

**PSYCHIATRY FOR
LAWYERS**

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JANUARY 2011

OUTLINE

- MAJOR MENTAL ILLNESSES
- TREATMENT
- 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
- Diagnosis requires 6 months of symptoms
- Positive symptoms gain attention, but 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
- Long term course variable

OTHER PSYCHOTIC DISORDERS

- SCHIZOAFFECTIVE DISORDER
 - Involves significant mood component
- DELUSIONAL DISORDER
 - Usually non-bizarre delusions
 - Less impact on overall functioning
 - Often refractory to treatment
 - Frequent involvement in the legal system
- SUBSTANCE-INDUCED PSYCHOSIS
 - Cocaine, marijuana, amphetamines most common
- PSYCHOSIS SECONDARY TO MOOD/COGNITIVE DISORDERS
 - Depression, Mania, Dementia syndromes
- PSYCHOSIS DUE TO MEDICAL CONDITIONS
 - Hypo/hyperthyroidism, Lupus, Nutritional deficiencies

MOOD DISORDERS

- Sustained disturbance in mood is predominate feature
- Associated disturbances in neurovegetative functioning and behavior
- Important to distinguish normal emotional response from mood episodes or syndromes
 - Time course
 - Severity of symptoms
 - Impact on functioning

MAJOR DEPRESSION

- Affects 10-20 % of Americans at some point in lifetime
- Women affected ~ 2:1
- Typically starts in 20's though can occur throughout lifetime
- 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
- It is estimated that < 50% of people with depression are adequately treated

BIPOLAR DISORDER

- Essential diagnostic component involves occurrence of at least one manic or hypomanic episode
 - Duration of symptoms important
 - Often (but not necessarily) involves episodes of depression as well
- Debate exists over whether overdiagnosed or underdiagnosed
 - Lifetime prevalence for Bipolar I ~ 1%, Bipolar II 2-4%
- Hypomania/Mania involves elevated or irritable mood
 - Risk taking and other aberrant behavior common
 - Behavior inconsistent with norm for the individual
 - 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
- Affects ~ 15% of the population

PERSONALITY DISORDERS

- Grouped into 3 clusters
 - Cluster A: Paranoid, Schizoid, Schizotypal
 - Odd, eccentric
 - Cluster B: Antisocial, Borderline, Histrionic, Narcissistic
 - Dramatic, erratic
 - Cluster C: Avoidant, Dependent, Obsessive-Compulsive
 - Anxious, fearful

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)- up to 75% of prison population
- **BORDERLINE PERSONALITY DISORDER**
 - Pervasive pattern of relationship and emotional instability and marked impulsivity
 - Most common diagnosis in inpatient setting

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
 - High comorbidity with psychiatric disorders

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

ANTIPSYCHOTIC MEDICATIONS

- Essentially all equally efficacious
 - Exceptions:
Recent studies show Olanzapine to have slight advantage
Clozapine for treatment resistance
- Differ with regard to side effect profile
 - Older drugs impact neuromuscular function (EPS, TD)
 - Newer drugs tend to promote metabolic problems (DM)
- Compliance problems common
 - Strategies include long acting injectable agents

ANTIDEPRESSANT MEDICATIONS

- Similar to antipsychotics in that there are older drugs (TCAs) that are effective but have disadvantageous side effects and newer drugs (SSRIs, SNRIs) that are no more effective but more tolerable and safer overall
- >50% of patients will fully recover if treated adequately

ELECTROCONVULSIVE THERAPY

- Very effective for severe depression, catatonia, bipolar disorders
- Safer, more humane than treatment decades ago
- Typically not a first line treatment, but used when patients are refractory to other treatments or have life threatening conditions

TALKING THERAPY

- Individual
 - CBT
 - DBT
 - Psychotherapy
- Groups
 - PTSD
 - Substance use disorders

SUICIDE

- Accounts for > 30,000 deaths per year in the US
- Suicides outnumber homicides 3:2
- 11th leading cause of death
- Still a relatively rare event- U.S. rate 10.6/100,000
 - Much higher in psychiatric disorders
- 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 (i.e. treat the underlying condition)
- 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
 - 2009 study in JAMA: Schizophrenia without comorbid substance abuse 1.2 times as likely to commit violent crime; with substance abuse 4X
 - NIMH ECA study lifetime prevalence of violence 16% in patients w/serious mental illness compared to 7% rate of patients without mental illness
 - Serious mental illness rare therefore relatively low contribution to society's risk
 - Violent behavior is a frequent antecedent to psychiatric hospitalization (10-20% of admissions)
- 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 very difficult
 - Research indicates most clinicians able to distinguish violent from nonviolent patients with only a modest better than chance level of accuracy
- Clinicians must evaluate acute v chronic risk
- Hospitalization; mandated outpatient treatment
- Pharmacologic interventions
 - Aimed at reducing aggression, psychiatric symptoms
 - Clozapine, lithium 2 agents with proven efficacy
