there is no solid data on the availability of psychiatric consultations in general hospitals, probably most of the general hospitals in the United States carry on psychiatric consultations, principally following the consultation model. This is particularly true in community hospitals, and is the sole model in many teaching hospitals.

The Liaison Model

Psychiatrists and other mental health workers are assigned by a liaison division of the department of psychiatry to selected hospital units (usually in the department of medicine) to consult, case find, and teach. This design is sometimes referred to as the consultation-liaison model. It often relies on "islands of excellence" or model demonstration. This design has been the one of choice in many training centers, with the implication in some that ultimately liaison arrangements will cover the entire hospital. This has never been fully achieved.

The principal example of the liaison model is at the University of Rochester.' The program was started in 1946, has remained under the same leadership and has had the full support of both the departments of psychiatry and medicine. It has been a principal area of psychiatric undergraduate teaching and has provided training for a large number of psychosomatic fellows (109 between 1946 and 1977), 60 percent of whom became full-time medical educators. Its operational strategy seems to have been to interdigitate or merge with medicine, through what has been termed the Medical Psychiatric Liaison Group. Through the years this group has consisted of five to ten full-time senior staff and six to nine fellows in training. Like leaders in several other liaison programs, the majority of the staff first received training in internal medicine and later qualified in psychiatry. The tightness of the liaison arrangement, which permits the liaison worker to act as a resource person in both psychiatry and medicine on select medical

hospital units and exemplifies the role model of the internist who integrates psychosocial factors into his clinical considerations by performance, is an important characteristic of the Rochester liaison program.

The Milieu Model

An extension of the liaison model, the milieu model places emphasis upon the group aspects of patient care, group process, staff reactions and interactions, interpersonal theory, and the methods of Stanton and Schwartz. Several centers combine the liaison and the milieu models. Mental health personnel are assigned to critical care units rather than to clinical departments. The goal is patient care with the psychiatrist a participating member of the unit team, in which he often becomes the unofficial leader. Teaching combines behavioral, biological psychiatric, and psychoanalytic theoretical models. This model was developed in the 1970s as a result of changes within clinical medicine.

There are now many centers in which psychiatric services attach psychiatrists to intensive care units in liaison arrangements. Two that can be cited as examples are the psychiatric departments of the Massachusetts General Hospital and the Hospital of the Albert Einstein College of Medicine. At the Massachusetts General Hospital active liaison psychiatry is an integrated part of clinical work in the intensive care unit, the coronary care

unit, the pulmonary care unit, burn unit, and in oncology.* At the Einstein Hospital, all available psychiatrists are scheduled for priority service on critical care units, in acute psychiatry, and in oncology and terminal care rather than assigned to liaison arrangements with clinical departments.

Additional liaison psychiatry centers may concentrate on the critical care model in one specific area, such as in hemodialysis units, as has been the case at the Downstate Medical Center and at the University of Southern California.

The Biological Psychiatry Model

This is a more exacting example of the critical care model with strict emphasis upon neuroscience and psychopharmacology in which the psychiatrist maintains his status as a peer scientist. He provides the psychological care by assessment of cognitive disturbance and changes in levels of awareness, and treatment at these biological levels by management with psychopharmacologic and other physical agents and by maintaining vigilance to assure an optimal environment for the patient. The Massachusetts General Hospital utilizes this model, as does Columbia, the University of Southern California, and Montefiore Hospital.

The Integral Model

The aforementioned models of liaison programs depend in the main upon traditional consultation with patients and staff and liaison arrangements whereby initiative for psychosocial intervention rests entirely with the non-psychiatrist physician. As a result of the burden of critical care, medicine with its load of technocratic systems and complexities and social pressures, the integral model of liaison psychiatry is developing a new direction in medical care. It was first conceptualized and established at the Hospital of Albert Einstein College of Medicine, while at the same time its possibilities were recognized and reported at Montefiore Hospital. This model is based upon the inclusion of psychological care as a component of patient care, as the right of every sick person, and provides for the availability of the psychiatrist to function at the points of clinical and administrative need. The initiative comes from staff consensus on the need for psychiatric intervention more than from the judgment of the non-psychiatrist physician. The integral model will be discussed at greater length later in the chapter.

Liaison Consultation

Whether the psychiatrist is a member of a liaison team or functions alone, his principal contribution to the medically ill and to medical and surgical colleagues is through the psychiatric consultation. Such consultations require skilled techniques about which much has been written since midcentury. We can distinguish between the “psychiatric consultation” and

the “liaison consultation.” The first is essentially an arrangement between the patient’s attending physician and the psychiatrist, ostensibly for purposes of diagnosis, management, or treatment planning in which the patient is interviewed and averbal or written report is given to the consultee. In the absence of a liaison program the result is apt to be a single examination, a so-called “one shot” consultation which may prove valuable as an assessment if properly done. The solitary psychiatrist, if he has undergone liaison training, will often develop the single contact into a liaison consultation.

This author has described the nature of the liaison consultation:

> At the core of liaison work is the dynamic contact between the liaison psychiatrist and the key figures in the clinical field: patients, families, physicians, nurses, social workers, administrators, psychologists and others. The interaction at this point of contact is called liaison consultation, and the principal participant is the liaison psychiatrist whose task it is to serve as the resource expert on psychological and social variables in disease. The substantive knowledge, methods, and techniques of psychiatry are brought to bear on the task. The liaison psychiatrist is expected to have additional knowledge concerning the characteristics of forces at the interface of psychiatry and the other medical disciplines. The points of dynamic contact are variable so that the consultations may be with the patient alone, with the patient and consultee, with the patient and nurse, with the patient and all key persons in his clinical field, with the consultee alone, with the family alone, or with other combinations. This fluidity of consultative endeavor is one of the principal skills of the liaison psychiatrist. He is adept at changing role models and is familiar with systems and boundaries of systems, [p. 132]

Approaches to the Psychiatric Consultation

The preceding description serves as a background for the definition and discussion of approaches to consultative work and of models of psychiatric consultation. Although the patient is ostensibly the object of the consultation, the working orientation to the basic purpose for the consultation helps to determine the approach. There are four approaches to consultation work: (1) the patient-oriented approach, (2) the consultee-oriented approach, (3) the situation-oriented approach, and (4) the professional-oriented or supervisory approach.

The patient-oriented approach is the traditional psychiatric consultation. How to carry this out has been carefully spelled out in many publications. There is general agreement on the method: preparation for the consultation, the setting for the examination, the approach to the patient, the interview, the consultant-patient relationship, the written report, and transactions with the consultee. The approach is always patient-centered; the objective is the assessment of the patient himself.

In 1959, Schiff and Pilot introduced the concept of the consultee-oriented approach.

> It is based on a point of view which is primarily consultee-oriented rather than patient-oriented, and attempts to examine carefully the manner in which the consultation is requested and the background of each situation. The assumption is made that every psychiatric consultation, if not every consultation, stems from the referring physicians concerns, of which the most cogent are frequently not explicitly stated, [p. 357]

This point of view focuses on the latent reasons for the consultee's request in terms of his position in the clinical situation and has become a frequently used component of the consultative process. Whether or not the results of the consultation will be acceptable to the consultee and be acted upon productively by him may depend on the incorporation of the consultee-oriented approach.

The situation-oriented approach has essentially a group process emphasis and was described by Greenberg in 1960:

> At times, the interaction of members of the clinical staff may produce an atmosphere in which certain aspects of the patient's historical behavior produce anxiety in one or more staff members, or in which covert symptoms became manifest... A situation-oriented approach is suggested to meet with the conditions found in some research settings, as well as with the conditions of a general hospital. This approach takes into account the interpersonal transactions of all the people involved in the direct care of the patient, [p.691]

This approach acknowledges that the medical-surgical inpatient unit is a therapeutic community, although it is usually neither organized nor monitored as such. We have here a transformation of the concepts and methods of Stanton and Schwartz and others in the psychiatric hospital setting. This approach is, of course, easier to use in the milieu liaison model, but should be considered in any consultation event.

The professional-oriented approach is essentially a supervisory one and

was described by Greenhill in 1977:

> In this approach psychiatrists consult with physicians regarding patients whom the latter does not want seen or whom it may not be necessary to see, may advise them on the psychological management of patients without interviewing everyone, and may conduct psychotherapy supervision as a learning experience for the medical trainee or practicing physician without meeting the patient. Nurses and social workers subscribe to this approach frequently, and in addition, some patients are electively not seen in staff conferences held in their behalf, [p. 133]

Although the implication is that this approach is reserved for situations in which the patient is not to be seen, this is not always the case. The supervisory function is at the core of the professional-centered approach with the psychiatrist in the background, whether he has seen the patient or not.

Theoretical Models of Psychiatric Consultation

In concept, theoretical models are not always different from these approaches to consultation except that they seem to include unified theories on the background and meaning of the consultation and how the process is worked through. There are four consultation models described in the literature: (1) The operational group model, (2) The communications model, (3) The therapeutic consultation model, and (4) The crisis-oriented model.

The operational group model was described in 1961 by Meyer and Mendelson. It is essentially a social process model. The operational group

consists of four people: the patient, the internist, the consulting psychiatrist, and the nurse. By the systematic collection of data from the transaction of these four people, the identification of the problem and its solution is forthcoming. Schwab interprets the concept as:

> the request for psychiatric consultation reflects a crisis within the group, usually a disruption of trust and communication between the patient and the "caring for" people. The entrance of the psychiatrist redefines the operational group, thus reducing anxiety and establishing trust and communication. The interaction between the patient and staff then becomes therapeutic.

The communication model was described in 1964 by Sandt and Leifer. It represents once more the application of a social science theoretical model to medicine, in this instance, communications theory. Sandt and Leifer do not go beyond analyzing the communication (language) factors in the request for psychiatric consultation by decoding latent reasons for the request. Brosin, in 1968, carried the communication concept beyond the request to the consultation process by suggesting that the consultant carry out a message system throughout the duration of the case. The successful encoding and decoding of messages determines the outcome of the specific liaison arrangement between consultee and consultant.

Weisman and Hackett's therapeutic consultation model has as its objective the formulation and implementation of a management program for patients with psychological problems. They have written:

> There are four phases to the work of therapeutic consultation: Rapid evaluation, with special attention to the personal factors and the reason for consultation; psychodynamic formulation of the major conflict, predominant emotional patterns, ego functions, and object relationships; rational planning of a therapeutic intervention, based on the formulation; and active implementation by the psychiatrist himself.

The theoretical approach is “patient-oriented, rather than disease-oriented” in that it attempts to provide psychiatric management by focusing upon crisis, conflict, and reality testing in the patient’s brief hospitalization.

The crisis-oriented model, as described by Greenhill, places a greater emphasis on behavioral therapy. It considers psychosocial factors as emotional stressors that produce exacerbations of symptoms and behavioral reactions by the sick person which are presented in some form as a crisis. The exacerbation that brought him to the hospital and his course in the hospital may be marked by a series of critical events, and he may be influenced in the social setting of the medical unit by crises within the staff or of other patients. In the consultation, the liaison psychiatrist identifies the event-dysfunction sequences and the patient’s communication defenses which attempt to shield him from disclosures to the staff. The consultant also screens for staff involvement in the relevant crises and for other sources of crises in the milieu. Thus a pattern of behavioral and somatic reactions to emotional stress is noted and communicated to the consultee and staff, and concomitantly a therapeutic approach to the patient is begun.

The Delivery of Mental Health Services to the Medically Ill

Psychiatric Consultations

In the field of medical care, those patients in need of psychiatric intervention who are referred for consultation are “case found” in liaison programs, or remain anonymous. As we shall see, the majority remain anonymous.

There are several categories of patients with medical and surgical disorders who require mental health services, but there are a limited number of studies on frequency. From a series of 2,521 consultations in two Yale teaching hospitals, Kligerman and McKegney listed diagnoses and frequency of occurrence:

1. Acute and Chronic Brain Syndromes 31.0 percent
2. Depressive Reactions 57.4 percent
3. Conversion Reactions 11.5 percent
4. Neurotic Reactions 32.2 percent
5. “Classical” Psychosomatic Disease 8.8 percent

When one considers Schmale’s figures on depression and separation reactions in medical patients, the incidence of depression ranges from 57.4

percent to 69.0 percent. Other studies show that the frequency is close to that range. Poe found that 52 percent of 191 patients at the Peter Bent Brigham Hospital suffered depressions and West and Bastani found depressive disorders in 52 percent of 1,039 patients at the University of Nebraska Medical Center. Shevitz, Silberfarb, and Lipowski diagnosed depressive reactions in 53 percent of 1,000 consultations; of those uncovered 20 to 25 percent were severe enough to warrant treatment. Mood disorders are undoubtedly the major psychiatric complication of the medically ill.

Statistics on other psychiatric diagnostic categories, dependent upon the population studied, vary more than depression. Organic brain syndromes varied from 18.0 percent to percent and neurotic reactions from 3.0 to 31.2 percent. It appears that mood disorders, organic mental syndromes, and management problems account for the principal efforts of psychiatric consultants. When added to this is the reported fact that 47 percent to 68.2 percent of referrals show both a physical and psychiatric disorder, the purpose of liaison psychiatry is clear.

But this is only a portion of those needing help. These patients are those on whom consultations had been requested. There are others. Kligerman and McKegney reported that between 39 percent and 45.8 percent of the patients on the Yale-New Haven Hospital Medical Service were moderately or severely emotionally disturbed. Lipowski, in 1967, cited the prevalence of psychiatric

morbidity in “medical” populations in nine studies as ranging between 15 percent and 72.5 percent, depending on the study. There is general agreement in all prevalence studies carried out since then that in 20 to 50 percent of medical-surgical patients there is an associated psychiatric morbidity, with most reports citing a figure of 40 to 45 percent.

In contrast, the frequency of psychiatric consultations requested is low. Kligerman and McKegney reported that only 2.94 percent of all patients at Yale-New Haven Hospital have been subjects of such consultations. At the same center, Duff and Hollings-head reported there were consultations requested on only 6 percent of 161 identified psychiatric problems on a medical-surgical unit. From eight other studies over several years (reviewed in 1967), the frequency ranged from 4 to 13 percent with an average of 9 percent. It is suspected that this is high, for all reports since then have shown that the consultation rate rarely goes above

percent. It is at this level at the Einstein Hospital, and at 3.3 percent in the Dartmouth study. Benson reported consultation rates of 0.5 percent, 0.7 percent, and 2.0 percent in three additional studies. Cavanaugh and Flood, in a survey of attending physicians, reported that 1 to 5 percent of their private hospitalized patients received in-hospital psychiatric consultation. At any rate, only a small proportion of the medically ill who need psychiatric intervention receive it; in round figures, only one in fifteen.

The obvious questions that arise are: Does this represent a striking lack of interest and strong resistance on the part of physicians, even where there are active educational programs? Or does it indicate that the liaison system itself provides enough "know-how" on the part of nonpsychiatric personnel that the mental health needs of patients are being met and not reported? Or are there forces at work that result in the emotional needs, the "felt needs," even the psychopathology, being grossly neglected, no matter how great the zeal and efforts of liaison people? There are no evaluation studies, but the answer is probably some of all of these. All of the evidence points to the fact that after forty years and two generations of effort by liaison psychiatrists, physicians as a class do little about emotional care.

The Liaison Program

The purpose of the liaison system is to improve the delivery of mental health care and to overcome the obstacles to its effectiveness. This is achieved, first of all, by insuring the availability of psychiatrists in the units of other clinical departments of the general hospital by utilizing strategies that attach them to clinical rounds, conferences, and teaching exercises. When the psychiatrist has been assigned by negotiation with the chief of another service, he utilizes opportunities for contact and relationship with the non-psychiatrist physicians and other staff members to insinuate and promote psychosocial considerations into patient care. This is brought about by case

finding and education. In distinction to the passive position of the psychiatrist who waits to react until he is invited during the traditional psychiatric consultation, the liaison psychiatrist, if he is skilled in the liaison process and psychosomatic approach, assumes an active posture for clinical intervention. His aim is to relate to the non-psychiatrist physician and to work through the latter's resistance to psychosocial intervention. This is best realized by education and training.

Education and Training

To teach the physician to include psychosocial variables in patient care and then to deal with them himself, or to teach him to permit a psychiatrist to participate, has proven to be a special and challenging task for the psychiatric educator. He aims at an improvement through education in clinical science for the benefit of the somatically ill patient. This he undertakes to do by broadening the base of clinical considerations by enlarging the concept of the biomedical model in use throughout medicine. Adolf Meyer attempted this early in the century by implementing his concept of psychobiology. Numerous others have followed with comprehensive and holistic approaches. Engel the most recent and vocal advocate, emphasized the necessity for a "biopsychosocial" model as fundamental to the theory of disease. The aim is to educate the medical clinician to be a "whole" thinker, not an exclusionist or reductionist.

The logistics of the teaching situation has special characteristics. A small number of liaison teachers (one to ten), with a small number of liaison fellows (one to six) or none at all, have undertaken the task of teaching clinical faculty, medical students, psychiatric residents, attending physicians, interns, residents, and fellows in other departments, nursing students, nursing staff, nurse clinicians, and a variety of ancillary personnel, whose multidiscipline collaboration is needed. The strategies developed to allow teachers to do an effective job in these proportions depend on the needs of the institution and the interest and personality of the liaison leader. On the whole, the attempted strategies aim at (1) concentrating the teaching area in a limited geographic area, that is, one or more medical units in the department of medicine; (2) establishing a demonstration model or "island of excellence" in one hospital unit or subspecialty; (3) attempting to reach the learner while he is still a medical student; (4) enlarging the population of available liaison workers by concentrating on graduate training (fellowships); and (5) utilizing the services of available fellows to do the principal work of teaching house officers in other departments by peer effect. As a matter of fact, in many programs the task is so disproportionate that the patient may become the end point of interest, so great must be the strategy of educating caretakers.

The following are a comprehensive group of teaching objectives that were derived from a survey of several centers, and that are applicable in degrees of intensity to the education of medical students, non-psychiatrist

residents, and fellows:

1. to teach those psychiatric methods and techniques that are relevant to the physically ill, including the collection and assessment of raw psychosocial data by use of interviewing technique and instruction in supportive therapy, limited-goal brief psychotherapy, and crisis intervention;

2. to present a body of substantive psychiatric knowledge the content of which is relevant to medical and surgical disorders. This would include delirium and dementia; depression, grief, and separation reactions; psychoneurotic equivalencies in somatic disease (anxiety attacks, conversion reactions), emotional stress-sensitive medical disorders (peptic ulcer, asthma, and so forth); psychological reactions to illness, to interpersonal stress, and to terminal states; and addictive reactions and borderline states;

3. to examine the administration of psychopharmacological agents to the physically ill;

4. to present the influence of social science, with the effect of social stresses and patterns on exacerbation and course of medical and surgical disorders;

5. to change the attitudes of the learner regarding psychological processes, the image of the psychiatrist, scientific dogma, the quest for certainty, and the counter values of other teachers;

6. to influence the learner's methods of communication, verbal and

written, to include recognition of psychosocial phenomena and willingness to engage the patient on emotional topics;

7. to interest the learner in the problems of chronicity;

8. to offer the learner experiential involvement in the physician-patient relationship in medicine by continued case supervision, brief, or extended; and

9. by a combination of points of concentration on interviewing technique, group process, physician-patient relationship, and modification of attitudes to increase the learner's humanitarianism.

We now come to the consideration of role models in this educational process. In 1967, Engel wrote:

> Of critical importance for the establishment of the program and its subsequent growth was, I believe, the fact that I and those who joined me in the early days were fully qualified as internists. This enabled us to establish ourselves as peers on the medical service and gradually to overcome the misconception that we were alien poachers on their domain. . . . When such programs are staffed only or predominately by psychiatrists, they never really become anything other than psychiatric consultation services. As a result students and house officers never have as a model a physician who combines in his own personal skill both the psychological and somatic aspects of illness. And without such a model the student has no alternative but to believe that it takes two specialists to deal with psychosomatic issues.

Kaufman presented another point of view in 1953:

> A psychiatrist is a catalyst, an integrator. He has a great deal to contribute to medicine, but his contribution must be made primarily as a psychiatrist. The writer has no patience with the type of psychiatrist who tries to smuggle himself into medicine under false colors and who feels that it behooves him to demonstrate to the surgeon or to the internist that after all he too, is a top internist or surgeon . . . The psychiatrist is a psychiatrist, just as the surgeon is a surgeon; and it is only as a psychiatrist, standing firmly based on his own discipline, that he can eventually demonstrate the value of his orientation in the understanding and treatment of patients.

The stand taken by liaison psychiatrists concerning role model appears to be influenced by their own predominant identifications. As a teacher of many years, this author knows that many liaison fellows are searching for their identity in medicine; most of them find it, on one side of the fence or on the other, but always retaining that "liaison touch." In 1977, this author wrote:

> I think we are historically beyond the image of the internist as the role model. The role model is a proven expert clinician in any field, including psychiatry, whose enthusiasm for clinical science is contagious, and who can demonstrate that psychosocial data and interpersonal processes are powerful factors in medicine. The internist role model may be less prepared to deal with the exigencies of social and behavioral pressures on medicine today than the psychiatrist or the professor of community medicine, [p. 152]

When all is said and done, if one cuts through all models, designs, and efforts in teaching and training in the psychosomatic approach in graduate and postgraduate education, the basic ingredients are *exposure* and *engagement.* Those patient care and teaching programs that encourage, by whatever means, consistent and meaningful exposure of the physician to the

emotional implications of the clinical state of his patients and that assist him to engage with the consultant, the patient, the nurse, and the family in open-ended acknowledgment of such implications reflect realistic expertise.

Resistance

Throughout the history of psychosomatic medicine and liaison psychiatry the obstacles encountered in patient care and teaching have been much discussed and reported. McKegney, Lipsitt, and Krakowski in the United States wrote about these during the 1970s. Limitations of the psychosomatic approach have been caused by several factors including economics, space, and curriculum, but the most serious and prevalent are physicians themselves.

For want of a generic term, I have called these particular physician-generated obstacles, “resistances.” In 1950, Greenhill and Kilgore reported on types of resisters encountered among medical house staff engaged in a liaison teaching program and on how to deal with their resistances. Although the term has been used frequently through the years, it bothers some who align it with resistance in the therapeutic process and the repression of unconscious conflicts. Here, the term “resistance” is used in a wider sense to denote the efforts of physicians to avoid, withstand, deny, deter, and obstruct, by any means, conscious or unconscious, the consideration of the influence of emotion in disease. It is a well-known fact, well documented in the literature,

that physicians tend to resist utilizing psychiatric service and give low priority to the emotional concomitants of clinical situations.

Resistance to psychological medicine on the part of non-psychiatrist physicians is complicated, puzzling, and stubborn. It has taken many forms, and many methods have been employed in attempts to combat it. Conciliation, concession, internist role modeling, use of somatic language, equality of rank, emphasis on physiology and biochemistry, and attitudes indicating the validity of a psychiatric approach are among the methods that have been used by liaison psychiatrists. Early exposure of the medical student, with reinforcement at later stages in his career, is another. Causes advanced for resistance to psychological medicine include the intensive pressures of medical training, assimilation by medical students of the negative attitudes toward psychiatry and psychological medicine held by teachers in other fields, anxiety aroused by unconscious forces within physicians, and a distrust of the perceived lack of certainty of human behavior.

But the non-psychiatrist physician is not alone in his resistance, for the psychiatrist participates in it in his own fashion. A factor that has not been thoroughly explored by liaison psychiatry is the resistance within psychiatry itself. Most psychiatrists prefer to work with the intricacies of interpersonal relations and intrapsychic forces, specific symptom groups, and psychotherapy. They are apt to be strongly individualistic or oriented toward

a particular social group. It may not always be a matter of psychiatrists feeling uncomfortable in the medical situation and with the medical model, but rather that they do not find medical patients very interesting psychiatrically. Such patients seem psycho-pathologically superficial and their psychological aberrations, not being readily presented, must be sought out. Besides, psychiatrists in the main do not like to work with unmotivated patients.

The behavior of psychiatrists toward medicine and other physicians has been considered by many to be an important source of avoidance of the psychosomatic approach on the part of their medical colleagues. For example, Lipsitt has written that (1) most psychiatrists withdraw from the medical model; (2) psychiatric residents tend to be uneasy in the liaison rotation, considering it "regressive"; (3) internists reject the psychiatrist or exhibit discomfort in his presence, and the psychiatrist helps to promote this; (4) the psychiatrist tends to misperceive the difference in style, rhythm, and demands of office practice; and (5) the psychiatrist has little understanding of how to synthesize with the "doctor's job." But the tendency to blame the interrelationship between physicians and liaison psychiatrists for this problem seems too narrow a view; many other causes are at work as well.

The Role of Psychiatric Units in the General Hospital

The general hospital has become the focal point for the delivery of

mental health care in the United States. This has come about as a result of the evangelical campaign for deinstitutionalization of the mentally ill and the concomitant expansion of the number of psychiatric units in general hospitals. The increase in such units has been phenomenal. In the decade of the 1940s, there were an estimated 40 psychiatric units in general hospitals; by 1971 there were 750. Another 289 hospitals provided inpatient psychiatric treatment on their regular wards. Therefore a total of 1,039 hospitals, a minimum of 19 percent of the 5,565 community general hospitals in the United States, admitted psychiatric patients from the community. In 1971, there were 542,000 patients admitted to these units, which was 43 percent of all psychiatric admissions compared to 34 percent admitted to state hospitals. That percentage has held to the present time. Of the general hospitals that have psychiatric units, the median unit size is twenty-eight beds.

These facts are presented in order to consider the relationship of liaison psychiatry to psychiatric units in the general hospitals. In actuality, there is very little relationship. It might be presumed that having an active psychiatric unit in their midst, physicians would request more consultations, and that medical-surgical patients with psychiatric complications would be transferred to the psychiatric units for optimal care. It might also be expected that liaison divisions of the hospital department of psychiatry would be strengthened. Nothing of the kind has occurred.

Benson has pointed out that the consultation rate remains constant when "It would be thought that a viable psychiatric unit alert to psychiatric problems in the rest of the general hospital population could increase the consultation rate." As for the transfer of medical-surgical patients with depressions, organic mental syndromes, psychological management problems, or other psychiatric conditions to the psychiatric units, all evidence shows that this seldom occurs. One has but to study the censuses of psychiatric units to see that they have a distinct population.

On the other hand, it has been reported that the psychiatric unit has a salutary effect on the general hospital. It is reassuring to medical and surgical staff, no matter what their criticism of the presence of a psychiatric unit in their midst, to know there is a backup facility at hand should any patient become unmanageable. It is ironical that these backup facilities are loathe to accept transfers. The units prefer to admit only patients with psychiatric disorders—and only from the community—because the pressure from the community to take psychiatric patients is great. Further, staff on psychiatric units believe that admission of medically ill patients will contaminate the therapeutic milieu, and psychiatric nurses find it difficult to take care of medical patients and psychiatric patients at the same time.

It is a paradox that psychiatric units in general hospitals do not serve the hospital populations, particularly in view of the high incidence of

psychiatric disorder within the general hospital population. At one time in the history of liaison psychiatry, it appeared that this problem might be avoided by the establishment of “psychosomatic units.” These were sections of the hospital that accepted only combined medical-psychiatric problems and were staffed by physicians and nurses from both psychiatry and medicine. Such units existed in the 1940s and 1950s at the University of Cincinnati, Mount Sinai Hospital in New York, Montefiore Hospital in New York, and the University of Maryland in Baltimore. With the exception of the unit at Cincinnati, they did not survive for various reasons, but the recommendation has been made that, notwithstanding the cost, general hospitals of the future should have two psychiatric units, one for psychiatric patients from the community and the second to serve the medically ill in the hospital. Otherwise, the latter are neglected and the hospital department of psychiatry does not have a proper liaison with its own liaison group.

Evaluation

Evaluation of the scope and effect of liaison psychiatry has been sparse. Houpt attributes this to the complexity of its goals and theoretical viewpoints, the characteristics of settings in which it operates, and the variety of the organizational structures of liaison programs. To this may be added the fact that so limited were the facilities and the number of workers in the field and so meager the financial support that demands for teaching and service were

all that could be handled, to say nothing of ongoing assessment. Besides, until they became required, methodologies of evaluation and accountability held little interest for psychosomatists and liaison psychiatrists. Few evaluation studies of liaison psychiatry existed before 1977. The increased number after that may well be a result of the high priority that, beginning in 1974, was given to the development and expansion of psychiatric consultation-liaison teaching services by the Psychiatric Education Branch of NIMH. Financial support has been provided for more than fifty programs each year since then, and each of the supported programs is required to have an evaluation component. This last requirement may also account for the increased quality of evaluation in recent studies.

The Roles of Nonmedical Disciplines

In essence, liaison psychiatry deals with multifactorial health issues through multidiscipline channels. In this pluralistic approach, any situation in the patient care setting involves not just psychiatrist and patient, nor attending physician and patient, nor psychiatrist and attending physician, nor nurse-patient-consultee-psychiatrist, but many professionals in a group effort that spans the boundaries of many disciplines. The more all disciplines dealing with the sick know about the psychosocial aspects of illness and include them in the techniques and attitudes of their clinical efforts, the more accurate the care. Nurses, social workers, psychologists, mental health

paraprofessionals, physical therapists, activity therapists, dieticians, and clinical technicians are all involved. Hospital administrators must be consistently informed and educated to the liaison approach. Because an informed therapeutic community is the aim of the experienced director of liaison psychiatry, he should include all health disciplines in his planning. The goal of a complete therapeutic community is beyond achievement because the systems of the general hospital are too numerous and complex, but the thrust of an active program is always in that direction.

The nonpsychiatric physicians and psychiatrists have the major responsibility in liaison psychiatry, but most of the work is performed by medical-surgical nurses:

> When all is said and done, the nurse deals with the emotional care of the patient more than anyone else. As a matter of proximity alone, it falls to the nurse either to be exposed to the crises of patients or to be confronted by them through default, because there may be no one else.

Nurses become involved in liaison programs as result of the recognition and enhancement of their clinical influence by the psychiatrist, by in-service training, and through the development of the concept of the psychiatric liaison nurse (PLN). The latter is usually a psychiatric nurse clinician but may be a medical nurse clinician with psychiatric liaison training. The PLN functions collaboratively with general hospital nurses in a fashion analogous to the work of the liaison psychiatrist with the non-psychiatrist physician.

In 1971, Barton and Kelso called attention to the following functions of the liaison nurse: (1) providing perspective from the viewpoint of the nursing profession; (2) gathering information about patients for the diagnostic process; (3) being involved in prevention of crises and intervening in crises; (4) providing specialized nursing care otherwise unavailable; (5) coordinating available resources by improving communication; (6) providing an educational experience for the members of the liaison team in the transactional field of the patient (nursing care); and (7) participating in research into aspects of nursing care. In 1973, Kimball cited the report of Pranulis on the role of the PLN at Yale, which included not only participation in diagnostic evaluations, staff sensitivity training, problem solving regarding gaps in patient-staff communication, and a brief psychotherapeutic approach, but also acted as a triage person for referral of the patient to the most appropriate liaison team member.

From the beginning, physicians have been more comfortable in referring the psychosocial aspects of patient care to medical social workers. In liaison work, the objective is to incorporate this tendency into the mainstream and not allow it to be a factor in the physician’s resistance. Social workers have considerable effect on the patient’s attitudes toward convalescence and recovery in planning for the after-hospital period, are in positions to take leadership in aiding families to cope with and accommodate to illness. Lately, they have made a major contribution to hospice and terminal care process in

the general hospital.

Psychologists are much needed in evaluation studies, case finding, research, and procedural planning regarding failure of coping devices and changes in levels of consciousness in critical care situations.

Attempts have been made to train and utilize paraprofessionals as mental health counselors on medical-surgical units and with cancer and dialysis patients, for case finding and triage, but these programs have been difficult to maintain within the hierarchy of the hospital structure.

The Economics of Liaison Programs

Reimbursement for consultative-liaison psychiatric services is poor. There are many reasons for this including: (1) the resistances of non-psychiatrist physicians, attitudes of general hospital administrators, and policies of third-party carriers; (2) national problems inherent in the issue of health insurance for psychiatric disorders; (3) low-key interest on the part of organized psychiatry and departments of psychiatry in campaigning for appropriate reimbursement for consultation-liaison work; (4) slowness of psychiatry to participate in general hospital quality assurance and medical audit developments; (5) inequities of reimbursement for consultation as a problem shared by several disciplines in addition to psychiatry; and (6) the unwillingness of medically ill patients to take responsibility for payment or to

press third-party carriers for it, either due to poor preparation for psychiatric intervention or because of characteristic reactions against such intervention. The attempts made to overcome this inequity have been of little or no avail, particularly in approaching third-party carriers or hospital administrators. In the face of the high costs of medical care, reimbursement for consultative-liaison psychiatry has low priority at the administrative level. Psychiatry is often put off by insistence that it must set down the criteria for diagnosis, therapy, and prognosis in order to provide a firmer basis for establishing fees.

Be that as it may, there is no third-party coverage for liaison services. As Sanders has pointed out, third-party carriers place several constraints on reimbursement:

> For inpatients, payment is allowed for one consultation, but follow-up care is not a covered service for most patients . . .
>
> Simultaneous care from one service, such as the provision of a general psychiatric consultation and the services of a psychopharmacologist, will not both be reimbursable; only one caretaker per discipline is covered.
>
> Important therapeutic functions are not covered; for example the hospital is not reimbursed when a patient is granted a leave of absence.
>
> Similarly, liaison work and the provision of one-to-one supervision for the house staff so necessary to protect the patients contract for a specific type of therapy and for confidentiality is not a recognized reimbursable service any more than is the care rendered to family members of a child who has been identified as the patient.

Within the arrangements for liaison between departments, the liaison service is usually inadequately subsidized by the department of psychiatry and little or not at all by the other departments it serves. At Rochester, with its thirty-year collaboration with medicine, in 1976 the Department of Medicine paid 10 percent of the budget of the psychiatric liaison department. Infrequently, another department will subsidize a liaison fellowship. It is reported that at the University of Vermont, the general medicine service contracts annually for a dollar amount of liaison service, but it is too early to measure its effects. In 1972, McKegney estimated that at the University of Vermont Hospital “the amount of time necessary for a staff psychiatrist to perform an adequate role on one non-psychiatric unit seems to approximate 10 hours per week” at a cost of $15,000 to $20,000 per year per inpatient unit based on an hourly rate for psychotherapy. At a contractual rate, a lower base could be reasonably expected. But almost all departments other than psychiatry contribute nothing at all. As for the hospital administration, if it budgets for a chief of psychiatry, it expects him to be responsible for the liaison work in addition to all other responsibilities.

It is well known that psychiatrists are poorly compensated for consultations. The lack of patient interest and frequently poor preparation for the consultation by the consultee contribute to this. Consultants spend at least double the time ordinarily given to a psychotherapy session and may receive half the fee or none at all. However, improvement is possible where patients

themselves pay for the service, particularly in well-organized liaison programs.

Guggenheim indicated the outlook for the future economics in liaison psychiatry.

> Can new national health legislation be influenced to benefit consultation psychiatry? Should hospital administrations be urged to put the cost of consultation psychiatry on to the per diem rate charge for all patients? The fiscal planning of consultation work offers the challenge of developing an optimum and a minimum cost-benefit figure in consultation psychiatry. Guidelines need to be established in setting up the disbursal of a given mental health budget for a general hospital as well as for the relative evaluation of the effectiveness of different models of consultation activity, [p.178]

The claim has been made that "as yet there are insufficient data to support the premise that caretaking in the general hospital is both more effective and more efficient when consultative-liaison psychiatry is present." These data will gradually be collected. Cost-benefit ratios are urgently needed in planning for the health insurance of the future. The data that exist (such as the studies demonstrating that early referral in consultation reduces long-term maladaptive responses, the medical audit at the Einstein Hospital, which shows that patients with organic mental syndromes who do not receive psychiatric intervention have appreciably longer hospital stays, and others) point to what will be proven to be obvious. Cost-benefit ratios will undoubtedly show that third-party carriers and hospital administrators are

emotionally blind to the importance of psychological care of the sick in reducing the overall cost of medical care. If they could add one to two dollars per day to the per diem hospital reimbursement rates, cost-benefit ratios would result and much needed psychological care would be improved at the same time.

The single most positive contribution to the financial aspect of liaison psychiatry is the financial support that is given to education and training in this field by the training branch of NIMH. This may be as far-sighted as the action of the Rockefeller Foundation in 1934 that led to the birth of the liaison design. It may in time produce the leaders who will guide health care toward the objectives of liaison psychiatry.

Empirical Therapeutic Approaches in Liaison Psychiatry

Liaison psychiatry is made up of three parts: a consultative process, a liaison program, and an integrated therapeutic approach to disease. That the first two parts are well recognized is demonstrated by common usage of the term consultative-liaison psychiatry. The therapeutic aspect of psychosomatic medicine has been well studied in clinical research and in the literature in connection with specific medical diseases and disorders of organ systems. With the exception of occasional overview studies of the treatment of psychosomatic disorders and a few position papers on the use of

psychotherapy in treating psychosomatic diseases, few attempts have been made to integrate models of comprehensive psychosocial management with medical treatment. Gildea, Alexander, Hopkins and Wolff, Sperling, and Lipowski made earlier approaches to this subject. But the place of the therapeutic or management approach as a major component in liaison psychiatry, although commonly practiced, has not been squarely addressed.

Recently, an interest in liaison therapy has been emerging. Hill, Wittkower, and Warnes, Strain and Grossman, Strain, Karasu, and Karasu and Steinmuller have published works on this topic. All make some attempt to assess the role of psychotherapy in medical illness, present programs for clinical management of the medically ill, or edit a series of articles by diverse authors on different aspects of management in an eclectic potpourri.

The state of knowledge on the subject of integration of psychosocial and medical therapy needs much investigation and refinement. Yet therapy and management proceed in a growing number of clinical settings; what is being practiced is mainly empirical. There are several such empirical approaches.

Conflict-Specificity Approach

Alexander, French, Graham, and Wolff were among the proponents of the conflict-specificity approach. Alexander was the first to present this idea in what has been termed his “tripartite” theory: (1) each psychosomatic

disorder has its specific psychodynamic constellation; (2) there is an onset life situation that activates the specific psychological conflict of the patient, leading to the exacerbation of the disorders; and (3) the disorder occurs only in the presence of a constitutional vulnerability of a specific tissue, organ, or system (X factor of Alexander). Psychiatrists working with medical patients continue to find this theory useful as a guideline, despite the contention of some modern theorists, such as Kimball, Reiser, and Weiner, that the "The Holy Seven Diseases" as they call them (hyperthyroidism, neurodermatitis, peptic ulcer, rheumatoid arthritis, essential hypertension, bronchial asthma, and ulcerative colitis) with which Alexander worked, are much too multifactorial to permit such a concept.

In general, the conflict-specificity approach identifies the type of conflict, psychodynamic constellation, and onset situation, and attempts to bring these to awareness in the patient by brief or recurrent focal psychotherapy, and by behavioristically teaching the patient to avoid, where possible, his particular critical issues.

Personality-Specificity Approach

Dunbar, Reusch, Rosenman and Friedman, Nemiah and Sifneos, Groves, and others have emphasized the significance of the personality patterns. The concept is to approach an infantile, borderline, or hypersensitive character

structure by direct and corrective management, with limit-setting and by appropriate staff planning.

Crisis-Specificity Approach

Engle, Schmale, Lindemann, Greenhill, and others give attention to the importance of the precipitating situation and its repetitive nature, such as separation, loss, bereavement, and other critical events, with accompanying crisis intervention. This will be discussed in more detail later.

Somatic Orientation Approach

Kiely, Hackett, Kornfeld, McKegney, Levy, and others assist and support coping mechanisms, emphasize life maintenance, and attempt to correct failing somatic mechanisms utilizing psychological and cognitive disturbances for guidance. This has led to such methods as the use of psychopharmacological agents in somatic disorders; conditioning and behavior modifications; biofeedback and self-control of physiological functions; increased psychophysiological considerations in pain, and in sleep disorders; consideration of the neurobiological basis of psychopathology; and psychiatric intervention in oncology, cardiac surgery, hemodialysis, and during treatment in intensive care units. This approach is an integral component of medical care, both acute and chronic.

Psychotherapeutic Approach

Since he is dealing with psychosocial influences in medical illness, the liaison psychiatrist is continually involved in interpersonal and intrapsychic phenomena, in one context or another. Consequently he maintains a ceaseless psychotherapeutic orientation to the transactions between the patient and himself, the patient and other caretakers, and staff and psychiatrist. In this day of emphasis on biological psychiatry during which the importance of interpersonal influences has receded, efforts are being made to maintain psychotherapeutic attitudes during liaison psychiatry.

It is beyond the scope of this chapter to review the details of psychotherapeutic intervention in liaison psychiatry. But the orientation of psychiatrist, nurse, social worker, and psychologist, among others, as well as the objectives in teaching non-psychiatrist professionals are the principal concepts used empirically as guidelines in liaison psychiatry. Whatever doubts have been raised concerning their usefulness remain unproven.

The Influence of the Cost of Care

The cost of health care is one of the major issues of the 1970s and 1980s, and economists have evolved an industrial concept based on their inquiries into the health care system. Critical care practice contributes significantly to this cost and as a result forces within society are exerting

pressure which influences patterns of care. What bearing does this have on liaison programs? The power structure within the hospital has shifted. The administrator and lay boards have greater power, supported as they are by Blue Cross reimbursement rates, hospital council edicts, governmental support, and utilization review. Admissions may be controlled and hospitalization is shortened. Liaison programs have too little time to work with hospitalized patients and are beginning to shift the site of clinical work to the outpatient department. Rotation of house officers is accelerated and this handicaps the liaison psychiatrist in his teaching. Protracted care of chronic and recurring medical disorders has been the ideal clinical situation for the teaching of psychosomatic medicine and for liaison arrangements. The tendency now is to keep many of these patients in the community rather than in the hospital, except for brief contact or in situations requiring heroic measures. The classic psychosomatic disorder either stays home, undergoes radical surgery, or receives emergency medical intervention.

The Changing Role of the Physician

The emergence of critical care medicine to change the patterns of patient care, the effects of social accountability upon the flow of patient care and its financing, and the recalcitrance of physicians to act upon the reality of a psychological and humanistic medicine is serving to reduce the influence and control on decision making of the individual physician. He appears to be

relinquishing some power to medical councils, peer review boards, hospital administrators, and governmental officials. He finds himself not only in greater need of the counsel of the psychiatrist because of critical care medicine and psychopharmacology, but because societal determinants more than education, compel him to consider psychosocial influences on clinical medicine.

The principal obstacle to the delivery of mental health services to medical and surgical patients has been the resistance of the physician. There has been ample proof that he uses psychiatric consultations sparingly and gives low priority to emotional care in his clinical management. The job of reaching the physician and of securing psychological care for patients has been a difficult one for the liaison psychiatrist, who began his mission forty years ago with enthusiasm and hope, expecting that he and his disciples could make converts out of overburdened physicians. He has persisted in that hope. Yet what scanty evaluation there is demonstrates, as we have seen, that only a small fraction of physically ill patients receive the psychiatric consultation or the emotional care they need.

John Whitehorn wisely wrote in 1963:

> Perhaps the greatest benefit of a liberal education is to escape the tyranny of first impressions and of naive preconceptions—to learn to suspend judgment and actions, not indefinitely and vaguely, but long enough and sturdily enough for the orderly review of evidence and the weighing of

> probabilities and values ... It is humanly difficult to weigh alternatives unless one can cultivate some *tolerance of uncertainty.*

His hope was that when students had more opportunities opened to them, as part of their educational program, for what he called “scientific questing,” there would be “less of the phobic aversion for the uncertainties of the human being.” Physicians have been erroneously taught to be secure only with the certainty of the fact that science is absolute, which it is not, and “the tolerance of uncertainty” which is required in the multi-variables of human behavior is anathema to them.

The changing role of the physician in the face of the changing patterns of health care has led to a reexamination of the traditional aim of liaison psychiatry to provide psychological care for the medically ill through the education of the physician. Greenhill has written:

> This leads to a conclusion which psychiatry should carefully consider. Perhaps one of the principle aims of liaison programs—the conversion of physicians—has been premature. We have grasped a problem but we do not have sufficient information to make much headway with it. I would suggest that we leave the doctor alone until we have that information, that we stop proselytizing, that we desist in our attempts to reform him.
>
> The physician is an earnest and overworked professional carrying the load of sick and dependent human beings and making crucial decisions, often in the face of fatigue. He needs our expertise but seems to fear it or drifts with our liaison programs half-heartedly. Let us not expect of the physician that he can be part psychiatrist. The emotional care of patients does not and will not reside entirely in his hands, but also in the hands of nurses and others who enthusiastically desire that function. The task of educating the

physician in psychological medicine need not be abandoned. But it is slow work, about which there is still much to be learned. It will take a long time, and the sick person should not have to wait. In the meantime, let us design programs in which Psychiatry is more direct and decisive in the care of the sick and the dying. Social forces have now given us that opportunity and the timing is right to grasp it. [p. 179]

Emerging Designs in Liaison Psychiatry

The concept of liaison psychiatry is an evolutionary step in the historical development of the psychological care of the sick and dying. It is but a stage in the process; in time it may not be a separate entity. Ultimately, there is no more need for "liaison psychiatry" than there is today for "liaison radiology" or "liaison pathology." The designs of new psychosocial programs to meet the changing patterns of health care and medical science appear to shape themselves around two forms: active psychiatric and societal intervention and the establishment of alternative approaches, such as primary care education, medical audit, bioethical monitoring, and terminal care (hospice) programs.

Active Psychiatric and Societal Intervention

It has been reported that in situations in which a liaison service functions, the percentage of patients receiving needed psychological care increases. Sanders has shown that at the Massachusetts General Hospital 3 percent of private, 10 percent of general hospital, and 40 percent of cardiac-

surgical admissions receive psychiatric consultation. Active intervention in the ICU and CCU accounts for the 40 percent consultation rate. Strain has claimed that active case finding is a part of the work on liaison units. In 1979, Torem, Saraway, and Steinberg described a controlled study in which an “active” approach increased the rate of referrals on liaison units from 2 percent using the “reactive” approach (traditional consultation model) to 20 percent.

In 1977, Greenhill described the integral model of liaison psychiatry developed at the Einstein Hospital. The integral model was based on the evidence that both the traditional medical model and liaison model were insufficient to meet the needs of the patient population of any hospital and that a new design was required. In the first place such a design must include, as the right of every sick person, psychological care as an integral component of patient care. In the second place, since it has been amply demonstrated that physicians do little about the emotional care of their patients, that care must be assured by another system.

There are five major components to the integral model. The first is open access psychiatric consultation in which the psychiatrist has the freedom to see any patient who needs his care and to enter into staff relationships in any situation in which the staff needs his assistance. Other staff members in addition to the physician, such as nurses, psychologists, social workers, and

physical therapists may ask for a psychiatric consultation by applying to the liaison department. Such procedures reduce the responsibilities of the physician only to the extent that they take from him the complete right to initiate formal psychological care. The key step in the free consultation procedure is that the physician is spoken to by the psychiatrist before the consultation takes place. If the physician resists in the face of the need for the consultation, it may become a matter for clinical and administrative review.

Mandatory high-risk evaluation and care of certain clinical situations in which most psychosocial oversights occur is the second component of the model. These are suicidal and homicidal risks, medical and surgical problems with psychiatric complications, open heart surgery, dialysis, and transplant patients, repeated hospital admissions, hospital stays beyond sixty days, instances of drug and alcohol abuse, repeated surgery, families with hard-core medical problems, and cancer patients. In these instances, the psychiatric service is administratively mandated to initiate consultations by the same method used in open access consultation.

A third component is the early identification of stress problems related to age, culture, and ethnicity. This monitoring is initiated by the social service department and nursing staff, beginning with the information gathered by the admitting office upon reception of the patient to the hospital unit. An open channel to psychiatry is available from the start.

A fourth and important component of the integral model is a system of triage that makes it logistically possible. It is ethical to expect that all patients should receive some psychological surveillance, but no staff is large enough to succeed at the task of providing emotional care without a screening process for focusing of effort. All patients do not have to be seen by mental health personnel; there are those that do, and those who can benefit by informal consultations between mental health personnel and physicians and nurses.

Data for triage come from consultations, informal reporting, case finding rounds at nurses' stations, and monitoring processed through the department of psychiatry. The system makes possible the assignment of clinical problems by triage workers to forms of intervention practical for the available staff, assuring that every patient identified as needing psychological help will receive it in some form.

A fifth and most recently developed component of the integral model is quality assurance monitoring. This is an outgrowth of the medical and auditing procedures correlated with utilization review, Medicaid review, and the influence of the Professional Standards Review Organization, all of which assess patient needs for greater economy and improved care. It is a built-in device that permits the refinement of psychological case finding and the evaluation of intervention in emotional reactions to illness. Since quality assurance is already practiced as an integral part of hospital medicine, the

expansion of this service to include emotional care monitoring is a logical step.

The integral model is a system of active intervention which is not meant to be intrusive, authoritarian, or aggressive. On the contrary, it requires diplomacy, tact, and above all, a long preparation by an experienced liaison director to build trust in the competence of his liaison workers. The system proceeds by negotiation and education in connection with every circumstance. At the Einstein Hospital, in four years of experience with the integral model, not one physician has prevented a consultation. Emergency consultations have been reduced 75 percent, and the request for psychological care of patients from all caretakers has doubled.

At the same time that active psychiatric intervention emerges in these ways, societal forces intervene. These interventions are mainly by third-party carriers and consumers. Hospital administrations are concerned with these forces and are frequently compelled to step into liaison territory to assure reimbursement and prevent legal complications. As a result, there is an increasing connection between hospital administration and liaison departments with signs of a slow realization by the former that patients with emotional reactions to illness must be identified and treated.

The forces of consumerism are accelerating their demands that

physicians and health care systems be accountable, not only for financial cost, but for a humanitarian program of health protection. Informed consent, pharmaceutical habituation, and advocacy have become areas of concern. It is but a short step to claims of patient abuse and class action suits against hospitals, in addition to malpractice suits against physicians. All of this is one aspect of emerging recognition of psychosocial considerations in the treatment of disease.

Alternative Approaches and Primary Care

Alternative means of achieving the goals of liaison psychiatry are developing in the context of changing patterns of health care. The most important is primary care and primary care education. Eaton and his coworkers have written:

> In 1974, the Psychiatry Education Branch of NIMH began to give high priority to the development and expansion of psychiatric consultation-liaison teaching services throughout the country. Among the many reasons for this emphasis was the fact that the country was moving toward a comprehensive health care system that would rely heavily on primary care physicians, who would be expected to handle preventive, diagnostic, and therapeutic tasks for which their training had not prepared them. An active consultation-liaison program would help educate non-psychiatric house officers and staff to recognize and manage the less complicated mental illness and to develop a more comfortable approach to the "problem patient." [p. 21]

They also pointed out that "there seemed to be increasing interest on

the part of primary care physicians in behavioral medicine and behavioral pediatrics" and that "the consultation-liaison psychiatrist would certainly be well-equipped to teach primary care faculty and trainees an open, comfortable approach to patients."

The demographic basis for these conclusions turns out to be sound. In 1978, it was pointed out that approximately 60 percent of mental health problems in the United States were treated by primary care practitioners and only 15 percent by mental health personnel. Brodie has written, "we are faced with the realization that primary care providers have a major responsibility for the recognition and treatment of mental illness and that they therefore need adequate training in the psychological aspects of patient care." There is universal agreement on this point.

There has as yet been little opportunity to test the results of the training of primary care providers and although the need for psychiatric training of such physicians is frequently expressed, only a few programs are in existence. No valid data on their locations and programs have been published. Yet there is no doubt that in time the sites for liaison psychiatry will extend from general hospitals to neighborhood primary care centers and health maintenance organizations. Indeed the trend has already begun.

Liaison with Health Care Functions

In the evolution of the role of the liaison psychiatrist within the health care systems, his presence has given indirect but significant psychosocial exposures to non-psychiatrist physicians, other caretakers, and administrators. The presence and participation of the psychiatrist at medical audit committee and bioethical committee meetings, and his input into hospital terminal care and clinical-pathological conferences, where non-psychiatrist physicians are reluctant to relinquish their leadership, provide useful educational forums for liaison psychiatry. In these arenas, the non-psychiatrist participants feel reasonably secure and the psychiatrists crystallize *their* competence.

Another indirect activity connected with changing patterns of health care, which may have an influence on liaison psychiatry, is modification of nomenclature by the newly revised *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III). Lipp, Looney, and Spitzer believe that the new classification system of psychosomatic disorders will “reduce conceptual ambiguity” and “promote collaborative care rather than care by triage.” The expectation is that a code number from DSM-III will be added to a diagnostic category for a physical condition now listed in the *International Classification of Diseases* which would indicate that psychological factors are important in etiology. Once such a notation becomes a requirement for hospital accreditation and third-party reimbursement, non-psychiatrist physicians should take collaborative care more seriously.

Beyond the Historical Perspective

As a branch of psychiatry, liaison psychiatry has advanced into the territories of general hospitals and health care in a manner analogous to the entry of fellow mental health professionals into legislatures and courts to improve the delivery of mental health care.

They have made a large contribution to psychiatry by increasing nation-wide recognition of mental health as an important part of the national health care system.

In his editorial establishing the journal *General Hospital Psychiatry,* Lipsitt wrote:

> whatever the determinants, psychiatry has clearly established its rightful role in and valid contribution to the teaching and practice of medicine. Now the potential exists for psychiatry to reach beyond the historical perspective. From its well established base in the general hospital, psychiatry can move in tandem with medicine in exploring new directions in health care.

For all of societies' concern for the sick and dying, they are the least protected against psychological vulnerability. In spite of the fear and despair expressed about the chronically psychotic, they are the most neglected. The liaison psychiatrist and the general psychiatrist have each deplored these conditions. From his firm base as a physician, the liaison psychiatrist has moved with greater ease into the councils plotting the future of general health

care, while the general psychiatrist, struggling with role diffusion, is concerned with changing patterns of psychiatric care "in the community." Both directions are important, but "beyond the historical perspective" the model of the physician-psychiatrist, with his scientific medical training, has to prevail as the integrationist of forces contributing to health and relief from disease. The predictable weight of future biological advances will ensure this.

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