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PERSPECTIVE PIECE

Consultation/Liaison Psychiatry During COVID-19

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Introduction

Consultation/liaison (C/L) psychiatry is a subspecialty that focuses on treating people with mental health disorders that co-exist with medical conditions.[1, 2] As part of patient evaluations, the C/L psychiatrist relates to and contends with the issues of others beside the patient: physicians, nurses, family, visitors, and patient roommates.[3] Dealing with pain and/or preoccupation with medical concerns, as well as being surrounded by hospital alarms and monitors, creates additional obstacles to establishing rapport and empathy.

Patients are often unaware that a psychiatric consultation has been requested; they may wonder whether their doctor questions their state of mind. The psychiatrist navigates these obstacles and tries to create an environment conducive to everyone being cooperative.[1] This is not easy. The responsibilities of the C/L psychiatrist include evaluations after a suicide attempt or for suspected suicidal ideation or plans; they also manage psychiatric sequelae resulting from medical conditions (*e.g.*, delirium), provide care for pre-existing mental disorders, assess decisional capacity, and treat substance abuse, including withdrawal states. Providing liaison and support to the medical and nursing staff is also important.[4]

In performing a clinical evaluation, the consultant reviews the medical record and discusses the case with the referring physician and nursing staff. They assess the patient, review findings and recommendations with the attending doctor, record documentation, and set potential follow-up arrangements.[1] Thus, the psychiatrist assesses the situation and the illness and/or emotions involved, suggests therapeutic interventions, and provides coordination.[1] To paraphrase Sir William Osler, "The physician can cure sometimes, relieves often, but comforts always."

The COVID-19 pandemic has created many economic, psychosocial and mental health difficulties for those affected and for anyone who employs protective measures such as social isolation, quarantine, and/or widespread lockdowns.[5, 6]

Psychologic Stressors for COVID-19 Patients

This pandemic has had discomforting implications for the psychosocial well-being of patients and medical caregivers. Stressors for those hospitalized for coronavirus infections include fear of infecting family and lost social support coping mechanisms, especially due to restricted hospital visitation. Pre-existing psychiatric disorders are often made worse—anxiety and dysphoria emerge with unemployment, school closings, in-person schooling, and housing problems; many also mourn loss of intimacy with their doctor due to the use of personal protective equipment (PPE) or remote communication via electronic devices. Some people complain about sleep deprivation and/or phobias about not awakening. People also report flashbacks and nightmares related to procedures such as intubation. Waiting for COVID-19 test results that may confirm infection and concern about whether they would be immune to future infection is also stressful. Oversaturation with pandemic-related news is common and troublesome. Many individuals are worried about substance abuse relapses, the uncertainty of recovery, and the fear of dying alone—concern about their uncertain prognosis and the fear of dying alone are particularly stressful (see **Table 1**). The psychiatric consultant must identify and try to mitigate these concerns while at the same time managing their own dread about contracting the illness and continuing to provide support to their medical colleagues.

Table 1. Stressors for patients.

Fear of having exposed family members
Being ill without family visitation
Loss of intimacy with medical caregivers
Fewer coping mechanisms
Worsening past psychiatric disorders
Helplessness and loss of control
Substance abuse
COVID-19-related news oversaturation
Post-hospitalization placement issues
Pandemic-related socioeconomic issues
Issues over death and dying

Challenges: Psychiatric Consultant

Maintaining visibility

Like their colleagues, the C/L psychiatrist is concerned with the possibility of being infected and/or sick with the virus. This might lead a clinician to utilize telemedicine as their primary means of practice and to avoid person-to person contact. However, there is a benefit to having our medical colleagues know that we too are on the front line of COVID-19 health care. Visible presence also supports other clinicians and reinforces collaborative relationships. When PPE is limited, supplies must be prioritized to those most directly involved in close patient contact, but if scarcity is less of an issue, having the psychiatrist at the bedside lets other clinicians know: "we are all in this together." They serve as good examples to other healthcare workers of the importance of personal care and that it can be done safely.

Loss of intimacy

"I wish I could see your face," one patient said to a consulting psychiatrist; this illustrates one difficulty of COVID-19 restrictions. Telecommunication is replacing in-person bedside healthcare, adversely affecting the therapeutic relationship with distractions less noticed at face-to face encounters. Physician instructions imparted at the bedside may be better followed than those conveyed by telecommunication. Diminished intimacy with a psychiatrist is of particular concern because patients already feel isolated from family, friends, co-workers, classmates, religious caregivers, and others. Appreciative patients may offer a handshake only to be reminded that touching is not advisable during this pandemic. Even with the psychiatrist at the bedside, other relationship barriers include masks, face shields, goggles, gowns, and gloves. This garb conveys the message, "I must not get close to you."

Loss of intimacy is worse when caring for elderly people, for whom a gentle touch is comforting; they are often uncomfortable with electronic devices; paranoid patients are even more suspicious about such instruments. Psychologic effects of decreased intimacy in caring for individuals with COVID-19 is reminiscent of the early days of the AIDS epidemic, when a handshake from the physician often precipitated tearfulness since people were afraid of acquiring HIV through contact.[7, 8] Some helpful interventions to address this loss of intimacy include gaining permission to enter the patient's room, starting the conversation sitting at eye level, making an effort to ensure privacy, and offering reassurance that all communication will be done in person.

Managing exacerbation of pre-existing psychiatric conditions

Anxiety: Most COVID-19-related psychiatric consultations are for management of anxiety, and anxiety disorders were common to many of the affected individuals. The most common contributors to patients' anxiety are:

1. Concern about prognoses
2. Socio-economic worries
3. Concerns about family members being exposed to the virus
4. Anxiety caused by restricted visitation policies
5. Suboptimal communication with medical providers
6. Unavailability of established coping methods
7. Fear of not being able to breathe (despite normal oxygen saturation)
8. Pain
9. Helplessness and loss of control

Patients with COVID-19 exposure and obsessive/compulsive disorder struggle with loss of control and inability to engage in ritualistic behaviors that were previously stress relievers. Those with panic disorders may become overly focused on somatic symptoms, convinced that such panic-related features as chest tightness, shortness of breath, or rapid heart rate

Table 2. Challenges for the psychiatrist.

Fear of self-contagion and/or infecting family
Maintaining a hospital presence
Supporting medical and nursing staff
Combating helplessness
Managing pre-existing and/or current psychiatric problems
Watching people die without family presence
Shortages of personal protective equipment
Conveying empathy despite telecommunication
Combating stigmatization of patients infected by COVID-19
Dealing with substance use issues
Assessing decisionality for COVID-19 patients
Attending to self care

are dangerous harbingers of deteriorating health. Individuals with claustrophobia beg not to be confined to their room with doors closed. Some people evidence acute stress and/or post-traumatic stress disorders with nightmares and flashbacks related to events such as intubation. Individuals with sleep disorders sometimes develop a sleep phobia, with fear of death during the night; sleep deprivation can worsen their overall status and lead to delirium.

Patients with anxiety disorders and COVID-19 infections may become worse when prescribed a corticosteroid or sympathomimetic drug. Pulmonary status may limit the prescribing of pharmacotherapies, such as benzodiazepines; those previously taking them must be monitored for withdrawal. For mild anxiety symptoms, antihistamines are often employed, but their application for older people increases the risk of delirium. Dexmedetomidine is often prescribed to calm severe anxiety or agitation unresponsive to other medications.

Anxiety is expected among people suffering from a disease about which little is known. Persons with preexisting anxiety are likely to have more intense emotional responses. The challenge in caring for these patients includes providing psychotherapies that empower them and promote autonomy. Open communication between patients and medical caregivers is usually reassuring. When able to ask questions of their providers, individuals can combat helplessness and feeling out of control. In providing care for such anxious persons, the C/L psychiatrist should:

1. Provide psychotherapy to empower active participation in medical care.
2. Be a patient advocate regarding issues such as pain control.
3. Encourage them to be grateful for incremental progress.
4. Support and debrief nurses to improve interactions, especially for staff who are anxious, stressed, inexperienced, and/or fearful of contagion.
5. Employ pharmacotherapies and behavioral interventions.
6. Utilize persons who have recovered from COVID-19 illness as peer supporters.

Depression: "I'm not suicidal," a depressed patient told a psychiatrist, "but I hope to die from COVID." Depression is a common reason for psychiatric consultations. Dysphoria is more intense among those with previous mood disorders. They often express concern about family members getting sick and missing their presence at the bedside. Many were already despondent because of unemployment and financial concerns. While people rarely express suicide intent solely related to COVID-19 positivity, some report conditional suicidal thoughts, such as "if I have to live with this pain, I'll just kill myself." Some of them require continuous, one-to-one, direct observation to prevent self-harm; this creates additional stress for the patient, the psychiatrist, and staff, since a staff member must be present to monitor the person for a prolonged time. The psychiatrist may be conflicted about ordering such observation for fear of putting hospital personnel at infection risk. Mitigating depression is complicated since antidepressant medications often have a delayed onset of action. Some have drug interactions and anticholinergic effects, which might produce a delirium. Some seriously ill patients might be intubated, precluding oral intake. Psychostimulant drugs such as methylphenidate are occasionally indicated because of a more immediate onset of action.[9]

Another challenging issue is the management of depressed COVID-19-positive patients who are medically stable but in need of psychiatric hospitalization. Some mental health facilities have opened COVID-19 wards, making continuity of care possible. During this pandemic, psychiatrists often treat depressed COVID-19-positive persons with supportive psychotherapy designed to maintain hope, celebrate signs of progress, and develop new coping strategies. The consistent presence of a supportive, non-judgmental caregiver can substantially elevate mood.

Substance abuse disorders: A damaging consequence of this pandemic is its influence facilitating substance abuse disorders.[10] Many people have a tenuous grip on sobriety, so decreased support, less social connection, and financial shortage are dangerous risk factors for drug relapse. Chemical dependency makes all aspects of medical services more complicated. The absence of in-person therapeutic systems, such as Alcoholics or Narcotics Anonymous meetings, and personal encounters with sponsors can have devastating consequences, including relapse and overdose. Some COVID-19 patients with chemical dependency complain of stigmatization by medical or nursing staff, and this loss of trust makes healthcare delivery more difficult. In such circumstances, advocating on behalf of patients and discussing clinical frustrations with the medical team is often helpful. For anyone with history of opiate abuse, analgesic dosages may require adjustment due to high tolerance. The use of buprenorphine can be helpful in managing pain while also preventing opiate withdrawal. In general, the prescription of controlled pharmaceuticals increases the likelihood of drug relapse after discharge. The consultant should therefore minimize prescription of potentially addictive agents for such conditions as anxiety and sleep difficulties.

Poor coping skills, a desire for immediate gratification, disrupted family relationships, and isolation-induced lonesomeness and boredom are other issues that must be addressed. While intoxicated, inappropriate behavior may have occurred, for which the patient, once sober, feels guilt. Some patients may wish to apologize for certain actions. Such concerns were heightened by the pandemic since stress levels were higher, and substance abuse issues were more prevalent. Open discussion should provide some comfort. Treatment for drug dependence, possibly with family counseling, should always be provided as well. Psychiatrists should have some knowledge of relapse warning signs and make use of such individuals as harm reduction healthcare personnel, many of whom are themselves in recovery. Hospital chaplains are beneficial, especially when there are spiritual issues.

Delirium: Delirium can be caused by infections, metabolic derangement, hypoxemia, sleep deprivation, pain, medicinal effects, drug withdrawal, postoperative complications, cerebrovascular events, intensive care unit sensory overload, and for people with dementia, being in an unfamiliar environment. Psychiatrists often manage patient behavior associated with these issues while the medical team investigates and/or treats the underlying ailment.[11] Many of these conditions complicate COVID-19 patient care. Evidence for central nervous system pathology induced by coronavirus infection is inconclusive with regard to predisposition for and persistence of neurologic features.[12]

COVID-19-mandated restrictive family visitation policies are another burden; contact with relatives could mitigate the need for pharmacotherapies.[13] Management of patients with delirium emphasizes having a familiar environment for patients, but this is difficult to provide in this pandemic era. Nocturnal accentuation of confusion ("sundowning") often leads to sleep deprivation, which can intensify delirium, and electronic communication devices can cause discomfort for older persons and anyone who is already psychotic or paranoid.[14] Patients with encephalopathy evidence more comfort when family or a familiar person are at the bedside. The consistent presence of the psychiatrist provides greater stability, too. Finally, the consultant may have to determine decisionality for COVID-19 patients who refuse treatment or insist on leaving the hospital against medical advice. In these instances, they must balance patient rights against the potential threat to society posed by a COVID-19-positive patient who might not possess the cognitive ability or judgment to comply with social distancing, mask wearing, and other preventive measures. Care of a COVID-19 patient with cognitive impairment represents a significant challenge for the consulting psychiatrist.

Maintaining staff morale: Morale is a concern particularly among nurses. Beyond caring for critically ill patients, they must cope with COVID-19-related issues, such as repeated calls from family members unable to visit, increased workloads, and shortages of PPE. Staff shortages result from personnel who are ill or quarantined. It is demoralizing to care for critically ill patients who seek medical care late in their course of illness due to COVID-19 infection fears. Healthcare workers thus experience frustration while being overworked and emotionally taxed. The psychiatrist should spend time with the hospital staff, exploring their issues through debriefing and discussion. Making appreciative comments about dedicated service and inquiring about the health and well-being of family members reaps a social dividend; it also improves all hospital and patient interactions. This is especially important for anyone providing care for cognitively impaired patients who may be non-compliant, verbally abusive, or combative. The simple question, "What's been your experience taking care of this patient?" can lead to a conversation that significantly boosts morale. Improving the quality of healthcare by attending to staff morale secondarily also promotes the psychiatrist's sense of well-being.

Combating helplessness: Psychiatrists are not alone in feeling helplessness about this disease. There is agony in watching patients die, especially if they are alone.[13] There is limited understanding about the adverse effects or interactions of psychiatric medications co-prescribed with antiviral agents, such as remdesivir. Fear of personally becoming ill and potentially infecting family members creates stress and helplessness. "I am afraid of taking this illness home to my fam-

ily," is often heard.[15] Shortages of, or not trusting in, PPE and impersonal means of communicating also contribute. Pulmonologists, critical care, and infectious diseases physicians are not immune to these feelings, so one should not assume that they are.

Usually, returning home offers a respite from patient care worries; however, COVID-19 care providers prominently maintain the fear that they might convey a viral infection to those at home. Balancing a sense of obligation to provide care for hospitalized patients while wanting to protect family creates a dilemma for all physicians, including the mental health caregiver.

The psychiatrist should focus on fixable things. Examples include improving communication between patients and caregivers, reassuring physicians and patients by her presence, alleviating patients' mental issues, being up to date on COVID-19 matters, attempting to improve the quality of whatever life remains, offering hope and combating pessimism, and realizing that she is not alone in her feelings of powerlessness with regard to this pandemic. Once back home, it is important to maintain protective precautions such as frequent handwashing, leaving shoes and outer garments outside, changing into clean clothing, and isolating when indicated. To avoid physician burnout, maintaining routines of a healthy diet, regular exercise, and avoiding substance use is important. Utilizing spiritual advisors, maintaining sleep, and taking vacations or time off also help.[16] In combating pandemic-related helplessness, the consulting psychiatrist will be well served to accept the things he cannot change, change the things he can, and acquire the wisdom to know the difference.

Conclusion

Providing psychiatric consultation for someone infected by COVID-19 is similar to treating hospitalized patients with any medical or psychiatric condition. There are, however, circumstances created by this pandemic that are unique; the psychiatrist ought to recognize these issues and respond while attending to their own frustrations. Providing good professional work and appropriate self-care is key. Doing so and being appreciative of clinical progress can empower physicians and everyone involved.

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References

1. Smith FA, Levenson JL, Stern TA. Psychiatric assessment and consultation. In: Levenson JL. The american psychiatric association publishing textbook of psychosomatic medicine and consultation-liaison psychiatry. Third edition. ed. Washington, D.C.: American Psychiatric Association Publishing, **2019**:3-24.

2. Lipowski ZJ, Lipsitt DR, Whybrow PC, eds. Psychosomatic medicine: Current trends and clinical applications. New York: Oxford University Press, **1977**.

3. Schwab JJ. Handbook of psychiatric consultation. New York,: Appleton-Century-Crofts, **1968**.

4. Bronheim HE, Fulop G, Kunkel EJ, et al. The academy of psychosomatic medicine practice guidelines for psychiatric consultation in the general medical setting. The academy of psychosomatic medicine. Psychosomatics **1998**; 39(4):S8-30. doi: 10.1016/s0033-3182(98)71317-9. PMID: 9691717.

5. Pfefferbaum B, North CS. Mental health and the covid-19 pandemic. N Engl J Med **2020**; 383(6):510-2. doi: 10.1056/NEJMp2008017. PMID: 32283003.

6. Parmet WE, Sinha MS. Covid-19 - the law and limits of quarantine. N Engl J Med **2020**; 382(15):e28. doi: 10.1056/NEJMp2004211. PMID: 32187460.

7. Frierson RL, Lippmann SB. Psychologic implications of aids. Am Fam Physician **1987**; 35(3):109-16. PMID: 3825841.

8. Frierson RL, Lippmann SB. Suicide and aids. Psychosomatics **1988**; 29(2):226-31. doi: 10.1016/s0033-3182(88)72403-2. PMID: 3368568.

9. Frierson RL, Wey JJ, Tabler JB. Psychostimulants for depression in the medically ill. Am Fam Physician **1991**; 43(1):163-70. PMID: 1986485.

10. Czeisler M, Lane RI, Petrosky E, et al. Mental health, substance use, and suicidal ideation during the covid-19 pandemic - united states, june 24-30, 2020. MMWR Morb Mortal Wkly Rep **2020**; 69(32):1049-57. doi: 10.15585/mmwr.mm6932a1. PMID: 32790653.

11. Kuhn WF, Bell RA, Frierson RL, Lippmann SB. Consultative psychiatry in both private and public general hospitals. Gen Hosp Psychiatry **1986**; 8(4):236-40. doi: 10.1016/0163-8343(86)90003-4. PMID: 3744030.

12. Helms J, Kremer S, Merdji H, et al. Neurologic features in severe sars-cov-2 infection. N Engl J Med **2020**; 382(23):2268-70. doi: 10.1056/NEJMc2008597. PMID: 32294339.

13. Wakam GK, Montgomery JR, Biesterveld BE, Brown CS. Not dying alone - modern compassionate care in the covid-19 pandemic. N Engl J Med **2020**; 382(24):e88. doi: 10.1056/NEJMp2007781. PMID: 32289215.

14. Harvey PD, Nascimento V. Helping older adults overcome the challenges of technology. Curr Psychiatry **2020**; 19(9):13-23. doi: 10.12788/cp.0021.

15. Rose C. Am i part of the cure or am i part of the disease? Keeping coronavirus out when a doctor comes home. N Engl J Med **2020**; 382(18):1684-5. doi: 10.1056/NEJMp2004768. PMID: 32187461.

16. Mohanty D, Prabhu A, Lippmann S. Physician burnout: Signs and solutions. J Fam Pract **2019**; 68(8):442-6. PMID: 31609356.