Psychosocial Rotation Notebook

January 13th, 2014
February 7th, 2014

Department of Medicine
College of Human Medicine
Michigan State University
PSYCHOSOCIAL MEDICINE

Patient-Centered Interview
1) Set the stage
2) Develop agenda
3) Nonfocused
4) Focused: symptoms → personal context → emotional context
5) Transition (to doctor-centered interview)

Management of Chronic Somatization
INFORM
1. Give diagnosis—not life-threatening & no more tests or docs
2. Cure unlikely but can improve
3. Stress & depression central but not “psychiatric”
4. Check understanding

COMMITMENT
5. Give general Tx plan
6. Obtain commitment

NEGOTIATE SPECIFICS
7. Jointly establish goals
8. Negotiate Tx non-PRN
9. Regular f/u visits non-PRN
   - always do limited PxD

Informing & Motivating Patients
INFORM
1. Check understanding
2. Inform RE harm & benefit from change

COMMITMENT
3. Check understanding
4. Give action required
5. Give general Tx plan
6. Obtain commitment

NEGOTIATE SPECIFICS
7. Jointly establish goals
8. Baseline behavior to change
9. Develop plan
10. Arrange follow-up
11. Reinforce commitment

NURS throughout
Cognitive Capacity Screening Exam
(30 points total; <20 diminished cog. capacity)

1-2 What day of the week is this? What month?
3-4 What day of the month? What year?
5 What place is this?
6 Repeat the numbers: 872
7 Say them backwards.
8 Repeat these numbers 6371
9 Listen to these numbers 694,
  Count 1 thru 10 out loud; repeat 694.
  (Help if nec. Next use nos. 573.)
10 Listen to these numbers 8143,
  Count 1 thru 10 out loud, then repeat 8143
11 Say the days of the week backwards. Begin with Sunday.
12 9 + 3 is ...
13 Add 6 (to previous answer, or “to 12”)
14 Take away 5 (“from 18”)
  Repeat these words after me & remember them,
  I’ll ask for them later: hat car tree 26
15 Opposite of fast is slow. Opposite of up is ...
16 Opposite of large is ...
17 Opposite of hard is ...
18 An orange & a banana are both ...
19 Red and blue are both ...
20-23 What were these words I asked you to remember?
  (hat) (car) (tree) (26)
24-30 Subtract 7 from 160; subtract 7 from what is left
  and keep going: 100-7 is ... (93)
  minus 7 (86); minus 7 (79); minus 7 (72)
  minus 7 (65); minus 7 (58); minus 7 (51)
PSYCHOSOCIAL ROTATION
Michigan State University

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Revised 7-2012
Schedules
# January 12, 2014 - January 18, 2014

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<th>13 Monday</th>
<th>14 Tuesday</th>
<th>15 Wednesday</th>
<th>16 Thursday</th>
<th>17 Friday</th>
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<td>D'Mello PS Rotation Teaching</td>
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<td>1:00</td>
<td>PS Orientation - Watch Patient Centered Interviewing Tape: Smith/Laird-Fick (Jnis 3-19:13) B307 Clinical Center Jinie Shirey</td>
<td>PS Teaching &quot;Interviews&quot;</td>
<td>ACHIEVE Must have client</td>
<td>Survey Plan - Regul Clinic A225 CC</td>
<td>DOC4 WEEK 1 ASSIGN</td>
<td>Gummi meet w/Thr</td>
<td>GMEE Activities/Noon Conference/Board Review, etc.</td>
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Jinnie Shirey
### January 26, 2014 - February 01, 2014

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<tr>
<td>Sunday 26</td>
<td>ACHIEVE: Vacation</td>
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<td>Monday 27</td>
<td>Residency Retreat</td>
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<td>Karmani PS Teaching</td>
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<td>Friday 31</td>
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<td>Care-Free Clinic, 790 E Columbia, Mason</td>
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<td>Kavadaella - Psychiatry for Primary Care</td>
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Psychosocial Rotation Instructors
PSYCHOSOCIAL ROTATION INSTRUCTORS

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353-3730
General Information
PSYCHOSOCIAL ROTATION ORIENTATION

This rotation is designed to provide you with a foundation in the psychosocial principles of medicine, with particular reference to their application in primary care. The psychosocial notebook is yours to keep and contains general information about the rotation, forms, handouts and some readings.

General Information:
Rotation schedule: The first section begins with your schedule for the next four weeks. It comprises interviewing, seminars, and patient rounds with the teaching faculty. During this period, except to attend the indicated conferences and outpatient clinics, your time and effort can be devoted entirely to this rotation. You will need to continue to be available to handle problems that arise with your clinic patients.

Attendance and preparation: There is considerable discretionary time built into the schedule for reading and taping interviews. It is expected that you will come to each session prepared and on time. If an unforeseen event prevents you from attending a session, please notify the session faculty before the seminar begins. A list of faculty and their telephone numbers is provided in this section. Excessive absence from scheduled sessions may require that you make-up work to successfully complete the rotation.

Vacation: If you are taking vacation during the rotation, and it does not appear on the schedule, please contact Jinie Shirey at 353-3730 so that all faculty can be notified.

Learning objectives and personal journal: Learning objectives derived from the input of earlier learners are included for your consideration. You should have received previously a letter explaining learning agreements, along with a blank learning agreement form. In that letter, we asked you to begin formulating your own objectives that you would like to work on during this rotation. Please continue to update your objectives throughout the rotation on the forms provided. We also recommend that you keep a personal journal of your experiences during the month. Journal guidelines are contained in a separate section to help you.

Reading list: The reading list includes two texts that are loaned to you to use during the rotation. The articles that are listed are included in the appropriate sections of this notebook.

Seminars:
This notebook contains sections for the psychosocial interviewing seminars and other seminars. Each section contains objectives along with additional notes and handouts.

Additional (optional) readings are available on a variety of subjects discussed in the seminars. Please don’t hesitate to ask about these if there are subjects that you would like to explore further. We also have a copy of the Bill Moyers’ series, “Healing and the Mind,” that you may borrow and you also will have access to doc.com, the focus of several assignments.
Interviewing Sessions:
A tape recorder is provided for you and will be required for many of our interviewing instruction sessions. Over the course of the month, you will be required to tape record 10 to 12 interviews with patients. These recordings are reviewed during some of the interviewing sessions. Be sure to bring the recorder and taped interviews with you to each interview session. You will need to find patients to record before the interviewing sessions. You can identify patients for interviewing through your resident and faculty colleagues on the FIRM service or in outpatient clinics. Talk briefly with the patient to obtain his/her approval for both interviewing and taping the session. Explain that his/her participation aids you in your work on communication skills and that the interview is entirely confidential.

There is no need to find patients with psychological difficulties; any willing patient will suffice. When you schedule patients in the clinic for these interviews be sure to notify clinic personnel. In addition to the interviewing work, it is recommended that you record at least one patient daily for your own review and self-critique.

Evaluation and feedback: As with all residency rotations, at the end of the psychosocial rotation, we provide a written evaluation of your performance. You will receive verbal feedback on all of your work as you progress through the objectives on your learning agreement. Because of the personal nature of many of the discussions, all sessions are considered strictly confidential.

Tape records and textbooks should be returned in to Jinie Shirey (B319 Clinical Center) at the end of the rotation.

We are looking forward to working with you and sharing ideas. Please contact Jinie Shirey (353-3730) if you have any questions or problems.
INTERVIEWING ASSIGNMENTS – DR. SMITH

During interviewing rounds, you will interview 1-2 patients at each of 12 sessions with Drs. Dwamena and Smith.

For this assignment, follow all the patients you have interviewed each subsequent day they are in the hospital with a 10-minute follow-up interview. Make brief notes of your own each day (not in the chart) regarding the following:

1. Clinical and psychological change in the patient and/or their circumstances
2. What you have done from an interviewing and doctor-patient relationship perspective
3. Your impact on the patient
4. The patient’s impact on you, especially your emotional reactions
5. What you have learned from this patient
6. Other comments

When the patient has been discharged, attach your daily notes to Dr. Smith: Robert.smith@hc.msu.edu

A minimum of 2 reports per week will be required for a passing grade.

See the times allotted for this activity on your schedule, although you may do these at other times as well.
INTERVIEWING ASSIGNMENTS – DR. DWAMENA

Tape one interview weekly and have one of your colleagues on the rotation critique it in terms of the 5-step, 21-substep interview you have learned. The interview can involve patients from your clinic. Care Free, or the hospital.

Turn the critique and the interview tape in to Dr. Dwamena by the end of each week.

A minimum of 1 critique/tape per week is required for a passing grade.

See the times allotted for this activity on your schedule, although you may do these at other times as well.
Psychosocial Rotation Objectives
PSYCHOSOCIAL ROTATION OBJECTIVES

PATIENT-CENTERED INTERVIEWING METHOD
(5-STEPS, 21-SUBSTEPS)

STEP 1 -- Setting the Stage for the Interview
1. Welcome the patient
2. Use the patient’s name
3. Introduce self and identify specific role
4. Ensure patient readiness and privacy
5. Remove barriers to communication
6. Ensure comfort and put the patient at ease

STEP 2 -- Chief Complaint/Agenda Setting
1. Indicate time available
2. Indicate own needs
3. Obtain list of all issues patient wants to discuss; e.g., specific symptoms, requests, expectations, understanding
4. Summarize and finalize the agenda; negotiate specifics if too many agenda items

STEP 3 -- Opening the HPI
1. Open-ended beginning question
2. 'Nonfocusing' open-ended skills (Attentive Listening): silence, neutral utterances, nonverbal encouragement
3. Obtain additional data from nonverbal sources: nonverbal cues, physical characteristics, autonomic changes, accouterments, and environment

STEP 4 -- Continuing the Patient-Centered HPI
1. Physical Story -- Obtain description of the physical symptoms [Focusing open-ended skills]
2. Personal Story -- Develop the more general personal/psychosocial context of the physical symptoms [Focusing open-ended skills]
3. Emotional Story -- Develop an emotional focus [Emotion-seeking skills]
4. Empathic Responses -- Address the emotion(s) [Emotion-handling skills: NURS]
5. Expand Story and Responses -- Expand the story to new chapters (focused open-ended skills, emotion-seeking skills, emotion-handling skills)

STEP 5 -- Transition to the Doctor-Centered Process
1. Brief summary
2. Check accuracy
3. Indicate that both content and style of inquiry will change if the patient is ready
Table 6-1. End of the Interview – General Guide

1. Orient patient to the End of the interview and ask for permission to begin discussion
2. Iteratively explain diagnosis/prognosis; incorporate patient’s informational needs
3. Invite the patient to participate in shared decision making
4. Iteratively explain testing and/or treatment options (including doing nothing) until agreement is reached; incorporate patient preferences
5. Summarize decisions and provide written plans/instructions
6. Acknowledge and support before saying goodbye

*Speak as plainly as possible, avoid jargon, and give information in small chunks with appropriate transitions. Use “teach-back” to explain each new topic. Answer patient’s questions, elicit and/or address patient’s emotional reactions throughout the encounter.*
Table 6-2. Giving Bad News

1. Prepare yourself to give bad news
   a. Prepare emotionally
   b. Confirm the medical facts
   c. Prepare your delivery (consider patient personality, health literacy)
   d. Arrange proper place and adequate time
   e. Determine who the patient would like to be present

2. Establish what the patient (and family) already knows
   a. Set the stage if not already done
   b. Ensure a safe, comfortable, private setting
   c. Ensure patient’s readiness to hear the bad news
   d. Set the agenda
   e. Address/negotiate another time for patient’s unrelated concerns
   f. Assess patient’s ability to comprehend the news

3. Determine how much the patient wants to know
   a. Recognize, support various patient preferences
      i. Decline voluntarily to receive information
      ii. Designate someone to communicate on his or her behalf
   b. People handle information differently
      Race, ethnicity, culture, religion, socioeconomic status, age and developmental level

4. Deliver the bad news
   a. Start with a warning shot
   b. Give the news, then stop
      Be comfortable with silence; do not rush patient
   c. Give information in small chunks (categories) with appropriate transitions
   d. Speak as plainly as possible
   e. Allow patient to determine pace and flow
   f. Encourage/answer questions directly

5. Use relationship building skills to express empathy
   a. Monitor/address patient’s emotional reaction throughout interaction
   b. Use emotion seeking and empathy skills (NURS)
   c. Recognize that your presence alone can be therapeutic
   d. Convey hope while avoiding false reassurances
   e. Reassure patient of your support; that you will not abandon
   f. Explore beliefs about implications of the bad news

6. Iteratively explain and negotiate next steps
   a. Provide details as requested by the patient
   b. Develop a plan for the future
      i. May include further testing, treatment, consultations
      ii. Schedule next follow-up telephone and/or in patient contact(s)
   c. Assess/address patient safety/suicidality
   d. Ensure support system is available, including spiritual resources. If necessary, help patient to access support
   e. Ask patient to summarize main points and next steps
   f. Correct misunderstandings.
   g. Provide (written or taped) summary of discussion
Table 6-3: End of Interview – Motivating Patients

<table>
<thead>
<tr>
<th>1. Education</th>
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<tbody>
<tr>
<td>a. Determine knowledge base, the patient’s specific situation, and readiness for change</td>
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<td>b. Clearly inform about adverse potential of health habit needing change</td>
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<td>c. Make brief, explicit recommendation for change</td>
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<td>d. Highlight patient’s capacity for change</td>
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<td>e. Emphasize that help is available</td>
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<td>f. Indicate that past failures do not bode poorly</td>
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<td>g. Check understanding and desire for change</td>
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<th>2. Commitment</th>
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<tr>
<td>a. Declare need for commitment</td>
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<td>b. Assess patient’s readiness to commit</td>
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<td>c. Reaffirm commitment</td>
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<td>Manage decisions against advice</td>
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<td>d. Reinforce victories great and small</td>
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<tr>
<td>e. NURS liberally</td>
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<th>3. Goals</th>
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<td>a. Set realistic long-term goals</td>
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<td>b. Set short-term goals to operationalize long-term goals</td>
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<td>c. Should be specific, behaviorally defined, limited</td>
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<td>a. Medical interventions</td>
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<td>c. Consultations and referrals</td>
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<td>d. Follow-up</td>
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DOC-COM Assignments
DOC.COM Assignments for Psychosocial Rotation

Select one module each week. Please hand in tests at the end of each module with 1 to 2 paragraph review of what you learned. Please submit to Dr. Dwamena (B427 Clinical Center) by 5:00 pm on Friday of each week (leave with her assistant Julie Doyle or slide under her door if she is not there).

******Must hand in all assignments to pass course.******

WEEK 1: Self-Awareness: Medically Unexplained Symptoms

Module 1 – Mindfulness and reflection

Module 2 – Therapeutic aspects of medical encounter

Module 4 – Balance, self-care

Module 31 – Medically Unexplained Symptoms

WEEK 2: Motivational Interviewing / Behavioral Change

Module 16 – Promoting adherence and health behavior change

Module 24 – Tobacco intervention

Module 25 – Motivating healthy diet and physical activity

Module 29 – Alcohol interview and advising

WEEK 3: Difficulty Conversations

Module 13 – Responding to strong emotions

Module 33 – Giving bad news

Module 34 – Communication near end of life

WEEK 4: Shared Medical Decision-Making / Oral Presentation

Module 17 – Informed decision making

Module 32 – Advance directives

Module 37 – The oral presentation

Revised 7-31-12
Learning Agreement
# LEARNING AGREEMENT

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<th>Specific Behavioral Objectives</th>
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Learner: ___________________________  Date: ___________________________
Personal Journal
GUIDELINES FOR PERSONAL JOURNALS

- Use a new page for each day of the course and enter the day and date.

- Using as much space of you need to elaborate, comment on the following (if appropriate) in the order suggested below:

1. What were the most memorable things that happened to you today?

2. What were the three most important things you learned today? How will you apply this new knowledge?

3. Did you experience any strong emotions or feelings today (positive or negative)? Describe.

4. In what ways do you see your own behavior changing as a result of the things you have learned?

5. What would you like to work on in the next days of the rotation of sometime in the future? Comment on how this is changed from the objective you have when the course started.

6. Is the rotation meeting your expectations? To what degree?

7. Comment on anything else about your experiences so far.
Psychosocial Psychiatry Seminars
Addiction
Addiction Medicine


Other Resources: MSU Patient Contract for Narcotic Medications and other Controlled Substances.

Session 1: Defining Addiction and an Overview of Drugs of Abuse
Learning Objectives:
By the end of the session, you should be able to:
1. Define addiction, pharmacologic tolerance, and pharmacological dependence
2. Identify and administer standardized screening tools for alcohol and substance use disorders
3. Describe the effects of common drugs of abuse - alcohol, marijuana, LSD, MDMA, cocaine, amphetamines, opioids and inhalants

Reading Assignment (to be completed before session): Manual of Therapeutics for Addictions. Chapter 1, 2, 3, 4, 5, 6

Session 2: Managing withdrawal from alcohol, sedative/hypnotics, stimulants, and opiates (pharmacologic and nonpharmacologic treatments)
Learning Objectives:
By the end of the session, you should be able to:
Identify therapies for withdrawal from alcohol, sedative/hypnotics, stimulants, opiates
Describe the use of Alcoholics Anonymous and Narcotics Anonymous

Reading Assignment (to be completed before session): Manual of Therapeutics for Addictions. Chapters 7, 8, 9, 20, 21, 22

Session 3: Chronic opioid use
Learning Objectives:
By the end of the session, you should be able to:
1. Identify guidelines for the use of chronic opioid therapy.
2. Describe the pharmacology of chronic opioid use.
3. Apply the criteria for addiction, tolerance, and dependence to clinical scenarios
4. Describe the care of patients with chronic opioid use

Additional materials provided during session.

Session 4: Addiction in Special Populations
Learning Objectives:
By the end of the session, you should be able to:
1. Describe the assessment of children and adolescents with substance use disorders
2. Create treatment plans for patients with comorbid addiction and acute pain or medical illness
3. Create treatment plans for patients with comorbid addiction and chronic pain

Reading Assignment (to be completed before session): Manual of Therapeutics for Addictions. Chapters 11, 12, 209
Patient Contract for Narcotic Medications and other Controlled Substances

Purpose:

The purpose of this contract is to maintain a safe, controlled treatment plan. I am asking for narcotic pain medication because other treatments and medications I have received have not given me enough pain relief. It is unlikely that any medication will completely take away my pain, but for humane reasons, narcotic pain medication will be given to me as long as my pain continues, provided that I follow the terms of this contract as outlined in the next section.

I understand that possible complication of chronic narcotic therapy include:

1. Chemical Dependence
2. Constipation, which could be severe enough to require medical attention
3. Difficulty with urination
4. Drowsiness
5. Nausea
6. Itching
7. Slowed respiration
8. Reduced sexual function

If I take more than what is prescribed, a dangerous situation could result, such as coma, organ damage, or even death. I understand that if I run out of medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms that can be very uncomfortable or dangerous. If I become pregnant, there are known or unknown risks to the unborn child, which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth. I am obligated to let my doctors know if I am pregnant, and they will help me find ways of controlling my pain without narcotics.

TERMS:
This is a contract between Michigan State University (MSU) HealthTeam and me, ________________, a patient receiving care from a MSU HealthTeam physician. The contract describes the terms that I must meet to be eligible to receive narcotic medications or other controlled substances on a
continuing or chronic basis. My signature on this contract means that I have read, understand and agree to its terms.

My MSU HealthTeam doctor ("my doctor") will continue to prescribe narcotic medications or other controlled substances for me only if I consistently meet all of the following terms of this contract:

1. My health condition and response to medication must make it medically appropriate to continue prescribing narcotic medications or other controlled substances for me. My doctor will periodically review my health condition to determine whether this is the case.

2. A current, valid, and signed copy of this contract must be on file in my MSU HealthTeam medical record.

3. I will only ask for and get prescriptions for narcotic medications or other controlled substances from my doctor or his/her authorized representative. Authorized representatives include:
   a. A MSU HealthTeam doctor who is covering for my doctor
   b. Doctors providing care for me at a hospital or urgent care facility
   c. Other doctors or facilities specifically identified in a written permission document signed by my doctor, which shall include the date range for which the document is valid.

4. I will have all of my narcotic prescriptions filled at the following pharmacy:
   
   Name: __________________________________________
   
   Address: __________________________________________
   
   __________________________________________

   Tel Number: ______________________________

5. I will not allow my narcotic medication or other controlled substances prescription to be used by another person

6. I will not use any narcotic medication or other controlled substance that was originally intended for use by another person.

7. I understand that any of the following represent violations of the terms of this contract:
   
   a. Evidence of medication hoarding
b. Increasing the amount of medication without notifying and receiving approval by my doctor

c. Increasing the amount of the medication despite significant side effects

d. Refilling my prescription too frequently

e. Getting my narcotic medications or other controlled substances from multiple doctors

f. Altering my prescriptions

g. Selling my prescription medication

h. Unapproved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with drug labeling) during narcotic analgesic treatment

i. Other behavior deemed unacceptable by my doctor

8. I agree to allow my urine to be tested for unauthorized medications or illicit substances at my doctor’s request. Testing may be done for cause or as part of random screening.

9. I must not take more than the prescribed dose of narcotic medication or other controlled substance. This includes taking a higher dose of the medication or taking it more often than prescribed.

10. To enable verification that I have met the terms of this contract, I agree to allow my doctor’s office to:

   a. Communicate with other doctors, pharmacists, offices and hospitals involved in my care.

   b. Obtain a periodic report from the State of Michigan Department of Community Health Michigan Automated Prescription System (MAPS) showing where and how narcotic medications or other controlled substances prescribed for me were filled and picked up.

11. I will consistently act in a manner that supports an effective doctor-patient relationship, including:

   a. Keeping appointments made for me at my doctor’s office

   b. Keeping referral appointments my doctor’s office sets up for me

   c. Following treatment plans

   d. Working cooperatively with nurses and staff in my doctor’s office

   e. Avoiding deceptive behaviors to get medications

   f. Refraining from behaviors viewed as threatening, hostile, disruptive or potentially dangerous
g. Paying MSU HealthTeam statements in a timely manner

FAILURE TO MEET THE TERMS OF THIS CONTRACT

I understand that my doctor may stop prescribing narcotic medications or other controlled substances to me (immediately and permanently) if:

1. I fail to meet any of the terms of this contract
2. Tolerance occurs rapidly (short-term escalation to high doses without significant benefit or adverse effects)
3. The medication loses its effectiveness at appropriate doses
4. Significant adverse effects develop

ELIGIBILITY AND CERTIFICATION

I understand that to be eligible to enter into this contract, I must certify or agree to the following:

1. I am not currently abusing illicit or prescription drugs
2. I am not undergoing treatment for substance dependence or abuse.
3. I have never been involved in the sale, illegal possession, diversion or transport of controlled substances (narcotics, sleeping pills, nerve pills, or pain killers).
4. (For premenopausal women) I am not pregnant. I will use appropriate contraception to prevent pregnancy during the course of my treatment.
5. My doctor and I have discussed:
   a. appropriate and realistic goals for pain relief
   b. how to take narcotic medications correctly
   c. narcotic medication side effects
   d. adverse interactions of narcotic medications with other drugs, foods and alcohol
   e. narcotic medication tolerance, dependence, habituation, addiction and withdrawal

6. I have had the opportunity to ask and receive answers to my questions regarding the use of narcotic medications.

7. I understand that the MSU HealthTeam will not replace any lost or inaccessible narcotic or other controlled substances prescriptions or medications FOR ANY REASON.
8. No narcotic or controlled substance prescriptions will be refilled on weekends or over the phone. Refills will only be issued at the time of my follow-up visit. If my prescription does not last until my next visit, that indicates a problem.

The above information has been fully explained to me. I have read it or have had it read to me, and I understand and agree to all of the terms of this contract.

<table>
<thead>
<tr>
<th>Patient Name (Print or Type)</th>
<th>MSU HealthTeam Physician Name (Print or Type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Signature Date</td>
<td>Physician Signature Date</td>
</tr>
<tr>
<td>Patient Representative (age &lt;18; print or type)</td>
<td>Witness Name (Print or Type)</td>
</tr>
<tr>
<td>Representative Signature Date</td>
<td>Witness Signature Date</td>
</tr>
</tbody>
</table>

I have reviewed the side effects of the narcotic medications or other controlled substances that may be used in the treatment of my health condition as mentioned above. I fully understand the explanations regarding the benefits and the risks of this method of treatment and agree to the use of narcotic medications or other controlled substances in the treatment of my health condition(s).

<table>
<thead>
<tr>
<th>Patient Name (Print or Type)</th>
<th>MSU HealthTeam Physician Name (Print or Type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Signature Date</td>
<td>Physician Signature Date</td>
</tr>
<tr>
<td>Patient Representative (age &lt;18; print or type)</td>
<td>Witness Name (Print or Type)</td>
</tr>
<tr>
<td>Representative Signature Date</td>
<td>Witness Signature Date</td>
</tr>
</tbody>
</table>

Adapted from: [http://www.painnetinc.com/contract.html](http://www.painnetinc.com/contract.html)
State of Michigan  
Department of Community Health  
Michigan Automated Prescription System (MAPS)  
P.O. Box 30202, Lansing, Michigan 48909  
Phone: 517/373-1737  Fax: 517/636-6449  Email: Mapsinfo@michigan.gov  
REQUEST FOR MAPS REPORT – Practitioner/Pharmacist

<table>
<thead>
<tr>
<th>Patient’s Full Name:</th>
<th>First</th>
<th>M.I.</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSN or Driver’s License Number (if available):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aliases and Other Addresses (if known):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Period Requested From:</td>
<td>Date</td>
<td>to</td>
<td>Date</td>
</tr>
</tbody>
</table>

Provide a brief summary of the facts and circumstances under which you are requesting information regarding this patient.

(If you need additional space, please continue on the reverse side of this form.)

<table>
<thead>
<tr>
<th>Practitioner or Pharmacy Name:</th>
<th>Please Print</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td></td>
</tr>
<tr>
<td>MI License Number:</td>
<td>DEA Number:</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>FAX Number:</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
</tbody>
</table>

I certify that this information shall be used for the purpose of providing medical or pharmaceutical treatment to a bona fide current patient. I shall not provide this information to any other person or entity except by order of a court of competent jurisdiction.

The Department of Community Health will not discriminate against any individual or group because of color, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Authority: P.A. 231 of 2001  
Completion: Voluntary

For Department of Community Health use only:

<table>
<thead>
<tr>
<th>Approved:</th>
<th>Yes</th>
<th>No</th>
<th>Signature</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Patient Name/Address</td>
<td>Birth Date</td>
<td>Issue Date</td>
<td>Medication</td>
<td>Form/Qty</td>
</tr>
<tr>
<td>----------------------</td>
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<tr>
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</table>

WARNING: This Report contains confidential information, including patient identifiers, and is not a public record. The information should not be provided to any other person or entity except by order of a court of competent jurisdiction.
# Michigan Automated Prescription System

## Selected Prescriptions Detail Report

<table>
<thead>
<tr>
<th>Patient Name/Address</th>
<th>Birth Date</th>
<th>Medication</th>
<th>Issue Date</th>
<th>Form/Cty</th>
<th>Rx Number</th>
<th>Practitioner Name</th>
<th>Practitioner DEA#</th>
<th>Drug Store</th>
<th>Dispenser DEA#</th>
<th>Dispenser City, State, Zip</th>
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</thead>
<tbody>
<tr>
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<td>TAB 150</td>
<td>1116220</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>01/12/2004</td>
<td>750 MG-7.5 MG</td>
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</tr>
</tbody>
</table>

Total Records Processed: 9

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**WARNING:** This Report contains confidential information, including patient identifiers, and is not a public record. The information should not be provided to any other person or entity except by order of a court of competent jurisdiction.
Glossary
a) Acute Pain – short, circumscribed period of causal organic illness, from minor sprain to major fracture to heart attack to acute low back strain – the pain clears when the causal disease clears, from a few days to a few months, depending on the causal disease
b) Acute Pain as an Exacerbation of Chronic Organic Disease may also occur but you need to be certain there is a causative organic process that accounts for the exacerbation. Sickle cell crisis is a good example when hemolysis is present; progressive malignancy is another example, often not remitting while a sickle cell crisis does after 7-14 days. More often, however, we see exacerbations of chronic pain conditions without an organic explanation
c) Chronic pain takes two forms: i) due to organic disease; e.g., neuropathy, cancer; ii) non-organic disease. Most cases of chronic pain are in the latter category where explanatory definitive testing has not demonstrated an organic basis for the pain, nor for exacerbations of it (see 2 above). Both groups with chronic pain have high levels of comorbid psychological and psychiatric disturbance, which also aggravates pain, treatment of which ameliorates the pain, especially common concomitant substance abuse of other types. In general, the greater the number of symptoms and comorbid conditions, the worse is the pain.
d) “Problematic chronic pain patients” are those with non-cancer pain who take high doses of narcotics, where there are two categories: i) those on stable doses whose pain is controlled; ii) those whose pain is not controlled and request/receive escalating doses with no more than temporary relief, only to request/receive even greater doses. It is the latter group we are concerned with, often being admitted for IV narcotics.
e) “Problematic narcotic use” is defined as using more than 120-180 morphine equivalents per day without relief for our purposes of addressing inpatient problems; we do not mean to imply that those using 120-180 morphine equivalents per day who are controlled are properly managed, but they are not the ones who present inpatient problems, our focus here.

This protocol is intended to aid management of problematic inpatients admitted with refractory pain and requesting large doses of narcotics, often IV. It provides a plan so they can be discharged in a timely way and obviate the need for many additional hospital days spent weaning them from narcotics.

It is not intended for:

i) chronic pain patients where moderate doses of narcotics are effective
   • Patients taking stable amounts of narcotics whose pain is controlled are not the problem and they can be continued on their outpatient dose; the only change you may need to make is to schedule the dose (non-prn)
ii) long-term chronic pain management – see UpToDate for that protocol for this outpatient plan
iii) acute pain
   • However, be especially careful not to “snow” acute pain patients with narcotics to the point of obscuring a still undiagnosed problem, such as abdominal pain
iv) cancer patients in the end stages of life
v) sickle cell patients in crisis

Your goal with the problem patients:

i) get them on a regularly scheduled dose and rapidly taper to a level no greater than what they were taking before admission, even if it exceeds 120-180 morphine equivalents/day
ii) no IV narcotics
iii) identify concomitant abuse problems with other agents – this is a contraindication to prescribing narcotics in the first place; but, on the inpatient ward, you do not need to discontinue them but recommend discontinuation for outpatient work.

The rationale given to problematic, narcotic-seeking patients:

- There is no cure; their hope is to live a better life with pain.
- The narcotic is not working but making them worse → explain:
  - If it worked, they wouldn’t have so much pain
  - No data indicate benefit of narcotics in chronic non-malignant pain
  - Data do indicate that narcotics may worsen pain
    - Opiate hyperalgesia → paradoxical increase in pain
    - Causing/aggravating depression; depression greatly increases pain, perhaps itself causing it
    - Side effects; e.g., narcotic bowel syndrome

Therefore, you recommend:

- Will not “cold turkey” discontinue, but will convert to oral and quickly return to amounts used before admission
- Will replace narcotic with better pain medication (antidepressant; meds for neuropathic pain)

If unable to follow the above detoxification protocol, either unwilling or too much pain, they need out- or in-patient drug detoxification and consult with a pain/addiction expert

If they threaten to leave, that is ok but against advice. Emphasize that you are concerned about them and doing what is best

If able to do follow this inpatient protocol, assuming other causes for admission have been resolved, they are discharged to their PCP with instructions to see them within the week and not to increase the dose, giving a prescription for just enough narcotic until they get to the PCP. The discharge narcotic is scheduled and does not exceed the amount taken prior to admission

If they have had recurrent admissions (or subsequently do), they are placed on an individualized protocol for them and followed according to this.

This approach includes sickle cell and other organic disease patients with chronic pain (diabetic neuropathy) who are not in acute crisis.

- This plan does not apply to cancer patients in severe pain or to sickle cell patients in a demonstrated crisis (hemolysis and falling Hb). These patients may have more liberal use of narcotics. In acute sickle cell patients, it is ok to let them set their regimen if it has worked before and the need clears when the crisis abates. IV narcotics may be temporarily needed in some cancer and sickle cell patients with acute pain.
- In all pain patients, be sure there are no underlying organic disease; e.g., severe abdominal pain; severe headache. Never assume the patient is “psychogenic” or “malingering” just because they seem that way. You always need a definitive investigation that may include consultation. Most of the chronic patients we see have already had the work-up and it should not be repeated.
You conduct these interactions in respectful but firm way, clearly indicating that there is no cure and that narcotics don’t work and that we cannot provide high dose narcotics when they only make the patient worse.

You reframe the argument: it is ‘how’ they are going to cut down (this is where their choice is) not whether they are. It is not negotiable that they will stay on doses above those prior to admission. What is negotiable is what times of day they will take the oral narcotics, whether to taper benzodiazepines at the same time or later, what NSAID or antidepressant has worked, what level of activity they can have, and when they would like to do other parts of treatment.

When patients become angry, cry, or otherwise are upset, hold your ground and don’t be intimidated. Repeat the rationale above and use your relationship building skills (NURS) in plentiful amounts. Repeatedly acknowledge how difficult it is for them. You do not have to please them but, rather, practice good medicine intended to benefit them, their protestations acknowledged with NURS and plenty of support.

**Identified needs to maximize treatment = unresolved issues:**

i) capable provider to conduct outpatient care  
ii) an outpatient clinic to manage recurrent admissions  
iii) more addiction specialists to consult on many of these and to manage the very severe ones  
iv) defining a sickle cell crisis in the absence of hemolysis
PROTOCOL FOR DISCUSSING TREATMENT

i) Education
   - Determine what they know and think regarding narcotic use; correct any misconceptions; e.g., cure possible, pain means bad disease
   - Provide information needed to correct erroneous beliefs
     - There is no cure; their hope is to live a better life with pain
     - The narcotic is not working but making them worse → explain:
       - No data indicate benefit of narcotics in chronic non-malignant pain
       - Data do indicate that narcotics may worsen pain in 2 ways
         - Opiate hyperalgesia
         - Causing/aggravating depression; depression greatly increases pain, perhaps itself causing it
     - Side effects; e.g., narcotic bowel syndrome

ii) Recommend treatment known to work
   - Quick taper of narcotics
   - Use scheduled dose
   - Use treatments known to work
     - Antidepressants are better pain medication
     - Exercise, relaxation, PT, NSAIDS

iii) Commitment to treatment
   - If they do not agree: be firm that this is best for them and you will not do otherwise; it can be helpful to respectfully indicate they are “addicted”
   - If they have some reasonable issues, it is ok to negotiate around those as long as they agree and engage in treatment; e.g., a slower reduction rate

iv) Negotiate specific plan
   - If on IV narcotics, discontinue or taper completely over no more than 6-12 hours; this is a good place the let them choose the schedule of reduction
   - When on oral narcotics, negotiate and schedule a rapid reduction regimen to reduce narcotics to what they were taking before admission
   - In addition to using full-dose antidepressants, for pain as well as for depression, symptomatic medications on a scheduled basis also are used; e.g., ibuprofen, anticholinergics, exercises, PT

Respond using NURS to expected frequent concerns, anger, crying, and withdrawal/pouting but keep your ground – reminding yourself that you’re practice better medicine
### Oral Opioid Dosing Equivalents and Conversions

<table>
<thead>
<tr>
<th>Typical Oral Q4H doses of short-acting opioids shown as equivalents to morphine: Morphine</th>
<th>30 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone</td>
<td>20 mg</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid)</td>
<td>6 mg</td>
</tr>
<tr>
<td>Oxymorphone (Opana) use not recommended</td>
<td>10 mg</td>
</tr>
<tr>
<td>Hydrocodone (Vicodin, Norco, Lorcet)</td>
<td>2 x 10 mg tabs</td>
</tr>
<tr>
<td>Codeine (Tylenol #3 or #4)</td>
<td>2 x #4 = 120 mg codeine</td>
</tr>
</tbody>
</table>

### Morphine to Fentanyl Patch Conversion

Each 2 mg PO morphine approximately equivalent to 1 mcg/hr fentanyl patch (e.g., morphine 100 mg/day → 50 mcg/hr patch applied q3days). Caution should be used in older adults or patients with cachexia—fentanyl is lipid soluble and requires subcutaneous fat for proper absorption.

### Opioid Taper

**Typical taper.** Taper every week by 10% of original dose until 20% remains. Then taper the remaining 20% by 5% of original dose each week until off or at goal.

**Rapid taper.** Reduce by 25% every 3–7 days, depending upon short vs. longer drug half life.
## Selected opioid analgesics for pain and equianalgesic doses

<table>
<thead>
<tr>
<th>Drug (US trade names)</th>
<th>Equianalgesic (mg) doses*</th>
<th>Sample initial dose for opioid naïve adult* (mg)</th>
<th>Half-life (in hours)</th>
<th>Duration of analgesic effect (in hours)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10 IV/SQ/IM^6</td>
<td>2-10 IV every 2 to 4 hours</td>
<td>2-3</td>
<td>3-4</td>
<td>Standard for comparison for opioids; multiple routes available (including tablet, rectal suppository, concentrated enteral liquid, parenteral infusion)</td>
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<tr>
<td></td>
<td></td>
<td>2-10 SQ/IM every 3 to 4 hours</td>
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<tr>
<td></td>
<td>20-30 PO</td>
<td>10-30 PO every 4 hours</td>
<td>2-3</td>
<td>3-6</td>
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<tr>
<td>Controlled-release morphone tablet (MS Contin®, Oramorph SR®)</td>
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<td>15 PO twice daily</td>
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<tr>
<td>Sustained-release morphone capsule (Kadian®)</td>
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<td>30 PO daily in one or two divided doses</td>
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<td>Extended-release morphone capsule (Avinza®)</td>
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<td>30 PO daily</td>
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<tr>
<td></td>
<td>1.5 IV/SQ/IM</td>
<td>0.3-1 IV every 2 to 4 hours</td>
<td>0.3-1 SQ/IM every 3 to 4 hours</td>
<td>2-3</td>
<td>3-4</td>
</tr>
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<td>------------------------</td>
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</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5 PO</td>
<td>2-4 PO every 3 to 4 hours</td>
<td></td>
<td>2-3</td>
<td>3-6</td>
</tr>
<tr>
<td>Controlled-release</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hydromorphone®</td>
<td></td>
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<tr>
<td>(Canadian trade name:</td>
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<tr>
<td>Hydromorph Contin®)</td>
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</tr>
<tr>
<td>Extended-release</td>
<td></td>
<td></td>
<td>8 PO every 24 hours</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>hydromorphone®</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Exalgo®)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>20G PO</td>
<td>30-60 PO every 4 to 6 hours</td>
<td></td>
<td>2-4</td>
<td>4-6</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>15-20 PO</td>
<td>5-15 PO every 4 to 6 hours</td>
<td></td>
<td>2-3</td>
<td>3-6</td>
</tr>
<tr>
<td>Controlled-release</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>oxycodone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Oxycontin®)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30 PO</td>
<td>5-10 PO every 6 hours</td>
<td></td>
<td>3-4</td>
<td>4-8</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>1 IV/SQ/IM</td>
<td>0.5 IV every 4 to 6 hours</td>
<td></td>
<td>7-9</td>
<td>3-6</td>
</tr>
<tr>
<td>Drug Type</td>
<td>Dose Description</td>
<td>Half-Life (h)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>---------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0.5-1.5 SQ/IM every 4 to 6 hours</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 every 4-6 hours (variable effect)</td>
<td></td>
<td>4-6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-10 every 4 to 6 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Extended-release oxymorphone (Opana® ER)</strong></td>
<td>5 twice daily</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Levorphanol</strong></td>
<td>0.5-1 IV/SQ/IM every 3 to 6 hours</td>
<td>11-16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.5-1 SQ/IM every 6 to 8 hours</td>
<td>11-16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 IV/SQ/IM</td>
<td>2-4 every 6 to 8 hours</td>
<td>4-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 PO</td>
<td>With long half-life, accumulation possible after beginning or increasing dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Methadone</strong></td>
<td>1.25-5 IV/SQ/IM every 4 to 8 hours</td>
<td>3-4 (initially)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>6-8</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Increases following repeated administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 IV/SQ/IM</td>
<td>Potency of commercially available formulation (a d,l racemic mixture) is</td>
<td>12-150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>presumably due to the d-isomer, which is an NMDA antagonist and can reverse</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>tolerance and augment analgesia. May be far more potent than indicated in the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>table. As total daily dose of morphine increases, the estimated equianalgesic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>dose of methadone decreases progressively. Effects may be further altered by</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>drug interactions involving CYP3A4. Due to its highly variable and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>prolonged half-life, methadone has the highest risk among opioids of overdose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and accumulation during initial titration to effect (as steady state levels are</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>approached) and during dose adjustment in chronic use.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 PO</td>
<td>2.5-10 PO every 4 to 8 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>Dose</td>
<td>Frequency</td>
<td>Duration</td>
<td>Dose Range</td>
<td>Administration Notes</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fentanyl injection</td>
<td>50-100 micrograms IV/SQ</td>
<td>10-50 micrograms IV/SQ every 1 to 2 hours</td>
<td>7-12</td>
<td>0.5-1 IV(^7) 1-2 SQ(^7) Increases following repeated administration</td>
<td>Can be administered as a continuous IV or SQ infusion</td>
</tr>
<tr>
<td>Fentanyl transdermal system</td>
<td>-</td>
<td>12 to 25 micrograms every 72 hours</td>
<td>20-27 upon removal</td>
<td>48-72 per patch</td>
<td>Refer to topic Fentanyl: Drug information for oral and transdermal medication equianalgesic dosing guideline. Not usually recommended for opioid naïve patients. Not recommended for acute pain.</td>
</tr>
<tr>
<td>Oral transmucosal fentanyl citrate lozenge (ACTIQ®)</td>
<td>-</td>
<td>NR</td>
<td>3.5-6 dose dependent</td>
<td>1-2</td>
<td>Not recommended for opioid naïve patients. Recommended starting dose for breakthrough pain, 200-400 micrograms, even with high &quot;baseline&quot; opioid doses.</td>
</tr>
<tr>
<td>Fentanyl citrate sublingual tablet (Abstral®)</td>
<td>-</td>
<td>NR</td>
<td>7</td>
<td>1-2</td>
<td>Applies to sublingual tablet, buccal tablet and nasal spray: not recommended for opioid naïve patients. Recommended starting dose for breakthrough pain, 100 micrograms, even with high &quot;baseline&quot; opioid doses.</td>
</tr>
<tr>
<td>Fentanyl buccal tablet (Fentora®)</td>
<td>-</td>
<td>NR</td>
<td>3.5-11 dose dependent</td>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td>Fentanyl nasal spray (Lazanda®)</td>
<td>-</td>
<td>NR</td>
<td>22</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine injection</td>
<td>0.3-0.4 IV/IM</td>
<td>0.3 every 6 to 8 hours</td>
<td>2-3</td>
<td>6</td>
<td>Partial agonist. Mu receptor antagonism, and associated risk of precipitating withdrawal symptoms, increased in patients dependent upon high opioid doses. Effects may be altered by drug interactions involving CYP3A4. Respiratory depression only partially reversed by naloxone.</td>
</tr>
<tr>
<td>Buprenorphine transdermal patch (Butrans(^{TM}))</td>
<td>5 or 10 microgram per hour patch</td>
<td>5 microgram per hour patch applied every 7 days</td>
<td>26 upon removal</td>
<td>7 days per patch</td>
<td>Slow onset of up to 72 hours following initial patch application requires tapering of previous opioid analgesia. Prolonged duration of effect following patch removal. Rate of absorption from patch may be increased with application of external heat</td>
</tr>
</tbody>
</table>
NMDA: N-methyl-D-aspartic acid; PO: orally; IV: Intravenously; SQ: subcutaneously; IM: intramuscularly; PR: per rectum.

NR: Preparation not recommended for initial treatment of opioid naive patients. The total daily dose requirement for long-acting formulation should be established first with the use of an appropriate immediate-release opioid analgesic. See text.

* Equivalence to a 10 mg dose of parenteral morphine sulfate.

+ Dose reduction of approximately fifty percent required for older or debilitated adults or patients with low cardiac output or respiratory compromise.

Δ IM route not preferred due to pain at injection site.

◊ Opioids such as morphine and hydromorphone have the same equianalgesic potency whether administered in an immediate-release or a sustained or extended release form. To convert from oral immediate release to extended release, use sum of doses of immediate release preparation administered during usual interval for the extended release form. For example, morphine sulfate immediate release 30 mg every four hours (180 mg daily) converts to morphine sulfate controlled release 60 mg every eight hours (180 mg daily).

§ Not presently available in US.

¥ Variable.

These conversion rates, which differ from those available in other tables and references, represent the recommendations of an expert panel convened to evaluate equianalgesic dosing (Kofozová H. J Pain Symptom Manage 2009; 38:418).

+ Bolus administration to opioid naive patients.
Barriers to Care
Assessing Patients' Ability to Access Health Care
(BARRIERS TO CARE)

Learning Objectives:

By the end of the session, you should be able to:
1. Define the different levels of equity of care
2. Describe five dimensions of access to care
3. Delineate patient-level factors that affect access to care
4. List questions that can be used to assess individual-level barriers to care
5. Brainstorm ways to improve access to care for individual patients.

Resources:

Powerpoint Handout/Dr. Heather Laird-Fick
Assessing Patients’ Ability to Access Health Care

Heather S. Laird-Fick, MD, MPH
Assistant Professor
Department of Medicine
Michigan State University

Learning Objectives
- By the end of this session, you should be able to:
  - Define the different levels of equity of health care
  - Describe five dimensions of access to care
  - Delineate patient-level factors that affect access to care
  - List questions that can be used to assess individual-level barriers to care
  - Brainstorm ways to improve access for individuals

What is equity in health care?
- Based on equal need,
  - Equal access
  - Equal utilization
  - Equal outcomes
- And do we have it — at any level?


Do we have equity of access?

Do we have equity of utilization?

Figure 8. Early prenatal care by race and Hispanic origin of mother: United States, 1999-2003

Do we have equity of outcomes?

Age-Adjusted Death Rates for Ischemic Heart Disease by Race/Ethnicity

HP 2010 Leading Health Indicators
- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- Responsible sexual behavior
- Mental Health
- Injury and violence
- Environmental quality
- Immunization
- Access to health care

But what constitutes access?
- Donabedian's 5 A's of Access
  - Availability
  - Accessibility
  - Acceptability
  - Accommodation
  - Affordability

Health seeking behavior

Think about these cases...
- 57 year old male with diabetes who presents to the ED with a gangrenous toe
- 61 year old female who presents with 6 months of irregular vaginal bleeding, and has had no preventive health care
- 36 year old male who hasn't been seen in the office for two years keeps calling with requests for urgent care via telephone
- 71 year old male who follows up regularly but has poorly controlled hypertension

Predisposing factors:
Demographics
- Socio-economic status
  - educational level
  - income
- Ethnicity
- Immigration status
- Gender
- Age

Assessing demographic factors
- "How far did you go in school?"
- "What is your racial or ethnic background?"
- "Where are you from? What made you decide to come here? How have you found life here compared to your country/city?"

Methy KAM. Nursing Research. 1988; 37:195-201
Predisposing factors:
Attitudes
- The barriers
  - Fear and anxiety
  - Non-acceptance of certain conditions and treatments
  - Lack of interest in preventive care
  - Lack of sensitivity to needed care
- Key word: Acceptable


Predisposing factors:
Knowledge
- Disease process(es)
- Services
- Insurance
- Key words: Accessible, acceptable


Predisposing factors:
Effort
- Chronic functional impairment
- Burden of diseases
- Persistence of symptoms
- Severe psychiatric disease (?)
- Key words: accessible, accommodating


Assessing attitudes
- Explore explanatory models – more under need
- “What worries you most?”
- “Are you more concerned about how your health affects you right now or how it might affect you in the future?”

Assessing knowledge
- We’ll discuss some of this under need
- “Do you know if your insurance will cover [prescription medications, etc]?”
- “Have you ever had [physical therapy, surgery, etc] before? What do you recall from that experience?”

Assessing effort/supports
- Medical history and impact of illnesses
- Social history – physical impairments, use of assistive devices, transportation issues
- “Do you have friends or relatives that you can call on for help? Who are they? Do they live close to you?”
Predisposing factors:

Cultural

- Potential barriers
  - Language and communication
  - Alienation from mainstream
  - Reliance on complementary medicine
  - Ethnicity

- Key words: acceptable, accommodating

Methen KAM. Nursing Research, 1988; 37: 196-201

Assessing cultural factors

- "What was medical care like where you came from, compared to here?"
- "What kind of treatment do you think would work?"
- "Do you have trouble reading your medication bottles or appointment slips?"
- "What language do you speak at home? Do you ever feel that you have difficulty communicating everything you want to say to the doctor or staff?"


Predisposing factors:

Family characteristics

- Denial of problem and need for care
- Large family size
- Prior negative experience by another family member
- Stress from family responsibilities

- Key words: acceptable, accommodating

Methen KAM. Nursing Research, 1988; 37: 196-201

Assessing supports and stressors

- Social and family history
- "What is causing the most difficulty or stress in your life? How do you deal with this?"
- "Do you have friends or relatives that you can call on for help? Who are they? Do they live close to you?"
- "Are you very involved in a religious or social group? Do you feel that God or a higher power) provides a strong source of support in your life?"


Need

- Perceived vs evaluated need
- Explanatory models

Kleinman's questions re: explanatory models

1. What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a short or long course?
6. What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?
Enabling factors:

Usual source of care

- Having a usual source of care increases use of outpatient visits, decreases emergency department visits, and increases use of preventive services

- Key words: available, accessible


Assessing usual source of care

- "Who advises you about your health? Do you have a physician that you can see for medical problems?"


Enabling factors:

Insurance

- "...Insurance status, ability to pay for healthcare...is the most important predictor of the quality of healthcare across racial and ethnic groups"

- Key words: available, affordable


Enabling factors:

Insurance

- "Do you have insurance? What does it cover?"
  - Alternate: What kind of insurance

MCHAIN KAM. Nursing Research. 1988, 37:156-201

Assessing insurance

- "Do you have insurance? What does it cover?"
  - Alternate: What kind of insurance

MCHAIN KAM. Nursing Research. 1988, 37:156-201

Structural

- Time
- Distance
- Cost
- Availability
- Organization of services
- Discrimination
- Provider-patient relationships

- Key words: available, accessible, acceptable, accommodating, affordable

MCHAIN KAM. Nursing Research. 1988, 37:156-201
### Assessing structural factors

- “Do you have difficulty seeing someone about health problems? What makes it difficult?”
- “Is money a big problem in your life? Are you ever short of food or clothing? Do you worry about how to pay for medicines or doctor’s visits?”
- “Do you feel that your doctor and the office staff respect and care about you?”


### Methods for evaluating barriers

- Questions that can assess each level (predisposing, need, enabling) and explanatory model
- Culturally competent care
  - Open, non-judgmental communication
  - Patient centered

### Scenario 1: Preventable hospitalization

You’re the FIRM senior resident. An ER resident pages you to admit a 57 year old obese male with poorly controlled Type II diabetes, who presented with blood sugars in the 400s and a gangrenous toe.

- The resident wonders aloud, “What took this guy so long to come in?”
- How can you find out? And how will the answer influence your discharge planning?

### Scenario 2: Lack of preventive care

- You are a general internist, and have just joined an established practice to replace a departing partner.
- A 61 year old female presents with complaints of irregular vaginal bleeding for the past 6 months, “even though I went through menopause at 50.”
- When you review her chart, you see that she has had only 2 visits over the past 5 years. She has not had a mammogram or pap smear in 4 years. She has never had colon cancer screening. There is no immunization documentation.
- What questions can you ask to learn:
  - Why she waited 6 months to come in
  - Why she hasn’t received preventive health services

### Scenario 3: The absent patient

Your patient, a 36 year old healthy female, has called the office four times over the last year requesting strap throat screens, because of known exposures. When the nurses have asked her to come in to be evaluated, she is resistant.

- She has not been seen in the office for more than two years.
- What can you do to assess her barriers to seeking care, and to improve her health care?

### Scenario 4: Uncontrolled hypertension

- You are seeing a long-time patient for a return visit for hypertension control. He is a 71 year old Hispanic male who is always very pleasant and follows up regularly for visits.
- You are frustrated, because his systolic pressure remains 170, although you titrated his second blood pressure medication up at his last visit 1 month ago. He seems unconcerned.
- How can you assess this patient further to improve his care in a patient centered way?
Cultural Competency
Psychosocial Seminars  
CULTURAL COMPETENCY

Churlsun Han, M.D.

Objectives:

A. Convey the importance of multiculturalism in medicine.

B. Learn about multiculturalism in the US and in Michigan.

C. Learn some general considerations for multiculturalism.

D. Learn about specific ethnic and geographic groups (African-American, Hispanic, Asian, Native American).

E. Learn about religion and multiculturalism.
Learning objectives

- Recognize need for multicultural education in medicine
- Recognize population diversity in the US, Michigan
- Understand general considerations for all groups
- Know considerations for specific groups
  - African-American
  - Hispanic
  - Asian
  - Native American
- Understand religion's role in multiculturalism

Multicultural issues in medicine

Charlsun Han, MD
Assistant professor MSU CHM
2012

Adapted from Ralph E. Watson, MD's "Caring for Multicultural Patients" lecture

Why do we need to know this?

- U.S. composed of many racial/ethnic groups
  - 'Country of immigrants'
  - Native Americans
  - Grouped into artificial ethnic groups
    - 'Hispanic,' 'Black,' 'Asian,' 'Native American,' etc.
- Modern immigrants preserve cultural identity rather than 'assimilate'
  - E.g. non-white populations
  - Cultural identity is valued
  - Many 'folk' beliefs and practices maintained

Why do we need to know this?

Wide differences in views on medical issues from culture to culture:
- Causes of disease (punishment, etc)
- Value of life
- Homeopathic or 'folk' remedies
- Beliefs in medications, surgeries, treatments
- Role of physician
- Role of religion in healing

Why do we need to know this?

- US history of discrimination
  - Manifest Destiny
  - American Indian relocations
  - Slavery
  - Segregation
  - Japanese-American internment in WW2
  - Citizenship laws
    - Toshio Ozawa v. United States, 1922
    - United States v. Bhagat Singh Thind, 1923
- Many cultural groups view modern medical care as a distinctly 'Western' and 'White' product
  - To some extent, this may be true!

Why do we need to know this?

- Minority racial/ethnic groups in US have disparate health care
  - Race and income assoc with wide health care disparities
  - Major diseases such as DM and HIV disproportionately burden minority populations
  - Minorities more likely not to have health insurance
  - Improving quality of care for minorities is becoming critically important
  - As minorities increase in US, disparities will worsen

Why do we need to know this?
Knowledge of cultural issues may help to:

- Avoid misunderstandings
- Especially cultural faux pas
- Clarify goals of care
- Address culturally specific issues
- Build better physician-patient relationships
- Address negative views of 'Western' medicine by many cultural groups
- Improve adherence

Multiculturalism in the US and MI

2010 Census: Race and Hispanic origin

- Hispanic/Latino versus not
- Racial groups
  - Black/African-American
  - Asian
  - American Indian/Native American and Native Alaskan
  - Hawaiian/Pacific Islander
- Still very generalized
- Many different nationalities, cultures, beliefs
- ~2/3 of US population is white, non-Hispanic

Multiculturalism in the US and MI

Hispanic / Latino

- Ethnically diverse
- Different races, nations, cultures, SES (areas of US)
  - Mexican-Americans (West, SW, Midwest)
  - Puerto Rican (Northeast)
  - Cuban-Americans (Florida)
- Other Central and South American groups
- Hispanics in US 16.5% (Michigan 4.4%)
- Special notes
  - Cuban-Americans: Spanish descent, education, income

Multiculturalism in the US and MI

Black / African-American

- Self-defined, usually based on appearance
- Vast majority in U.S. descendants of slaves
- Significant variation
  - Southern slave descended 'African-American'
  - West Indies, Black Hispanic
  - Newer African immigrants
    - Like Drs. Dwamena and Dibonou
- Blacks in US 12.6% (Michigan 14.2%)

To capture beyond 'African-American' will use 'Black' for this lecture
Multiculturalism in the US and MI
Asian, Hawaiian / Pacific Islander (and white)
• 2010 Census puts all together, divides by subgroup
  • Asian = Pakistan through Far East
  • Hawaiian / PI = Hawaii, Guam, Samoa, etc.
  • Predominantly California, NY, Texas, Hawaii
• Asians in US 4.8% (Michigan 2.4%)
  • Chinese, Filipino, Indian, Vietnamese, Korean, Japanese
• Poor 2010 census data for Middle East
  • Dearborn area accepted to be one of largest groupings of Middle Eastern peoples in US

Multiculturalism in the US and MI
American Indian, Alaska native
• Extremely diverse
  • 562 federally recognized nations
  • Each group has own traditions, language, art, etc.
  • Geographically mixed due to forced migrations
  • Many misconceptions about heritage
• AI/AN in US 0.9% (Michigan 0.6%)
• Michigan has 11 federally recognized tribes
  • e.g. Chippewa, Ottawa, Potawatomi, Odawa, Huron
  
  Most self-identify as American Indian over Native American

Multiculturalism in the US and MI
American Indian, Alaska native, continued
• Reservations
  • Land ‘given’ to Indian tribes by US government
  • ~1/2 of American Indians live in reservations
  • Majority located west of Mississippi River
  • Land was often unusable or unclaimed
• Alaskan natives similarly diverse
• Overlap with American Indian and Mexican
  • Mestizo: a person of mixed Spanish and indigenous Mexican ancestry, the majority of Mexico’s population

General considerations
• Western, scientific medicine relatively new concept
  • Hippocratic medicine first time illness was not tied to gods/spirits
• Religion and health
  • Most cultures associate religion and health
    • Medicine men, shamanism
    • Folk remedies
  • In many non-Western societies, health and religion are still intimately tied

General considerations
Suffering and health
• Variety of views to causes of suffering
  • Divine, punishment for sins
  • Part of everyday life
  • Sign of weakness
  • Spiritual test
• Variety of responses to suffering
  • Shame, reluctance to discuss
  • Delay seeking medical care
  • Do nothing – ‘God’s will’
  • Folk remedies, religious aid
General considerations

**Variety of views of Western medicine**
- Often last resort
- Concept of chronic illness not ubiquitous
- Preventive medicine
  - Novel concept for many cultures
- Does not address spiritual causes of disease
- Discredits religious practice
- Western medicine *causes* disease
  - "You go to the hospital and die"
- Test subjects, experiments

**Approach to non-Western views of medicine**
- Elicit explanatory model of disease
- Ask about home remedies
  - Remember, Aspirin came from tree bark
- Ask what patient wants from interaction
- Do not condemn or belittle practices
- Do not judge non-traditional approaches
  - Most non-traditional medicine relatively benign
  - Address patients' spiritual concerns

Black/African-Americans & medicine

- Distinct subgroups of black people in the US
  - US slave descendant 'African-Americans'
  - Black Hispanic – West Indies/Caribbean, South American
  - Newer African immigrants
- Slavery in the Americas
  - Ubiquitous throughout Americas 1600-1800's
    - In US, slavery concentrated in South: farming, crop work
  - Slaves from all over Africa – difficult to trace heritage
  - In US, slavery ended following US Civil War
    - Surnames – took former owner’s or created a name
    - After slavery ended, racism and discrimination remained

Black/African-Americans & medicine

- Black racism and discrimination in US
  - ‘Jim Crow’ laws
    - Segregation: separate but equal under the law
    - Voting laws: disenfranchising Black voters
  - 1960’s Civil Rights movement
    - Many reforms addressing discrimination
    - Black racism still present in US
- 33% live in poverty (10% whites)
- Notes about this lecture
  - Primarily addresses black people with low socioeconomic status
  - ‘Black’ vs ‘African-American’

Black/African-Americans & medicine

**Being black in the medical system**
- Inadequate access to health care
  - Often forced to use public care (like residency clinics)
  - "Practice" for residents and students
  - Often feel used, humiliated
- Paternalistic treatment
  - Called by first name – harkens back to slavery
  - US medical training more difficult to access
  - History of unethical treatment to blacks
    - Tuskegee Syphilis Study
    - The impetus for IRB’s and informed consent in research
Black/African-Americans & medicine

Attitudes of black people regarding health care
- Fear of receiving substandard care
- DNR discussions often extremely complicated
- Mistrust of doctors, testing, medications
- Alienated and belittled by medical system
- Manifestations of attitudes to care
  - No-shows to appointments
  - Hide any confusion or lack of understanding
  - Do not express dissatisfaction
    - You may not know that your pt is unhappy with your care

Black/African-Americans & medicine

Dietary habits
- ‘Soul food’
  - High in fat and salt
  - Southern ‘comfort food’
  - Food of farming days
- Lactose intolerance
  - Lactose intolerance is highly prevalent (throughout world)

Black/African-Americans & medicine

Blood terms
- Once commonly used in black communities
- Watch for confusion with common ‘blood’ terms
- High blood: location, such as a rush of blood to the head
- Low Blood: can refer to anemia
- Thin blood: susceptibility to diseases
- Thick blood: impedes circulation, impurities accumulate
- Impure blood: malfunction of kidneys or GI tract
- Bad blood: venereal diseases

Black/African-Americans & medicine

Folk remedies
- Geophagia/Pica
  - Uses: pregnancy, diarrhea, GI parasites
    - GI flora?
      - Seen in iron deficient patients, why?
    - Seen throughout ancient world, still today
  - Common practice among 19th century South
    - Substitutions: laundry or corn starch
      - Can cause GI impaction

Black/African-Americans & medicine

Folk remedies, continued
- Salves and ointments
  - Pepper mixed with lard and spread on joints
  - Turpentine topically for joint pain, colds
- Garlic
  - Sometimes garlic salt is used, worsening HTN
- Copper bracelets for arthritis
- Regular laxative use to keep system open
- Many others

Hispanics & medicine
Hispanics & medicine

Hispanic diversity
- Covers all of Central/South America, parts of Caribbean
- Not a racial group
- 28% live in poverty in the US
- Limited access to care by numerous factors
  - No insurance or under-insured
  - Illegal immigrant
  - Language barrier
  - Migrant workers
  - No continuity of care

Hispanics & medicine

Pain and suffering
- Test of faith
  - Enduring suffering viewed as admirable
  - Fact of life or Fate, unavoidable
  - Miracles happen
  - Minimize symptoms, pain
- Punishment, deserved
  - May be non-compliant

These views are not unique to Hispanic cultures, but are prevalent

Hispanics & medicine

Attitudes of Hispanic people regarding health care
- Physician role highly respected
- May hide disagreement, confusion (nod yes to everything)
- Patient expectations of physicians
  - Listening, sympathetic, reassuring (often cold, impersonal)
  - Greetings and social mores expected
  - Personal anecdote #1 - the never ending handshake
- Modesty in gender roles
  - Husband may wish to stay in room with wife during exam
  - Remember good draping technique

Hispanics & medicine

End of life care
- Rich extended family support
  - Many visitors, all hours
  - Family should be at bedside at time of death
  - Concern for dignity and respect in dying
- Fears of substandard care
  - Similar to African-American communities
  - Deference to doctor’s advice
- Autopsies
  - Ante-mortem requests viewed as 'giving up'
  - Post-mortem requests seen as useless (pt is dead)

Hispanics & medicine

Family decision making
- Decisions often require extended family
  - Head of family (M or F) may be primary decision maker
  - Patient may defer all decision making to head of family
  - Many people: plusses and minuses
- Individual decision making (even by patient) may be less valued than family
- Discussing diagnosis with pt may be bad luck
  - Personal anecdote #2 - Mrs. M, 56F with CHF

Hispanics & medicine

Hispanic folk illness concepts
- Body imbalance: balancing hot and cold
  - Everything (diseases, food, meds) *innately* hot or cold
  - Health = balance: hot diseases need cold treatments
    - Vitamins (hot) neutralized with fruit juice (cold)
  - Similar to many systems of body balance worldwide
  - Derived from Hippocratic body humors?
- Mal aire: cold air, wind
  - Going from warm to cold environment or cold wind
  - Stiff neck, headache, neck and back pain
  - Treatment can involve cupping
Hispanics & medicine

Hispanic folk illness concepts, cont.
- **Empacho**: GI blockage
  - Cause: eat too much, spoiled food, wrong combination
  - Treatment: rubbing of abdomen, laxatives
    - Rarely, mercury and lead containing compounds used
    - May delay treatment of acute issues (appendix, etc)
- **Caido de la mollera**: fallen fontanelle
  - Cause: sudden bump or fall, feeding issues
  - Treatment: pushing up palate, holding baby upside down

Hispanics & medicine

Curandero/a
- Traditional folk healer
- Prescribe herbs, physical acts, religious practices
- Method of healing is supernatural (not herbal)
- Remedies done by family
- Can incorporate Catholic practices
- Central/South America

Hispanics & medicine

Santería
- Merged religious traditions
  - Yoruba religion (Nigeria), Catholicism, native Indian
  - Religious practices disguised with saint celebrations
  - Often coexist in Catholic practices
  - Caribbean, West Indies

Hispanics & medicine

Catholicism and Hispanic culture
- Vast majority are Catholic
- Concentration on certain aspects
  - Saints, the Virgin Mary, sacred heart of Jesus
- Often carry charms or medals of saints
  - Desire not to be removed from body
- Catholic beliefs/practices found all over the world

Asians & medicine
Asians & medicine

Demographics
- Fastest growing minority (by percentage)
- Chinese, Filipino, Indian, Vietnamese, Korean (in order)
- Vast majority of Asians in NY, CA and Hawai'i

Historical perspective
- Many living in US for multiple generations
- More likely to form immigrant communities
  - Feeling ostracized or excluded from mainstream society
  - "Chinatown"

Attitudes of Asians regarding health care
- Physician role: highly respected
  - Voice of authority and fund of knowledge
- Patient expectations: authority of physician
  - Recommendations often followed without question
  - Great reluctance to show disagreement
  - Defer decision making to doctor's judgment
  - Physician follows social role
    - Modest, respectful (esp. elders, seniors)
    - Uses respectful language (do not address by first name)
    - Handshake and touching may not be desired

Common cultural values
- Paternalistic family structure
  - Family input valued but often subordinate
  - Patient may not be decision maker
  - Age equated with wisdom, respect
- Dignity and respect prized
  - Rude behavior, faux pas poorly tolerated
- Disease and suffering viewed as facts of life
- Western medicine is not the only choice

Religious beliefs affecting interactions
- Confucianism
  - Reciprocity, filial piety, propriety, meritocracy
  - Family and community > individual
- Buddhism and Hinduism
  - Karma (cause and effect) and samsara (cycle of rebirth)
  - Reincarnation and value of life
- Multiple other religions present in Asia
  - Islam, Christianity, Shinto, and many others

Views at end of life
- Deferral to physician assessment
- End of life care
  - Dying with dignity prized
  - Family should be present at time of death
  - Personal anecdote #3 - my friend's grandmother
  - Family responsible for end of life care
  - May attempt to care at home past ability to manage
  - Patient should not know prognosis
  - May refuse autopsy as body should remain intact

Alternative medicine
- Many different cultural practices
- Alternative, not complementary
- "Herbal" medicine
  - Herbs and animal extracts treat specific conditions
  - Some remedies poisonous
  - Ingredients balance forces
    - Ying and yang (Chinese); vāyu vāta, pittā, kapha (Ayurveda)
  - Some common Asian herbs and foods
    - Ginseng, Ginkgo nuts
Asians & medicine

Alternative medicine, cont.
• Acupuncture and acupressure
  • Goal: free flow of chi through body
  • Uses a series of non-anatomical pathways
  • Points related to function, not structure
• Western evidence
  • Helps in some conditions
  • No Western scientific explanatory model
• Acupuncture = needles
• Acupressure = physical pressure
  • Elbows, etc. on pressure points

Asians & medicine

Special populations: Hmong
• Principally in mountainous Laos
• 'Hidden war' in Laos during Vietnam War
  • Fled to US due to persecution
  • Clustered in California and Minnesota
• Difficult interactions with US health care
  • Disease is due to spirits
  • Non-compliant with chronic medications and therapies
  • Non-acceptance of Western model of disease
  • Personal anecdote #4 - My Hmong patient

Asians & medicine

The Spirit Catches You and You Fall Down
by Anne Fadiman
• Lii Lee: infant with severe epilepsy
• Hmong not equipped to deal with a child with serious medical condition
  • In Laos, Lii would’ve died in infancy
• Parents: Western medicine arrogant, inflexible
• Doctors not equipped to deal with such a different view of health care
  • Doctors, parents ignorant, non-compliant, abusive?

This book is the perfect example of the need for multicultural consideration in medicine

Native Americans & medicine

• Demographics
  • Smallest, most diverse minority population
  • ~1/4 live in poverty (on reservation 39%)
  • ~1/2 live on reservations
  • Disproportionate burden of disease
• US moral and ethical obligation
  • Oppression, murder, germ warfare, robbery, relocation
  • Reservations
    • Usually unwanted land
    • Self-governance
Native Americans & medicine

Values and medicine
- Health is living in harmony with nature
- Disease causality: due to events in the past or future
- Emphasis on living in moment
  - NOT 'Time is money' 'Carpe Diem'
- Indian healers address physical, spiritual wellbeing
- Traditional remedies, natural cures

Native Americans & medicine

American Indians in US health care system
- Disproportionate disease burden
  - Prevalence DM2 (16%), alcoholism (10%), smoking (32%)
  - 33% without health insurance
- Indian Health Service
  - Care similar to urban poor and VA
  - Many IHS physicians fulfilling obligations
    - Do not stay and establish ties
    - Inexperienced doctors practicing or experimenting on them
  - Limited IHS facilities and access
  - Indian Preference hiring: mixed blessing?
  - Invaluable services: free clinics, nursing services, social work, community outreach, health care transportation

Native Americans & medicine

Traditional medicine
- Magical power used to rapidly arrive at diagnosis
  - 'Thorough' may be seen as ignorant or incompetent
- Herbs, natural medicines
  - Large quantities at episodic intervals
    - Pills several times a day regularly is foreign, nonsensical
- Addresses spiritual concerns
  - Western medicine only addresses physical ailments

Native Americans & medicine

Patient Physician Interactions
- Physician should address spiritual concerns
- Cultural, spiritual mores important
  - Firm handshake a sign of aggression
  - Small talk expected (not getting down to business)
  - Staring, excessive eye contact invading privacy
  - Taking notes may generate concern
    - Most cultures have oral traditions

Native Americans & medicine

Patient Physician Interactions, cont.
- Silence and speaking
  - Often will say little, so must appreciate non-verbals
  - Interrupting, being impatient is rude
  - Silence is highly valued and shows respect
- Volume and tone of voice
  - Low tone of voice used, so pay attention
  - Don't ask patient to repeat self (ensure quiet setting)
  - Loud, confident tone seen as rude, arrogant
- Accoutrements
  - Cultural items signify status, heritage, profession
    - Pouches, beads, jewelry, feathers

Parker IHS Hospital, Parker AZ
- Personal anecdote #5 - my mom was an IHS nurse
Religion & multiculturalism
- Often religion plays an integral part of a patient’s explanatory model of disease
- Worthwhile to be familiar with major world religions
  - Christianity
  - Islam
  - Hinduism
  - Buddhism
  - Judaism
- Important to remember that religions are not necessarily exclusive

Conclusions
- This lecture not authoritative, generalizes
- Your patient is an individual
- Approach your patient in a non-judgmental fashion
- Elicit explanatory model
- Inquire about religious or traditional practices
- Find out if other family should be involved
- Avoid obvious faux pas and social blunders
- If unsure, inquire about beliefs and practices

Conclusions
Hopefully this will help you navigate complex cultural issues!

Questions?
Delivering Bad News
Psychosocial Seminars
DELIVERING BAD NEWS

Objectives:

A. To develop strategies for effectively and empathetically delivering bad news to patients and/or their families

B. To examine strategies for discussing and negotiating DNR status with patients and patients’ families

C. To understand what patients view as supportive and unsupportive from physicians

Readings:

Depression
Interviewing
Psychosocial Seminars
INTERVIEWING

Using a Patient-Centered Approach to Elicit the Patient’s Story

Objectives:

A. To understand how patient-centered interviewing differs from physician-centered interviewing

B. To understand how and why using a patient-centered approach relates to potential outcomes (e.g. patient compliance, patient satisfaction) and the reliability of data gathered

C. To be able to differentiate between open-ended and closed-ended questions, between the patient-centered and the physician-centered portion of the interview, and between the directive and non-directive dimensions of the interview

D. To rehearse the model for a patient-centered data gathering interview

E. To understand emotion-seeking and emotion-handling skills (N.U.R.S.)

Readings:


Interacting Effectively with Various Personality Styles & Developing Self-Awareness of Responses to Various Personalities

Objectives:

A. To be able to identify key distinguishing characteristics of four primary personality styles (dependent, obsessive-compulsive, histrionic, self-defeating)

B. To be able to identify and demonstrate appropriate interaction management techniques depending on the patient personality style

C. To be able to identify personality characteristics

D. To begin to develop a self-awareness of previously unrecognized responses (countertransference) and signs of personal discomfort during patient encounters

Readings:

A PATIENT-CENTERED INTERVIEWING METHOD FOR ESTABLISHING
EFFECTIVE COMMUNICATION AND RELATIONSHIPS

STEP 1 -- Setting the Stage for the Interview

1. Welcome the patient
2. Use the patient’s name
3. Introduce self and identify specific role
4. Ensure patient readiness and privacy
5. Remove barriers to communication
6. Ensure comfort and put the patient at ease

STEP 2 -- Chief Complaint/Agenda Setting

1. Indicate time available
2. Indicate own needs
3. Obtain list of all issues patient wants to discuss; e.g., specific symptoms, requests, expectations, understanding
4. Summarize and finalize the agenda; negotiate specifics if too many agenda items

STEP 3 -- Opening the HPI

1. Open-ended beginning question
2. 'Non-focusing’ open-ended skills (Attentive Listening): silence, neutral utterances, nonverbal encouragement
3. Obtain additional data from nonverbal sources: nonverbal cues, physical characteristics, autonomic changes, accouterments, and environment
STEP 4 – Continuing the Patient-Centered HPI

1. Obtain description of the physical symptoms [Focusing open-ended skills]

2. Develop the more general personal/psychosocial context of the physical symptoms [Focusing open-ended skills]

3. Develop an emotional focus [Emotion-seeking skills]

4. Address the emotion(s) [Emotion-handling skills]

5. Expand the story to new chapters (focused open-ended skills, emotion-seeking skills, emotion-handling skills)

STEP 5 – Transition to the Doctor-Centered Process

1. Brief summary

2. Check accuracy

3. Indicate that both content and style of inquiry will change in the patient is ready
MHC Model (MUS)
Psychosocial Seminars
SOMATIZATION

Diagnosing and Managing a Somatizing Patient

Objectives:
A. To understand the general patient education model of interviewing
B. To be able to identify the various distinguishing characteristics and "symptoms" that lead to suspecting a somatization disorder
C. To understand the process of diagnosing a somatizing patient through ruling out organic disease
D. To examine and rehearse various techniques for informing somatizing patients of the potential for a non-organic basis for their illness
E. To examine techniques for negotiating a treatment plan with somatizing patients

Readings:
   A similar article is in UpToDate under "Medically Unexplained Symptoms".
Treating Patients with Medically Unexplained Symptoms in Primary Care

Robert C. Smith, MD, ScM, Catherine Lein, MS, FNP, Clare Collins, RN, PhD, Judith S. Lyles, PhD, Barbara Given, RN, PhD, Francesca C. Dwamena, MD, John Coffey, MS, AnneMarie Hodges, MS, Joseph C. Gardiner, PhD, John Goddeeris, PhD, C. William Given, PhD

BACKGROUND: There are no proven, comprehensive treatments in primary care for patients with medically unexplained symptoms (MUS) even though these patients have high levels of psychosocial distress, medical disability, costs, and utilization. Despite extensive care, these common patients often become worse.

OBJECTIVE: We sought to identify an effective, research-based treatment that can be conducted by primary care personnel.

DESIGN: We used our own experiences and files, consulted with experts, and conducted an extensive review of the literature to identify two things: 1) effective treatments from randomized controlled trials for MUS patients in primary care and in specialty settings; and 2) any type of treatment study in a related area that might inform primary care treatment, for example, depression, provider-patient relationship.

MAIN RESULTS: We developed a multidimensional treatment plan by integrating several areas of the literature: collaborative/stepped care, cognitive-behavioral treatment, and the provider-patient relationship. The treatment is designed for primary care personnel (physicians, physician assistants, nurse practitioners) and deployed intensively at the outset; visit intervals are progressively increased as stability and improvement occur.

CONCLUSION: Providing a comprehensive treatment plan for chronic, high-utilizing MUS patients removes one barrier to treating this common problem effectively in primary care by primary care personnel.

KEY WORDS: physical symptoms; somatization; somatof orm: primary care; evidence-based.


The medical system fares poorly with patients seeking care for medically unexplained symptoms (MUS). We prefer the more encompassing and descriptive term MUS, but many use terms like somatization and somatoform disorders for these patients. Unfortunately, many MUS patients avidly seek care to find an organic disease they fear but do not have. Doctors then may test for and even treat (nonexistent) organic disease. This produces high utilization of services, unnecessary laboratory testing and consultation, increased costs, and high iatrogenic complication rates (e.g., ill-advised tests, drug addiction, and trial treatments for presumed but absent organic diseases).

Further problematic is that we overlook patients' basic problem of psychosocial distress. Rates of mental and physical dysfunction are high: disability and poor work records are common; relationships are poor; and personal distress prevails. Magnifying the impact, MUS patients constitute a large proportion of all outpatients. The entire system suffers not only from a harmful effect upon patients, but also from excessive costs and utilization. With some urgency, evidence-based treatment is required if we are to reverse these problems. This article describes a comprehensive treatment plan for MUS patients designed for primary care personnel, a well-recognized need.

In a literature review, we sought not only to understand work in primary care and specialty settings, but also to go beyond present approaches to find additional research that might inform treatment. Some urge that simply doing better with what we now have is insufficient, that synthetic new models designed for primary care are needed, and that producing evidence for the models is the essential next step.

FORMULATING THE INTERVENTION

Literature Review

We synthesized the treatment from our own experiences, consultation with experts, and from an extensive review of the literature. We searched the MEDLINE database from April 2002 back to 1966 using the Silverplatter WinSPIRS interface. Terms such as "somatoform disorders," "chronic fatigue syndrome," "functional colonic diseases" (e.g., irritable bowel syndrome, colitis),
“fibromyalgia,” “premenstrual syndrome,” “myofascial pain syndromes,” unexplained “chronic pain,” functional “dyspepsia,” and psychological components of allergies (“hypersensitivity”) were used. Wherever possible, these terms were searched as Medical Subject Headings (MeSH) selected from the database Thesaurus, and other subjects not adequately represented in the Thesaurus were searched as keywords in the title and/or abstract fields. The combined set of citations for all subjects of interest was then limited to randomized controlled trials and articles in English and in human populations. Separate searches also were run on “nurse practitioners” and/or “primary care” insofar as either subject relates to the above terms, limited to English. Using the same interface, all of the above topics were searched again in the American Psychological Association’s PsycINFO database from April 2002 back to 1967.

We evaluated over a thousand abstracts produced by our searches, and reviewed several hundred full articles derived from the search (in addition to our own files). We looked for two things: 1) clinical trials in primary care and specialty settings; and 2) any type of study that might inform a new treatment. We included reviews. There were many unidimensional treatment studies of high quality, and we used these data to inform which components we considered for what proved to be a multidimensional treatment. We selectively reference our findings.

The vast majority of randomized controlled trials (RCTs) have been conducted by mental health specialists in mental health settings, whereas treatments in primary care have been limited and brief, and the topic rarely studied. A single consultation letter to primary care physicians decreased costs (via decreased hospitalization) and, secondarily, it minimally improved functional status, symptoms, and quality of life, and had a mild effect on physical functioning in severe MUS patients. A subset of patients underwent additional group therapy experiences conducted by a specialist, and they improved psychologically and physically. Because of more stringent rules for hospitalization in the present environment, it is unlikely that the cost benefits would be obtained today. Also, this approach gained little following because it lacks the comprehensive, multidimensional type of care most believe will be needed for complex problems in mental health care like MUS. Other brief, limited interventions also have not been effective. We found only 1 study of a multidimensional treatment for primary care. That intervention entailed eight 2-hour sessions for groups of 17 in cognitive-behavioral treatment (CBT) techniques, relaxation, meditation, and stress management, and showed no impact compared to controls.

Cognitive-Behavioral Therapy

We found much valuable experience in multidisciplinary chronic pain and other somatization management programs and in consultation-liaison psychiatry efforts with difficult, high-utilizing patients. All employed CBT. Many have shown that CBT interventions delivered in specialty care settings have improved short-term outcomes in MUS patients. Kronke and Swindell provide a nice review of CBT in MUS, including its effectiveness in just 5 to 6 sessions.

However, health care systems have not incorporated these models in routine care, because of cost and because MUS patients often refuse to seek services outside of the primary care setting. Some report as few as 10% completing referral; in contrast, 81% of MUS patients were willing to have psychosocial treatment in primary care by their physician. For those who agree to referral, treatment for MUS has not proven effective over the long-term, largely because of the time-limited exposure to MUS patients, in the range of once weekly for 8 to 10 weeks (e.g., counseling, pain clinic). Although there are occasional reports of effects lasting upwards of 1 year and 1 report of incomplete improvement over 5 years, most MUS patients revert to their baseline state upon discontinuing specialty care.

We concluded that CBT was potentially useful in primary care and we configured its basic skills for use by primary care personnel. While we eschewed the more complex, specific techniques that might require special training, such as desensitization and immersion therapy, we included active cognitive reorientation at many visits based upon an understanding of the patient's explanatory model, often facilitated by using symptom diaries. Further, behavioral approaches based upon operant mechanisms were employed (e.g., regular visits and medication schedules independent of symptoms). We also were guided by an earlier RCT, in which we showed that the CBT model presented later was easily learned and effectively deployed by primary care residents, and that it had an impact on MUS patients. Although data were lacking, we further concluded that deploying cognitive behavioral treatment over longer periods of time merited exploration.

Collaborative, Stepped Care

The difficulty physicians experience in treating depression led experts to recommend a multidimensional approach, as used often in pain clinics, rather than focusing on physician education. Collaborative care leads to interactions among various parts of complex health problems and, continuing to involve the physician, multiple other domains are integrated with medical care, e.g., social services, physical therapy, pain clinic, specialty medical referral, psychological referral. These activities typically are not coordinated by the physician but, rather, by a case manager. Moreover, following stepped-care principles, these services are used only as needed on an individualized basis. In our view, collaborative, stepped-care approaches appeared promising for meeting the mental health needs of other primary care patients with mental health problems like MUS.
We adapted these principles for use in primary care by primary care personnel. Rather than initially delegating the key coordinating role to someone other than the primary provider, however, we believed that primary care providers could not only handle the coordinating role but also could themselves conduct some of the work rather than triage it. Depending upon their skills and interests, physicians, physician assistants (PAs), and nurse practitioners (NPs) could conduct first-line treatment in the following areas: social worker, physical/occupational therapist, exercise/relaxation instructor, and diet counselor, as well as conducting the intervention (to be described). We believed this approach would be less costly, more efficient, and more effective, in addition to greatly enhancing the provider-patient relationship (PPR) by actively involving the provider in most dimensions of care. Providers would need to recognize failures in each area, and at that point, to make appropriate referrals. We anticipated also that referral could occur with successes, such as the patient who improves (gains insight) and wishes formal counseling. Certain problems also would initially be outside the provider’s capability and necessitate referral: psychological/psychiatric treatment, osteopathic manipulative therapy, and specialty medical treatment. In addition, whereas PAs or NPs are primarily responsible for treatment, the usual care physician would remain actively involved in a collaborative way as a back-up and informal consultant for ongoing issues, thus remaining integral to treatment.

Provider-patient Relationships and the Psychosocial Dimension

The literature is just as replete with reports of the centrality of the PPR to the care of MUS patients as it is with concerns about typically poor relationships with MUS patients. Although the centrality of communication and the PPR has been recognized, we found only 1 intervention that explicitly addressed the PPR, but it did not report a systematic procedure to establish it. We concluded that this major barrier to care should be addressed.

We used a patient-centered method described by Smith and tested by our group. This method describes in behavioral terms how to communicate and establish the PPR. Our group showed in an RCT that it was learned easily by first-year primary care residents and, in turn, that there was evidence of a positive impact upon patients. We incorporated this PPR method as the centerpiece of the intervention for MUS patients, where we integrated it with the CBT model.

Consistent with this orientation of viewing the person and their relationship with others as paramount, we went beyond isolated reliance upon the PPR (while maintaining it central) to consider social issues and social relationships, and more recent interpretations of sociosomatics that focus on how everyday processes relate to cultural expectations and values. In going beyond the dyadic relationship, the treatment was consistent with relationship-centered care and with sociopsychosomatic conceptualizations. Treatment reflected incorporation of the broader psychosocial dimension by, for example, incorporating significant others, actively addressing role constriction and social isolation, and generally working to decrease both perceived and real social marginalization from healthy states.

THE INTERVENTION

Provider-patient Relationship

The 5 steps and 21 substeps of the evidence-based patient-centered interviewing method are relied upon as the mainstay throughout treatment. The method is a provider’s main data-gathering, relational, and therapeutic activity. Table 1 shows the steps and substeps providers use, always integrating them with doctor-centered interviewing for disease and other relevant details.

Table 1. Patient-centered Method for Communication and PPR

<table>
<thead>
<tr>
<th>STEP 1: Setting the stage for the interview</th>
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<tbody>
<tr>
<td>1. Welcome the patient</td>
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<td>5. Remove barriers to communication</td>
</tr>
<tr>
<td>6. Ensure comfort and put the patient at ease</td>
</tr>
</tbody>
</table>

STEP 2: Chief complaint/agenda-setting

| 1. Indicate time available                  |
| 2. Indicate own needs                       |
| 3. Obtain list of all issues patient wants to discuss, e.g., specific symptoms, requests, expectations, understanding |
| 4. Summarize and finalize the agenda; negotiate specific if too many agenda items |

STEP 3: Opening the HPI

| 1. Open-ended beginning question           |
| 2. “Nonfocusing” open-ended skills (attentive listening): silence, neutral utterances, nonverbal encouragement |
| 3. Obtain additional data from nonverbal sources: nonverbal cues, physical characteristics, autonomic changes, acoutemments, and environment |

STEP 4: Continuing the patient-centered HPI

| 1. Obtain description of the physical symptoms (focusing open-ended skills) |
| 2. Develop the more general personal/psychosocial context of the physical symptoms (focusing open-ended skills) |
| 3. Develop an emotional focus (emotion-seeking skills) |
| 4. Address the emotion(s) (emotion-handling skills) |
| 5. Expand the story to new chapters (focusing open-ended skills, emotion-seeking skills, emotion-handling skills) |

STEP 5: Transition to the doctor-centered process

| 1. Brief summary                           |
| 2. Check accuracy                          |
| 3. Indicate that both content and style of inquiry will change if the patient is ready |


PPR, provider-patient relationship; HPI, history of the present illness.
Providers focus upon actively eliciting and responding to emotions. Distress, upset, anger, and sadness are among myriad emotions that MUS patients will express, and these are explored, including those surrounding troublesome medical experiences. Emotion is addressed in a way that enhances the relationship. Specifically, when patients express emotion, the provider Names it, Understands it, Respects it, and Supports it; that is, one NURSs the emotion. Past research suggests that these skills are important tools that physicians learn in improving relationships with and satisfaction of patients. In addition to patient-centered communication, there are additional ways providers can improve their relationships with chronic MUS patients:

1. Speaking and behaving in a way that connotes positive regard, trust, and caring are patient-centered attributes that providers rely upon throughout management.

2. Attending to the patient's personality style, providers find many different personality patterns in MUS patients. Care is tailored to the individual patient, according to the unique dictates of the personality. For example, the relationship with histrionic patients is uniquely benefited by reassurance about bodily integrity and appearance, deemphasizing cognitive material, and working with their prominent emotions. In contrast, the relationship to the obsessive MUS patient is individualized by highlighting cognitive data, encouraging the patient's control, and emphasizing less the emotions.

3. Encouraging patients to be responsible leads to the best relationship. Many have highlighted the importance of negotiating expectations and limitations and have urged openness to compromise as well. This process leads to an agreement or contract in which both parties share responsibility and are clear about their roles, sometimes making them explicit or, rarely, even developing a written contract to resolve ambiguity. Goals, diagnostic work-up, eventual naming of the diagnosis, and treatment require negotiation and compromise on both sides. The provider, however, always retains the responsibility to establish the standards of care. Usually, if the provider is open to the patient's needs and shows a willingness to inform and negotiate, his/her medical responsibilities can be met and the patient's needs met at the same time.

4. Working on self-awareness issues helps to maximally develop the relationship. To do this, the provider must become involved in the difficult, often painful task of recognizing and addressing her/his own negative reactions to the frequently disliked MUS patient. Especially worrisome is a report that senior medical students in the present culture find it acceptable to dislike MUS patients, while it is not acceptable to dislike difficult geriatric patients.

Four-point Cognitive-Behavioral Treatment Plan

Each of 4 provider behaviors occurs at every visit, initially introducing the material and later reinforcing it, and introducing evolving new issues. These behaviors are designed to alter thinking patterns and associated behaviors around symptoms and other aspects of patients' lives. The PPR principles above are liberally employed and integrated with CBT, especially NURSs, in discussions of the frequent difficult problems and attendant emotions that these patients typically have.

I. Goals. The provider, in collaboration with the patient, first identifies achievable long-term goals with the patient, e.g., decreased symptoms, improved functioning and well-being, less disruptive behavior, improved work/school record, and improved interpersonal relationships. Patients are told not to plan on cure, and instead the provider negotiates specific treatment goals with the patient. Short-term goals are facilitated by the provider at each visit in a way that the patient has been responsible for identifying goals rather than having them prescribed. Short-term goals are designed to actualize long-term goals, e.g., a patient with chronic pain and fatigue negotiates to walk one-half block 3 times daily until the next visit. Providers identify achievable goals and limit their number to no more than 2 to 3 for the next visit; these are often labeled homework.

II. Achieving Patient Understanding and New Ways of Thinking About Symptoms. Initially, the provider determines the patient's explanatory model, starting with an open-ended, patient-centered approach and later pinning down the following specifics if they do not develop open-endedly: learning what the patient believes is wrong, the type of treatment expected, the hoped for outcome of the treatment, the cause of illness, the reasons for symptoms at any one time, the mechanism of the illness and symptoms, and the patient's understanding of the course of the illness and of its treatment. These ideas of the patient must be understood, because reorientation and retribution are often needed as part of treatment. To achieve this, patients must be understood in an empowering way. Patients typically are worried about the causes of their symptoms and have definite expectations for care. Understanding these enhances the PPR and provides guidance for treatment. Explanations that do not blame the patient are important. Differences in doctors' and patients' expectations seem to be a factor contributing to the frequent poor PPR.
Table 2. Achieving Patient Understanding of the Following

1. Ominous conditions have not been found
2. Surgery, further testing, and consultation not necessary
3. Problem is somatic and real
4. Their somatic diagnosis and its mechanism
5. Stress, depression, and anxiety key part of illness — and medications help
6. They are not a "psych case"
7. Narcotics and tranquilizers aggravate the problem
8. Cure is not likely — but improvement is possible

Summarized in Table 2, as a key part of CBT, the provider confidently establishes the following points initially, typically needing to reinforce them frequently:

1. Relieve worry about ominous conditions, especially those that the patient is concerned about (e.g., multiple sclerosis, cancer, AIDS, heart disease). Also emphasize that surgery, further testing, and additional consultation are not required, but that the provider will maintain close clinical observation for organic diseases.

2. Acknowledge the problem is "real." The provider accepts the problem as somatic and avoids the implication that the difficulty is "all in your head."

3. Provide diagnoses and explain the mechanism. The caretaker reassures the patient by confidently emphasizing that she/he knows the diagnosis and has experience with this common problem. A benign somatic diagnosis and its mechanism are provided, e.g., chronic muscle strain is a good explanation for many pain syndromes, "altered brain chemicals" can help to describe depression, and the use of popular names such as irritable bowel syndrome or fibromyalgia also works well. This gives patients a "medical" diagnosis or explanation that they can give relatives and employers and helps them to "save face" by having something "real" that is not in their head.

4. Develop patients' awareness of the roles that stress, anxiety, and depression play in their illness. The provider conveys that depression and anxiety result from the pain (or other MUS complaint) and also aggravate or "cause" it. The provider simultaneously reassures patients that "anybody with this much trouble would be depressed" and that "you aren't crazy or a 'psychiatric' case." The specter of being labeled psychiatric must be offset. One can further normalize the idea of stress by self-disclosure, indicating how the provider herself/himself develops headaches (or whatever) when under stress. One always gauges the patient's response to introducing psychological factors and sets the pace accordingly, not wanting to make the patient uncomfortable with what may be a new emphasis.

5. Explain the negative effects of narcotics and tranquilizers in treatment of symptoms. The provider indicates that these addicting medications, because they cause depression, do more harm than good. One explains that not only does depression contribute to the pain (or other symptoms), but that these addicting drugs themselves cause depression and, therefore, the patient may unwittingly aggravate the problem by using them. In response to the frequent "It's the only thing that helps," the provider indicates that the medications will not be withdrawn abruptly but, rather, only slowly and after an antidepressant is begun. It also is indicated that the antidepressant is a far better pain medication than sedatives or narcotic agents, and that it is not addicting.

6. Explain the difference between cure and management of symptoms. The provider empathically explains that cure is unlikely but conveys hope that the treatment recommended can help the patient live a better and more productive life. To suggest cure or marked improvement can provoke fear or lead to disappointment and diminution of the relationship when it does not occur. Indeed, the provider often predicts that the patient will not see much improvement for a while.

III. Obtaining a Commitment. The provider gives an overview of the treatment options for the patient, e.g., antidepressants, tapering of addicting medications, exercise, and regular visits. The next step is crucial: obtaining an explicit commitment to work on the treatment program. This involves the patient equally in their program, another part of the negotiation process, and establishes the patient's responsibility for their health. The provider also will often obtain a key family member's commitment to work as comanager.

IV. Negotiating a Specific Treatment Plan for Illness Behavioral Change. Providers conduct multiple elements of the treatment plan (summarized in Table 3). The specific order and initial emphasis varies according to unique patient circumstances and needs, e.g., exercise might receive more initial emphasis in a de-conditioned patient. Further, the specific treatment elements are negotiated and developed over time rather than being unilaterally prescribed. The patient's progress and response to initial work, as well as her/his interests, determine the course of treatment. Providers are careful not to overload patients and to match introduction of new aspects of treatment with
Table 3. Elements of a Specific Treatment Plan

1. SSRI or related medication in full doses — for depression and/or anxiety
2. Lower doses of SSRIs or other antidepressants for sleep and pain management independent of depression diagnosis
3. Taper and discontinue addicting medications — do not initiate addicting medications
4. Nonaddicting, symptomatic medications, e.g., for irritable bowel syndrome or fibromyalgia
5. Symptom diary and symptom reattribution work
6. Physical exercise, graded
7. Relaxation techniques: deep breathing or progressive muscular
8. Dietary counseling, especially around weight
9. Physical therapy/conditioning
10. Family visit with closest person to patient — possibly enlist as a co-manager
11. Referral for special, sometimes refractory problems, e.g., counseling, osteopathic manipulative therapy, psychiatry for medication recommendation
12. Management of comorbid disease problems, new and pre-existing
13. Support and common-sense advice
14. Medical investigation and referral only with objective evidence of disease or a refractory problem
15. Maximize the PPR
   a. Elicit, understand, and address the patient’s emotion
   b. Identify and work with patient’s personality characteristics
   c. Positive regard/caring, negotiate rather than prescribe, trusting atmosphere
   d. Encourage patient responsibility and self-management without forcing it
   e. Provider self-awareness

SSRI, selective serotonin reuptake inhibitor; PPR, provider-patient relationship.

Table 4. Tapering and Discontinuing Addicting Medications

<table>
<thead>
<tr>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ascertain present dose</td>
</tr>
<tr>
<td>2. Negotiate how much patient thinks they need on more severe days</td>
</tr>
<tr>
<td>3. Prescribe this amount on a fixed schedule</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taper</th>
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<tbody>
<tr>
<td>1. Negotiate reduction schedule: appropriate to suggest decrease in 1 tablet daily each week, but be prepared to accept up to monthly: e.g., 1 tablet q.i.d. for next week, then 1 tablet t.i.d. the following week, etc.</td>
</tr>
<tr>
<td>2. When more than one addicting medication, determine patient’s initial preference for reduction or if they prefer simultaneous reduction</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Discontinue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Simply stop after down to one or one-half tablet daily</td>
</tr>
<tr>
<td>2. Most achieve this by 2-4 months, many in 1 month</td>
</tr>
<tr>
<td>3. A few cannot psychologically completely stop; appropriate to maintain at lowest dose as long as they have made some reductions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Give just enough medication to last until next visit</td>
</tr>
<tr>
<td>2. Provide only one “grace period” refill when patient reports losing medication</td>
</tr>
<tr>
<td>3. May need written contract for problematic patients</td>
</tr>
<tr>
<td>4. Agreement to obtain medications only from the provider</td>
</tr>
</tbody>
</table>

muscular relaxation can be taught in addition to simple physical therapy procedures. Usual prescriptions are for 20 to 30 minutes once or twice daily. These procedures are taught to patients by providers and integrated into the remainder of the program. To further offset the effects of often-severe deconditioning, exercise programs are demonstrated, discussed, and individualized rather than just giving the patient a print-out or costly referral. It almost always is necessary to warn patients to adhere to the negotiated agreement even when they are having the most pain (or other difficulty, such as fatigue or palpitations) ever and, conversely, not to exceed the agreement even if they are having no problem whatsoever. Any change in treatment schedule is negotiated at the next visit. Such pacing and adherence to graded, negotiated programs is essential. These types of CBT work require repetition over time and remain prominent throughout treatment.

Providers do not initiate narcotics and tranquilizers. For patients already taking these agents, a program of gradual tapering is negotiated, understanding that compromise around speed of reduction and, occasionally, complete discontinuation may be necessary. The key points for tapering and discontinuing addicting medications are summarized in Table 4. This slow reduction precludes psychological withdrawal and provides for comfortable psychological withdrawal in a safe, supportive circumstance. By following this approach, providers can have many patients completely off all addicting medications in 2 to 4 months. Some patients, however, will be unable to completely discontinue the medications, and it is
acceptable to negotiate just a reduction in the dosage. The remainder of the program provides alternatives to narcotics. Sometimes, it can be helpful to negotiate a specific contract with the patient about amount of narcotics to be used.90

Some MUS patients have dysthymia or major depression, varying from mild to severe; when combined they have "double depression.27 Sometimes, just vegetative manifestations are present.100,110 Although data are limited on the treatment of depression in patients who somatize, these data suggest that treatment is successful111,112; other data suggest improvement in pain at low doses and independent of an antidepressant effect.113,114 We briefly summarize an approach derived from recently validated115,116 Agency for Health Care Policy and Research guidelines117,118 in Table 5 and refer the reader to more detailed reviews.119 Treatment can involve both counseling and antidepressants in full doses. Preferably selective serotonin reuptake inhibitors (SSRIs) because of their lower side-effect profile.120,121 Of note, SSRIs have not been shown to be different from tricyclic antidepressants in rates of falls among nursing home residents.122

Many chronic MUS patients have panic disorder and other types of anxiety, often in combination with depression.123 As in the above review, providers use SSRIs,119,124 but we do not recommend the use of either monoamine oxidase (MAO) inhibitors or tranquilizing agents because of their severe side-effect profiles; patients already taking tranquilizing agents will have them weaned and fully discontinued in many instances.

It is explicitly negotiated with the patient that they neither see other providers nor visit the emergency room without prior consultation with the provider; similarly, patients are asked not to get medications refilled from prior sources.76 In addition, patients must sometimes be educated to distinguish emergencies from those problems that can be handled during working hours.

Except with a change in pattern of complaints or the development of objective manifestations of organic disease, providers avoid additional investigation or hospitalization.31 During regularly scheduled office visits, while continuing to integrate patient-centered approaches, including the patient's agenda,44,79,81 it is important that the provider determine that there is no change in symptoms suggesting organic disease and, on the other hand, recognize that not every complaint needs investigation. Recalling that change is slow and treatment occurs over a long period, the provider often must shift the conversation away from the somatic complaints by showing a preferential interest in the psychosocial aspects of the patient's story.5,79 but she/he always performs a brief physical examination pertinent to the patient's complaint.79

The provider also reviews the patient's diaries, helps the patient understand the relationship of symptoms to stress and, when necessary, reviews previous material (e.g., no cancer and no need for further evaluation). New plans are negotiated for activity levels or other actions to be conducted before the next visit. When patients have comorbid organic disease, treatment of the disease is integrated with the 4-point program and may become a major focus.

The provider asks patients to have a significant-other person in their life accompany them for a visit. During the visits, providers are open-ended and empathic and keep the conversation focused upon the patient's health and its impact upon the family member. Providers carefully observe the interaction, how supportive the family member is, and assess if and how the family member can become an ally in care. One must determine the family member's perception of the need for and willingness to seek change; when this is absent, progress is unlikely.125 Because the patient's basic illness behaviors must change, the best allies often are less supportive of the patient's present efforts, less understanding of failure to improve, and less facilitative of continuing the patient's current situation.125 It also is important, oftentimes, to reiterate much of the same material the patient needed to understand.125

These already high-utilizing patients require regular, frequent visits,1 particularly at the outset when most need to be seen weekly: as stability occurs and progress begins, the visit intervals are progressively lengthened as long as the patient remains stable.31,48,76

### Table 5. Depression Management Guidelines

| 1. Education and discussion of the problem with patients and families. |
| 2. Antidepressant medications in full doses usually with the selective serotonin reuptake inhibitors (SSRIs) and related drugs because they have fewer side effects, greater compliance, and greater likelihood of achieving full doses. Tricyclics can be used if the patient prefers. We believe that MAO inhibitors should be used only with treatment failures and under supervision of a psychologist. |
| 3. Judge response at 5-6 weeks |
| a) Full responders (expected response), reassessed for complete remission in another 6 weeks, are placed on continuation treatment at the same dosage for 12 months. At that point, a reduction to one-half the dose can be tried if the depression was mild or a first episode, especially in younger patients. |
| b) Nonresponders (little or no response) will be reassessed for accuracy of diagnosis and compliance: especially important are observing for unrecognized medical illness, interference from other medications, and covert substance abuse. Referral to psychiatry occurs if the patient is willing. Antidepressants can be increased in dose or changed, with continued close follow-up during the next 6 weeks, usually in consultation with the psychiatrist. |
| 4. Counseling is urged, especially for patients who refuse or cannot take antidepressants. When that is refused, we urge consultation with a minister or other respected person. Other aspects of the treatment program also can be helpful in treating depression, e.g., exercise, relaxation, treatment of pain. |
| 5. We also use smaller than therapeutic doses of a SSRI or other antidepressant for both sleep and pain management. |
stable patients are 4 to 12 weeks. With crises, frequent visits may again be needed. Visits should be time-contingent; this conveys that the provider is more interested in the patient than in the symptom. Providers also can reduce the number of visits with 3- to 5-minute phone calls. Intake visits take longer than usual, and 60 to 90 minutes are allotted, sometimes spreading the time over the first 2 visits. Thereafter, visits are 15 to 20 minutes. This recommended method can be continued indefinitely in managing MUS patients.

DISCUSSION

This literature review, while systematic, was a screening procedure to ensure comprehensiveness, in contrast to a formal literature review comparing treatments and characterized by more stringent control of bias. There were few treatments in primary care to compare, and our task was, rather, to synthesize existing work from all sources. Although not yet published, our experiences using NPs to deploy this treatment with over 100 MUS patients have been that most patients can be diagnosed and treated without referral for medical or psychological assistance. NPs successfully treated the majority of depressed patients, performed all the drug tapering and discontinuation, and managed most comorbid organic diseases. Psychological and medical consultation were sought if failure in parts of the treatment occurred, e.g., unresponsive depression, worsening headache. Providing back-up for NPs was key, because none had managed a panel of patients independently; they needed to ask questions about medical management, especially at the outset. These issues around treating comorbid organic diseases would not be a problem for a physician provider. Indeed, NPs were in contact daily with the primary care physician and problems usually were first addressed at this level; sometimes, the physician saw the patient but generally offered advice about a patient they already knew quite well in a fully collaborative arrangement.

Preliminary results suggest that patients have been pleased with the treatment, as have physicians and administrators. NPs understandably have been more measured in their responses although they overwhelmingly favor the approach, would do it again, and, most telling, continue to see these patients in their practices after the research treatment concludes.

Even an established treatment, however, will not solve the other problems that also prevent effective management of MUS patients. We will need to address these in parallel. Encouragingly, the field has moved away from blaming the physician and has recognized the many realistic impediments to effective treatment that need to be addressed: 1) through no fault of their own, physicians' education does not prepare them for dealing with mental health and psychosocial problems; 2) it is not yet known whether these so-called “difficult” patients will respond to treatment in primary care. anyone know how to handle their high rates of resistance and noncompliance. 3) High rates of refusal by patients of referral for mental health consultation also can impair care. 4) Compensation also has been an issue with these patients, who may require more and longer visits, as well as telephone contacts, and they also may be impeccable. 5) A satisfactory classification/diagnosis system has not been established, rendering it difficult to identify a treatment when we cannot make a diagnosis. 6) The role of medical comorbidity in MUS patients has not been understood, and 7) competing demands upon the provider compound the problem. By, in the absence of enough time to do everything, forcing him/her to make an active choice from the multiple priorities of patients, the practice ecosystem, the policy environment, and themselves.

Therefore, we must walk soberly, warningly, and fully aware as we face one of the great problems of this new century in primary care and, indeed, all of medicine—at least if we want a medicine rooted in scientific and humanistic principles.

CONCLUSION

We have identified an intervention for managing MUS patients that: 1) is conducted by primary care personnel in primary care; 2) utilizes CBT methods similar to those previously reported effective (in specialty care) but deploys them more intensively over a much longer time period; and 3) employs a strong emphasis on communication and provider-patient relationships. We thus have identified a longer, more comprehensive, and more intensive MUS management program for primary care. We presently are testing the method to determine if it will lead to improved mental and physical health outcomes.

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REFERENCES


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The difficult patient

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UpToDate performs a continuous review of over 350 journals and other resources. Updates are added as important new information is published. The literature review for version 14.3 is current through August 2006; this topic was last changed on March 23, 2006. The next version of UpToDate (15.1) will be released in February 2007.

INTRODUCTION — The last twenty years have seen an increase in study of the difficult patient [1-11]. The literature warns against considering the patient as the only cause of the problem. It suggests, rather, that the clinician and the clinician-patient relationship constitute the proper focus for understanding and working with difficult patients [1,2,5,7,9-12]. Clinician-patient relationships typically are poor in situations where clinicians perceive patients as difficult.

WHO IS THE DIFFICULT PATIENT? — The difficult patient can be defined as one who impedes the clinician’s ability to establish a therapeutic relationship [13]. The following definition of the difficult patient is proposed by one author: "a person who does not assume the patient role expected by the healthcare professional, who may have beliefs and values or other personal characteristics that differ from those of the care-giver, and who causes the caregiver to experience self-doubt" [14]. This definition highlights the literature's focus on patients' behaviors that deviate from expected patient roles, patient personal characteristics that conflict with providers' beliefs and values, and patient behaviors that are perceived to challenge providers' competence and/or control.

A number of studies have investigated the types of clinician-patient interactions that result in labeling patients as difficult.

• One study had physicians identify 92 patients they perceived as difficult, by each clinician's own criteria, and compared them to 166 randomly selected controls [12]. Compared to controls, the difficult patient group was older, more...
separated or divorced, contained more women, had more acute and chronic problems, took more medications, underwent more x-rays and tests, were referred more often, and had more visits (6.8 versus 3.7 visits per year). Adjusting for age and sex, significant differences remained between the two groups for chronic problems, tests, medications, and visits.

- A second study used the validated Difficult Doctor-Patient Relationship Questionnaire to rate 627 patients in four primary care clinics [4,5]. Physicians rated 15 percent of patients as difficult, ranging from 12 to 20 percent at different clinics. Compared to nondifficult patients, difficult patients were much more likely to have a mental disorder, especially multisomatoform disorder, panic disorder, dysthymia, generalized anxiety, major depression, and alcohol abuse or dependence. Difficult patients also had more symptoms, greater functional impairment, higher health care utilization, and lower satisfaction with their care. There were no distinguishing demographic or physical symptom characteristics.

Physicians in this study often disliked difficult patients. They were unenthusiastic about providing care, saw difficult patients as frustrating and time-consuming, felt manipulated by them, and did not look forward to return visits. In one-half of encounters, physicians harbored hopes that the difficult patient would not return. Accounting for 23 percent of variance in difficulty scores, difficult patient status was strongly associated with the total number of mental disorders, somatoform and physical symptoms, multisomatoform disorder, and alcohol abuse. The authors propose that multiple physical symptoms, especially somatization, generate distress and frustration in physicians because of uncertainty about diagnosis and treatment. (See "Somatization", and see "Primary care management of medically unexplained symptoms").

- A review from 1975 found that caretakers described the "good patient" in the following terms: trusting, cooperative, noncomplaining, and nondemanding [15]. Patients who interrupted a caretaker's established routines and made extra work were considered difficult or problem patients. If difficult patients were perceived by caretakers as seriously ill, their complaining, emotionality, and need for attention were viewed as problematic but forgivable because the situation was beyond their control; these patients received the attention they wanted, especially if they expressed gratitude for it. Seriously ill patients who were cheerful, cooperative, uncomplaining, and objective about their illness were viewed as "great" patients. Patients who were perceived as not being seriously ill but were complaining, emotional, and uncooperative were condemned by caretakers and often discharged early, tranquilized, or referred to psychiatry.

**Patient characteristics**—Studies have aimed at defining the patient characteristics and circumstances that produce negative reactions in physicians and lead to the difficult patient label (show table 1) [2,7,10-12,16-19].

**Patients' expressions of emotions**—Clinicians often find emotional expression by patients very troublesome, especially anger, sadness (crying), anxiety, and
depression. Students and physicians are often not taught how to deal with patients' emotions [20]. This is especially unfortunate because addressing patients at the emotional level is the most important determinant of the clinician-patient relationship [21].

Patients' personality features—Patients with personality disorders (personality characteristics in the pathological extreme) almost always cause problems for physicians. Examples of personality disorders include borderline [22], obsessive-compulsive, dependent, self-defeating, histrionic, narcissistic, paranoid, and schizoid [21]. (See "Personality disorders").

Even where the patient's personality structure is normal, physicians can have problems with patients' personality features. As an example, consider an interaction between a Type A (obsessive-compulsive) clinician [23] and a Type A patient when the patient tries to take control of the interaction, a situation likely perceived as difficult by the doctor. Clinicians might also perceive passive (dependent) patients with progressive dependence, as difficult.

Patients' personal characteristics—Personal characteristics of the patient that differ from those of the clinician are often factors in perceiving a patient as "difficult." Such characteristics may include: foreign language and other communication barriers (deaf, blind); malodorous; having a communicable disease; race or ethnicity difference; impecunious; higher/lower social status; different sexual orientation.

Patients' specific clinical problems—Many clinical problems, especially mental health issues, cause physicians to perceive patients as difficult. Examples include somatization (including chronic pain), drug/alcohol abuse, psychiatric problems, sexual problems, organic mental syndromes, cancer, suicidality, worsening or undiagnosable medical problem, noncompliance, death/dying, discussing end-of-life care and advance directives, and adverse health habits. Difficult patients tend to have more symptoms, vaguer symptoms, poorer self-rated health, and more symptom amplification [25].

Patients' direct demands/stresses on the physician—Patients who place direct demands or stresses on their clinicians cause the greatest discomfort [16]. With few exceptions, threat of dismissal by the patient identifies a difficult patient, as does the patient who disagrees strongly with an explanation or recommendation, or the patient who complains about care or the health system. Other circumstances producing the difficult patient label include the patient who requires more time than is available, the seductive patient, the aggressive or threatening patient, and someone with many legal or insurance papers to fill out. The patient with unnecessary lab, referral, medication, and disability requests, or who wants social interactions or advice about nonmedical issues, also is usually seen as difficult.

Psychosocial training—One common theme is that patients' psychosocial
problems and issues lead physicians to label them as difficult. Physicians and
students receive little training in psychosocial medicine [24]. Rather, their
predominantly biomedical training focuses upon organic disease, where a
so-called good patient presents, according to one author, with "objective signs
and symptoms of a treatable disease process, makes no emotional demands on
the clinician, cooperates in the treatment process (ie, obeys orders), and upon
getting well displays gratitude for the help received" [25]. This biomedical focus
during training may lead to poor psychosocial attitudes, causing physicians to
view more of their patients as difficult [7].

Streptococcal pharyngitis, angina pectoris, and appendicitis are examples where
the biomedical model can be effective. However, most patients do not fit the
biomedical paradigm. Over one-half of outpatients have no organic disease at all
[26-28], and only 16 percent of new complaints have an organic disease basis
[27]. Furthermore, many patients who have organic diseases also have
complicating psychosocial issues (eg, noncompliance, depression) that make them
difficult. Thus, the typical good patient is the uncommon patient with a treatable
organic disease and no psychosocial problems. The typical difficult patient may or
may not have an organic disease but does have significant psychosocial problems.

Psychosocial medicine training can effectively address the difficult patient problem.
This is discussed in detail separately. (See "Integrated patient-doctor
interviewing"). Difficult patients with medically unexplained symptoms can be
effectively managed by primary care providers who emphasize the
provider-patient relationship while implementing cognitive-behavioral,
antidepressant, and other aspects of treatment [29]. (See "Primary care
management of medically unexplained symptoms").

Clinician characteristics — A number of clinician characteristics, in combination
with a lack of training in psychosocial medicine, increase the likelihood of viewing
patients as difficult. Physicians who are overworked may perceive patients as
difficult [1]. Patients are perceived as difficult when their physicians dislike them or
their circumstances (ie, there is a relationship problem) [10]. It is the clinician's
responsibility more than the patient's to address and resolve the relationship
problem. We have far more access to and control over our own reactions than we
have over the patient's.

Negative emotional reactions to patients (and consequent harmful behaviors)
usually are not fully recognized by physicians [20,30-33]. These negative
responses are the primary controllable determinants of the physician-patient
relationship and the key underlying problem when patients are perceived as
difficult [16,18-20,33-38]. As an example, a patient repeatedly mentions his
imminent death from carcinoma of the lung, but the doctor unwittingly avoids this
discussion and notes only that she feels tense and anxious when the patient
keeps mentioning death. This is a difficult patient she would prefer to avoid
[19,37]. To the extent this clinician can become aware of her own unrecognized
feelings (e.g., personal fear of death, fear of discussing "unpleasant" topics, uncertainty what to do), she will work better with this patient and will be less likely to perceive him as difficult [20,39,40].

Studies of these potentially harmful, unrecognized responses in physicians and students are rare but needed [41].

- Following observation of just one learner-patient encounter, open-ended inquiry of learners showed that unrecognized responses with deleterious potential for the patient occurred in 13 of 15 students [18] and 16 of 19 residents and fellows. This led us to propose that the vast majority of physicians and students have unrecognized, potentially harmful responses to patients. Common unrecognized feelings included: fear of losing control, addressing psychological material, appearing unpleasant, or harming the patient; unique personal issues (e.g., reminds one of own difficult divorce, fear of cancer in self); and performance anxiety. Uncommon feelings included: sexual feelings; attitude favoring biomedical over psychosocial data; anger; fear of involvement; intimidation by the patient; inadequacy; disdain; identification with the patient. Severe anxiety and depressive feelings were not found. Common harmful and unrecognized behaviors included over control of the patient and interview (e.g., inappropriate interrupting or changing subject), avoidance of psychological material (e.g., death, loneliness, disability), superficial behavior (e.g., overly reassuring, overly social, cocktail party atmosphere), passivity (e.g., no control or direction, inactive, detachment). Uncommon unrecognized behaviors included seductiveness, fault-finding, intimidation, passive-aggressiveness, lack of respect and sensitivity, withdrawal, distancing, and awkward interactions.

- In two other studies [20,42], we used an explicit method to teach self-awareness of unrecognized responses as part of teaching communication and doctor-patient relationship skills.

Similar to our earlier study from 1986 to 1989 [42], we showed that most learners could be taught awareness of their previously unrecognized, harmful responses, which improved their physician-patient relationships and diminished potential harm with difficult patients [20]. As examples, learners were able to recognize and change the following previously unrecognized reactions: to take control (replaced by allowing the patient to lead); to be pleasing and thereby avoid painful topics (replaced by addressing painful topics); to view emotions as harmful and avoid them (replaced by actively addressing emotions); to believe that doctors should keep their distance from patients (replaced by actively relating to the patient); to believe there is nothing to do for incurable patients (replaced by being present and supportive even with the most incurable patients); to behave like patients can't protect themselves (replaced by recognizing patients' abilities to set limits); and to assume that patients are weak (replaced by recognizing their strength to address difficult problems and emotions). With these changes, physicians perceived patients more positively and as less difficult.
Not all physicians respond to patients the same way. While the earlier
descriptions of common features and medical conditions of difficult patients are
instructive in general, the individual clinician’s previously unrecognized responses
determine the specifics. They determine which physicians see which patients as
difficult. Designations as difficult can vary considerably from one clinician to
another. Other clinician factors associated with perceiving more patients as
difficult include less experience [1], higher perceived workload, lower job
satisfaction, and lack of communication skills training [6]. Communication skills
training appears to be able to alter clinician attitudes and beliefs [43].

**Competing demands**— The change in the healthcare environment in the US over
the past twenty years has contributed to an increase in patient and clinician
frustrations [44,45]. Increased productivity demands, disease screening and
health maintenance requirements, disease complexity, and visit interruptions all
decrease the time for physicians and patients to explore concerns [8]. This
increases the risk of patients leaving the visit with unmet expectations and being
dissatisfied with their care [46]. Dissatisfaction may then lead to increased patient
demands and clinician frustration, which can create difficulty in the
physician-patient relationship [8].

**WORKING MORE EFFECTIVELY WITH THE DIFFICULT PATIENT**— It is
apparent that, in addition to more training in communication skills and
psychosocial medicine, the clinician must develop increased awareness of
previously unrecognized, negative responses to difficult patients
[30,33,36,38,47-50]. Balint Groups (self-help groups of physicians to discuss
difficult patients) [51,52], meditation [53,54], keeping a journal [55-57], reading
and discussing appropriate literature and poetry [58], co-teaching with a mental
health professional [20], psychotherapy [36], and special communication skill and
personal awareness training (eg, American Academy on Physician and Patient
courses: [www.physicianpatient.org](http://www.physicianpatient.org)) all can be helpful. Raising consciousness of
one's own emotions (eg, by reading or seeing movies about emotional topics)
[21] and obtaining feedback on one's communication skills [8] are also useful.

The evidence-based patient-centered interviewing method is particularly useful
when dealing with difficult physician-patient relationships [21]. (See "Integrated
patient-doctor interviewing""). The key is to elicit the difficult patient’s emotions
and then address the emotion by Naming it, Understanding it, Respecting it, and
Supporting it; that is, NURS the emotion [21]. With many distressed patients,
especially with anger or sadness, the emotion-handling skills (NURS) will be
needed many times, as will an understanding of the problem by using
open-ended skills, such as echoing and summarizing. Considerations about the
general approach to the patient are discussed in more detail separately. (See
"Approach to the patient").

The salient feature of the individual difficult patient’s personality should be
identified; this information can then be used to enhance the relationship by
"going with the flow" of the major thrust of the patient's personality [21].

- With an obsessive patient, compliment him on his intellectuality, precision, and organization; avoid battles over control or pushing the patient for much emotion which these patients usually like to avoid.

- With a dependent patient, the relationship is enhanced by meeting some of his special needs and not pushing him to be independent; over time, as the relationship is established, the clinician wants to facilitate the patient's more independent functioning.

- For the histrionic patient, the clinician can compliment him upon his flair, uniqueness, fun-loving nature, and attractive clothing and not use as much intellectual discussion as with an obsessive patient.

- For the self-defeating patient, the relationship is enhanced by simply acknowledging his plight and not trying to fix the situation.

- For the patient with borderline personality disorder, empathic acknowledgement of abandonment fears coupled with clear limit setting is an important part of the treatment plan [22, 59].

Being self-aware and patient-centered and incorporating knowledge about the patient's personality are baseline requirements for working with all difficult patients. The clinician also must be prepared to apologize to the angry (or otherwise emotional) patient when that is in order (eg, waiting one hour to see the doctor) [60].

Physicians must be savvy in identifying psychosocial problems. Problem-solving skills also are essential, as is a willingness to participate in the solution. The clinician may need to function as an advocate, counselor, friend, disciplinarian, coach, cheerleader, or whatever the situation demands. A difficult noncompliant diabetic patient might variously need some of the following: advocacy with the patient's spouse around his diet; counseling about issues not directly related to diabetes (marital problems); a friendly interaction and ongoing concern; a forthright talk about the need to better monitor his diabetes and adhere to diet; coaching about how to integrate diabetic treatment needs into a job with varying demands for exercise and dining with clients; and nearly overt cheering for success with weight loss. Thus, one is an active participant in care. This conveys genuine interest and concern.

It is appropriate to be human and express discomfort and disappointment as well as joy, which can be done without manipulating, attacking the difficult patient personally, or making the patient unduly uncomfortable. The clinician might say to one patient, "You know, I can't tell you how disappointed I am that the glycohemoglobin has not come down one bit," and to another patient, "I'm really proud of you and what we've done in getting this diabetes controlled. Good going!"
When difficult patients have a negative impact on the clinician's self-esteem, it is important to recall that often the negativity is not personal, but rather a way certain patients express themselves. Being aware of transference and countertransference is also important [18,61].

Healthcare environment improvements include developing links to community mental health resources, altering scheduling systems to allow for more time for certain patients, and ensuring frequent, regular follow-up [8,44,45].

**SUMMARY** — When feeling stressed, the wise clinician relies most upon his or her own self-awareness. Becoming consciously aware of our own underlying emotions first and then asking ourselves if we wish to act on them is key; as examples, anger towards a noncompliant patient, helplessness with a terminal patient, frustration with a somatizing patient, fear of incompetence with a depressed patient, sexual feelings towards an attractive patient, passive feelings with a dominating patient, and competitive feelings with an argumentative patient. In a sense, difficult patients define the type of clinician we are by allowing us to exhibit selfishness or generosity, hostility or compassion [62].

The description on the temple of Apollo at Delphi provided clues to the problem of the difficult physician-patient relationship centuries ago: "Know yourself."

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**REFERENCES**


29. Smith RC, Lyles JS, Gardiner JC, et al. Primary Care Clinicians Treat Patients with Medically Unexplained Symptoms A Randomized Controlled Trial. Journal of General Internal Medicine 2006; :.


60. McComb, RS, Floyd, MR, Lang, F, Young, VK. Responding effectively to patient anger directed at the physician. Fam Med 2002; 34:331.

**GRAPHICS**

Patient characteristics that lead physicians to label them difficult

<table>
<thead>
<tr>
<th>Patients' expressions of emotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients' personality/characterologic features:</td>
</tr>
<tr>
<td>Obsessive-compulsive; dependent; self-defeating; histrionic; narcissistic; paranoid; and schizoid</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patients' personal characteristics:</th>
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</thead>
<tbody>
<tr>
<td>Language and other communication barriers (deaf, blind); malodorous; communicable disease; racial/ethnic; impecunious; higher/lower social status; different sexual orientation from the doctor; and many other features that make the patient different from the doctor</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patients' specific clinical problems:</th>
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</thead>
<tbody>
<tr>
<td>Somatization (including chronic pain); drug/alcohol abuse; psychiatric problems; sexual problems; organic mental syndromes; cancer; suicidal; difficult medical problem and getting worse; undiagnosed medical problem in spite of evaluation; noncompliance; giving bad news; death/dying; advance directives; and adverse health habits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patients' direct demands/stresses on the physician:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threat of dismissal; patient disagrees with an explanation; patient complains (about care, the HMO); patient requires more time than available; seductive patient; aggressive or threatening patient; many legal/insurance papers to be filled out; unnecessary lab/referral/medication requests; unnecessary disability request; patient takes control of interaction; and patient wants social interaction or advice about nonmedical issues</td>
</tr>
</tbody>
</table>
Smoking Cessation
Psychosocial Seminars
SMOKING CESSATION

Objectives:

A. To be familiar with the health risks related to tobacco use.

B. To be familiar with counseling methods for smokers who are ready to quit and those who are not yet ready.

C. To understand the pharmacotherapy used in smoking cessation.

Readings:

Psychiatry for Primary Care
Psychosocial Seminars
PSYCHIATRY FOR PRIMARY CARE

Dale D’Mello, MD & Jeffrey A. Frey, D.O.
Psychosocial Seminars
PSYCHIATRY FOR PRIMARY CARE

Melpomeni Kavadella, MD

1) A review of general concepts of depression, diagnostic criteria and focal areas such as sleep, mood, behavior, with focus on suicidality explored in depth by vignette between resident. Also exploring effective and respectful ways to address patient’s sexuality and pertinent information gathering and dispersing for education and prevention, discussed in depth also by using a vignette between residents. Antidepressant pharmacotherapy.

2) Review general concepts of bipolar disorders diagnosis, criteria, brief overview of pharmacotherapy and illustration of gathering information by using a vignette between residents regarding substance use/abuse. Specific techniques to address sleep architecture and information gathering.

3) Anxiety disorders, using a simple clarification for diagnostic concepts criteria and initial diagnosis, brief pharmacotherapy overview.

4) Emphasis is given on reflection of the interviewer of his/her own body language, concepts, behavior patterns, spiritual background, assumption making and use of language when gathering information.

5) In the last session job searching, contractual agreements and malpractice insurances characteristics discussed.

6) The last component of this presentation is a relaxation technique illustration.
BECK INVENTORY

Name ___________________________________________ Date ____________________________

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failure.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.
10. 0 I don't cry anymore than usual.
   1 I cry more now than I used to.
   2 I cry all the time now.
   3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
   1 I get annoyed or irritated more easily than I used to.
   2 I feel irritated all the time now.
   3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
   1 I am less interested in other people than I used to be.
   2 I have lost most of my interest in other people.
   3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
   1 I put off making decisions more than I used to.
   2 I have greater difficulty in making decisions than before.
   3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
   1 I am worried that I am looking old or unattractive.
   2 I feel that there are permanent changes in my appearance that make me look unattractive.
   3 I believe that I look ugly.

15. 0 I can work about as well as before.
   1 It takes an extra effort to get started at doing something.
   2 I have to push myself very hard to do anything.
   3 I can't do any work at all.

16. 0 I can sleep as well as usual.
   1 I don't sleep as well as I used to.
   2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
   3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
   1 I get tired more easily than I used to.
   2 I get tired from doing almost anything.
   3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
   1 My appetite is not as good as it used to be.
   2 My appetite is much worse now.
   3 I have no appetite at all anymore.

19. 0 I haven't lost much weight if any lately.
   1 I have lost more than 5 pounds.
   2 I have lost more than 10 pounds.
   3 I have lost more than 15 pounds.

20. 0 I am no more worried about my health than usual.
   1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
   2 I am very worried about physical problems and it's hard to think of much else.
   3 I am so worried about my physical problems, that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
   1 I am less interested in sex than I used to be.
   2 I am much less interested in sex now.
   3 I am completely disinterested in sex now.
This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

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<td>1</td>
<td>I do not feel sad.</td>
<td>I feel sad.</td>
<td>I am sad all the time and I can't snap out of it.</td>
<td>I am so sad or unhappy that I can't stand it.</td>
<td>I do not particularly discouraged about the future.</td>
<td>I feel discouraged about the future.</td>
<td>I feel I have nothing to look forward to.</td>
<td>I feel that the future is hopeless and that things cannot improve.</td>
<td>I do not feel like a failure.</td>
<td>I feel I have failed more than the average person.</td>
<td>As I look back on my life, all I can see is a lot of failures.</td>
<td>I feel I am a complete failure as a person.</td>
<td>I get as much satisfaction out of things as I used to.</td>
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Subtotal Page 1 CONTINUED ON BACK
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
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<tr>
<td>I don't feel I look any worse than I used to.</td>
<td>I am worried that I am looking old or</td>
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<td>unattractive</td>
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<td>I feel that there are permanent changes in</td>
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<td>my appearance that make me look unattractive.</td>
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<td>I believe that I look ugly.</td>
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<tr>
<td>I can work about as well as before.</td>
<td>It takes an extra effort to get started at</td>
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<td>doing something</td>
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<td>I have to push myself very hard to do</td>
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<td>anything,</td>
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<td></td>
<td>I can't do any work at all.</td>
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<tr>
<td>I can sleep as well as usual.</td>
<td>I don't sleep as well as I used to.</td>
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<td>I wake up 1-2 hours earlier than usual and</td>
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<td>find it hard to get back to sleep.</td>
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<td></td>
<td>I wake up several hours earlier than I</td>
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<td></td>
<td>used to and cannot get back to sleep.</td>
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<td>I don't get more tired than usual.</td>
<td>I get tired more easily than I used to.</td>
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<tr>
<td></td>
<td>I get tired from doing almost anything.</td>
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<td></td>
<td>I am too tired to do anything.</td>
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<tr>
<td>My appetite is no worse than usual.</td>
<td>My appetite is not as good as it used to be.</td>
</tr>
<tr>
<td></td>
<td>My appetite is much worse now.</td>
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<tr>
<td></td>
<td>I have no appetite at all anymore.</td>
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<tr>
<td>I haven't lost much weight, if any, lately.</td>
<td>I have lost more than 5 pounds.</td>
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<td>I have lost more than 10 pounds.</td>
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<td>I have lost more than 15 pounds.</td>
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<td>I am purposely trying to lose weight by</td>
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<td>eating less.</td>
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<td>Yes, No</td>
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<tr>
<td>I am no more worried about my health than usual.</td>
<td>I am worried about physical problems such as</td>
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<td>aches and pains; or upset stomach; or</td>
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<td>constipation.</td>
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<td>and it's hard to think of much else.</td>
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<td>I am so worried about my physical problems</td>
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<td>that I cannot think about anything else.</td>
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<tr>
<td>I have not noticed any recent change in my interest in sex.</td>
<td>I am less interested in sex than I used to</td>
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<td>be.</td>
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<tr>
<td></td>
<td>I am much less interested in sex now.</td>
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<td></td>
<td>I have lost interest in sex completely.</td>
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Subtotal Page 1

Subtotal Page 2

Total Score
### Yale-Brown Obsessive Compulsive Scale (Y-BOCS)*

Questions 1 to 5 are about your obsessive thoughts.

Obsessions are unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. They usually involve themes of harm, risk and danger. Common obsessions are excessive fears of contamination; recurring doubts about danger; extreme concern with order, symmetry, or exactness; fear of losing important things.

Please answer each question by writing the appropriate number in the box next to it.

#### 1. Time Occupied by Obsessive Thoughts

Q. How much of your time is occupied by obsessive thoughts?

- [ ] 0 = None
- [ ] 1 = Less than 1 hr/day or occasional occurrence
- [ ] 2 = 1 to 3 hrs/day or frequent
- [ ] 3 = Greater than 3 and up to 8 hrs/day or very frequent occurrence
- [ ] 4 = Greater than 8 hrs/day or nearly constant occurrence

#### 2. Interference Due to Obsessive Thoughts

Q. How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don’t do because of them?

- [ ] 0 = None
- [ ] 1 = Slight interference with social or other activities, but overall performance not impaired
- [ ] 2 = Definite interference with social or occupational performance, but still manageable
- [ ] 3 = Causes substantial impairment in social or occupational performance
- [ ] 4 = Incapacitating

#### 3. Distress Associated with Obsessive Thoughts

Q. How much distress do your obsessive thoughts cause you?

- [ ] 0 = None
- [ ] 1 = Not too disturbing
- [ ] 2 = Disturbing, but still manageable
- [ ] 3 = Very disturbing
- [ ] 4 = Near constant and disabling distress

#### 4. Resistance Against Obsessions

Q. How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?

- [ ] 0 = Try to resist all the time
- [ ] 1 = Try to resist most of the time
- [ ] 2 = Make some effort to resist
- [ ] 3 = Yield to all obsessions without attempting to control them, but with some reluctance
- [ ] 4 = Completely and willingly yield to all obsessions

#### 5. Degree of Control Over Obsessive Thoughts

Q. How much control do you have over your obsessive thoughts? How successful are you in stopping or diverting your obsessive thinking? Can you dismiss them?

- [ ] 0 = Complete control
- [ ] 1 = Usually able to stop or divert obsessions with some effort and concentration
- [ ] 2 = Sometimes able to stop or divert obsessions
- [ ] 3 = Rarely successful in stopping or dismissing obsessions, can only divert attention with difficulty
- [ ] 4 = Obsessions are completely involuntary, rarely able to even momentarily alter obsessive thinking

---

*This adaptation of the Y-BOCS is abridged from the original version with permission from Wayne Goodman. For additional information on the Y-BOCS, please contact Dr. Wayne Goodman at the University of Florida, College of Medicine, Gainesville, Florida 32610. The original version was published by Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive Compulsive Scale I: Development, use, and reliability. Arch Gen Psychiatry. 1989;46:1006-1011.
ADULT ADHD QUALITY OF LIFE - 29 : (AAQoL-29)

The following questions are about how ADHD has impacted your life over the past 2 weeks. For each item, evaluate the degree or frequency with which you find each quality of life issue troublesome or problematic. Please answer each question by placing an X in the box ( X ) for your response. There are no right or wrong answers.

### During the past 2 weeks, how difficult has it been for you to:

<table>
<thead>
<tr>
<th>Question</th>
<th>not at all</th>
<th>a little</th>
<th>somewhat</th>
<th>a lot</th>
<th>extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Keep the house/apartment clean or uncluttered</td>
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<tr>
<td>2. Manage your finances, such as cashing checks, balancing your checkbook, paying bills on time</td>
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<tr>
<td>3. Remember important things</td>
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<tr>
<td>4. Get your shopping done (such as for food, clothes, or household items)</td>
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<tr>
<td>5. Pay attention when interacting with others</td>
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</table>

### During the past 2 weeks, how often have you felt:

<table>
<thead>
<tr>
<th>Question</th>
<th>never</th>
<th>rarely</th>
<th>sometimes</th>
<th>often</th>
<th>very often</th>
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<tbody>
<tr>
<td>6. Overwhelmed</td>
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<td>7. Anxious</td>
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<td>8. Depressed</td>
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</tr>
<tr>
<td>9. You have not been able to meet others' expectations of you (either at home or work)</td>
<td></td>
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</tr>
<tr>
<td>10. You annoyed people</td>
<td></td>
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<tr>
<td>11. Getting things done requires too much effort</td>
<td></td>
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<tr>
<td>12. People are frustrated with you</td>
<td></td>
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<tr>
<td>13. You have overreacted in difficult or stressful situations</td>
<td></td>
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<tr>
<td>14. Your energy is well spent (has positive results)</td>
<td></td>
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<tr>
<td>15. Able to enjoy time spent with others</td>
<td></td>
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</tr>
<tr>
<td>16. You can successfully manage your life</td>
<td></td>
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</tr>
<tr>
<td>17. As productive as you would like to be</td>
<td></td>
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</tr>
</tbody>
</table>

### During the past 2 weeks, how troubled have you been by:

<table>
<thead>
<tr>
<th>Question</th>
<th>not at all</th>
<th>a little</th>
<th>somewhat</th>
<th>a lot</th>
<th>extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Tension in relationships</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19. Not having quality time to spend with others</td>
<td></td>
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</tr>
</tbody>
</table>

### During the past 2 weeks, how bothered have you been by:

<table>
<thead>
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<th>a little</th>
<th>somewhat</th>
<th>a lot</th>
<th>extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Feeling fatigued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Fluctuations (ups and downs) in your emotions</td>
<td></td>
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</tr>
</tbody>
</table>

### During the past 2 weeks, how much of a problem has it been for you to:

<table>
<thead>
<tr>
<th>Question</th>
<th>not at all</th>
<th>a little</th>
<th>somewhat</th>
<th>a lot</th>
<th>extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Complete projects or tasks (either at work or at home)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>23. Get started with tasks you don't find interesting</td>
<td></td>
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</tr>
</tbody>
</table>

### During the past 2 weeks, how much of a problem has it been for you to:

<table>
<thead>
<tr>
<th>Question</th>
<th>not at all</th>
<th>a little</th>
<th>somewhat</th>
<th>a lot</th>
<th>extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Balance multiple projects</td>
<td></td>
<td></td>
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<tr>
<td>25. Get things done on time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Keep track of important items (such as keys, wallet)</td>
<td></td>
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</tr>
</tbody>
</table>

### During the past 2 weeks, how often have you felt:

<table>
<thead>
<tr>
<th>Question</th>
<th>never</th>
<th>rarely</th>
<th>sometimes</th>
<th>often</th>
<th>very often</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Good about yourself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. People enjoy spending time with you</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>29. Your intimate relationship is going well emotionally</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Instructions: Indicate how much you have been bothered by each symptom during the past week, including today, by clicking the number in the column that most closely corresponds to how you've been feeling.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>NOT AT ALL</th>
<th>MILDLY It did not bother me much.</th>
<th>MODERATELY It was very unpleasant but I could stand it.</th>
<th>SEVERELY I could barely stand it.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness or tingling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling hot</td>
<td></td>
<td></td>
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<tr>
<td>Wobbliness in legs</td>
<td></td>
<td></td>
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<tr>
<td>Unable to relax</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Fear of the worst happening</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dizzy or lightheaded</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart pounding or racing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsteady</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terrified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feelings of choking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hands trembling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shaky</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear of losing control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficultly breathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear of dying</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scared</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigestion or discomfort in abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faint</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face flushed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweating (not due to heat)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score: 7 15 25 63
10. I don't cry anymore than usual.
   1 I cry more now than I used to.
   2 I cry all the time now.
   3 I used to be able to cry, but now I can't cry even though I want to.

11. I am no more irritated now than I ever am.
   1 I get annoyed or irritated more easily than I used to.
   2 I feel irritated all the time now.
   3 I don't get irritated at all by the things that used to irritate me.

12. I have not lost interest in other people.
   1 I am less interested in other people than I used to be.
   2 I have lost most of my interest in other people.
   3 I have lost all of my interest in other people.

13. I make decisions about as well as I ever could.
   1 I put off making decisions more than I used to.
   2 I have greater difficulty in making decisions than before.
   3 I can't make decisions at all anymore.

14. I don't feel I look any worse than I used to.
   1 I am worried that I am looking old or unattractive.
   2 I feel that there are permanent changes in my appearance that make me look unattractive.
   3 I believe that I look ugly.

15. I can work about as well as before.
   1 It takes an extra effort to get started at doing something.
   2 I have to push myself very hard to do anything.
   3 I can't do any work at all.

16. I can sleep as well as usual.
   1 I don't sleep as well as I used to.
   2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
   3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. I don't get more tired than usual.
   1 I get tired more easily than I used to.
   2 I get tired from doing almost anything.
   3 I am too tired to do anything.

18. My appetite is no worse than usual.
   1 My appetite is not as good as it used to be.
   2 My appetite is much worse now.
   3 I have no appetite at all anymore.

19. I haven't lost much weight, if any lately.
   1 I have lost more than 5 pounds.
   2 I have lost more than 10 pounds.
   3 I have lost more than 15 pounds.

20. I am no more worried about my health than usual.
   1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
   2 I am very worried about physical problems and it's hard to think of much else.
   3 I am so worried about my physical problems, that I cannot think about anything

21. I have not noticed any recent change in my interest in sex.
   1 I am less interested in sex than I used to be.
   2 I am much less interested in sex now.
   3 I have lost interest in sex completely.
Stress Management Workshop
RESIDENTS ADVANCED WELLNESS PROGRAM

COURSE INSTRUCTORS:

Shalabh Chandra, MD MPH
Nitya Sthalekar, MD

Background: Medical training in the current days has become very comprehensive and there is a need for physicians to understand the principles of mind-body wellness and the scope of its application. Today's patient is more aware of these alternative methods and physician training needs to keep up with the methodologies to serve increasing number of patients looking for holistic care.

Moreover, residency training could be very stressful and does take a toll on residents and medical students in terms of their personal life and overall attitude towards patient care. It is very important for current medical graduates to address the issue of personal stress and emotional wellness.

This workshop is designed to provide information and skills to current medical residents to understand, address and handle their personal stress through various non-invasive and non-drug therapies. Each participating resident will learn a series of breathing and meditation techniques that can be practiced everyday in a short duration of time.

Based on their personal experience in the workshop and through structured training sessions, residents will learn the skills to teach simple relaxation techniques to their patients.

OBJECTIVES:

- Understand Tendencies of Mind: How our defense mechanisms work against us and how to work around them.
- Learn and experience breathing techniques & meditation.
- Learn 30 minutes home practice.
- Learn skills to teach relaxation techniques to patients.

Course Description:

Day 1:
- Stress: Medical and psychological effects of stress.
- Causes of stress & how our defense mechanisms work against us.
- Tendencies of Mind: Day 1.
- Sources of energy and role of breath
- Session 1: Breathing techniques.
- Homework

Day 2:
- Review Day 1 and Homework.
- Tendencies of Mind: Day 2
- Review & Practice of Breathing techniques
- Meditation.
- Group Therapy and Bonding.
- Resident Demo: Teach a colleague! (Followed by discussion)
- Homework.

Day 3:

- Review Day 1 & 2: Q&A
- EGO & Tendencies of Mind: Day 3
- Breathing & Meditation.
- Home Practice: Q&A
- Training: Teach a patient!
- Resident Demo: Teach a patient!
- Role Playing and practice: Teach a patient.
- Critique the Teacher and discussion.
- Q&A.
A Question

"A" open coffee shop.
"B" buys coffee for $20 and gives $100 note.
A goes to neighbour "C" to take change and get 5 $20 bills and gives $80 back to B.
C comes back and says $100 bill is fake and takes new $100 bill.
How much money did A lose.

Personal Stress Management
Shalabh Chandra MD, MPH
Michigan State University

Listening

Stress is a condition or feeling experienced when a person perceives that "demands exceed the personal and social resources the individual is able to mobilize."

When things are 'out of control!'

A specific response by the body to a physical or mental stimulus that disturbs or interferes with the normal physiological equilibrium of an organism

"Juggling the ball" experiment

Symptoms of stress

<table>
<thead>
<tr>
<th>Headache</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back pain</td>
<td>Worrying</td>
</tr>
<tr>
<td>Chest pain</td>
<td>Irritability</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Depression</td>
</tr>
<tr>
<td>Heart palpitations</td>
<td>Sadness</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Anger</td>
</tr>
<tr>
<td>Decreased immunity</td>
<td>Feeling insecure</td>
</tr>
<tr>
<td>Stomach upset</td>
<td>Lack of focus</td>
</tr>
<tr>
<td>Sleep problem</td>
<td>Forgetfulness</td>
</tr>
</tbody>
</table>

Eating disorder
Angry outbursts
Drug or alcohol abuse
Increased smoking
Social withdrawal
Crying
Spells
Relationship conflicts

Effects of Stress
Children don't see the intimate couple.

They have no prior memory association of such scenarios.

Children see nine dolphins.

Effects of Stress

- External stressors include:
  - Physical environment: noise, bright lights, heat, confined spaces
  - Social (interaction with people): rudeness, loudness or aggressiveness on the part of some people
  - Organizational rules, regulations, "red tape," deadlines
  - Major life events: death of a relative, lost job, promotion, new baby
  - Daily hassles: commuting, misplacing keys, mechanical failures

- Internal stressors
  - Lifestyle choices: caffeine, not enough sleep, overloaded schedule
  - Negative self-talk, pessimistic thinking, self-criticism, over-analyzing
  - Mind traps: unrealistic expectations, taking things personally, disorganizing
  - Thinking (rigid thinking, dramatic personality traits): Type A, perfectionist, workaholic, pleasure

Can you see three women?

Your mind is programmed to follow the patterns.

Your perception is based on your prior experiences!

Tendencies of the Mind

"Our strongest and most vivid human memories are usually associated with strong emotional events such as those associated with extreme fear, love and rage." University of Queensland (2008, October 22). New Understanding Of How We Remember

In people who suffer from those conditions (PTSD, Schizophrenia) emotional experiences can become distorted, casting the person to 'lose touch' with reality. University of Western Ontario (2009, April 22). Controlling Our Brain's Perception Of Emotional Events. ScienceDaily

We Remember Bad Times Better Than Good "Negative Emotion Enhances Memory Accuracy," Current Directions in Psychological Science

We always remember bad evaluations, never good ones!
Happiness

- When will you be happy?
- What do you need to be happy?

Present Moment is Inevitable

- Trying
- Agree/Disagree
- Past/Future
- Resist/Persist

New Year's resolution!
- Don't be angry, jealous, etc.

- What is that you want in life?
- What are the things that bother you?
- What do you expect to gain out of this workshop?
Controlling the Breath

Breathing Techniques:
Victory Breath
WILL TEACH THIS TO PATIENTS!

Three stage Victory Breath
WILL TEACH THIS TO PATIENTS!

- Food
- Sleep
- State of Mind
- Breath

Every emotion has a corresponding rhythm in the breath.
Bellows Breath
*WILL TEACH THIS TO PATIENTS!*

OM
*A-U-M*
*WILL TEACH THIS TO PATIENTS!*

Meditation

Homework
- 10 Victory breath before going to sleep
- What do you take responsibility for?
- What do you not take responsibility for?

Recommendations

End of day 1

Responsibility
- Belongingness=>Responsibility
- Responsibility bring control/power
- Action or Inaction: U R Still responsible.
- Take responsibility of your feelings.
Football of Peoples Opinion

Tom & Jerry

100%

Brings you to present moment
Gives you peace of mind

Review

Victory breath.
Bellows breath.
AUM

SKY Breathing & Meditation

A Story
Homework

3 Stage Victory Breath+Bellows Breath+AUM.
Random act of kindness.
A Gift!
Who are you?
Where are you?

End of day 2

You are here
WHERE ARE YOU?

WHERE R 'U' IN UR BODY?

who r u?

Lets all close our eyes

EGO
Don't See Intention Behind Peoples
MISTAKE
If you see intention, you will be in tension!!

Accept People As They Are

Five Pearls of Wisdom

SKY Breathing & Meditation

Home Practice
SKY Breathing & Meditation
3 Stage VICTIM MEDITATION
1st stage: 8 cycles (4-4-6-2)
2nd stage: 8 cycles (4-4-6-2)
3rd stage: 6 cycles (4-4-6-2)
Bellows Breath: Total 3 Rounds
20 cycles per round

Taking a Position

Opposite values are complimentary
Dont see intention behind peoples mistake
Dont be a football of peoples opinion
Accept people and situation as they are
Present moment is inevitable

X 3
20 large circles
40 medium circles
40 small circles
Rest for 5 mins
What can u teach pts? & How?

Victory Breath
Bellows Breath

Let's Practice Teaching!!

Steps to Teach

Victory Breath Practice
Demonstrate Urself First
Don't Interprete too much
Convey the idea and let them practice
Build up there confidence
Listen to them while they do that
Make sure they are not straining

Steps to Teach

3 Stage Victory Breath Practice
Demonstrate the 3 stages: positions
Talk about the rhythm: the counts
Let them just practice the rhythm with the posture
Once rhythm is perfected, tell them to do the postures
Listen to them while they do that
Make sure they are not straining or uncomfortable

Steps to Teach

Bellows Breath Practice
Demonstrate Urself First
Come in normal breath not victory
Enthusiastic inhalation and exhalation
Do it with them to show them
Make sure they are not straining

Steps to Teach

Bellows Breath Practice
Demonstrate the 3 stages: positions
Talk about the rhythm: the counts
Let them just practice the rhythm with the posture
Once rhythm is perfected, tell them to do the postures
Listen to them while they do that
Make sure they are not straining or uncomfortable

Role Playing

Watch me teach: Critique
Groups to three
Patient
Doctor
Observer
GIFTS

Disclaimer

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IAHV
International Association of Human Values:
www.iahv.org

- Non-profit/NGO, 150 countries.
- Multiple Graduate level Workshops available.
- Workshop is taught in community, various universities and corporate companies

You are only allowed to teach you pts and at no charge! IAHV reserves the final rights for permission to teach.

Thank you!

Thank You
If u r ever stressed, come and see us!! :))
woof woof, woof
Shalabh Chandra
chandra.shalabh@gmail.com
517-282-7378
Appendices
Appendix A
Appendix A:

Some Words to Describe Feelings

<table>
<thead>
<tr>
<th>Abandoned</th>
<th>Cautious</th>
<th>Disturbed</th>
<th>Gloomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adament</td>
<td>Challenged</td>
<td>Dominated</td>
<td>Glum</td>
</tr>
<tr>
<td>Afraid</td>
<td>Charmed</td>
<td>Doubtful</td>
<td>Good</td>
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<tr>
<td>Aggravated</td>
<td>Cheated</td>
<td>Down</td>
<td>Grateful</td>
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<tr>
<td>Agitated</td>
<td>Cheerful</td>
<td>Downtrodden</td>
<td>Gratified</td>
</tr>
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<td>Agony</td>
<td>Childish</td>
<td>Drained</td>
<td>Great</td>
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<td>Alert</td>
<td>Clever</td>
<td>Driven</td>
<td>Grief</td>
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<td>Alienated</td>
<td>Combative</td>
<td>Dubious</td>
<td>Grouchy</td>
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<tr>
<td>Alive</td>
<td>Comfortable</td>
<td>Dumb</td>
<td>Guilty</td>
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<tr>
<td>Alone</td>
<td>Committed</td>
<td>Eager</td>
<td>Gullible</td>
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<tr>
<td>Amazed</td>
<td>Compassionate</td>
<td>Ecstatic</td>
<td>Happy</td>
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<tr>
<td>Ambiguous</td>
<td>Concerned</td>
<td>Edgy</td>
<td>Hassled</td>
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<tr>
<td>Ambivalent</td>
<td>Condemned</td>
<td>Elated</td>
<td>Hateful</td>
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<tr>
<td>Amused</td>
<td>Confident</td>
<td>Embarrassed</td>
<td>Helpful</td>
</tr>
<tr>
<td>Angry</td>
<td>Conflicted</td>
<td>Empty</td>
<td>Helpless</td>
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<tr>
<td>Annoyed</td>
<td>Confused</td>
<td>Enchanted</td>
<td>Hesitant</td>
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<tr>
<td>Anxious</td>
<td>Consumed</td>
<td>Encouraged</td>
<td>High</td>
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<td>Apathetic</td>
<td>Contended</td>
<td>Energetic</td>
<td>Hopeful</td>
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<tr>
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<td>Contrite</td>
<td>Enervated</td>
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<td>Apprehensive</td>
<td>Controlled</td>
<td>Engrossed</td>
<td>Horrible</td>
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<td>Ashamed</td>
<td>Creative</td>
<td>Engulfed</td>
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<td>Cruel</td>
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<tr>
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<td>Crummy</td>
<td>Enraged</td>
<td>Hurt</td>
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<td>At ease</td>
<td>Curious</td>
<td>Envious</td>
<td>Ignorant</td>
</tr>
<tr>
<td>Awed</td>
<td>Decetful</td>
<td>Euphoric</td>
<td>Ignored</td>
</tr>
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<td>Deceived</td>
<td>Evil</td>
<td>Impatient</td>
</tr>
<tr>
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<td>Defeated</td>
<td>Exasperated</td>
<td>Impulsive</td>
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Appendix A:

Some Words to Describe Feelings

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Appendix B
Appendix B:

Psychosocial Rotation Alumni

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Page 1 of 2
Revised 02-2013

MSU – College of Human Medicine – Department of Medicine

S:\PS 2012 NOTEBOOK revised 7-13-2012\27. PS Appendix B - Alumni List.doc
Appendix B:

Psychosocial Rotation Alumni

2001 – 2002
Shazaman Abbasi
Abeer Abu Taleb
Haris Athar
James DeMuth
Sherif El-Mahdy
Ehab Eltahawy
Tamar Finan
Mehdi Khosravi
Angel Lake
Tarek Mohamed
Ibrahim Shah
D. Soundararaj
Terence Whiteman

2002-2003
Kristopher Dosh
Anas Kayal
Venkata Parsa
Kwsai Al-Rahhal
Asad Mohmand
Mini Kamboj
Fadi Hayek

2003-2004
Timothy Crone
Anjali Kalra
Apoorva Kalra
Sharat Mayya
Dexter Estrada
Tibor Kalnoky-Kis
Syed Raza
Sandeep Sohal

2004-2005
Amir Azeem
Atul Khasnis
Aatha Parsa
Roshan Patel
Panchali Khanna
Jesus Mireles
Kiran Sarikonda
Mary Ann Tran

2005-2006
Nitesh Gadeela
Kalyan Kosuri
Oluchi Opara
Amarbir Mattewai
Anand Tandra
Molly Caldwell-McMillan
Chursun Han
Adriano Tonelli
Fadi Yasin

2006-2007
Madhussudan Grover
Grace Kim
Siddharth Mukerji
Mohammad Pervaiz
Sachin Gupta
Amit Gupta
Shalabh Chandra
Feras Aloka
Deepa Jagtap

2007-2008
Keerthy Nariseti
Abhijeet Dhoble
Robert Vaidya
Nandu Gourineni
Dana Houghton
Saahbada Latif
Ashwani Gupta
Albert Pham
Gautam Choure
Tarundeep Kaur

2008-2009
Won Chung
Sridevi Durga
Nephetiti
Effovbokhan
Santhossh Naryanan
Kevin Patel
Rubens Ribeiro
Enir Sarznyski
Neethi Sural
Rudruidee
Karnchanasorn

2009-2010
Abrar Sayeed
Deepthi Vodnala
Manisha Bhutani
Supratik Rayamajhi
Pavan Gorukanti
Srikan Sudini
Deepthi Rao
Amit Banga
Menelito Lilagan
Santhossh Narayanan
Tahmeed Contractor
Oliver Abela
Mohamed Akkad
Alvin Dandan
Naomi Mathew
Priyank Patel
Nizam Imsail
Vinoda Balakrishnan
Kristy Beckholt
Megha Tewari

2010-2011
Ali Al Arab
Subjan Ameda
Hemarsi Tokala
Maan Ekkah
Kristine Sunio
Anmar Al Jajah
Jennifer Czaplcki
Nausheen Hussain
Greg Lawson
Linda Murray
Lizbeth Dalaza
Sonya Gupta
Kwasi Karikari
Shaza Khan
Deng Zhang
Leela Reddy

2011-2012
Santosh Chandolu
Mamata Ojha
Srinivasa Vasireddi
Shanti Viruppanavar
Shima Isaac
Hershey Jayasuriya
Abdulmetin Dursun
Aimee Nichols
Ashish Tiwari
Dareen Almanabri
Eric Hogan
Megan Crawford
Michael Darabos
Mrinal Yadava
Tyler An
Osama Alsara

2011-2012 Cont.
Fleur Broughton
Anthia Dasari
David Kim
Joosook Kim
Waddah Saba
Danielle Watkins

2012-2013
Amit Mehta
Divya Sharmar
Ian Chang
Jinsoo Chang
Abraham Alsherneti
Dane Gruenebaum
Madalina Opreanu
Richa Tikaria
Woo Jong (James Chang)