Psychiatric consultation, albeit with varying models and styles, is an integral component of patient care in inpatient general medical settings. The consultant can prepare for the patient evaluation by clarifying the consultation request, establishing the psychiatric service’s role, reviewing relevant records, and understanding the care team’s immediate concerns. During the patient interview, psychiatric consultants may need to adapt to the medical setting and be mindful of time constraints, interruptions from other care providers, and the patient’s medical needs. Whether the psychiatric interview is a focused or comprehensive evaluation, the assessment typically includes relevant components of a cognitive evaluation, physical examination, and lethality assessment.

Psychosomatic medicine explores how psychological, behavioral, and social factors influence the health and quality of life of a person and focuses on the treatment of individuals with concurrent medical and psychiatric illness. The conceptual roots of psychosomatic medicine extend back to ancient Greece. The term came into use in the nineteenth century—as distinguished from the emerging field of “organic” medicine. In modern times the field has continued to grow and has developed subspecializing branches, including behavioral medicine, health psychology, and consultation-liaison (C-L)
psychiatry. In the United States, C-L psychiatry started to evolve in the early 1900s, seeded by the creation of psychiatry departments within the medical hospital as opposed to the asylum. The field underwent a series of developmental changes over the following century, culminating in the garnering of formal subspecialty status in 2003, as “psychosomatic medicine.” The practice of C-L psychiatry was later adopted in Europe and is similar to that in the United States.

Relapse Prevention
Dennis Daley and Lisa Maccarelli

Chapter 9 discusses relapse prevention, including key points, introduction to recovery and relapse, recovery, and substance use lapse and relapse.

Future Directions in Psychosomatic Medicine
Christopher R. Dobbelstein, Ghennady V. Gushchin, Bradford Bobrin, and Kurt D. Ackerman

The division between mind and body is artificial; both are aspects of the human organism as a whole. In the future, healthcare will follow a new illness model that treats each person as an integrated whole. Applications of this new model will include reducing stress to ameliorate physical illness, harnessing the power of conditioning to decrease medication doses, and bringing behavioral healthcare into medical settings using computer-aided decision-making, telepsychiatry, and collaborative care.

Psychiatry in Palliative Care
Kevin R. Patterson

Palliative care is a symptom-based, quality-of-life approach to the management of patients with major medical illnesses. It provides an ideal space for the integration of medical and psychiatric services. While trained palliative care providers have a good degree of comfort with treating basic anxiety, depression, and delirium, there are many more complicated scenarios where psychiatric input or intervention are valuable. Additionally, there are many places where formal palliative care services do not exist and where the consult psychiatrist can provide guidance in quality-of-life care and complex medical decision-making. Rapid treatment and overlapping symptom management are important considerations for psychopharmacologic practice in palliative care.
Substance Intoxication and Withdrawal States in the General Medical Setting
Jody Glance, Priya Gopalan, and Kurt D. Ackerman

Substance use disorders (SUDs) are commonly encountered by medical professionals across specialties in the general hospital setting. Failure to recognize intoxication and withdrawal states can lead to improper treatment and unnecessary medical complications. This chapter provides an overview of the clinical approach to identification and management of intoxication and withdrawal states in an acute medical setting. Substances covered include alcohol, benzodiazepines and other GABA-agonists, opioids, cocaine and other stimulants, hallucinogens, and designer drugs including synthetic cannabinoids, synthetic cathinones, and MDMA. Urine drug testing, long-term opioid maintenance treatment, and mixed delirium states are discussed. The necessity to refer patients for further treatment of the SUD is also stressed.

Pharmacotherapy of Substance Use Disorders
Julie Kmiec, Jack Cornelius, and Antoine Douaihy

Chapter 7 covers pharmacotherapy for SUDs, including medications for the treatment of alcohol, opioid, nicotine, cocaine, methamphetamine, and cannabis dependence, as well as common guiding principles for pharmacology use in treatment.

Anxiety in the General Medical Setting
Robert Hudak and Rolf G. Jacob

Anxiety is exceptional among psychiatric symptoms in that it also presents in the absence of overt pathology, and can occur in virtually everyone. As a result, complaints of anxiety are common among patients hospitalized in the medical setting and are frequently cited as reasons for psychiatric consultation. The psychiatrist consulting in the medical setting needs to determine the etiology of the anxiety in order to appropriately address it. In a C-L setting, psychiatrists will be asked to diagnose and differentiate anxiety arising from different causes. This chapter aims to assist the C-L psychiatrist in properly assessing and treating anxiety in the medical setting.
Chapter 13 provides an overview of substance use disorders (SUDs) in older adults. It examines the prevalence and the consequences of SUDs among older adults, as well as the higher rates of medical comorbidities and accelerated rates of biologic aging in the elderly who exhibit SUDs.