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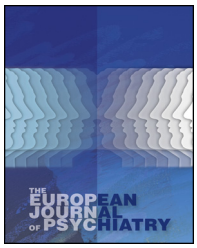

SHORT COMMUNICATION

Personality disorders in patients referred to consultation-liaison psychiatry: Characteristics and medical treatment in a large general hospital

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KEYWORDS
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Abstract The association of somatic illness and personality disorders (PD) has important and potentially negative implications for patients. We compare characteristics and treatment variables of 3032 patients with and without PD in a large sample of consultation-liaison (CL) psychiatry patients.

2434 patients had a psychiatric disorder other than a PD, 66 a PD only, and 532 a combination of both. The most frequent combination of disorders on Axis I and II was that of a Cluster-B-PD and substance related disorders. CL-patients with PD were significantly younger, living alone more often, showed better general functioning and had a shorter length of stay.

Introduction

The increased prevalence of chronic illness leads to higher comorbidity of mental and physical conditions, attaining up to 41–47% in the general hospital.[1] While research on comorbidity increases, there is little study of patients with personality disorders (PD) and somatic illness in consultation-liaison (CL) psychiatry. PD is associated with reduced quality of life[2] and more general health problems.[3]

Small-scale studies indicate that the prevalence of PD in CL-settings varies from 4 to 12% but give little information about functioning or procedural variables.[4,5]

Therefore, this explorative study describes baseline and process variables of these patients and compares them to those with other psychiatric disorders.

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Methods

We present a retrospective cohort analysis of patients referred to the CL-psychiatry service of Mount Sinai Hospital (tertiary care, 1200 beds, 30,000 annual inpatient admissions during the study period), New York City, between 1988 and 1997, with all patients whose psychiatric consultation was requested by a somatic ward. Since several specialty units (e.g. gerontology, HIV/AIDS) employ their own psychiatrists/psychologists, consultation requests were issued predominantly by general medical or surgical wards. 3032 patients with a diagnosis of Axis-I and/or II of the DSM-III-R or DSM-IV system between the ages of 17 and 65, without private insurance (care provided by private attending physicians), were included.

Patient characteristics including somatic (available for 2848 patients) and psychiatric diagnoses and process data were collected using the MICRO-CARES Questionnaire.[6] Psychiatric diagnosis was made by the consulting physician without structured diagnostic interviews, based on clinical interviews only. PD were grouped into three clusters as defined by DSM. The Karnofsky Index (low values meaning high care needs) was used to assess general functioning. Details on variables are provided in the supplement. Variables compared those with psychiatric disorders exclusive of PD, PD only, or both conditions combined. We used multiple regression in a secondary analysis to assess whether a PD diagnosis had an independent impact on LOS (see supplement). Independent variables were chosen based on a priori clinical hypotheses.

Results

2434 (80.3%) patients had a psychiatric disorder without a comorbid PD, 66 (2.2%) a PD only and 532 (17.5%) a combination of both (see Table 1).

The most frequent main diagnoses were organic mental disorders, followed by adjustment-disorders. The share

Table 1 Descriptive analysis of patients with psychiatric disorders on Axis I and/or II ($n = 3032$).

Variable	Axis I $N = 2434$ ''A_I''	Axis I and II $N = 532$ ''A_I+II''	Axis II $N = 66$ ''A_II''	p-value	Missing (n)
Age (years)	43.8 ± 12.5	39.0 ±11.9	41.9 ± 15.2	.000	0
Gender % male	50.8	55.6	60	.055	18
Lag time (days)	8.8 ± 21.7	6.7 ± 20.5	15.1 ± 53.1	.001 for A_I vs. A_I+II	653
Number of reasons consultee	1.8 ± 1.0	2.1 ± 1.2	2.1 ± 1.3	.000 for A I vs. A I+II	0
Number of reasons consultant	2.5 ± 1.4	3.1 ± 1.4	2.3 ± 1.4	.000 for A_I+II vs. all others	0
Living alone %	31.3	41.0	46.6	.000	40
Unemployed %	81.7	85.8	87.9	.038	16
Karnofsky index	60.8 ± 24.2	67.8 ± 21.8	69.9 ± 20.6	.007 for A_I vs. all others	55
LOS (days)	21.6 ± 34.1	15.6 ± 23.6	25.4 ± 60.6	.043 for A_I vs. A_II .001 for A_I vs. A_I+II	653
Follow-up (n)	5.0 ± 6.9	4.3 ± 5.2	4.1 ± 6.7	.082	215
Major psych. treatment last year (% yes)	23.5	31.1	16.0	.001	272
Psychopharm. recommended %	46.3	41.2	16.7	.000	0
Psychometr. test recommended %	5.4	5.2	5.1	.973	55
Non-medical consultation recommended %	28.9	38.3	20.3	.000	77
Ext. information recommended %	62.1	58.6	61.0	.327	64
Behavioral management recommended %	20.1	28.2	22.4	.000	86
Psychological management recommended %	76.5	84.6	77.8	.000	42
Environ. change recommended %	22.3	27.5	15.3	.014	60
AMA possible %	4.7	10.1	10.2		
AMA refused %	6.1	5.8	3.4	.000	114
AMA no issue %	89.2	84.1	86.4		

Values are mean ± SD unless otherwise stated. After Bonferroni-correction for multiple testing, statistical significance is set at $p < .003$. LOS = length of stay. AMA = discharge against medical advice.

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