The Diagnostic and Statistical Manual (DSM-IV) is published by the American Psychiatric Association – it classifies by symptoms based on current consensus of current formulations, hence it is constantly evolving. This is a typological system, allowing for borderline and heterogenous cases.

1. Terminology
   a. Diagnosis
   b. Severity and course specifiers – mild/moderate/severe, qualifiers, in partial/full remission, prior history, recurrence

2. Diagnostic groupings
   a. Disorders of infancy, childhood or adolescence
   b. Psychotic disorders (schizophrenia, schizoaffective)
   c. Mood disorders (major depression, bipolar disorder, dysthymia)
   d. Anxiety disorders (GAD, OCD, PTSD, panic, social phobia)
   e. Somatoform disorders (somatization, hypochondriasis)
   f. Cognitive disorders
   g. Substance abuse disorders
   h. Personality disorders
   i. Medical condition causing mental disorder
   j. Other disorders – factitious, dissociative, sexual, eating, sleep, impulse control

3. Multiaxial diagnosis
   a. Axis I – Mental disorders
   b. Axis II – Personality disorders and mental retardation
   c. Axis III – General medical conditions
   d. Axis IV – Psychosocial and environmental problems
   e. Axis V – Global assessment of functioning (GAF)

4. Tips for diagnosis
   a. What’s most obvious?
   c. Stressors? Recent life events?
   d. Do not forget substances and medical conditions
   e. 5 axes

The Psychiatric Assessment

General aspects:
1. Why this person? Why this way? Why now?
2. Aspects of the referral
3. Background information
4. Interview – family/individual
5. Gathering and processing information

Psychiatric history should include presenting complaint, history of presenting complaint, past psychiatric history, family history, past medical history, social/personal history, premorbid personality, substance abuse, forensic history

The mental state examination comprises the examiner’s observations/impressions of the patient during the interview, and elicited phenomena. ‘Phenomenology’ is the study of signs and symptoms of mental disorder – objective description and naming of phenomena.

1. Appearance, Activity, Attitude
   a. Appearance – physical characteristics including age, consciousness, posture, attire, grooming, eye contact, physical abnormalities (including odour, marked facies)
   b. Activity – physical movement – psychomotor retardation or agitation, abnormal movements (tremor, tics, involuntary movements, responding to hallucinations)
   c. Attitude – approach to interview/examiner; changes with anxiety, rapport

2. Speech – rate, rhythm, fluency, tone, volume, abnormalities

3. Thought form – tangential, circumstantial, flight of ideas, loosened associations, word salad; others (clang associations, echolalia, neologisms, perseveration, thought blocking)

4. Thought content – may have poverty of speech/content, ask about homicidal/suicidal ideation
a. Delusions – paranoid (persecutory/grandiose), Schneiderian (passivity, thought broadcasting/insertion/withdrawal, delusional perception, commenting hallucinations), somatic, jealousy, erotomanic, misidentification, referential, nihilistic, denial
b. Near delusional beliefs – overvalued ideas, magical thinking (more connectedness to events than actually present), obsessions, preoccupations, ruminations
c. Phobias

5. **Perception** – hallucinations, illusions, depersonalisation/derealisation, deja/jamais vu
6. **Mood** – predominant internal feeling state at a given time that colours the person’s perception of the world e.g. euthymic, euphoric, dysphoric, angry, anxious, apathetic
7. **Affect** – external and dynamic manifestation of patient’s internal emotional state, described as
   a. Appropriateness – appropriate or inappropriate
   b. Intensity – normal or blunted/exaggerated/heightened/overdramatic
   c. Mobility – mobile or constricted/fixed/immobile/labile
   d. Range – full range or restricted range
   e. Reactivity – reactive or non-reactive
8. **Cognition:**
   a. Orientation – time, place, person (including orientation to the event)
   b. Mini Mental State Examination
   c. Frontal Lobe Extensions
   d. Neuropsychological Testing
9. **Insight, Judgement and Safety**
   a. Insight – acceptance/recognition of mental illness, compliance with treatment, ability to re-label psychotic phenomena as abnormal when well
   b. Judgement – patient’s capability for social judgement/decision making
   c. Safety – deliberate and inadvertent harm to self/others

### Risk Assessment for Violence and Self-Harm

**Significance** of violence and self-harm:
1. **Violent behaviour**
   a. Mentally ill people are often victims
   b. Their families are often victims
   c. They suffer an increased burden of shame and guilt if they harm others, loss of liberty
   d. The confidence in the mental health system is undermined, and events feed public stigmatisation of mentally ill people
2. **Suicide**
   a. Approximately 500 New Zealanders die by suicide each year (conservative estimate)
   b. Maori rates are rising rapidly towards Pakeha
   c. Youth suicide highest in OECD in 1993
   d. Burden on family and careers immense
3. Inquiries into violence and suicide incidents commonly report the following errors:
   a. A failure of mental health workers to take the reports of others seriously
   b. Undue emphasis on a narrow concept of liberty
   c. Failure to use compulsory treatment
   d. Tendency to be cross-sectional and not take on board past history
   e. Failure to share information

**Evidence for a relationship** between mental illness and violence/self-harm varies but it is agreed:
1. There is a clear relationship of increased risk correlated with diagnosis – about the same order of magnitude as being a substance abuser or a male aged 17-25
2. Co-morbidity is an important contributor
3. Active symptoms are more important than diagnosis
4. Particular forms of symptoms and circumstances may be very important

**Management**
1. **Identifying risk:**
   a. Careful gathering of information regarding past dangerous events
   b. Ability to relate to the person in a non-blameworthy fashion and ask about fear, anger and details of symptoms
   c. Ask about and record the person, the symptoms and the situation
   d. Construct a formulation regarding the pathway to relapse and violence ("signature")
DSM-IV Criteria

e. Attention to current circumstances and degree of change since prior violence or risk

2. Applying risk to a management plan:
   a. Make a 2-4 sentence formulative statement of the risk
   b. Identify the 4-5 key factors which you must manage/monitor to reduce risk effectively
   c. Management plan requires no more than assigning proper intervention to each risk
   d. Assertive reduction of risk variables with person and their family

3. Example management plan for suicide:
   a. Risk factors:
      i. Young Maori male, older Pakeha male
      ii. ‘Aloneness’ – single, divorced, widowed
      iii. ‘Disconnectedness’ – unemployed, lost connections, ill heath, social disarray
      iv. Illness – depressed mood (90%), schizophrenia, alcohol, physical illness
      v. Psychological – worthless, hopeless, helpless
      vi. Situations – exposure to suicide/jails, life events, means, intoxication
   b. Suicide assessment – formulate
      i. Assess presence of risk factors
      ii. Assess the meaning of the risk factor for this particular person
      iii. Consider intent, rather than lethality (e.g. non-lethal intent → lethal outcome)
      iv. Consider circumstances, precipitating events, intent, degree of change

Civil Commitment – Mental Health Act

Civil commitment is the process of compulsory assessment and treatment of people with serious mental illness who are unable or unwilling to consent to assessment and treatment. This typically involves hospitalisation, but is increasingly community based.

1. Ethical justification:
   a. Police powers – to protect members of society from others
   b. Parens patriae – to assist those unable to assist themselves

2. Indications (UN):
   a. Has a mental illness, that:
   b. Results in serious danger to oneself or others, and
   c. Person is unable or unwilling to consent to treatment

3. Contraindications
   a. ‘Social deviance’ – e.g. sexual orientation/preference, religious belief, cultural belief, political ideology, criminal behaviour
   b. Some patient groups (e.g. borderline personality disorder) – process of admission may contain other hazards that may need consideration

Clinical trials of civil commitment:

1. Efficacy
   a. No relationship to poorer outcome in large Israeli study (Fennig et al, 1999)
   b. Outpatient involuntary commitment significantly reduces rates of violence in randomised study if committed for >179 days (Swanson et al, 1999)

2. Adverse reactions
   a. Persisting negative feeling stemming from threats/force (police, seclusion, restraint)
   b. Those at greatest risk appear to be those with high levels of premorbid autonomy, those who felt ignored and not listed to
   c. Unclear what the long term treatment effects of these feelings may be

3. Interventions to reduce adverse outcomes (attendance to the demands of procedural justice):
   a. Inform the person as much as possible
   b. Respectful persuasion
   c. Hear their views and continue to talk about their feelings
   d. Later, talk with them about the experience and plan for future episodes

4. Dosage and administration
   a. With thought, and within the boundaries of respect for autonomy (i.e. least restrictive and shortest necessary duration)
   b. Consider longitudinal history when deciding whether or not to apply
   c. ‘Process minded’ rather than ‘events minded’ approach
   d. Consider Ulysses contract, advanced directives, proxy decision makers

Management of serious risk:
DSM-IV Criteria

1. **Structure:**
   a. The nature and magnitude of harm
   b. Its imminence
   c. Its frequency
   d. Situational variables relevant to risk
   e. Balance of the harm that may arise and the nature of the intervention

2. **Procedures:**
   a. Application by member of the public and a doctor
   b. Duly Authorised officer (usually a psychiatric nurse) assesses and arranges psychiatric assessment
   c. 5, then 14 day assessment before final application is heard by a Family Court Judge
   d. Type of order – inpatient or community

Relevant sections of the Mental Health (Compulsory Assessment and Treatment) Act, 1992:
- **Section 2**
  - Abnormal state of mind whether of continuous or intermittent nature, characterised by delusions, or disorders of mood or perception or volition or cognition
  - To such an extent that the person poses a serious danger to the health and safety of that person or others or results in a serious incapacity to care for oneself
- **Section 4**
  - Procedures in parts I and II shall not be invoked only in respect of any person by reason only of
    - That person’s political, religious or cultural beliefs; or
    - That person’s sexual preferences; or
    - That person’s criminal or delinquent behaviour;
    - Substance abuse
    - Intellectual handicap

**PSYCHIATRIC DISORDERS (WITH A DSM-IV FOCUS)**

- **Mood Disorders**
  
  The DSM-IV describes episodes of abnormal or pathological mood – note that a mood episode is not a diagnosis, but the pattern of episodes may lead to a diagnosis. Other systems see mood disorders on a continuum – use of some scales with cut-off points implies this.

  1. **Major Depressive Episode** (distress or impaired function, not 2° to organic or bereavement)
     a. 5 or more of the following symptoms have been present nearly every day during the same 2 week period and represent a change from previous functioning; at least one of which is either a) depressed mood or b) loss of interest or pleasure (anhedonia)
        i. Depressed mood most of the day
        ii. Markedly decreased interest or pleasure in usual activities
        iii. Significant weight change (>5% in 1/12) or appetite change
        iv. Insomnia or hypersomnia, nearly every day
        v. Psychomotor agitation or retardation
        vi. Fatigue or loss of energy
        vii. Feelings of worthlessness or excessive/inappropriate guilt
        viii. Diminished ability to think or concentrate
        ix. Recurrent thoughts of death or suicide (or has made an attempt)

  2. **Manic episode** (impaired function, hospitalisation or psychosis; not due to organic causes)
     a. At least one week of abnormally and persistently elevated, expansive or irritable mood (any duration if hospitalisation necessary); and any three of:
        i. Inflated self-esteem or grandiosity
        ii. Decreased need for sleep (<3hr/night)
        iii. More talkative than usual or pressured speech
        iv. Flight of ideas or subjective experience that thoughts are racing
        v. Distractibility
        vi. Increase in goal-directed activity
        vii. Excessive involvement in pleasurable activities that have a high potential for painful consequences

  3. **Mixed episode**
     a. Criteria are met for manic episode and depressive episode nearly every day for at least one week
b. Symptoms cause marked impairment in occupational functioning or in usual social activities or relationships; or necessitate hospitalisation to prevent harm to self or others; or if there are psychotic features

c. Symptoms do not meet criteria for a mixed episode and are not due to the physiological effects of a substance or general medical condition

4. Hypomanic episode

a. At least 4 days of persistently elevated, expansive or irritable mood clearly different from the usual non-depressed mood; and any three (four if mood is only irritable) of the symptoms for manic episode

b. Symptoms are associated with an unequivocal change in functioning that is uncharacteristic of the asymptomatic person and observable by others

c. Symptoms are not severe enough to cause marked impairment in social or occupational functioning; or to necessitate hospitalisation; with no psychotic features

d. Symptoms are not due to the direct physiological effects of a substance or general medical condition

Mood disorders generally represent recurrent episodes of abnormal or pathological mood.

1. Depressive disorders:

   a. Major depressive disorder – one or more depressive episodes, no manic or mixed
      i. Recurrence – single episode or recurrent
      ii. Severity:
         1. Mild – few (if any) symptoms in excess to those needed to make the diagnosis, with only minor impairment in occupational/social function
         2. Moderate – between mild and severe
         3. Severe – without psychotic features (several excess symptoms and marked interference with function) or with psychotic features:
            a. Mood-congruent – content is consistent with typical themes of inadequacy, guilt, disease, nihilism, deserved punishment
            b. Mood-incongruent – including persecutory delusions, thought insertion, thought broadcasting and delusions of control
      iii. Other descriptors – chronic (2 years), post-partum onset (4/52)
         1. Melancholic features – loss of pleasure in all, or almost all activities or lack of reactivity to usual pleasurable activity, and three of:
            a. Distinct quality of mood (as different from sadness or grief)
            b. Depression worse in morning (diurnal variation)
            c. Early morning wakening
            d. Marked psychomotor agitation or retardation
            e. Excessive anorexia or weight loss (>10%)
            f. Excessive or inappropriate guilt
         2. Atypical features – mood reactivity (brightens in response to actual or potential positive events) and two or more of:
            a. Significant appetite increase or weight gain
            b. Hypersomnia
            c. Leaden paralysis (heavy, leaden feelings in arms or legs)
            d. Long-standing pattern of interpersonal rejection sensitivity (not only when depressed) that impairs function
         3. Catatonic features – at least two of:
            a. Motor immobility including cataplexy, waxy flexibility or stupor
            b. Excessive motor activity that is apparently purposeless
            c. Extreme negativism or mutism
            d. Posturing or stereotypy
            e. Echolalia or echopraxia
   b. Dysthymic disorder:
      i. Depressed mood for most of the day, for more days than not, for at least 2 years (in children can be irritable with duration at least 1 year) with two of:
         1. Poor appetite or overeating
         2. Insomnia or hypersomnia
         3. Low energy or fatigue
         4. Low self-esteem
         5. Poor concentration or difficulty making decisions
DSM-IV Criteria

6. Feelings of hopelessness
   ii. During this period the person has never been without the symptoms for more than 2 months at a time, and no major depressive episode has been present
   iii. Symptom cause clinically significant distress or impairment in functioning
   iv. Symptoms are not due to another mood disorder or occur during a chronic psychotic disorder, nor are they due to a substance or medical condition
   v. Specify – early onset (<21yrs), late onset (>21yrs), with atypical features

c. Depressive disorder not otherwise specified

2. Bipolar disorders:
   a. Bipolar I disorder (at least one manic or mixed episode) – characterised by recurrent episodes separated by months to years, varying degrees of function, descriptors as per Major Depressive Disorder
   b. Bipolar II disorder (hypomanic and depressive episodes without manic or mixed episodes) – characterised by hypomania occurring before or after depressive episodes (may occur independently), family history, high rate of substance abuse
   c. Cyclothymia (mild swings between the two poles of depression and mania, but not quite reaching criteria for either)
   d. Bipolar disorder not otherwise specified

Epidemiology and Aetiology:

1. Epidemiology:
   a. 5-10% of the adult population will have a depressive episode – this is the most common form of disability in the world (lower in China, Taiwan, Japan, Korea)
   b. 0.5-1.0% have bipolar disorder – this is in the top 10 causes of disability in the world
   c. In community surveys F=M, in clinical setting F>M (varies depending on culture)
   d. 10% of persons with depressive episodes will complete suicide if untreated
      i. At risk – male, young/old, unmarried, childless, substances, antisocial traits
      ii. Extended suicide – parents (e.g. post partum), history of domestic abuse

2. Aetiology:
   a. Psychodynamic – mourning and melancholia
      i. Expansion from apparent loss 
      Æ loss of unconscious needs and drives
      ii. Cannot be explored directly, except nonverbal communication (transference)
      iii. Interpersonal psychotherapy, family therapy, psychodynamic therapy
   b. Cognitive
      i. Depression is due to distorted habits of thinking (cognitions)
      ii. Cognitions are accessible – altered by challenging and performance of tasks
      iii. Explain, measure (self-monitor), record thoughts 
      Æ “corrected” thoughts
   c. Biological
      i. Initial theories based on biogenic amines – antidepressants increase levels of adrenalin/dopamine/serotonin, drugs that decrease dopamine 
      Æ depression
      ii. Functional neuroimaging (PET, MRI) has been used to investigate frontal lobe asymmetry, size of amygdala, cingulate gyrus, hippocampus and thalamus but has been limited by the level of precision of phenomenology
      iii. Genetics:
         1. Familial loading, increased co-morbidity in twin studies
         2. Multiple sites of genomic variation (bipolar share some with schizophrenia) – polygenic explanations are likely

Clinical assessment:

1. History
   a. Referral – urgency, risk (rapid change in mood 
   Æ high risk of suicide)
   b. Sleep, appetite, energy, concentration
   c. History (including past history), patient’s understanding
      i. What medications worked?
      ii. What psychotherapies worked?
   d. Developmental, social supports, substances

2. MSE – standard stuff here

3. Investigations – don’t forget organic causes
   a. Investigate as per symptoms, but commonly FBC, B12, folate, T4, TSH, urea, creatinine, Na⁺, K⁺, liver function (GGT), urine toxicology (THC)
DSM-IV Criteria

b. Serial interviews/observation by staff if unsure of phenomenology
c. Collateral history to rule out anxiety disorders, substance abuse, personality disorders

4. Differential diagnosis:
   a. Medical conditions, medications, drugs of abuse
   b. Schizophrenia – note that depression is common as co-morbidity
   c. Schizoaffective disorder (rare)
d. Anxiety disorder (high co-morbidity)
e. Personality disorders (affective instability)

Management:
1. General
   a. Ensure safety – consider involuntary admission, consider if family can contain
   b. Ensure sleep
   c. Control agitation/overactivity – high potency benzodiazepine (alprazolam 0.5-1.0mg)
d. Control psychosis – risperidone 0.5-1.0mg or olanzepine 10-20mg stat; 5-15mg/day
2. Psychotherapies
   a. Behavioural – exercise (20-30min walking a day), activity diaries, bibliotherapy
   b. Cognitive behavioural – usually 8-12 sessions, as effective as medications by 6wks
   c. Interpersonal psychotherapy concentrates on grief role changes, relationship difficulties, interpersonal defects – 10-16 sessions, as effective as medications
3. Biological treatment
   a. ECT – most effective short-term treatment, cognitive side-effects minimal
   b. Transcranial magnetic stimulation – evidence of effectiveness not yet available
c. Antidepressant medications
   i. SSRI (fluoxetine, paroxetine, citalopram) – first-line, 60-70% effective, fewer side-effects and not as risky in overdose
   ii. TCA (amitryptiline, nortriptyline) – 60-70% effective, significant sedative and anticholinergic side effects, pro-arrhythmic especially in overdose
   iii. MAOI (phenelzine, trancypromine) – >70% response rate, some risk of malignant hypertension if on tyramine rich diet or sympathomimetics
d. Treatment of mania
   i. Lithium (levels 0.8-1.2 acutely, 0.4-0.8 for prophylaxis) is most effective but narrow therapeutic index – monitor for toxicity (polydipsia, polyuria, sedation)
   ii. Antiepileptics – valproate most effective, then carbamazepine. Newer agents (e.g. gabapentin) are under investigation

Psychotic Disorders

Psychosis is a state of impaired reality testing, and impaired ability to organise thought, mood and behaviour with associated hallucinations (in any sensory modality) or delusions. Note that it is a description of a group of conditions with a number of causes (organic, psychotic and mood disorders).

1. Gross disorganisation in thoughts and behaviours
   a. Disorder of form – loosening, tangential, flight of ideas, circumstantial, word salad
      i. Speech – perseveration (recurrent word), neologism (making new words), clanging (similar to tangential thought)
   b. Disorder of possession – thought insertion, thought withdrawal, thought blocking
c. Disorder of content – paucity, poverty

2. Hallucinations – sensory perceptions without an external stimulus (c.f. illusion/misperception)
   a. Auditory, visual, olfactory, tactile, somatic, gustatory

3. Delusions – a fixed false belief out of keeping with the patient’s cultural background based on an incorrect inference. May be bizarre, grandiose, persecutory, nihilistic, of being controlled, of reference, somatic, jealousy, systematised

Schneider’s first rank symptoms are a useful group of hallucinations and delusions that commonly occur in schizophrenic patients but also in patients with psychoses of other causes:

1. Hallucinations:
   a. One’s thoughts being spoken out loud
   b. Voices in the form of a running commentary about the patient
   c. Voices conversing about the patient (‘third person’) or arguing
d. Somatic hallucinations attributed to outside forces (e.g. X-rays, hypnosis)

2. Delusions:
DSM-IV Criteria

a. Thoughts being withdrawn or inserted into the patient’s mind by an outside force
b. Thoughts being broadcast so that the patient’s private thoughts are known to others
c. Perceptions in which highly personal meanings are attributable to perceptions
d. Being influenced or forced to do things or want things the patient does not wish/want
e. Being made to feel emotions/sensations (often sexual) that are not the patient’s own

Schizophrenia is a chronic (>6 months) relapsing condition characterised by a number of positive and negative symptoms not due to organic, mood or substance-related causes. It has a variable time course and outcome (depends on context – person, family, occupation etc, society).

1. >2 of the following (1 if delusions bizarre or hallucinations are commentary/conversatory), each present for a significant portion of time during a one month period (less if treated):
   a. Delusions – e.g. persecutory, paranoid, passivity
   b. Hallucinations – e.g. certain voices for different situations
   c. Disorganized speech/though form – e.g. derailment or incoherence
   d. Grossly disorganised or catatonic bizarre behaviour
   e. Negative symptoms – affective flattening, alogia (not talking), avolition-apathy, anhedonia-asociality, inattention

2. For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning are markedly below the pre-morbid level

3. Continuous signs of the disturbance persist for at least 6 months – this must include at least 1 month of symptoms (less if treated) and may include periods of prodromal/residual symptoms

4. Symptoms are not secondary to other psychiatric disorders (schizoaffective disorder, mood disorder with psychotic features, pervasive developmental disorders) or organic causes

5. Descriptors:
   a. Timecourse – episodic (± inter-episode residual symptoms), continuous (± prominent -ve symptoms), single episode (± partial/full remission, ± prominent -ve symptoms)
   b. Subtypes – paranoid, catatonic, disorganised, undifferentiated, residual

Management:

1. Aetiology – lifetime prevalence is about 1%, with age of onset averaging 25 years (generally earlier and more severe in males). Risk factors (don’t forget family/social) can be divided into:
   a. Genetic
   b. Neurobiological (schizotypal personality, dopaminergic/noradrenergic overactivity)
   c. Substance use (e.g. cannabis) and
   d. Developmental (e.g. anoxia, respiratory tract infections)

2. Prognostic issues:
   a. Prodromal phase
   b. Good – female, drug compliance, engagement with services, affective symptoms
   c. Bad – male, earlier/insidious onset, social isolation, industrial societies, drug users
   d. Rule of thirds (1/3 good, 1/3 bad, 1/3 in between)

3. Principles of treatment:
   a. Careful assessment and safe containment of risk:
      i. Previous history
      ii. Overall disability and present situation – suicidal/homicidal ideation; impulsivity, intoxication, impaired judgement, psychosis
   b. Comprehensive management (short, medium and long term) taking into account biopsychosocial, cultural, ethical, forensic and rehabilitation issues/aspects

4. Evidence for interventions:
   a. Medication – all equal (clozapine better), treat positive symptoms, prevent relapse.
      Data unclear on negative symptoms and atypical drug usage
   b. Assertive community treatment – lowers admissions, less likely to be homeless, function at superior level, more satisfied
   c. Psychoeducation/family education – lowering EE, CC and face-to-face exposure improves satisfaction, reduces readmission and improves family interactions
   d. Psychotherapy – CBT for people with active symptoms improves affective regulation, lowers symptom load
   e. Social skills training/occupational rehabilitation

Other psychotic disorders include:

1. Delusional disorder – erotomaniac, grandiose, jealous, persecutory, somatic, mixed
DSM-IV Criteria

1. Brief psychotic disorder
   a. Presence of one or more of: delusions, hallucinations, disorganised speech, or grossly disorganised or catatonic behaviour out of keeping with cultural practices
   b. Duration is at least a day, but less than a month with full return to premorbid function
   c. The disturbance is not due to another psychiatric condition or organic causes

2. Schizoaffective disorder – bipolar type or depressive type
   a. Uninterrupted period of illness with a Major Depressive Episode, Manic Episode or Mixed Episode concurrent with symptoms that meet criteria for schizophrenia
   b. During the same period there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms
   c. Symptoms that meet criteria for the mood episode are present for a substantial portion of the total duration of the active and residual forms of the illness

3. Schizophreniform disorder – acute reactive psychoses in persons with normal personality
   a. Patient has symptoms that meet criteria for schizophrenia that are not due to other psychiatric conditions, substance use or general medical conditions
   b. An episode (including prodromal, active and residual phases) lasts at least 1 month but no more than 6 months. The qualifier ‘provisional’ may be used.
   c. Good prognostic features – onset of prominent symptoms within 4 weeks of the first noticeable change in behaviour/function, confusion or perplexity at the height of the psychotic episode, good premorbid function and absence of blunted or flatted affect

4. Brief psychotic disorder – with or without marked stressors; with postpartum onset
   a. Presence of one or more of: delusions, hallucinations, disorganised speech, or grossly disorganised or catatonic behaviour out of keeping with cultural practices
   b. Duration is at least a day, but less than a month with full return to premorbid function
   c. The disturbance is not due to another psychiatric condition or organic causes

5. Shared psychotic disorder
   a. A delusion (similar in context to the other person) developed in the context of a close relationship with another person(s) who has an already-established delusion
   b. The disturbance is not due to another psychiatric condition or organic causes

6. Psychotic disorder not otherwise specified

ANXIETY DISORDERS

Anxiety symptoms are very common – ~99.5% of people will experience anxiety symptoms every once in a while. These are generally adaptive – but a certain percentage of the population have increased symptoms to the extent of interfering with normal function. They are also highly comorbid with depressive conditions and alcohol/substance abuse/dependence. Differential diagnosis:

1. Medical – angina, arrhythmias, CHF, hypoglycaemia, hypoxia, PE, severe pain, thyrotoxicosis, carcinoid, phaeochromocytoma, Menière’s disease (endolymphatic dilatation)
2. Psychiatric – schizophrenia, mood disorders, personality disorders, adjustment disorder with anxious mood
3. Drugs – caffeine, aminophylline, sympathomimetic agents, MSG, psychostimulants, hallucinogens, EtOH or benzodiazepine withdrawal, thyroid hormones, antipsychotic agents

Panic disorder is characterised by recurrent and unexpected panic attacks followed by at least one month of persistent concern about having another attack, or concern about the implications of the panic attack or significant change in related behaviour. It may be associated with agoraphobia (fear of situations where escape may be difficult), and occurs during instances with no real danger.

1. Panic attack (DSM-IV) – four or more symptoms, abrupt onset, peak in 10 minutes
   a. Dizziness, light-headedness, unsteadiness, faintness, blurred vision
   b. Shortness of breath, choking sensation, chest tightness, pounding heart, palpitations
   c. Trembling/shaking, paraesthesiae, hot/cold flashes, sweating, dry mouth, nausea
   d. Derealization, depersonalisation (patient feels detached from their body)
   e. Fear of dying, losing control or going mad

2. Differential diagnosis – phaeochromocytoma, hyperthyroidism, social phobia, mood disorder

3. Management
   a. Education about the disorder
   b. CBT specific to panic disorder – control of symptoms, desensitisation to feared places
   c. Medications – antidepressants, benzodiazepines (short-term)
DSM-IV Criteria

Generalised anxiety disorder is characterised by persistent, generalised and excessive feelings of anxiety, often with free-floating worry. Common themes include possibility of becoming ill or having an accident, financial difficulties, and poor work/social performance.

1. DSM-IV criteria (significant loss of function/distress, not other psychiatric or organic)
   a. Excessive anxiety/worry difficult to control, more days than not for at least 6 months, about a number of events/activities (not features of an Axis I disorder)
   b. Anxiety and worry is associated with three or more of the symptoms with at least some present for more days than not for at least 6 months (one symptom in children)
      i. Restlessness or feeling keyed-up or on edge
      ii. Being easily fatigued
      iii. Difficulty concentrating or mind going blank
      iv. Irritability
      v. Muscle tension
      vi. Sleep problems (difficulty falling/staying asleep, restless/unsatisfying sleep)

2. Differential diagnosis – organic causes, mood disorder

3. Management – note CBT and medication are not as effective as other anxiety disorders
   a. Education about anxiety
   b. CBT in controlling anxiety and reducing stress
   c. Avoiding/managing alcohol and substances
   d. Medication – SSRIs (avoid chronic use of benzodiazepines)

Phobic disorders:

1. Social phobia is commonly trigged by eating/drinking/speaking/writing in public, using public toilets, or being in social situations in which the individual may say or do foolish things
   a. DSM-IV criteria (6 months if <18yrs, significant loss of function/distress, not organic)
      i. Marked and persistent fear of one or more social/performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others, fearing that they will act in a way that will be humiliating/embarrassing
      ii. Exposure to the feared social situation provokes anxiety, which may be a situationally bound/predisposed Panic Attack (or behavioural change in kids)
      iii. The person recognises that the fear is excessive or unreasonable, but attempts to avoid the situations or endures them with intense anxiety/distress
   b. Differential diagnosis – ‘Normal’ social anxiety or avoidance, avoidant personality, agoraphobia, specific phobia, schizophrenia, delusional disorder
   c. Management
      i. Education about the anxiety condition
      ii. Managing co-morbid substance abuse
      iii. CBT – controlling symptoms, graded exposure to feared situations, relearning basic social and conversational skills
      iv. Medications – antidepressants, benzodiazepines (short-term)’

2. Specific phobia can be divided into two themes – places where falling/suffocation/drowning are possible; and potentially harmful objects (spiders, insects, snakes, carnivorous animals).
   a. DSM-IV criteria (6 months if <18yrs, significant loss of function/distress, not organic)
      i. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation
      ii. Exposure to the phobic stimulus provokes an immediate anxiety response, which may be a situationally bound/predisposed Panic Attack
      iii. The person recognises that the fear is excessive or unreasonable, but attempts to avoid the situations or endures them with intense anxiety/distress
   b. Differential diagnosis – panic disorder, social phobia, agoraphobia, obsessive compulsive disorder, post-traumatic stress disorder
   c. Management
      i. Education about the anxiety condition
      ii. CBT – control of anxiety/panic, graded exposure

Post-traumatic stress disorder often follows traumatic or violent events e.g. violent assault, torture, being held hostage, severe accidents, witnessing unexpected death/injury

1. DSM-IV criteria (duration >1 month, causes clinically significant distress/impairment)
DSM-IV Criteria

a. Exposure to a traumatic event with experienced/witnessed/confronted events that involved actual/threatened death, serious injury or a threat to physical integrity of self or others; responding with intense fear, helplessness or horror

b. The event is persistently re-experienced in one or more of the following:
   i. Recurrent and intrusive distressing recollections
   ii. Recurrent distressing dreams of the event
   iii. Acting or feeling as if the traumatic event were recurring
   iv. Intense distress at exposure to internal/external cues similar to event
   v. Psychological reactivity on exposure to cues similar to the event

c. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by three or more of:
   i. Avoidance of thoughts, feelings or conversations related to the event
   ii. Avoidance of activities, places or people that arouse recollections
   iii. Inability to recall an important aspect of the trauma
   iv. Markedly diminished interest or participation in significant activities
   v. Feeling of detachment or estrangement from others
   vi. Restricted range of affect
   vii. Sense of a foreshortened future

d. Persistent symptoms of increased arousal as indicated by two or more of:
   i. Difficulty falling or staying asleep
   ii. Irritability or outbursts of anger
   iii. Difficulty concentrating
   iv. Hypervigilance
   v. Exaggerated startle response

2. Differential diagnosis – acute stress disorder (basically the same thing, but lasts 2/7 to 4/52 and occurs within 4 weeks of the traumatic event)

3. Management – education about PTSD, CBT, medications

Obsessive-compulsive disorder:

1. DSM-IV criteria (obsessions or compulsions cause marked distress, are time consuming or significantly interfere with function; not related/due to other Axis I disorders or organic causes)
   a. Obsessions (e.g. contamination, blasphemy, disasters, violence, sex, harm)
      1. Recurrent and persistent thoughts, impulses or images (not simple excessive worries about normal problems) that are experienced as intrusive and inappropriate, and cause marked anxiety or distress
      2. The person attempts to ignore or suppress such thoughts, impulses or images; or to neutralise them with some other thought or action
      3. The person recognises that the obsessional thoughts, impulses or images are a product of their own mind (not thought insertion)
   b. Compulsions (e.g. washing, cleaning, arranging, specific orders, counting, praying)
      1. Repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession, or due to rules that must be applied rigidly
      2. Behaviours or mental acts are aimed at preventing or reducing distress or preventing a dreaded event/situation, but there is no logical or realistic connection and they are clearly excessive
   c. At some point during the course of the disorder the person has recognised that the obsessions or compulsions are excessive or unreasonable

2. Differential diagnosis – excessively repeated pleasurable behaviours, depressive disorders, delusional/psychotic disorders (note relatively high co-morbidity with schizophrenia).

3. Management
   a. Education about the disorder
   b. CBT – graded exposure and response prevention
   c. Medications – high dose serotonergic antidepressants (SSRIs, clomipramine, MAOIs)

• Delirium and Dementia

Dementia is a degenerative brain disease occurring usually in later life – prevalence 5% over 65, 20% over age 80. It may be caused by a range of organic and irreversible processes – pathophysiology involves loss of neurotransmitters and degeneration of brain cells.

1. Types of dementia:
   a. Alzheimer’s disease – commonest cause (~50%)
DSM-IV Criteria

i. Generalised degeneration, initially temporo-parietal (atrophy, amyloid plaques, neurofibrillary tangles)
ii. Presentation – loss of memory for recent events, names, appointments; language word finding problems; poor orientation/perception
iii. Treatments (cholinesterase inhibitors) slow progress – variable effectiveness

b. Vascular dementia – previously multi-infarct dementia
   i. Gross infarction or microvascular change – imaging important
   ii. Classically stepwise, sometimes gradual
   iii. Vascular risk factors and/or focal neurological signs often present

b. Lewy body dementia – Lewy bodies present throughout brain
   i. Parkinsonism or antipsychotic sensitivity
   ii. Fluctuation in consciousness/alertness
   iii. Vivid visual hallucinations, paranoid delusions

d. Others – fronto-temporal dementia, alcohol dementia (Korsakoff syndrome), head injury, infections, mixed aetiology

2. Regional functions:
   a. Frontal – planning, sequencing, abstract, initiation, inhibition, social behaviour
   b. Parietal – spatial awareness, praxis (ability to perform a task), calculation
   c. Occipital – sight, recognition of objects
   d. Temporal – language (reading, writing, comprehension, naming, semantics), memory
   e. Limbic system – emotion

Clinical assessment and management:
1. Presenting features:
   a. Memory decline (short-term – long term, procedural, emotional usually preserved)
   b. Neurological deficits – apraxia, agnosia, aphasia
   c. Disturbance of ‘executive function’ – plan, sequence, abstract, initiate, inhibit, insight
   d. Personality change
   e. Declining social and occupational function

2. Behavioural and psychological symptoms of dementia (BPSD):
   a. Symptoms – delusions, hallucinations, illusions, ‘sundowning’, agitation, anxiety/depression
   b. Behaviours should be considered to be a result of the person, their disease, their caregivers and their environment (note antecedents, behaviour, consequences)
      i. Walking about/attempting to leave
      ii. Disrobing/inappropriate sexual behaviour
      iii. Calling out
      iv. Aggression (verbal/physical)
      v. Repetitive questions
      vi. Inappropriate urination/defaecation

3. Behaviour analysis/modification – try to consider from patient’s perspective
   a. Analysis of system supporting behaviour (ABCs) → clear plan, consistently applied
   b. Behaviour and validation therapies – monitor with positive/negative reinforcement
   c. Compensation for physical or cognitive deficits (hearing aids, glasses, lighting)
   d. Drugs (SSRIs, anticonvulsants, antipsychotics, tranquillisers)
   e. Environmental manipulation, education and support of carers

Delirium is a reversible organic mental syndrome of acute onset and is very common (particularly in the unwell elderly) with significant mortality associated. Note that elderly people cannot be assumed to have a dementia – additional history from caregivers is required to determine if there has been a recent change in mental state. Beware comorbid delirium/dementia and hypoactive delirium!

1. Vulnerabilities – age, cognitive impairment/insults, medical problems, sensory impairment
2. Precipitants
   a. Drugs:
      i. Alcohol/benzodiazepine intoxication or withdrawal
      ii. Analgesics – opiates, NSAIDs, tramadol
      iii. Anticholinergics – antipsychotics, antidepressants, antihistamines, antispasmodics
      iv. Antiarrhythmics, digoxin, some antihypertensives
      v. H2 antagonists, anti-nausea drugs
DSM-IV Criteria

vi. Anticonvulsants, lithium, steroids, anti-Parkinson’s, serotonergic drugs
b. Infection – pneumonia, UTI, catheterisation, constipation
c. Metabolic, hypoxic, endocrine, fluid, electrolyte, nutritional
d. Trauma – CNS, acute stroke, other system trauma/surgery
e. Psychological – restraints, sensory deprivation

Clinical assessment and management:

1. Presenting features may include:
   a. Abrupt change in mental state – confusion, impaired everyday function
   b. Fluctuation over the course of the day – often worse at night
   c. Global impairment of cognition – especially focusing, sustaining or shifting attention; forgetfulness and disorientation
   d. Alertness/awareness – reduced LOC/hypervigilant, altered sleep-wake cycle
   e. Psychomotor changes – agitation/retardation
   f. Disorganised thinking – rambling, incoherent, illogical, suspiciousness
   g. Misperceptions – visual hallucinations, illusions, recognition failures
   h. Emotional changes – anxiety, tearfulness, anger, blunting

2. General approach:
   a. Be as clear as possible about the diagnosis – MMSE or MSQ + CAM
   b. Collateral history, observation, physical examination, investigations
      i. CXR, ECG
      ii. Metabolic – urea/ electrolytes, creatinine, glucose, calcium, liver function
         1. Magnesium, phosphate, B12, folate, thyroid, cortisol, blood gases
      iii. Infective – full blood screen, ESR, urinary analysis
         1. Serology (HIV, HSV, syphilis), CSF analysis
      iv. Drugs – consider intoxication, withdrawal, interactions, adverse reactions
         1. Urinary drug screen
      v. Neurological – reassess for focal signs, EEG, CT or MRI
   c. Find and treat possible causes
   d. Educate and support family and staff – involve family in care

3. Treatment aims to prevent further morbidity:
   a. General – treat pain, prevent constipation/retention, mobilise, monitor nutrition/H2O
   b. Medication – note that all medications can make delirium worse
      i. Use for specific symptoms – agitation, aggression, delusions, hallucinations may require antipsychotics. Wandering/noisiness alone do not respond well
         1. Risperidone 0.25-1.0mg per 24hrs
         2. Haloperidol 0.25-1.0mg per 24 hrs (avoid in Parkinson’s disease)
      ii. Reserve benzodiazepines for sedative or alcohol withdrawal, or in refractory cases as an adjunct to antipsychotics
   c. Environmental modification
      i. Night light, orientation devices, familiar objects/pictures
      ii. Minimise noise, over/under-stimulation
      iii. Remove dangerous objects – cot sides, O2 masks etc. may be threatening
   d. Nursing care
      i. Anticipate supervision/safety requirements
      ii. Speak clearly and slowly, face the patient, non-verbal cues
      iii. Respond to emotion, not illogic
      iv. Support reality, reorient repeatedly, avoid confrontation – calm, reassure

Substance Abuse and Dependence (aka Dual Diagnosis: The Lecture from Hell)

Substance abuse is characterised by a strong and overpowering desire to take drugs (depressants, hallucinogens, stimulants, inhalants), difficulty controlling use, and problems associated with use (social, legal, physical or mental health). DSM-IV criteria describe different patterns of substance abuse/dependence and plot drug use on a continuum (moderate, hazardous, harm).

Dual diagnosis is the concurrence of a psychiatric disorder and substance abuse in one person.

1. Epidemiology
   a. 1 in 16 (alcohol) to 1 in 50 (other drugs) have a substance disorder in the last year
      i. Lifetime prevalence for alcoholism – 10-13% (other substances 5-6%)
      ii. Suicide in alcoholism like in depression – 10%
DSM-IV Criteria

b. 1 in 5 patients with a mental disorder has comorbidity with substance abuse
   i. BPAD 8x, MDD 3x, schizophrenia 6x, anxiety 2x (♀), antisocial 30-60%
   ii. 1/3 of substance abusers have comorbidity with mental disorders

c. Important issues:
   i. 30% of males with EtOH abuse will be dependent in 4 years
   ii. Suicide risk is much higher in those who are dually diagnosed – 20x
   iii. Homicide risk with substance abuse/schizophrenia – 17x males, 80x females

2. Risk factors
   a. Males more than females (11.6% compared to 7.3%)
   b. Young people (16-20), peaks in 20-30s
   c. Unemployed
   d. Minority groups
   e. Medical professions

3. Aetiology:
   a. Biological models
      i. Familial transmission – e.g. first degree relatives: alcoholism 3-4x, BPAD 8-18x, MDD 2-3x, SCH 2x, OCD 35%, panic disorder 4-8x
      ii. Polygenic cause
      iii. Reward deficiency syndrome in schizophrenia – mesocortical projections (VTA to PFC) are hypoactive, abused substances enhance brain reward by activating ascending mesolimbic dopaminergic system
   b. Neurochemical activity of abused substances:
      i. Alcohol – dopamine, noradrenaline, 5HT2 (euphoria), GABA (anxiolysis)
      ii. Cannabis – dopamine
      iii. LSD, ecstasy – serotonin
      iv. Cocaine – blocks reuptake of dopamine/noradrenaline, serotonin
      v. Nicotine – dopamine and acetylcholine
      vi. Amphetamines – dopamine, noradrenaline
   c. Temperament
      i. Type 1 (late onset) – anxiety states, guilt, low impulsivity, high 5HT (HA)
      ii. Type 2 (early onset) – impulsivity, low 5HT, less cortical inhibition (low GABA)
   d. Self-medication theory – correction of underlying clinical deficits
      i. Negative symptoms – stimulants, cannabis
      ii. Side effects, social anxiety – sedatives
      iii. Dysphoria/depression – heroin
      iv. Sleep problems – sedatives, hypnotics
      v. Cognitive deficits – nicotine, stimulants
   e. Psychosocial hypothesis – traumatic events and conditions of suffering, destitution or affliction that persist over time – increase risk for schizophrenia, antisocial personality disorder, substance abuse in men and depression in women.

Mental disorders and substance abuse:

1. Schizophrenia
   a. More time in psychiatric hospitals, more perpetual abnormalities, treatment resistant
   b. More likely homeless, poor follow-up, poor living skills
   c. Increased rates of tardive dyskinesia, increased violence and crime

2. Affective disorders:
   a. Depressive disorders
      i. Cannabis → irritability, worsens psychosis and paranoid features
      ii. Increased risk of suicide
      iii. Lower self-esteem, greater impulsivity, more functional impairment
   b. Bipolar disorder
      i. Rapid cycling, dysphoric mania
      ii. Resistant to lithium, respond to anticonvulsant (valproic acid)
      iii. Cannabinoids may alter the presentation of mania (misdiagnosis – schizophrenia)

3. Anxiety disorders
   a. Social phobia and agoraphobia – family history of alcoholism
   b. PTSD – double the risk of substance abuse (opiates, benzodiazepines, cannabis)

4. Eating disorders
   a. 44% of patients with bulimia are also substance abusers
DSM-IV Criteria

b. Family history of alcoholism
c. Impulsivity, novelty seeking and higher psychopathology

Drug-induced psychosis:
1. Alcohol
   a. Delirium tremens (organic psychosis)
      i. Occurs within 2-8 days after reducing drinking, lasts 3-4 days to weeks
      ii. Clouded consciousness, quick onset, impaired attention, disorganised thinking, impaired orientation, impaired memory, disturbed sleep/wake cycle, perceptual disturbances (visual, tactile, audio, vestibular), metabolic
   b. Alcohol induced psychotic disorder (alcohol hallucinosis)
      i. Sounds and voices (mainly unpleasant, derogatory, threatening) temporarily associated with alcohol withdrawal (usually within the first three days)
      ii. May be over within a week or be chronic
      iii. Clear sensorium, impaired reality testing – can be dangerous/self-destructive

2. Cannabis induced psychotic disorder
   a. History of recent/long-term use of potent cannabis, no history of schizophrenia, pre-existing personality disorder (cluster A or B)
   b. Agitation, disorientation, amnesia, emotional lability, hallucinations (transient), persecutory delusions and delusions of reference (transient)
   c. If used with amphetamines Æ bad trip
   d. Amotivational syndrome – resembles negative symptoms of schizophrenia

3. Amphetamine psychosis
   a. Sympathomimetic delusional disorder (difficult to distinguish between drug-induced and paranoid schizophrenia) – usually a few days, but may last longer than a year
   b. Immediate persecutory delusions, ideas of reference, more visual than auditory hallucinations, appropriate affect, hyperactivity/hypersexuality, clear consciousness but with hostility and anxiety, no loosening of associations, no insight

4. LSD, Mescaline
   a. Persisting perceptual disorder
      i. 50-80% have flashbacks with hallucinogenic symptoms (may last for years)
      ii. Insight preserved
      iii. More difficult diagnosis with PTSD, seizures, migraines, visual abnormalities
   b. LSD psychosis
      i. Prolonged psychotic symptoms (perceptual changes, body image distortion, unconscious material) but preserved reality testing Æ ‘bad trip’
      ii. Prolonged psychotic reaction in schizoid personality disorder and pre-existing psychosis

Assessment of dually diagnosed patients:
1. General principles:
   a. Patients are poor historians with strong denial, frequent symptoms, poor compliance
   b. Collateral data, medical review, previous referrals, forensic history, urine toxicology

2. Guidelines for diagnosis:
   a. If psychiatric symptoms precede substance use
   b. Presenting problems are qualitatively different when only substance abuse is involved
   c. If psychiatric symptoms continue 4/52 to 2/12 after withdrawing from alcohol/drugs
   d. A family history of major mental illness, especially in biological parents of siblings
   e. Client has a history of multiple treatment failures
   f. Client responds positively to medications, but meets problem substance use criteria

3. Mental state examination
   a. Appearance and behaviour – poor/fastidious grooming, bizarre/deviant clothing, unusual postures/mannerisms, facial expressions suggesting strong/unusual feelings
   b. Attitude – suspicious, hostile, ingratiating, dependant
   c. Psychomotor activity – restlessness, agitation/retardation, slow movement/speech
   d. Affect and mood – flat blunted affect with minimal display of emotion, emotional lability, inappropriate affect, excessively sad, euphoric, anxious or angry
   e. Speech and thought – rambling, loose, illogical, unconnected, pressured, bizarre content or suicidal/homicidal thoughts
   f. Perceptual disturbances
DSM-IV Criteria

g. Orientation – poor
h. Attention – poor
i. Intelligence – concrete interpretation
j. Reliability, insight and judgement – poor motivation and honesty

4. Suicide risk:
   a. Depression increases the risk 30x
   b. 10-20% schizophrenia patients commit suicide, 5-30% BPD, doubled with alcohol
   c. 15% of alcoholics suicide (25% for general population)
   d. Substance abuse is the greatest predictor of future completion

Management of dual diagnosis:

1. General principles
   a. Removal/reduction of substances (2-4wks for a proper diagnosis)
      i. Note that more side effects causes more substance abuse
      ii. Abstinence is not an option for some patients – use harm reduction model
   b. Cognitive/motivational problems (frontal lobe) require good relationship with carers
   c. Schizophrenia patients use drugs to reduce dysphoria, anxiety, social isolation – they are drug addicts rather than mentally unwell

2. Acute management
   a. Assessment – immediate risk (overdose, delirium, suicide)
   b. Suicide and violence – hospitalisation, MHA
      i. General medical history, examination, investigations (blood, urine, breath)
      1. Urinotoxicology – cannabis and phenylcyclidine up to 7 days
      2. EtOH – 100-200mg/100mL serious, >400mg lethal
      ii. Mental state exam, collateral data, family and social history
      iii. Detoxification – benzodiazepines, methadone

3. Intermediate treatment:
   a. Consider safety, differential diagnosis, substance abuse/dependence assessment, severity of depression, readiness to change
   b. Medical treatment (don’t forget to treat co-morbid psychiatric and medical conditions)
      i. Atypical antipsychotics – lower EPS, improve cognition, reward deficiency
      1. Avoid typical neuroleptics – more substance abuse
      2. Avoid anticholinergics – can be abused
      ii. Disulfiram – nausea, vomiting, palpitations, hypertension if EtOH consumed
      iii. Naltrexon – reduces number of drinking days during the maintenance phase
      iv. Acamprosate calcium – restores the chemical imbalance due to EtOH abuse
   c. Psychosocial intervention – CBT, IBT, problem solving, anger management, skills training, assertiveness training, communication skills, relaxation, family and group therapy, organisation social support

4. Long-term treatment:
   a. Safety
   b. Psychiatric assessment and management
   c. Regular follow-up, therapeutic alliance, trust, hope
   d. Relapse prevention and ongoing psychoeducation
   e. Others – rehabilitation and recovery, self-help groups, long term residential facilities

THERAPEUTIC ISSUES IN PSYCHIATRY

• Biological Treatments in Psychiatry

There are a number of biological treatments used in psychiatry:
1. Previously – convulsive treatments (camphor), asylums, spa treatments, fever/shock treatment, bromides, alkaloids, ‘potions’, lobotomies
2. Currently – psychopharmacology, electroconvulsive treatment, transcranial magnetic stimulation, light treatment, psychosurgery, psychotherapy
3. Future – transcranial magnetic stimulation, vagal nerve stimulation, psychopharmacology (2° messenger modulators, neuropeptides), low emission electromagnetic treatment
4. Alternative agents (no proven benefit, proven interactions) – herbs (kava, valerian, St John’s Wort, gingko biloba), vitamin E, melatonin, omega fatty acids/fish oils

General principles of psychopharmacology:
1. Prescribing principles:
DSM-IV Criteria

a. Interactive education and follow up sessions with patient and supports
   i. Symptoms, disorder, possible explanation (biological, psychosocial, spiritual)
   ii. Treatment options, availability, limitations; adverse events, time-line
   iii. Involving patient and supports in decision making and follow-up
   iv. Take patient’s reports seriously, address intolerable side effects urgently
   v. Flexibility
b. Active monitoring for adverse and desired effects (particularly on new treatment), changing doses, increased frequency of contact, open policy for queries
c. Documentation – what, when, why, who

2. Neurobiological considerations:
   a. Depression:
      i. Early life trauma – behavioural changes, disturbed HPA axis (animal models)
      ii. Neuroanatomy – limbic activation, cortical deactivation, hippocampal toxicity
      iii. Biochemical – biogenic amine dysregulation (noradrenaline, 5HT depletion)
      iv. Neuroendocrine – alteration in HPA, HPT, GH systems
      v. Immune – cytokine dysregulation (interleukin, interferon, TNF)
   b. Anxiety:
      i. GABA-benzo system dysfunction (major inhibitory neurotransmitter system)
      ii. Locus caeruleus – noradrenergic system dysfunction
         Æ peripheral signs
      iii. 5HT excess
   c. Psychosis:
      i. Overactivity in the mesolimbic dopamine pathway Æ positive symptoms
      ii. Overactivity in the mesocortical dopamine pathway Æ cognitive defects
      iii. Overactivity in the nigrostriatal dopamine pathway Æ EPS symptoms
      iv. Overactivity in the tuberoinfundibular pathway Æ hyperprolactinaemia

Antidepressants require appropriate dose and duration (try 4-6wks, change if no response). They are generally used up to 6-12 months past full clinical recovery to prevent relapse – a further 1-5 years on maintenance may prevent unipolar recurrences. Chronic course may be useful for patients who have 3 or more episodes. Optimal dosing in the long term has not been determined.

1. Tricyclics – imipramine, amitryptiline, nortriptyline, desipramine, doxepin, clomipramine
   a. Effects – norepinephrine reuptake blockade, serotonin reuptake inhibition, anticholinergic (primarily), alpha adrenergic antagonist, antihistamine
   b. Adverse effects:
      i. Anticholinergic signs – dry mouth, blurred vision, urinary retention, constipation, memory disturbances
      ii. Antihistaminic effects – sedation, weight gain
      iii. Alpha adrenergic blockade – dizziness, hypotension, QT prolongation
   c. Potential lethality in overdose – 2 week supply usually lethal (prevent stockpiling)

2. MAOIs – phenelzine, tranylcypromine (not moclobemide, which is a reversible MAOI)
   a. Monoamine oxidase breaks down norepinephrine and serotonin in the presynaptic neuron – inhibition Æ more NE and 5HT for synaptic release
   b. Hypertensive crisis when tyramine (pressor) restricted diet is not adhered to. Avoid:
      i. Red wine, yeast, broad beans, marmite, preserved meats, aged cheese
      ii. Meperidine, dextromethorphan, cocaine, other antidepressants

3. SSRIs – fluoxetine, paroxetine, citalopram
   a. Serotonin (5HT) reuptake inhibition Æ more serotonin in the synapse
   b. Adverse effects – GI, headache, sexual dysfunction, P450 interactions (except citalopram), serotonin syndrome (delirium, myoclonus, autonomic instability)
   c. Safe in overdose

4. Atypical/novel antidepressants:
   a. SNRI (venlafaxine) – 5HT, noradrenergic reuptake inhibition
   b. NDRI (bupropion) – noradrenergic and dopamine reuptake inhibition
   c. SARI (nefazodone) – serotonin antagonist and reuptake inhibition
   d. Psychostimulants (methylphenidate) – dopamine agonists

Anti-anxiety agents:
   1. Benzodiazepines and analogues – triazolam (t½ 1-5hrs), clonazepam (t½ 18-50hrs), diazepam (t½ 20-50hrs, 50-100hrs for metabolites), alprazolam, zopiclone
DSM-IV Criteria

a. Increase GABA – anxiolytic, sedative-hypnotic, alcohol withdrawal, anticonvulsant, muscle relaxant (not indicated in patients with sleep disorders due to dependence)
b. Adverse effects – sedation, abuse/dependence, CNS depression, withdrawal
c. Choice depends on T½, +/- active metabolites, speed of action, dependence potential

2. Antidepressants – SSRIs, TCAs, MAOIs

3. Antipsychotics should not be used (neuromuscular side-effects)

Mood stabilisers:
1. Lithium – gold standard for bipolar, preferred treatment for classic/euphoric mania. May also need 2nd/3rd mood stabiliser in rapid cyclers, mixed manics, and uncontrolled bipolars
   a. Probably involves 2nd messengers (inhibition of inositol monophosphatase)
   b. Adverse effects – GI, renal, thyroid, skin, CNS toxicity
   c. Important to monitor serum levels, renal and thyroid function
2. Valproic acid
   a. Reduces Na⁺ influx, changes GABA metabolism (inhibits breakdown, decreases turnover, increases GABAb receptor density, enhances neuronal response)
   b. Adverse events – CNS toxicity, GI, hepatic, haematologic (aplastic anaemia, TCP, agranulocytosis)
3. Carbamazepine
   a. Reduction of high-frequency neuronal discharge (bind to voltage-gated Na⁺ channels)
   b. Adverse events – CNS toxicity, GI, hepatic, haematologic (aplastic anaemia, TCP, agranulocytosis)
4. Others – lamotrigine, olanzepine, gabapentin, anticonvulsants (tiagabine, topiramate)

Antipsychotics:
1. Traditional agents – haloperidol, thiothixine, chlorpromazine
   a. Extrapyramidal – dystonia, akathisia (motor/internal restlessness), parkinsonism
   b. Tardive dyskinesia
   c. Neuroleptic malignant syndrome – autonomic instability, acute confusion/delirium, leukocytosis, increased creatinine kinase
2. Atypical agents – clozapine, risperidone, olanzipine, quetiapine
   a. Less D2 receptor blockade, less extrapyramidal symptoms, less tardive dyskinesia
   b. More specific to mesolimbic system (nigrostriatal tract sparing)
   c. Better for positive symptoms, slightly better on negative symptoms/mood stabilisation
   d. Preferred by patients, but problems with weight gain and are much more expensive
3. Anticholinergic agents – benztropine mesylate, trihexyphenidyl, diphenhydramine
   a. Counteracts dystonia and extrapyramidal symptoms
   b. Can cause anticholinergic signs/toxicity – dry syndrome, cognitive side-effects

Non-pharmacologic biological treatments:
1. Electroconvulsive treatment:
   a. Mechanism of action – seizure necessary, electrical equilibrium (stabilised dysregulated intracellular signalling linked to multiple transmitter systems)
   b. Indications – severe depressive disorder, acute suicide risk, psychotic depression; also severe mania, treatment resistant schizophrenia, Parkinson’s, catatonic stupor
   c. Efficacy – 30-50% response in truly medication resistant depression
   d. Adverse effects – mortality (0.002% per treatment, 0.01% per patient), dysrhythmias, confusion, cognitive dysfunction (transient memory loss/gaps)
2. Light treatments:
   a. Indications – depressive disorders with seasonal patterns, shift work
   b. Mechanism of action – light phase advances the delayed circadian rhythm
   c. Adverse effects – headache, eyestrain, irritability
3. Magnetic treatments:
   a. Transcranial magnetic stimulation – use of high-powered magnets to treat mood and anxiety problems, one RCT shows similar to ECT in treatment-resistant depression.
   b. Low-emission electromagnetic treatment – promising role in insomnia, only one RCT
4. Psychosurgery – including newer techniques (guided cingulotomies, capsulotomies)
   a. Indications – treatment/medication resistant depression and OCD
   b. Efficacy – 50-70% of carefully selected patients with significant clinical improvement and minimal side effects
   c. Adverse events – <3% worse after treatment, <0.3% hemiplegia, <1% epilepsy
Psychotherapy has been referred to as the 'talking cure'. There are numerous models based on underlying theories of psychological function – the aim is to modify psychological state or behaviour:

1. **Psychodynamic** – psychoanalysis (Freud – drive theory), object relations (internalisation of relationship), self psychology (construct of self as formed within a relationship)
   a. Defence mechanisms – splitting, denial, repression, suppression, conversion
   b. Importance of early relationships on subsequent functioning
   c. Transference – earlier conflicts emerge in the therapeutic relationship
   d. Supportive-expressive continuum

2. **Behaviour therapy** – classical and operant conditioning. Examples include:
   a. Behaviour analysis, ABC charts
   b. Graded exposure
   c. Activity scheduling
   d. Aversion therapy
   e. Token economies

3. **Cognitive therapy** – short-term goal-oriented therapy, thoughts-emotions linked
   a. 5-part model – situations, thoughts, emotions, body reactions, behaviour
   b. Monitoring and rating mood states
   c. Behavioural techniques
   d. Cognitive techniques – elicit, evaluate, modify thoughts

4. **Interpersonal therapy**
   a. Developed for treatment of depression (link between interpersonal relations)
   b. Also useful for unresolved grief, interpersonal disputes/deficits, role transitions

5. **Family therapy**
6. **Group therapy**

**Clinical applications**:

1. **Schizophrenia** – cognitive therapy, supportive therapy, structured family interventions, social skills training, vocational
2. **Mood disorders**:
   a. Bipolar affective disorder – psychoeducation, CBT, family therapy
   b. Depression – BT, CBT, IPT all effective (equivalent to antidepressants)
3. **Anxiety disorders**:
   a. Panic disorder – CBT preferred (respiratory control, cognitive techniques, exposure)
   b. GAD – relaxation ≤ CBT
   c. Specific phobia – exposure, CBT
   d. Social phobia – exposure based effective, may combine with cognitive elements
   e. OCD – exposure and response prevention, CBT
   f. PTSD – exposure therapy, CBT, anxiety modification techniques, EMDR

4. **Personality disorders** – controversial, difficult to treat
   a. Historically – psychodynamic, therapeutic community treatments
   b. Borderline PD – dialectic behaviour therapy (CBT), self psychology

5. **Eating disorders** – CBT plus nutritional advice

**Determinants of outcome** – experience, training, model adherence, supervision

**SPECIAL ASPECTS OF PSYCHIATRY**

1. **The Blueprint, Recovery, Consumers in Mental Health**
2. **National Mental Health Strategy 1994**
   1. To decrease the prevalence of mental illness and mental health problems in the community
   2. To increase the health status of and reduce the impact of mental disorders on consumers, their families, caregivers and the general community

**Moving Forward 1997**
1. Encouraging services that empower individual consumers and family
2. Encouraging services that enable people to participate in society
3. Encourage Maori involvement in planning and designing services
4. Ensuring safety standards to protect the health of consumers and public
5. Encouraging services to contribute to the best outcome for consumers and their families
6. Respecting personal dignity and privacy
7. Encourage services to be developed in a way that minimizes the disruption to the lives of the people with mental health problems

The Blueprint is a statement of developments required for more and better mental health services produced by the Mental Health Commission in 1997 (Mason Report 1996). It targets the 3% of adults and 5% of children most severely affected by mental illness in any given month (note prisoners).
1. Acknowledges the need for an intersectorial approach between public health services, primary health care and mental health
2. Guiding philosophy of the ‘recovery approach’
3. Describes the services needed for adult consumers, Maori, youth, older people, drug and alcohol, and forensic
4. Important aspects:
   a. Regional service needs and planning
   b. Issues of accessibility and coordination of services
   c. Workforce issues
   d. Quality of services
   e. Improving outcomes
   f. Zero tolerance for discrimination

“A recovery approach is recommended as a framework... acknowledges the primary importance of hope, the uniqueness of each person and their own contribution to their recovery, and the role of family/whanau, hapu, iwi, friends and individual support networks in the recovery process” – Blueprint
1. Realization that people need more than symptom relief
   a. Needs apparent post-deinstitutionalisation
   b. Multidimensional concept – not a linear process
2. Deeply personal and unique process of changing attitudes, values/feelings, goals, skills/roles
3. A way of living a satisfying, hopeful, contributing life even with illness limitations
4. Development of new meaning and purpose in life beyond the effects of the illness

Psychiatric rehabilitation is the process of assisting people to acquire and to use the internal and external skills and supports and resources necessary to be successful and satisfied living, learning and working in the environments of their choice. Three different levels – impairment (symptoms), disability (functional life domain), handicap (social role).

Barriers to recovery:
1. Risk management vs risk taking
2. Autonomy vs beneficence and paternalism
3. Attitudes of staff may be ‘old school’
4. Pressure on resources encourages symptom focus
5. Dehumanising of the mentally ill by the media (stigma)

Old Age Psychiatry
New Zealand has an ageing population – not only are people living longer, the proportion of older people is getting larger.
1. Political and economic Issues
   a. Increased numbers, relative increase in post-80 cohort (60-80 cohort healthier)
   b. Greater use of healthcare by older people → greater demand for fixed resources
   c. Provision of financial support for the older person
   d. Multigenerational and multicultural society
   e. Issues of gender – more females than males
2. Developmental issues
   a. Physical → decline
   b. Relational → disengagement
   c. Psychological → disintegration vs wisdom
3. Losses may lead to psychiatric morbidity in some people
   a. Health, independence, self-esteem/confidence
   b. Work, income, activities and pastimes
   c. Bereavements, family, status (some cultures)
4. Adjustment to life problems in old age:
DSM-IV Criteria

- Most common stressor is illness (25%)
- Most older people see bereavements and retirements as normative events (<3%)
- Adjustment to major life change can result in depression, anxiety, major personality breakdown, decreased functioning, failure of coping etc.
- Poor physical health and physical disability are most likely to be associated with poor psychological adjustment

Important issues of old age psychiatry:
1. Diagnosis and treatment of the diagnostic triad – depression, dementia and delirium
2. Diagnosis and treatment of other psychiatric disorders occurring in later life
3. Treatment of adjustment disorders and life problems in old age
4. Continuing care of chronic psychiatric disorders complicated by ageing
5. Caregiver stress

Clinical assessment:
1. General principles
   - Relevant medical history – medical and GP files, as well as psychiatric notes/letters
   - Setting – quiet room, as older people often have hearing problems
   - Pace – slower, may have to take breaks if the patient becomes fatigued
   - Family and/or nursing home, rest home or inpatient ward nursing staff nearly always need to be consulted early on – assess caregiver stress
2. Barriers to good assessment:
   - Patient has not given informed consent to interview
   - Patient perceives stigma in having a psychiatric interview
   - Sensory deficits – hearing and vision
   - Older patients may be disorientated or highly anxious in unfamiliar environments
   - Assessment interviews take longer – histories are more extensive, patients slower
   - Clinician ageism, transference and countertransference issues
3. Ageism and discrimination:
   - Ageism is a subjective, negative biases or prejudicial attitudes that discredit individuals based on chronological age. This includes stereotyping, patronizing superiority of younger over older, and social exclusion or avoidance of the aged.
   - Discrimination is institutionalised policies/practises that use the arbitrary discriminator of chronological age to exclude older people from services or social groups.

Psychiatric issues in older patients (see above for delirium and dementia)
1. Depression is underdiagnosed and often missed. However, it is often severe, has sizeable mortality, is often treatable and complicates other disorders of the elderly.
   - Epidemiology – one-month prevalence of 2.9%, given a population of 38,500 (11%): 
     - 11,100 older New Zealanders in 1998 could have MDE
     - 35,823-50,000 older New Zealanders could have lesser depression
     - 10,000+ older New Zealanders with anxiety disorders
   - Barriers to accurate diagnosis
     - Symptoms often confused with, or masked by those of physical illness
     - Symptoms may be considered appropriate for life stage (missed diagnosis)
     - Poor knowledge about depression and dementia (especially treatment)
     - Older people considered less deserving of referral
   - Consequences of missed diagnosis
     - Poor quality of life
     - Premature or inappropriate institutionalisation
     - Suicide
     - Increased morbidity and longer hospitalisations for comorbid physical illness
2. Suicide:
   - Epidemiology
     - >65 years successful suicides was 11.3% of all suicides in 1993 in NZ (>65 rate 17.3/100,000, elderly males 33.4/100,000)
     - Worldwide figures show consistently high rates for people over 65 years
     - Ratio of incomplete to completed suicides is 1:4 (c.f. adults 1:200)
     - Murder-suicide by the despairing depressed elderly person is increasing
   - Risk factors:
DSM-IV Criteria

i. Male, living alone or recently widowed, poor social supports/network
ii. Physical illness or chronic pain, terminal illness, psychiatric disorder
iii. Financial difficulty, low socio-economic group, increased EtOH consumption

3. Anxiety is also common in older people (prevalence of 17% in males, 21% in females) and often coexists with depressive disorders. Agitation is also common. Management includes:
   a. Medical – antidepressants (TCA, SSRI, SNRI), mood stabilisers, hypnotics, ECT
   b. Psychological – cognitive therapy, family therapy, group Psychoeducation therapy, insight-orientated or interpersonal therapy
   c. Behavioural – activities, exercise, hydrotherapy, hypnotherapy, relaxation, sleep hygiene, home visits/help/support

Maori Mental Health

In order to understand indigenous health, it is necessary to consider historical, cultural and political forces and to appreciate the dimensions of adversity. Pertinent issues best discussed elsewhere include the Treaty of Waitangi (English and Maori versions), depopulation, loss of land and cultural suppression (language, tohunga – outlawed 1907-1974).

Epidemiology – there are ~500,000 Maori people in New Zealand, comprising 15% of the population. A third are under the age of 15, with a median age is 21. 80% live in urban areas.

1. Unemployment
   a. General population – 18% Maori, 7% non-Maori
   b. 15-19 year olds – 30% Maori, 20% non-Maori

   a. Ownership – 50% (72% general population)
   b. Income <$28,000 – 48% (39% general population)
   c. Government benefits – 36% (14% general population)

   a. A or B bursary – 368 Maori (10,223 other)
   b. 1/3 of Maori leave school unqualified
   c. <2% of doctors/nurses/psychologists are Maori

   a. Infant hospitalisation (2x), hearing test failure in 0-14yrs (2x), SIDS (4.9x)
   b. Mortality – diabetes (4.5x), stroke (3x), cervical cancer (3x)
   c. Maori IHD mortality rate is 257/100,000 compared to 150/100,000 for the population
   d. Maori have 70% higher rate of DALYs – ½ cardiovascular, 1/3 cancer

5. Disparities in psychiatry (based admission rates – not a reliable source, but nothing better)
   a. Admission:
      i. Maori male and female rates of first admission 70% higher than non-Maori
         1. Schizophrenia 3x, affective psychosis 2x total population
         2. Paranoid states 2x, personality disorder 2x total population
         3. Alcohol and drug abuse/dependence 2x total population
      ii. Maori were initially largely absent from institutions (1950’s) but since 1974 first admission rates have surpassed non-Maori for all age groups
      iii. Readmission:
         1. 1981-1990 – Maori rates rose 40%, while Pakeha rates fell 25%
         2. 36% Maori readmissions were schizophrenia (16% Pakeha)
   b. Psychiatric referral:
      i. Relatively high referral from law enforcement, low from GPs
      ii. Higher percentage of referrals are under the Mental Health Act
      iii. Hospital admission indicates late intervention, particularly if under the MHA
   c. Late intervention
      i. Miscommunication between cultures
      ii. Financial barriers (including prescription charges)
      iii. High tolerance of emotionally charged behaviour in stressful situations
   d. Family/whanau are very important:
      i. Mate Maori (tapu infringement) – patients may be kept from doctors
      ii. Makutu (malicious interference) – patients may be kept from doctors

Clinical approach:

1. General principles:
DSM-IV Criteria

a. Risk factors – nature vs nurture
   i. Socioeconomic
   ii. Cultural – stereotypes, marginalisation, racism, alienation (land, language)

b. Psychiatric sequelae – stress leading to psychological distress, anxiety, depression, substance abuse, psychosis, suicide

2. Individual characteristics:
   a. Maori are shy and will not push themselves forward, some will over-react
   b. Maori will not make eye contact as this is perceived as a sign of disrespect
   c. Maori will often try to please the interviewer, answering yes when not true
   d. Maori will often leave out important details

3. Family/cultural characteristics:
   a. Have family members and a cultural advisor in the interview – ask the cultural advisor to open the interview with a short prayer
   b. Maori come not only as themselves, but also with their ancestors – address yourself to the eldest person in the room to find out who the spokesperson is
   c. Some Maori are more comfortable with non-Maori than other Maori
   d. Remember the cultural advisor is there to look after you, as well as the family

4. Maori-specific issues:
   a. Most common Maori model of mental health is the whare tapu wha (4-walled house):
      i. Wairua – spirituality
      ii. Hinengaro – thoughts, feelings, behaviour
      iii. Tinanna – physical health
      iv. Whanau – significant others
   b. Common to see/hear deceased relatives (high suicide risk if they wish to join them)
   c. Whakama is a reaction to loss of standing or sense of disadvantage with marked slowing of responses, refusal to engage with the speaker, lack of responsiveness to questioning. Similar to depression or catatonia, but quicker onset

SELF-DIRECTED LEARNING TOPICS

• Somatoform Disorders

Somatoform disorders include:

1. Somatization disorder:
   a. A history of many physical complaints before the age of 30 that occur over several years, resulting in treatment being sought or significant functional impairment
   b. Symptoms include four pain symptoms, two gastrointestinal symptoms, one sexual symptom and one pseudoneurological symptom
   c. These symptoms cannot be explained by a substance or known medical condition; or the physical complaints or resultant symptoms are out of proportion to expected
   d. Symptoms are not intentionally produced or feigned (factitious disorder, malingering)

2. Conversion disorder – ± motor/sensory symptom/deficit, seizures/convulsions, mixed
   a. Symptoms or deficits (not occurring during somatization disorder) affecting voluntary motor/sensory function that suggest a neurological or general medical condition
   b. Psychological factors are judged to be associated with the symptom or deficit as the initiation or exacerbation of the deficit is preceded by conflicts or other stressors
   c. These symptoms cannot be explained by a substance, other psychiatric or medical condition and causes clinically significant or impaired function

3. Hypochondriasis – ± poor insight
   a. Preoccupation with fears of having (or the idea that one has) a serious disease based on misinterpretation of symptoms that persists despite proper evaluation/reassurance
   b. Belief is not of delusional intensity (delusional disorder) and is not restricted to a circumscribed concern about appearance (body dysmorphic disorder)
   c. These symptoms cannot be explained by a substance, other psychiatric or medical condition and causes clinically significant distress or impaired function

4. Pain disorder – ± psychological factors, general medical condition
   a. Pain in one or more anatomical sites causing clinically significant distress or impaired function; psychological factors affect onset, severity, exacerbation or maintenance
   b. Pain is not intentionally produced or feigned, is not better accounted for another psychiatric disorder and does not meet criteria for dyspareunia
Personality disorders are defined as enduring patterns of inner experience and behaviour that deviates markedly from the expectations of a person’s culture, is pervasive and inflexible, has an onset in adulthood, is stable over time, and leads to distress or impairment.

Cluster A (mad):
1. **Paranoid personality disorder** – distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood
2. **Schizoid personality disorder** – detachment from social relationships with restricted range of expressed emotion in interpersonal settings, beginning by early adulthood
3. **Schizotypal personality disorder** – acute discomfort with and reduced capacity for close relationships as well as cognitive or perceptual distortions and eccentricities of behaviour, beginning by early adulthood

Cluster B (Bad):
1. **Antisocial personality disorder** – complete disregard for and violation of the rights of others with irritability, aggressiveness, irresponsibility and lack of remorse since age 15,
2. **Borderline personality disorder** – instability of interpersonal relationships, self-image, affect and marked impulsivity, beginning by early adulthood (can use DBT with some success)
3. **Histrionic personality disorder** – excessive emotionality and attention seeking, beginning by early adulthood
4. **Narcissistic personality disorder** – grandiosity (in fantasy or behaviour), need for admiration, lack or empathy; beginning in early adulthood

Cluster C (Anxious)
1. **Avoidant personality disorder** – social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation beginning by early adulthood
2. **Dependent personality disorder** – excessive need to be taken care of leading to submissive and clinging behaviour and fears of separation, beginning in early adulthood
3. **Obsessive-compulsive personality disorder** – preoccupation with orderliness, perfectionism and mental/interpersonal control at the expense of flexibility, openness and efficiency beginning in early adulthood

**Eating Disorders**

**Anorexia nervosa** – restricting type, binge-eating/purging type
1. Refusal to maintain body weight at or above a minimally normal weight for age and height
2. Intense fear of gaining weight or becoming fat, despite being underweight
3. Disturbance in the way body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of current low body weight
4. In postmenarcheal females, amenorrhoea (absence of three consecutive menstrual cycles)

**Bulimia nervosa** – purging type, non-purging type
- Recurrent episodes of binge eating (at least 2x a week for 3 months) characterised by eating an amount of food definitely larger than that most people would eat in a similar period of time and circumstances, with a sense of lack of control during the episode
- Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives/diuretics/enemas, fasting, or inappropriate exercise
- Self-evaluation is unduly influenced by body shape and weight, and disturbance does not occur exclusively during episodes of anorexia nervosa

**Clinical issues:**
1. **Aetiology** – biologic/genetic, personality traits, developmental, trauma history, interpersonal difficulties, poor family dynamics, sociocultural
2. **Epidemiology** – prevalence 0.5% and 3% of women aged 15-45 (3-5% and 10% subclinical)
3. **Complications** – endocrine (Bartter’s syndrome, ↓K+, ↑cortisol, euthyroid sick syndrome, ↑LDL), GI (gastroparesis, GORD, constipation), cardiac (many), O&G (amenorrhoea, miscarriage), osteoporosis, oral/dental (enamel erosion, parotid enlargement), haematological
4. **Management** – treat complications (note re-feeding syndrome (rapid glucose uptake → ↓PO4Æ fatal cardiovascular collapse), psychotherapy, medication (SSRIs), ongoing monitoring and support (eating disorders service treatment programme available for urgent and subacute)