

**PSYCHIATRY FOR
LAWYERS**

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JANUARY 2009

OUTLINE

- MAJOR MENTAL ILLNESSES
- PHARMACOLOGIC TREATMENTS
- CAPACITY
- SUICIDE
- VIOLENCE
- DISCUSSION

PSYCHOTIC DISORDERS

- COLLECTION OF SYNDROMES DEFINED BY THE PRESENCE OF:
 - DELUSIONS
 - FIXED FALSE BELIEFS
 - HALLUCINATIONS
 - ABNORMAL PERCEPTIONS
 - DISORGANIZED SPEECH
 - DISORGANIZED BEHAVIOR

SCHIZOPHRENIA

- Affects ~ 1% of the population
- Usually presents late teens, early 20's
- Course variable
- Negative syndrome may be predominate for some
- Major areas of functioning affected (academic, occupational, social)
- Lack of insight into illness and poor compliance with treatment common

OTHER PSYCHOTIC DISORDERS

- SCHIZOAFFECTIVE DISORDER
 - Involves significant mood component
- DELUSIONAL DISORDER
 - Usually non-bizarre delusions
 - Less impact on overall functioning
- SUBSTANCE-INDUCED PSYCHOSIS
 - Cocaine, marijuana, amphetamines most common
- PSYCHOSIS SECONDARY TO MOOD/COGNITIVE DISORDERS
 - Depression, Mania, Dementia syndromes
- PSYCHOSIS DUE TO MEDICAL CONDITIONS

ANTIPSYCHOTIC MEDICATIONS

- Essentially all equally efficacious
 - Exception: Clozapine for treatment resistance
- Differ with regard to side effect profile
 - Older drugs impact neuromuscular function
 - Newer drugs tend to promote metabolic problems
- Compliance problems common
 - Strategies include long acting injectable agents

MOOD DISORDERS

- Disturbance in mood is predominate feature
- Associated disturbances in neurovegetative functioning and behavior
- Important to distinguish human emotion from mood episodes or syndromes
 - Time course
 - Impact on functioning

MAJOR DEPRESSION

- Affects 10-20 % of Americans at some point in lifetime
- Women affected ~ 2:1
- Typically starts in 20's
- Major depressive episode involves specific time course and impacts sleep, appetite, energy, concentration in addition to the central features of depressed mood and pervasive loss of interest
- Antidepressants relatively effective and safe
 - Compliance again presents problems

BIPOLAR DISORDER

- Essential diagnostic component involves manic or hypomanic episode
 - Duration of symptoms important
 - Current debate whether overdiagnosed or underdiagnosed
- Often (but not necessarily) involves episodes of depression as well
- Hypomania/Mania involves elevated or irritable mood
 - Risk taking and other aberrant behavior common
 - Other biologic changes typical
 - Decreased sleep, increased energy

OTHER MOOD DISORDERS

- **DYSTHYMIA**
 - Chronic form of depression
 - Symptoms less severe
- **SUBSTANCE-INDUCED MOOD DISORDER**
 - Most common agents alcohol, cocaine
- **MOOD DISORDER DUE TO MEDICAL CONDITION**
 - Multiple associated medical problems (cancer, vascular disease, hypothyroidism, Parkinson's)

PERSONALITY DISORDERS

- Enduring, life-long pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture
- Pervasive and inflexible
- Onset in adolescence or early adulthood
- Stable over time ("stably unstable")
- Leads to distress or impairment

CLUSTER B

PERSONALITY DISORDERS

Individuals in this spectrum often appear dramatic, emotional, or erratic

- **ANTISOCIAL PERSONALITY DISORDER**
 - Pattern of disregard for, and violation of, the rights of others (i.e. criminals)
- **BORDERLINE PERSONALITY DISORDER**
 - Pervasive pattern of relationship and emotional instability and marked impulsivity

SUBSTANCE USE DISORDERS

- Related to the taking of a drug of abuse, whether legal or illegal
 - Multiple criteria exist that include use over time, development of tolerance and withdrawal symptoms, using more than intended, unsuccessful efforts to quit
 - Substance use is continued despite the realization of harmful effect, adverse consequences

ALCOHOL

- Best estimate is ~ 10% Americans are alcohol dependent (by far the most commonly abused drug outside of tobacco)
- Significant adverse effects of
 - Intoxication- DUI, assault
 - Withdrawal- DT's, seizures
 - Long-term use- heart disease, cancer
- Commonly comorbid with other psychiatric disorders
- Treatment options
 - 12 Step programs still best approach
 - Pharmacologic interventions show modest benefit

ILLICIT DRUGS

- CANNABIS
 - Most common illicit drug of abuse
 - Potency of drug ~4x since the 70's
 - Adverse effects on health, cognition, motivation
- COCAINE
 - Extremely potent euphoric effects, short half-life and delivery system (crack) contribute to high risk for dependency in short periods of time
 - High financial costs contribute to illegal behaviors to maintain drug habit (theft, prostitution, drug sales)

PRESCRIPTION DRUGS

- SEDATIVES/ANXIOLYTICS
 - Benzodiazepines widely prescribed for anxiety, sleep
 - Produce intoxication and withdrawal picture similar to alcohol
- OPIOIDS
 - Used for both acute and chronic pain syndromes
 - Dependency will result in withdrawal that, while not fatal, is extremely unpleasant

DEMENTIA SYNDROMES

- Multiple causes/etiologies, but Alzheimer's type most common
- Primarily affects cognition- memory, orientation, executive functioning
 - Other symptoms such as mood disturbance and psychosis not uncommon
- Course variable and presentation can differ
 - Most cases occur after age 65 and progress slowly
 - Variations can include early age of onset and rapid decline

SUICIDE

- Accounts for > 30,000 deaths per year in the US
- Suicides outnumber homicides 3:2
- 11th leading cause of death
- Estimated 8-25 attempted suicides for every death
- Females attempt 3X as often as males
- Males succeed 4X as often as females

CLINICAL ASSESSMENT

- Clinicians' role to assess risk
- Assessment of risk factors allows accurate identification of suicidal patient, but low predictive success in determining which patient will commit suicide
- Separate acute v chronic risk, modifiable v static
- Identify protective factors

RISK FACTORS

- Major mental illness
 - Mood disorders account for ~80%
 - 10% of patients w/ Schizophrenia complete suicide
- Alcoholism/chemical dependence
 - Risk increased 5X
- Borderline Personality Disorder
 - Notorious for suicidal/parasuicidal behavior
 - 3-8% incidence completed suicide

RISK FACTORS

- Suicidal thoughts/behaviors
- Genetics/family history
- Gender
- Race
- Age
- Psychosocial factors
 - Marital status, unemployment, social isolation
 - Domestic violence

MANAGEMENT

- Involves the mitigation of those risk factors that are modifiable
- Hospitalization, frequent contact with mental health often necessary during periods of increased risk

VIOLENCE

- Debate exists as to the relationship between major mental illness and violence
 - Psychiatric patients do have increased arrest rates, including arrests for violent crimes
 - Significant confounders make interpretation of data difficult
 - Violent behavior is a frequent antecedent to psychiatric hospitalization (10-20% of admissions)
 - Higher prevalence of mental illness among incarcerated offenders
- Approximately 40% of psychiatrists report being attacked at least once during their career

VIOLENCE IN MENTAL ILLNESS

- Multiple psychiatric conditions carry risk of violence
 - Psychotic disorders (particularly paranoid delusions)
 - Bipolar disorder, mania
 - Personality disorders: Antisocials, Borderlines
 - Substance abuse/intoxication: alcohol, cocaine, amphetamines, PCP, steroids
 - Intermittent Explosive Disorder
 - CNS Disorders

ASSESSMENT/MANAGEMENT

- Predicting violence essentially impossible
- Clinicians must evaluate acute v chronic risk
- Hospitalization
- Pharmacologic interventions
 - Aimed at reducing aggression, psychiatric symptoms
