

Bedside psychotherapy

Brief and surprisingly effective

A therapeutic alliance often develops within minutes

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Bedside psychotherapy is not only possible but invaluable for some medical-surgical patients, despite hospitals' distractions, lack of privacy, and short stays. If you are asked to evaluate a hospitalized patient, a 5-step strategy can help you:

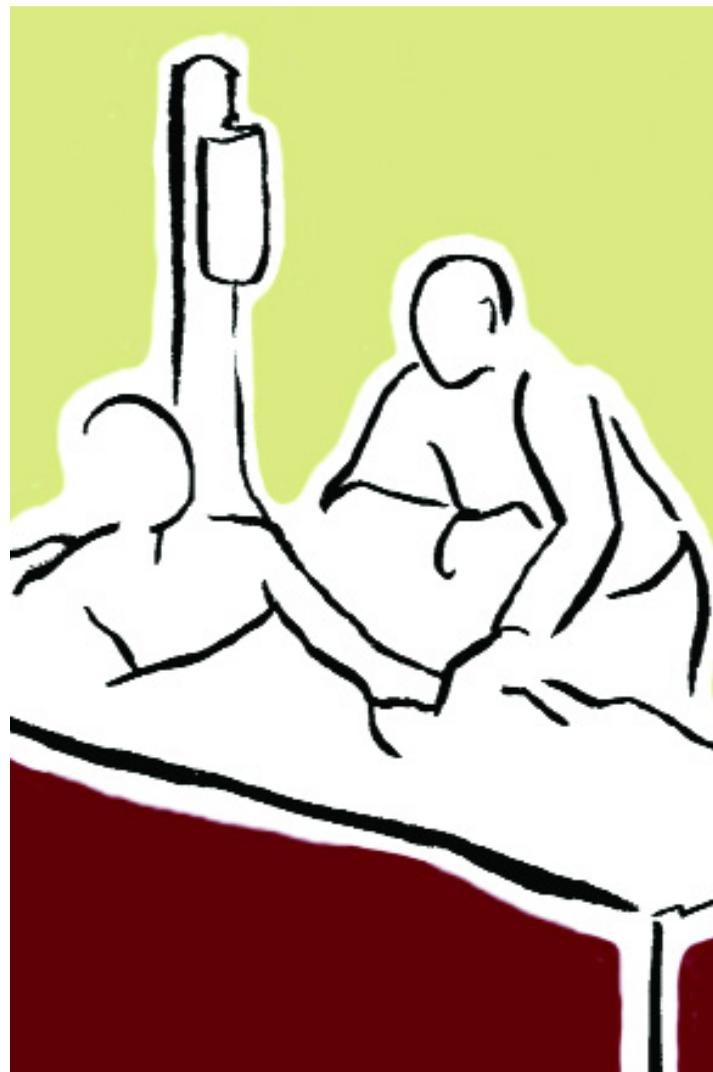
- identify acute psychiatric problems that psychotherapy can help
- watch for common psychodynamic themes
- choose a beneficial psychotherapy
- integrate drug/psychotherapy, as needed
- quickly establish rapport by using an effective bedside manner.

CASE REPORT: A DEEPLY WOUNDED PATIENT

Ms. T, age 45, was admitted to the trauma unit with gunshot wounds. Her estranged husband shot her during an argument and killed her 14-year-old son, who tried to help her.

She underwent multiple surgeries to repair internal organs and endured intense pain. She was medically stable after 10 days, and the surgical team called on the psychiatric consultation-liaison (C-L) service to evaluate her "depression."

continued



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Table 1

5 steps to bedside psychotherapy

1. **Identify** problems and patients that psychotherapy can help
2. **Watch for** psychodynamic themes (denial of illness, loss of control, dependency and regression, fear of abandonment, loss of identity, fear of death)
3. **Select** a psychotherapy approach, knowing that your patient may need different approaches from day to day
4. **Integrate** psychotherapy with medication, as needed
5. **Combine** steps 1 to 4 with an effective bedside manner

Ms. T told the psychiatrist she was having nightmares and re-experiencing the shootings. She felt overwhelming guilt and blamed herself for her son's death. She reported hyperarousal, muscle tension, and palpitations. She also worried about facing her son's killer in court.

The C-L psychiatrist felt Ms. T would benefit from medication and psychotherapy for anxiety while hospitalized.

OBSTACLES TO BEDSIDE PSYCHOTHERAPY

Hospitalized patients do not usually seek psychiatric consultation but are referred by their physicians. Pain and injuries, medications, and illness can limit patients' energy and motivation to participate in therapy, as well as their concentration and cognition. Moreover, bedside psychotherapy sessions are likely to be interrupted for blood draws, medical rounds, investigations, and procedures.

Despite these obstacles, medical patients are often receptive to psychiatric care.¹ An alliance often develops within minutes, and the psychiatrist can achieve effective psychotherapy during a single bedside visit.²

The Academy of Psychosomatic Medicine considers psychotherapy a required skill for anyone who evaluates and treats psychiatric disorders in general medical settings.³

HOW TO OVERCOME OBSTACLES

STEP 1. Identify when psychotherapy may help.

Not every problem or patient benefits from bedside psychotherapy. The C-L psychiatrist's first task is to identify:

- Problems that warrant psychotherapy. These may include depression, bereavement, adjustment disorder, maladaptive coping, anxiety related to medical procedures, acute stress disorder, posttraumatic stress disorder (PTSD), and demoralization.
- Patients likely to benefit. Look for evidence of ego strength, ability to interact in the first session, psychological-mindedness, ability to experience feeling, and absence of severe cognitive deficit.²

These patient traits are not prerequisites, however, and clinical judgment applies on a case-by-case basis.

Demoralization is the most common reason for psychiatric evaluation of medically-ill patients, though their physicians typically request a "depression" evaluation.⁴ Demoralization is an understandable response to serious illness or disabling, agonizing, or deforming treatment.⁵ Symptoms include anxiety, guilt, shame, depression, diminished self-worth, and possibly somatic complaints or preoccupation.⁶

Ms. T was experiencing survivor guilt—she blamed herself for her son's death—and she described herself as feeling "lost." Four strategies can treat demoralization (*Table 2, page 17*).

STEP 2. Watch for common psychodynamic themes, such as denial of illness, loss of control, dependency and regression, fear of abandonment, loss of identity, and fear of death.⁷ Other issues include survivor guilt, anger at the treatment team or family, and knowing someone who had a negative experience with the same illness or treatment.

Identifying these themes and integrating them into the treatment plan can improve outcomes. For example:

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Table 2

4 bedside strategies to treat demoralization

Strategy	Examples
Validate the patient's feeling and experience	Say, "I can see this is frustrating to you to be in the hospital so long," or "You must feel as if everything is out of your control"
Reassure the patient that demoralization is a natural response to a difficult situation	Say, "I can imagine that anyone in your place would feel the same way," or "It's only natural to feel this way after what you've been through; this does not mean you have a mental illness or are 'going crazy'"
Make simple gestures that promote an improved outlook	Use an effective bedside manner (<i>Box 1, page 18</i>)
Alleviate feelings of isolation, and foster a sense of hope	Use resilience-building questions (<i>Box 2, page 19</i>)

- Giving an empathic validation can help overcome fear of abandonment.
- Letting the patient choose the time when blood is drawn increases feelings of control.

STEP 3. Select appropriate psychotherapy. The psychiatrist's challenge is to know:

- when to use which approach
- when to combine approaches
- what problems each approach targets.

A hospitalized medical patient often has a fluctuating course and may require more than one approach—or even a different approach at each visit. Thus, flexibility and creativity are keys to successful bedside psychotherapy.

STEP 4. Integrate psychotherapy with medication, as needed. Consider target symptoms for using psychotropics and how medication may help the patient attain treatment goals. Does the patient require medication to allow psychotherapy to occur?

STEP 5. Combine steps 1 to 4 with a good bedside manner. An empathetic approach will help most patients, no matter which psychotherapy model you use (*Box 1, page 18*).^{4,8,9}

CASE CONTINUED: FIRST AID FOR THE EGO

The C-L psychiatrist diagnosed Ms. T as having acute stress disorder and identified four target symptoms: bereavement, demoralization, anxiety, and hyperarousal. During the initial interview, Ms. T appeared to be psychologically-minded and open to psychiatric intervention.

The psychiatrist considered her at high risk for PTSD and prescribed citalopram, 20 mg/d, because selective serotonin reuptake inhibitors may prevent PTSD. Ms. T was also given clonazepam, 0.25 mg as needed, for severe anxiety.

The psychiatrist visited her 20 to 30 minutes daily. Initial psychotherapy focused on supporting Ms. T's ego. Resilience-building interviews—using questions to counter feelings of despair, meaninglessness, and sorrow—addressed her demoralization and grief. She regained some sense of meaning and hope by focusing on caring for her other son and on her family's love. She also found a sense of peace through prayer and by visualizing her lost son safe in God's hands.

The psychiatrist also taught her relaxation skills



Box 1

Elements of an effective bedside manner

- **Start by attending to basic physical needs** (help the patient get some water or move into a more comfortable position)
- **Sit down**, even for a brief session
- **Smile and touch the patient** when appropriate
- **Ask “What troubles you most?”**
- **Inquire about the patient’s experience** (ask what the medical illness or treatment was like, not just what happened)
- **Look for opportunities** to comment on the patient’s strength and accomplishments
- **Avoid using confusing medical terms** or psychiatric jargon
- **Be sensitive** to cross-cultural, spiritual, and religious issues, as well as culture-specific health beliefs

to manage her anxiety symptoms. These included abdominal breathing and guided imagery (picturing herself in a safe, comforting place).

PSYCHOTHERAPEUTIC OPTIONS

Three psychotherapeutic approaches are particularly useful at bedside—supportive therapy and resilience-building, cognitive-behavioral therapy (CBT), and psychodynamic therapy.

Supportive therapy and resilience-building is the most common bedside model. Supportive therapy’s goal is to strengthen coping skills, thereby reducing anxiety and enhancing well-being, self-esteem, and function.

Fostering a good working relationship is the first priority.¹⁰ The therapist works to contain the patient’s anxiety and provide an “auxiliary ego” to supplement his or her reality testing, planning and judgment, and sense of self.^{2,10} Supportive techniques include suggestion, clarification, limit-setting, reinforcement, reassurance, and empathic listening.

Much of the work relies on positive transference to build the supportive relationship.^{8,10} Transference is interpreted only when negative transference disrupts treatment; the therapeutic goal is to decrease the patient’s anxiety. Resilience-building questions (*Box 2*)^{4,11} help identify the patient’s skills and competencies and mobilize his or her internal resources.

CBT attempts to identify, challenge, and correct a patient’s inaccurate or dysfunctional beliefs about illness, treatment, or self-image. For example:

- a patient with second-degree burns may be convinced she is the world’s ugliest person
- a patient facing an operation may believe he will be permanently disabled, as was his father after a similar procedure.

CBT can also help dispel beliefs that psychiatric treatment is for “crazy” people.

Behavioral therapy can help patients manage distress related to their medical care, such as shortness of breath while being weaned from a ventilator or arousal and anxiety related to procedures. Techniques that work in office settings—systematic desensitization, *in vivo* exposure, breathing exercises, progressive muscle relaxation, guided imagery, meditation, and hypnosis—also can be effective at bedside.¹²

Psychodynamic therapy. Patients can develop insight through psychodynamic therapy, even in brief therapeutic relationships. Useful bedside techniques include clarification, confrontation, and interpretation of behavior, conflict, and transference.

For example, a patient who survived heart surgery later developed depression and suicidal ideation. Psychiatric interview revealed she was experiencing survivor guilt because her mother had died from a heart attack. Emphatic clarification

and validation of feelings often can help lift such a patient's mood and allow a dialogue to begin.

A “psychodynamic life-narrative” approach¹ can help treat depression in medically ill patients. The therapist first asks the patient to describe the illness' meaning in his or her lifespan, then formulates a statement (the “narrative”) of its meaning at the moment. The narrative is intended to:

- create a new perspective
- increase self-esteem by emphasizing the patient's strengths
- support coping mechanisms that worked in the past.

This approach also can help the patient understand that a psychiatric symptom is an understandable response when a previously successful adaptive method cannot be used.

CHOOSING A PSYCHOTHERAPY

Three factors—patient characteristics, therapist characteristics, and evidence—determine the psychotherapeutic approach.

Patient characteristics include ego functioning level and maturity, object relationship stability,¹³ history and experience of psychotherapeutic treatment, personality and coping style, and physical condition. For example:

- CBT and education may be effective for patients who cope through analytical thinking, controlling emotional expression, and managing situations.

- Psychodynamic methods may help those who cope through expressing feelings, self-reflection, and a wish to be understood.

Therapist characteristics include experience, preference, and degree of comfort in conducting each therapeutic approach, as well as time and schedule.

Box 2

Sample questions for resilience-building

The goal of a resilience-building interview is to enable patients under stress to focus their attention and mobilize their emotions while answering each question.^{10,14} Here are sample questions, grouped by issues the psychiatrist wishes to address.

Countering isolation

- Who understands your situation?
- In whose presence do you feel peaceful?

Countering meaninglessness

- For whom or what does it matter that you continue to live?

Countering despair

- What keeps you from giving up on difficult days?
- From what sources do you draw hope?

Countering sorrow

- What sustains your capacity for joy in the midst of pain?
- What has this experience added to your life?
- Are there things that take your mind off your illness and comfort you?

Promoting resilience

- What part of you is strongest right now?
- What is still possible?

Promoting continuity of self/role preservation

- What should I know about you as a person that lies beyond this illness?
- How have you prevented this illness from taking charge of your life and identity?
- What did you do before you were sick that was important to you?
- What about yourself or your life are you most proud of?
- What have you learned about your life during your illness that you would want to pass along to others?

Evidence of efficacy. Psychiatric literature supports using CBT for depressive cognition in major depression,¹⁴ resilience-building interviews for demoralization,⁴ and behavioral therapy and relaxation for anxiety related to medical procedures.¹²

continued



CASE CONTINUED: COMING HOME

As Ms. T's medical condition improved over several days and her discharge was planned, the psychiatrist began to emphasize practical issues, such as:

- limiting visitation to allow her time to grieve
- addressing her anxieties about outpatient treatment and moving in with her parents.

At discharge, Ms. T was taking citalopram, 40 mg/d, and clonazepam, 0.25 mg as needed. With this regimen, her nightmares and re-experiencing had decreased. The psychiatrist had treated Ms. T in the hospital for 21 days. She continued psychiatric care for acute stress disorder at a local outpatient center.

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Psychotherapy is possible in hospitals, despite limited time and privacy, and many patients respond quickly. Identify problems and patients that be helped, watch for psychodynamic themes, choose appropriate psychotherapies, and use psychotropics as needed.

BottomLine

Related resources

- ▶ Academy of Psychosomatic Medicine. www.apm.org
- ▶ American Psychosomatic Society. www.psychosomatic.org
- ▶ Griffith JL, Griffith ME. *Encountering the sacred in psychotherapy: how to talk with people about their spiritual lives*. New York: Guilford Press, 2002.
- ▶ Dewan MJ, Steenbarger BN, Greenberg RP (eds). *The art and science of brief psychotherapies: a practitioner's guide*. Washington, DC: American Psychiatric Publishing, 2004

DRUG BRAND NAMES

Citalopram • Celexa
Clonazepam • Klonopin

DISCLOSURE

Dr. Lolak reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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