

Psychiatry (GENERAL)

Last updated: September 5, 2017

ANATOMY	1
TRANSMITTERS	1
DEFINITIONS	1
ETIOLOGY	3
CLASSIFICATION OF MENTAL DISORDERS	3
EPIDEMIOLOGY	4
PSYCHOTHERAPY	4
Supportive Therapy	4
Cognitive / Behavioral Therapy	4
Hypnosis.....	4
Psychodynamic (Expressive) Therapy	5
Family Therapy	5
PSYCHOPHARMACOLOGY	5
ELECTROCONVULSIVE THERAPY (ECT)	5
SPECIAL SITUATIONS	5
PATIENT WHO REFUSES MEDICAL ADVICE	5
NONCOMPLIANCE WITH TREATMENT	5
PSYCHIATRIC EMERGENCY (CRISIS), AGGRESSIVE PATIENT	6
Components of stress-induced responses	6
Principles of evaluation and management of aggressive patient.....	6
TELEPHONE CALLS	6
LEGAL ISSUES	6
Dual agency.....	6
Psychiatrists in court	6
Involuntary psychiatric hospitalization	6
Confidentiality.....	6
Duty to third parties.....	7
Criminal Issues	7
Guardianship and conservatorship	7
Testamentary capacity	7
Workers' compensation	7
Psychiatric malpractice	8
PEDIATRIC ASPECTS	8
Developmental Concepts.....	8
Treatment	8
Circular Behavioral Pattern	9
Temper Tantrum.....	9
Bonding, Attachment	9
Thumb Sucking	10
Adolescent Problems.....	10

ANATOMY

Most important structures in control of emotions: see p. A139 >>

1. **Amygdala** (gives sensory stimuli affective & motivational significance).
2. **Temporal lobe**; effects of temporal lobectomies:
 - improvement in some behaviors (particularly excessive aggression, irritability, and social misconduct).
 - no improvement of psychosis (psychosis may actually develop postoperatively, esp. when surgery involves right temporal lobe).
 - postoperative depression (and both early and late suicide) may develop.
3. **Frontal cortex** (“seat of intellect”)
 - famous 1868 case of Phineas Gage, in which subject survived explosion in which metal bar 3 cm wide by 1 meter long went through his left frontal lobe; patient then demonstrated marked alteration in personality*
 - three major circuits connecting frontal lobes with subcortical structures:
 - dorsolateral prefrontal-subcortical circuit** - involved with **executive function** (supervising other brain functions related to developing and implementing plan).
 - orbitofrontal-subcortical circuit** - necessary for **social behaviors** and **inhibition of inappropriate activities**; lesions → **obsessive compulsive disorders**.
 - medial frontal-subcortical circuit** - involved with **motivation**; lesions → **apathy**.

Frontal lobe syndrome: also see p. Onc1 >>, p. A156 (5) >>

- 1) **bilateral slowly developing** abnormalities → significant intellectual and affective decline (simulates Alzheimer's disease).
- 2) **bilateral ventromedial** damage → inappropriate, uncontrolled histrionic displays of affect, with laughing or crying fits (not precipitated by obvious stimuli and unrelated to subject's mood).
- 3) **orbital prefrontal** lesions → inappropriate emotional reactions (**disinhibitions**), **mood lability** with euphoria (classically termed **witzelsucht**) – **PSEUDOPSYCHOPATHIC**.
 - dysfunction of frontal-orbital cortex may be involved in mania!
- 4) **dorsolateral prefrontal** lesions → **apathy**, **flat affect** (dulling / shallowness of response) – **PSEUDODEPRESSED**.
- 5) impulsiveness, little insight into difficulties, lack of originality and creativity, inability to focus attention, recent memory problems.

Recently, investigators have become interested in role of **cerebellum** in nonmotor function (incl. mood and executive function).

- syndrome of mutism and behavioral disturbances has been reported in some children after cerebellar resections.

TRANSMITTERS

Neurotransmitters closely related to mood, emotion, and thought disorders: further see p. A4b >>

1. **NOREPINEPHRINE** - involved in many neurophysiological functions (learning, memory, sleep-wake cycle regulation, anxiety, nociception);
 - ↓ / ↑ causes **depression** / **mania**.
2. **DOPAMINE**
 - ↑ causes **schizophrenia**, psychomotor activation.
3. **SEROTONIN** – involved in sleep-wake cycle control, behavior control (sexual, self-stimulation, activity level, aggression).
 - ↑ causes **mania**, **obsessive-compulsive disorder**, **insomnia**, **autism**;
 - ↓ causes **depression**, **insomnia**.

DEFINITIONS

MENTAL HEALTH (Ginsburg, 1955) – “ability to hold job, have family, keep out troubles with law, and enjoy usual opportunities for pleasure”.

MENTAL DISORDER:

- "clinical syndrome with behavioral and psychological symptoms, causing significant distress or dysfunction".
- definition by Spitzer (1973) – condition with primarily psychological manifestations and involves alterations in behavior; condition in its full-blown state is regularly and intrinsically associated with subjective distress, generalized impairment in social effectiveness or functioning, or voluntary behavior that subject wishes he could stop because it is regularly associated with physical disability or illness; condition is distinct clinically from other conditions.
- any significant deviation from ideal state of positive mental health*.
- part of continuum of conditions ranging from highly desirable to highly undesirable, placing cutoff point for mental disorder close to highly undesirable end (i.e. only conditions unequivocally associated with suffering and disability are designated as disorder)**.

*used by most USA psychiatrists

**used by most European psychiatrists (that's why studies conducted in Europe report much lower incidence of mental disorders)

- normal reactions to stressful events** (such as death of loved one) are not considered mental disorders.
- socially unacceptable behavior** (such as crime) is not necessarily indicative of mental disorder.
- historically, mental disorders are dealt with separately from physical disorders - this practice perpetuates belief of **mind-body dualism**.

Positive vs. Negative symptoms:

Positive symptoms (hallucinations, delusions, bizarre behavior, pressured speech) - extra features superimposed upon normal behavior; it is "release" phenomenon (lost inhibitory control).

Negative symptoms (loss of affect, diminished thought, anhedonia, diminished attention) - attributed to loss of neurons leading to direct loss of function.

MOOD - sustained INTERNAL emotional state of person.

- broadly divided into three realms:
 - elevated**
 - normal** - includes several gradations of elevation or depression
 - depressed**.

AFFECT (s. EMOTIONAL EXPRESSION) - EXTERNAL expression of emotional content (i.e. apparent emotion).

- may coincide or be at odds with **patient's mood** (i.e. *mood congruent** and *mood incongruent***).
 - *accurately reflects person's inner state
 - **subject appears to be very happy or sad but in fact feels quite opposite
- emotional expression has enormous range (obviously wider in some people than in others):
 - normal**
 - expanded** (emotional expression is amplified at both ends of mood spectrum).
 - restricted** (little chance for either happy or sad emotions to be displayed).
- flattened affect** is lack of emotional display;
labile affect - emotional state changes rapidly and out of proportion to changes in situation.

N.B. **EMOTIONAL EXPERIENCE** and **EMOTIONAL EXPRESSION** are quite different!

e.g. one can appear to be emotionally detached and have little concern or interest in situation, when in fact one is greatly moved - such discordance between apparent and true emotion may be highly adaptive in some situations and cultures and not at all pathological.

APATHY - lack of feeling.

ABULIA - general behavioral slowing and lowered activity; may be associated with inability or refusal to speak.

AKINETIC MUTISM - patient appears awake and may follow examiner with his or her eyes but lacks spontaneous motor and verbal responses.

ANXIETY - uncomfortable and unjustified sense of apprehension that may be diffuse and unfocused and is often accompanied by physiological (autonomic) symptoms.

- anxiety disorder** connotes significant **distress** and **dysfunction** due to anxiety.
- fear** can also produce symptoms of anxiety, but, in contrast to anxiety, its cause is obvious and understandable.

THOUGHT is in many ways unrelated to mood or emotions; thought is evaluated in terms of:

also see p. D10 >>

Thought "process" (s. **form of thought, mechanics of thinking**) - structure of thought as experienced by patients and displayed through verbal communication.

- Reduced content**, incomplete sentences
- Circumstantiality** - excessive amount of detail* (circumstances) to avoid making direct statement or answer to question; observed in **schizophrenia** and in **obsessional disorders**.
*often tangential, elaborate, and irrelevant
- Tangentiality** - digression from one topic under discussion to other topics which arise in course of associations; observed in **bipolar disorder** and **schizophrenia** and certain types of **organic brain disorders**.
- Derailment** (s. loose associations)
- Clang associations** - psychic associations resulting from sounds; observed in **mania**.
- Blocking** - long pauses before answers to questions or odd pauses in middle of answers.
- Flight of ideas** - uncontrollable streams of unrelated words and ideas at rate that is impossible to vocalize despite marked increase in individual's overall output of words; observed in **mania**.
- Confabulation** - bizarre and incorrect responses; readiness to give fluent but tangential answer, with no regard whatever to facts, to any question put; seen in **amnesia** and **Wernicke-Korsakoff syndrome**.
- Echolalia** (repetition of words or phrases of examiner), **perseveration** (uncontrollable constant repetition of meaningless word or phrase; word or phrase may have been previously appropriate or correct response, but now it became inappropriate or incorrect), **verbigeration** (persistent repetition of words or phrases).
- Word salad** (complete lack of language), **neologisms** (new word or phrase of patient's own making, or existing word used in new sense; have meaning only to patient; seen in **schizophrenia**).

about thought "process" disorder see p. Psy11 >>

e.g. **schizophrenia** - "loosened" thought processes

Thought content (e.g. delusions, suicidal / homicidal thoughts & plans, feelings of hopelessness, worthlessness, guilt, somatic preoccupations, religiosity, phobias, etc)

e.g. **schizophrenia** - delusional thought content

PSYCHOSIS (broad term) - severe **mental illness** characterized by loss of contact with reality → severe impairments in personal and social functioning. see p. Psy9 >>

vs. **DELIRIUM** - impairment of consciousness associated with **organic cause**.

HALLUCINATIONS - false sensations that arise without stimulus.

- hallucinations are *indistinguishable from real stimuli* (i.e. appear real).
- occur in every sensory realm (visual, auditory, olfactory, gustatory, tactile sensations).
Formication – tactile hallucination of insects crawling over skin.

Hallucinosis - hallucinations in otherwise *normal mental state* (without confusion, disorientation, or psychosis) - sensations are quickly interpreted as false (vs. hallucinations are experienced as real).

ILLUSION - misperceptions or misidentifications of identifiable environmental events / objects.

- may occur in any sensory modality; typically visual (e.g. perceiving lamp as person) but may also be auditory or tactile.
 - may occur in healthy people.
1. **"Déjà vu" feelings** (unfamiliar situations feel strangely familiar); may occur as normal phenomenon and in epilepsy.
 2. **"Jamais vu" feelings** (familiar situations feel novel and unfamiliar); may occur in epilepsy.
 3. Distorted perceptions of time also occur in variety of conditions such as dissociative states and anxiety.
 4. Misperceptions of movement, perspective, and size, which are typical of organic conditions and anxiety, also occur in schizophrenia.
 5. Changes in body perception of one's own body or body of others also occur.

DELUSION - false and irrational belief that is unalterable by rational discourse;

DSM-IV-TR: false beliefs based on incorrect inference about external reality that persist despite evidence to contrary and these beliefs are not ordinarily accepted by other members of person's (sub)culture.

- since delusion is irrational belief, argument over its logic is fruitless, but examiner should not agree with it.
 - delusion may have culturally based content (e.g. Americans who believe that they are targets of influence by Central Intelligence Agency).
 - delusions may be relatively circumscribed or may pervade all aspects of patients' life and thinking.
 - delusions may appear relatively trivial to patients, but, more commonly, they become organizing force in patients' lives.
 - delusions may be simple in their organization or highly complex and systematized.
1. **Delusions of persecution** (beliefs that others are trying to harm, spy on, influence, or humiliate patients or interfere with their affairs); most frequent type of delusion in paranoia.
 2. **Grandiose delusions** (patient believes he has great powers); more common in mania than in schizophrenia.
 3. **Delusions of reference** (beliefs that random events in environment have special meaning and are directed specifically at patients; e.g. talking by strangers, television, or radio about patients; random events such as accidents that have been designed to harm or influence patients).
 4. **Delusions of influence** (beliefs that patients' thoughts and actions are controlled by outside forces; in extreme cases, patients feel as if they were robots without thoughts and actions of their own).
 5. **Thought broadcasting** (thoughts leaving patient's head and going directly to objects in environment; patients may experience this as physical sensation).
 6. **Somatic delusions** (feelings that body has been manipulated or altered by outside forces; e.g. electronic device has been placed in body); major depression with melancholic features has other type of somatic delusions (e.g. having cancer or decaying body).

OBSSESSIONS, COMPULSION, RITUALS → see p. Psy25 >>

ETIOLOGY

- causes of mental illness can be:

- A. Biological
- B. Psychological
- C. Sociocultural-environmental

CLASSIFICATION OF MENTAL DISORDERS

DSM-IV is based on empiric findings from literature reviews of data reanalysis and field trials.

DSM-IV uses multiaxial assessment:

1. **Diagnostic axes**

Axis I - clinical syndromes - organic mental disorders (e.g. head trauma), schizophrenia, depression, substance abuse, and other conditions.

Axis II - personality disorders - prominent *maladaptive personality* features and defense mechanisms.

Axis III - general medical disorders - necessarily causes of psychiatric symptoms, but relevant to treatment.

2. **Other domains for assessment**

Axis IV - psychosocial and environmental problems - *stresses* that may affect context in which disorder developed.

- only psychosocial or environmental stresses that were present *during last year* are listed; stresses that occurred *before previous year* are noted if they clearly contribute to current disorder or treatment.
- common sources of stress:
 - (1) *change in marital status* (e.g. engagement, marriage, separation)
 - (2) *parenting stress* (e.g. birth, child illness, problem with child)
 - (3) *interpersonal problems* (e.g. disagreement with friends, dispute with neighbors)
 - (4) *occupational problems* (e.g. trouble at school or work, unemployment, retirement)
 - (5) *change in living circumstances* (e.g. moving)
 - (6) *change in financial status* (esp. loss)
 - (7) *legal problems* (e.g. arrest, lawsuit, trial)
 - (8) *developmental milestones* (e.g. puberty, menopause)
 - (9) *physical illness / injury* (when related to development of Axis I disorder, it is listed in Axis III)
 - (10) *other stresses* (e.g. natural disaster, rape, unwanted pregnancy, death of close friend)

Axis V - global assessment of functioning (GAF) - physician rates patient's level of psychological, social, and occupational functioning at time of evaluation (GAF may also be used to rate at least few months during last year).

Global Assessment of Functioning (GAF) scale:

Consider psychological, social, and occupational functioning on hypothetical continuum of mental health and illness. Do not include impairment in functioning caused by physical or environmental limitations.

Code (Note: use intermediate codes when appropriate, e.g. 45, 68, 72.)

100 - 91	No symptoms; superior functioning in wide range of activities; life's problems never seem to get out of hand; patient is sought out by others because of his many positive qualities
90 - 81	Absent or minimal symptoms (e.g. mild anxiety before examination); good functioning in all areas; interested and involved in wide range of activities; socially effective; generally satisfied with life; no more than everyday problems or concerns (e.g. occasional argument with family members)
80 - 71	Symptoms are transient and predictable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g. temporarily falling behind in school work)
70 - 61	Some mild symptoms (e.g. depressed mood, mild insomnia) or some difficulty in social, occupational, or school functioning (e.g. occasional truancy, theft within household), but patient is generally functioning well; has some meaningful interpersonal relationships
60 - 51	Moderate symptoms (e.g. flat affect, circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g. no friends, unable to hold job)
50 - 41	Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) or serious impairment in social, occupational, or school functioning (e.g. no friends, unable to hold job)
40 - 31	Some impairment in reality testing or communication (e.g. speech is sometimes illogical, obscure, or irrelevant) or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently bullies younger children, is defiant at home, and is failing at school)
30 - 21	Behavior is considerably influenced by delusions or hallucinations or patient has serious impairment in communication or judgment (e.g. sometimes incoherent, grossly inappropriate behavior, suicidal preoccupation) or is unable to function in almost all areas (e.g. stays in bed all day; has no job, home, or friends)
20 - 11	Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequent violent behavior, manic excitement) or occasional failure to maintain minimal personal hygiene (e.g. smears feces) or gross impairment in communication (e.g. largely incoherent or mute)
10 - 1	Persistent danger of severely hurting self or others (e.g. recurrent violence) or persistent inability to maintain personal hygiene or serious suicidal attempt with clear expectation of death
0	Inadequate information

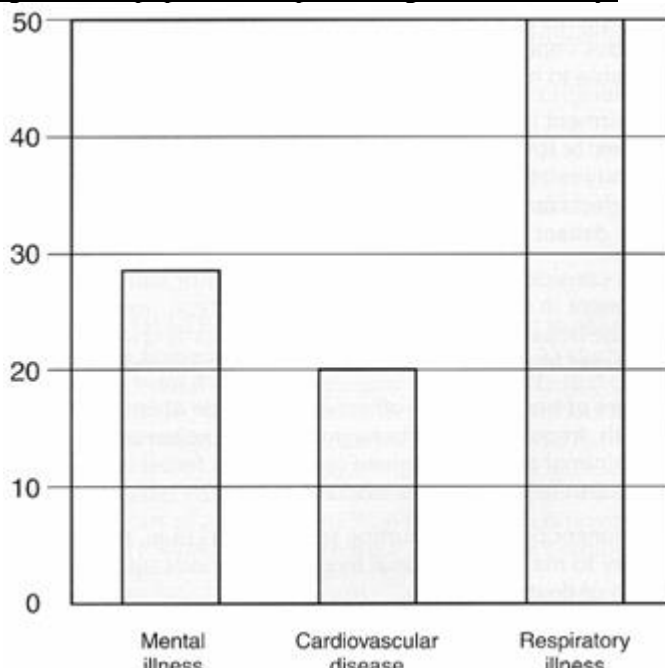
EPIDEMIOLOGY

- largest study of prevalence of psychiatric disorders is **Epidemiologic Catchment Area (ECA)** study.

INCIDENCE - **mental disorder** or **substance abuse disorder** affects **28.1%** of American population older than 18 years of age yearly (> 52 million people).

- severe mental illness affects 2.8% of American adult population.
- at least 10% of USA population have mental disorder that could benefit from professional help.
- there are more patients in hospitals with mental disorders at any time than all other diseases combined (incl. cancer and heart diseases); readmissions to mental hospitals are common (> 1/3 of all admissions); *number of hospitalizations steadily decreases* due to development of more effective psychotropic agents.
- major depression is most common disorder (lifetime incidence - 17.1%); alcohol dependence has associated lifetime history of 14.1%.

Percentage of U.S. population experiencing illness annually:



- men ≈ women; rates for men and women differ for specific disorders:
men - higher rates of **substance abuse** and **antisocial personality disorder**.
women - higher rates of **depression**, **phobia**, **dysthymic disorder**.

PSYCHOTHERAPY

Fundamental psychotherapeutic skills:

- empathy
- sensitivity to emotional cues
- capacity to listen actively
- ability to intervene with corrective information at acceptable time points.

SUPPORTIVE THERAPY

- useful for acutely ill patients, and patients with limited emotional and psychosocial resources (e.g. because of social isolation or other psychiatric illness).

- Support of defenses** (principal therapeutic approach) – encourage defenses that are as adaptive as possible.

e.g. patients with acute MI should receive help minimizing immediate danger, because intense fear may contribute to onset of lethal arrhythmias (however, when symptoms first appear, denial may lead to fatal delay in seeking medical attention).

e.g. marginally compensated schizophrenic patients might be encouraged to direct their attention to problems in everyday living that can be solved; they should not pay too much attention to psychotic thoughts that cannot be dealt with constructively.

- Reality testing:** with patients who tend to distort reality and misinterpret events, physician may offer alternative explanations - tactfully pointing out lapses in reality testing helps patients assess situation more objectively.

- Advice** with problem solving.

e.g. patient might be advised to stop attempting to relieve anxiety by arguing with spouse and to go for walk instead.

COGNITIVE / BEHAVIORAL THERAPY

- based on general principle that interventions should be **focused on behaviors / thoughts / emotions that are actually present at given time**.

- first-line therapeutic strategy for most mild psychiatric problems.
- key elements - clarification, education, emotional support.
- for examples of techniques → see p. Psy25 >>

HYPNOSIS

- altered state of consciousness - permits heightened concentration and attention.
- patients who have excessive fear of loss of control or who have organic brain disease often cannot be hypnotized.

PSYCHODYNAMIC (EXPRESSIVE) THERAPY

- derives from one of **basic concepts of psychoanalytic theory** - **INTRAPSYCHIC DETERMINISM** - psychological events are not produced randomly or by chance but by causal forces* operating, often unconsciously, within individual.

*basic human drives, sexuality and aggression, life experience, early development of individual.

- useful for patients who are able to understand and are interested in understanding themselves.
- Freud allowed his patients to think and speak freely during his sessions with them, while he listened intently for clues about meanings and motivations that were not quite consciously understood by patients.
- **most important technical skills** - active listening, empathic connecting with patient, ability to make interpretive connections to previous life events.
- **components:**
 1. **Clarification** of patient's statements in order to make them more comprehensible
 2. **Confrontation** of aspects of reality or patient's emotions that patient is ignoring.
e.g. "You say that you are not anxious, but you look very nervous"
 3. **Interpretation** of unconscious thoughts and feelings to bring them into patient's awareness
e.g. "Do you think that you are anxious around your boss because he is so much like your father?"

FAMILY THERAPY

- divided into three schools:

1. **Behavioral-psychoeducational school** - principles of *SOCIAL LEARNING THEORY*: *interpersonal behavior is controlled, maintained, and shaped by current environmental events* - interpersonal behavior is changed most effectively through manipulation of these events.
2. **Structural-strategic school** - concepts from *GENERAL SYSTEMS THEORY*: *all problems are result of dysfunctional attempts by family to adapt to current life context*.
Cognitive reframing assumes that family's view of problem can interfere with resolution of problem.
e.g. "Our family would be perfectly all right if it wasn't for our daughter Mary, who has spent all her time recently moping and crying." By suggesting another explanation, therapist opens other avenues for family. For example, therapist might say, "Maybe Mary is remembering Grandma Jean for all of you. After her death last year, you all got back to business as usual pretty quickly. Mary might be taking care of some important unfinished business for family."
Paradoxical interventions - counterintuitive suggestions that therapist makes to family to break pattern of complex interpersonal reflexes that, once triggered, run their course - *therapist prescribes symptom* in attempt to change context and inhibit reflex.
e.g. therapist urges couple who has frequent arguments to have at least one argument before next therapy session, even if one partner must provoke other - therapist is attempting to inhibit reflex to argue by raising suspicion in each partner that other is not really arguing, but simply following therapist's orders.
3. **Intergenerational-experiential school** - *dysfunctional behavior is result of family developmental fixation* (e.g. insufficient differentiation from or excessive obligation toward families of orientation).

PSYCHOPHARMACOLOGY

- **long-term effects** of psychotropic drugs on psychological development (as well as development of enzyme, neurotransmitter, and endocrine systems) in **CHILDREN** are unknown.
- **ELDERLY** may be more vulnerable to **side effects** of psychopharmacologic agents (e.g. disorientation, urinary retention, cardiovascular effects), even at therapeutic concentrations.
- **informed consent** is necessary for **NEUROLEPTICS**.
- **noncompliance** is common cause of failure to respond to prescribed drug regimen; several factors contribute to noncompliance:
 - 1) physician may not explain both nature of disorder and rationale for prescribing drug.
 - 2) outpatients (esp. elderly living alone) are much less likely to comply.
 - 3) side effects.
 - 4) complicated regimens.
- nonspecific **placebo effects** occur even when patient is taking active medication; depend on quality of physician-patient relationship and expectations that physician and patient have for drug.
- all drugs that patient is taking (incl. nonprescription) must be considered before new drug is prescribed:
 - 1) drugs can have interactions!
 - 2) some nonpsychiatric medications have psychiatric side effects!
- treatment regimen must be **individualized**.
- **frequent reevaluation** (both therapeutic response and adverse reactions) is crucial.
- avoid **large prescriptions** (in lethal amounts) and **frequent renewal without close monitoring!**

ELECTROCONVULSIVE THERAPY (ECT)

- safe and effective treatment.

- uses electric shock to **induce seizure**.
- advances in *brief anesthesia* and *neuromuscular paralysis* have improved safety and tolerability, but use of ECT remains limited because of bias remaining from years when it was much cruder procedure.
- **EEG monitoring** during ECT is used to determine occurrence of **seizure**.
- **complications** - **confusion** (immediately after procedure), **short-term memory loss** (usually resolves within 6 months).
N.B. there is **no evidence that ECT causes permanent brain damage!**

SPECIAL SITUATIONS

PATIENT WHO REFUSES MEDICAL ADVICE

Attempt to determine factors that led to patient's refusal:

1. **Denial of illness** (can be fostered by fear and anxiety of disease consequences)
2. **Cognitive impairment** (dementia, delirium) can cause patient not to fully understand reason for hospitalization.
3. **Personality disorders** - problems with authority, fear of confinement (e.g. drug addicts may not tolerate hospitalization).

NONCOMPLIANCE WITH TREATMENT

To manage noncompliance:

1. First of all - discuss **side effects** – most common cause of nonadherence (→ switch to medication with different side effect profile).
2. **Simplify regimen** and make financial burdens more realistic
3. Use **visiting nurse** to augment compliance
4. **Discuss treatments** (provide **sufficient information**)

PSYCHIATRIC EMERGENCY (CRISIS), AGGRESSIVE PATIENT

- *stress-induced pathologic response* that **physically endangers** affected individual / others or **significantly disrupts functional equilibrium** of individual / his environment.

aggressive, violent patients → see p. Psy49 >>

- individual with **any psychiatric diagnosis** or individual with **no preexisting disorder** can have psychiatric emergency.
- **stressors** from any source create problem for individual; in crisis, normal **coping mechanisms** of individual are insufficient, and individual is overwhelmed → *increased anxiety and disorganization* (sense of helplessness, accompanied by panic, depression) → further impaired individual's functional integrity and problem-solving capacity.
- *impulsive, maladaptive*, and even *desperate* attempts by individual to regain psychological equilibrium are likely in this situation; new equilibrium may help individual cope and reduce dysphoria, but still be maladaptive because it limits function of individual or disrupts environment required to maintain it (e.g. individual may use alcohol to lower anxiety and reduce frequency of nightmares after traumatic event; however, medical-social-occupational complications may result from excessive alcohol use).
- diagnosis of **major mental disorder** may be result of individual's maladaptive responses.

COMPONENTS OF STRESS-INDUCED RESPONSES

- dynamic interplay occurs among stressor, affected individual, and social system that influences individual's response.
 1. **Stressors:**
 - a. **INTERNAL stress** - **individuals** face normal developmental task for which they **are ill equipped or ill prepared**, i.e. normal environmental event may have great psychological meaning for given person and may cause disruptive increase in needs, loss, or conflict.
e.g. anxious adolescent who becomes disorganized when she leaves her family to attend college; aging, lonely woman who becomes suicidal after her cat dies.
 - b. **EXTERNAL stress** - **life event that is normally recognized as significant source of stress** (e.g. death of family member, divorce, serious illness).
 2. **Nature of response:**
 - a. *healthy individuals* may become so overwhelmed by stress that they have pathologic adaptation (→ more vulnerable to future stress).
 - b. *individuals with significant disorders* may decompensate with even minor environmental stress.
 3. **Social support system:**
 - a. some individuals have many supportive resources that facilitate adaptive resolution to crisis.
 - b. some individuals have sources of support that are insufficient in face of severe stress.
 - c. some individuals have sources of support that are easily overwhelmed or are even actively intolerant of their attempts to resolve crisis (external environment becomes another source of stress).

PRINCIPLES OF EVALUATION AND MANAGEMENT OF AGGRESSIVE PATIENT

→ see p. Psy49 >>

TELEPHONE CALLS

- people may call ED for variety of reasons, some of which may be covert or overt requests for help for any of crises described.
 - 1) patient's name, telephone number, address should be obtained.
 - 2) physician should attempt to establish alliance with patient without becoming too involved.
 - 3) physician should encourage patient to come to ED as next step in treatment.
 - 4) if patient refuses to come in for evaluation, physician's assessment of patient's potential dangerousness dictates how persistently physician should encourage patient to come to hospital.
- every ED has contingent of **chronic callers** - some of these people are lonely and need reassurance, some are consciously or unconsciously expressing anger by repeatedly frustrating staff.

LEGAL ISSUES

FORENSIC PSYCHIATRY - psychiatric issues as they interface with legal system.

DUAL AGENCY

- serving both as treater and evaluator of patient who is involved in legal proceeding.
- can be very damaging to therapeutic alliance and physician-patient relationship - dual agency situations should be avoided!

PSYCHIATRISTS IN COURT

1. **Fact witnesses** testify to events; fact witnesses *are not allowed to give expert opinions* about patient's mental illness as it relates to legal issue.
e.g. psychiatrist called as fact witness might testify to dates and type of treatment, diagnosis assigned, and medical record documentation.
2. **Expert witnesses** (qualified as experts after court reviews their credentials) testify to issues outside knowledge of average lay person.
e.g. psychiatrist called as expert witness may be used to establish standard of care in malpractice suit or to determine defendant's legal sanity in criminal trial.

INVOLUNTARY PSYCHIATRIC HOSPITALIZATION

- in most states, patients who are hospitalized involuntarily are afforded formal hearing before or shortly after they are hospitalized (during this hearing, judge or jury determines whether commitment criteria have been met based on testimony of clinicians).
- commitment statutes require that individuals be suffering from **treatable** mental illness.
- involuntary psychiatric commitment is **based on one of following legal doctrines:**
 - a) **police power** - emergency commitment model **to protect public safety** (mentally ill patient represents danger to themselves or public at large).
 - b) **parens patriae** ("father of country") - **to protect** mentally ill **individuals who cannot take care of themselves**.
- for all other cases, **individuals must be competent** in order to admit themselves to psychiatric hospital VOLUNTARILY (admitting psychiatrists should ascertain that patients understand, at very least, purpose of hospitalization and criteria and procedures for release).

CONFIDENTIALITY

- clinician's duty (obligation) to prevent communications received in physician-patient relationship from being divulged to third parties.
- physician—patient relationship is *based on trust* (many patients routinely reveal intimate details of their lives to their treating clinicians).

- all communication between patient and clinician is **privileged** and **legally protected**; courts have found clinicians liable for **revealing patient information*** **without expressed written consent of patient**.

*e.g. to family members (incl. parents of adolescent child), other nontreating physicians, insurers, managed care companies, medical researchers.

- EXCEPTIONS to confidentiality:**
 - medical personnel** involved in **direct care** of patient on hospital ward.
N.B. although medical personnel must know patient name, it is standard in presentation of case information to use only **patient initials** or **general descriptors** (also, if patient agrees to participate in educational activity, any presentation must keep this standard).
e.g. "L. K. is a 55-year old female Caucasian postal worker with a 10-year history of hypertension"
 - emergencies (incl. suicidal threats)** - release of information to other health care providers to guarantee patient's immediate welfare.
 - release of information to hospital accepting **patient transfer**.
 - duties to third parties:** *see also below >>*
 - most states have requirements concerning reporting of **certain infectious diseases** and **child / elderly / mentally or physically disabled abuse**.
 - when patient threatens to **harm others**.

N.B. clinician's obligation to maintain confidentiality continues even after patients are deceased!
e.g. widow can no get information about her deceased husband

Privilege - patient's right to prevent physician from testifying in legal proceeding about material gained from therapeutic relationship.

- if psychiatrist receives subpoena for records or testimony (i.e. subpoena *duces tecum*), she should contact patient and, with patient's permission, patient's attorney.

DUTY TO THIRD PARTIES

- legal precedent** - 1976 case of *Tarasoff v. Regents of University of California* (college student who had told university psychologist that he planned to kill his estranged girlfriend); California Supreme Court held that "**when therapist determines, or pursuant to standards of his profession should determine, that his patient presents serious danger of violence to another, he incurs obligation to use reasonable care to protect intended victim against such danger**"; court found that **psychiatrist has duty not only to warn but to protect intended victim as well** (e.g. to hospitalize patient, to warn police, to warn intended victim).

Legitimate concern regarding **patient's safety**, or his possible **danger to others**, takes precedence over **confidentiality**

- court decisions relating to *Tarasoff* decision vary widely from state to state.
- psychiatrists have been held liable for physical assaults by their patients, automobile accidents in which their patients were drivers, and more recently, "false memories" of childhood abuse uncovered in psychotherapy that led to subsequent disruption of family relationships.

CRIMINAL ISSUES

Mentally ill defendants present two main issues for trial courts:

- I. Competency to stand trial (CST)** - defendant's ability to **understand court proceedings** and **assist attorney with defense**.

Criteria of patient competency to stand trial:

- patient understands pending criminal charge(s) and potential penalties
- patient appreciates roles of court personnel (lawyer, judge, prosecutor, jury, and witnesses)
- patient knows potential pleas available and understands process of plea bargaining
- patient is able to control behavior in courtroom
- patient appreciates significance of evidence and witness testimony
- patient is able to be appropriately self-protective
- patient is able to describe desired legal outcome
- patient is able to communicate effectively with his lawyer

- II. Criminal responsibility (legal insanity)** – psychiatrist must make retrospective determination of defendant's mental state at time alleged crime was committed.

- especially difficult if long period of time has elapsed between alleged crime and time of evaluation of criminal responsibility.
- most difficult when defendant was acutely psychotic at time of crime but was subsequently treated and psychotic symptoms have resolved prior to evaluation
- insanity defense is **rarely successful** (only < 1% felony prosecutions result in insanity acquittal).
- statutory criteria for legal insanity vary from state to state; **most states use one of following three standards of legal insanity:**
 - McNaughten standard** (most widely used test of legal insanity in USA) - person failed to know nature and quality of criminal act she was committing or failed to know that act she was committing was wrong as result of mental disease or defect.
 - Model Penal Code (s. American Law Institute Rule)** - mental disease or defect impaired defendant's capacity to appreciate criminality of her conduct or to conform her conduct to requirements of law; it excludes illnesses that are manifested only by repeated criminal or antisocial conduct (such as antisocial personality disorder or pedophilia).
 - Durham rule** (least restrictive of all insanity tests) - crime is product of mental illness or defect.

GUARDIANSHIP AND CONSERVATORSHIP

Guardian (s. committee of person) - person designated by court to manage **property** and **rights** and to make **decisions related to physical well-being** of globally incompetent individual (i.e. global decision making).

- globally incompetent patients** lose many civil rights (right to vote, right to own firearm, right to have driver's license).
- psychiatrists** may serve as **experts to court** in these proceedings, describing specific patient impairments and effect of impairments on patients' decision-making ability.
N.B. psychosis, dementia, or other mental illness does not constitute incompetence per se, so **functional assessment must be performed!**

Conservator (s. limited guardian) - person designated by court to manage another person's* **financial affairs**.

*individuals in need of conservator do not have to be declared globally incompetent.

TESTAMENTARY CAPACITY

- individuals capacity to make will (simplest of all competencies).

- evaluation of testamentary capacity at time will is signed can prevent challenges to will by family members after death of testator.
- to have testamentary capacity:
 - individuals must understand nature and purpose of will, their assets (legally, extent of their bounty), their natural heirs, and their relationship to their heirs.
 - decision-making abilities must be free of delusion.
- only small percentage of contested wills are overturned (most successful challenges involve proof of undue influence, manipulation or deception of testator by others to gain affections of testator).

WORKERS' COMPENSATION

Three categories of claims for psychiatric injury:

- Physical-mental claim** - physical injury that causes mental impairment.
e.g. employee is physically injured in industrial explosion and subsequently develops posttraumatic stress disorder; she is unable to return to work after physical injury heals.
- Mental-physical claim** - recurrent job stress that causes / aggravates physical condition; can be difficult to prove because of issue of causality.
e.g. technician who is required to work overtime subsequently develops bleeding gastric ulcer requiring hospitalization.
- Mental-mental claim** - job stress leads to development of mental condition.
e.g. policeman who witnesses murder of partner in line of duty is unable to return to work due to depression.

PSYCHIATRIC MALPRACTICE

- psychiatrists are less likely to be sued for malpractice than their physician counterparts.
- most common psychiatric malpractice claims (in order of frequency of occurrence):
 - incorrect treatment
 - suicide
 - improper diagnosis
 - inadequate supervision of other mental health professionals.
- most malpractice suits fall into legal category of unintentional tort (**negligence**).
- prevention against malpractice claim:
 - maintenance of healthy therapeutic alliance with patient.
 - maintenance of thorough medical record that clearly documents psychiatrist's reasoning behind treatment decisions.
- psychiatrists who supervise other mental health professionals may be liable for their negligence as well (legal concept known as **respondeat superior**).

PEDIATRIC ASPECTS

pediatric aspects of psychiatric examination → see p. Psy3 >>

- seemingly major difficulties may be normal at certain ages** (e.g. negativism is usual at 2 years and again at adolescence, but is problematic during latency period and in adulthood).
- most disorders are more common in **boys** (inherent increased male vulnerability to stress and trauma).
- psychopathology** usually is result of **chronic**, maladaptive interactions between child and environment, often combined with some genetic, physiologic, or temperamental propensity toward developing mental illness; **isolated traumatic events** (e.g. single episode of brief sexual fondling by nonfamily member) can cause only transient anxiety, anger, and depression.
- misbehavior** may be result of conscious or unconscious prompting by parents (children behave in way that is consistent with their parents' desires).
- there is much overlap between symptoms of many **disorders** and challenging behaviors-emotions of **normal children** (i.e. psychiatric symptoms are often confused with behavior related to developmental stage); whether child is behaving like typical child or has disorder is determined by presence of impairment and distress related to symptoms at hand.
e.g. 12-yr-old girl may be frightened by prospect of delivering book report in front of her class; this fear would not be viewed as social phobia unless her fears were severe enough to cause clinically significant impairments and distress.

Assessment of children differs from assessment in adults in 3 important respects (child evaluation is more complex than adult evaluation!):

- developmental context** is critically important in children (behaviors that are normal at young age may be indicative of serious mental illness at older age).
- children exist in **family system context** (normal child living in family troubled by domestic violence and substance abuse may superficially appear to have one or more mental disorders).
- children have **no cognitive and linguistic sophistication** needed to accurately describe their symptoms - clinician must rely very heavily on direct observation, corroborated by observations of others, such as parents and teachers.

DEVELOPMENTAL CONCEPTS

- multifactorial model** of development - **genetically** determined capacities, individual differences in **temperament**, **physiologic** variables, and **environmental** interactions all contribute.
- epigenesis** - natural and unalterable sequence in which development must occur (e.g. in Freudian psychology, anal period must follow oral stage and cannot be reversed); later stages are necessarily viewed as "advances" from earlier stages.
- developmental continuities** - some childhood personality traits and experiences may be "continuous" with and have ramifications for adulthood; others do not.
e.g. children who are abandoned at 3 years of age by their parents may feel depressed every time someone leaves them later in life.
- critical phases** - particular phases of development must occur at certain ages.
e.g. 4-year-old child who suffered severe psychological trauma that arrested his development might not experience normal oedipal period, even though trauma is overcome, and his development recommences at 7 years of age; distorted oedipal phase might result in irrational fears of physical or psychological harm in competitive situations—a fear that could persist into adulthood.
 - concept of critical phases has been largely supplanted by that of **"sensitive" phases**, in which development is most efficient (although development with regard to specific developmental task is not limited to that phase of development).
- TEMPERAMENT** - dimension of **relative vulnerability/invulnerability** - certain children are able to negotiate seemingly overwhelming psychological trauma with minimal overt effect on their subsequent personality development; others, however, manifest marked symptomatology in face of considerably less trauma and stress.
e.g. temperamentally difficult children may do well developmentally if they have highly competent parents.

TREATMENT

- behaviors are more difficult to change longer they exist.
- for **simple problems**, parental education, reassurance, and few specific suggestions often are sufficient.
 - spend at least 15-20 min/day in pleasurable activity with child!
 - parents also can be encouraged to regularly spend time away from child.
- ineffective discipline may result in inappropriate behavior.**
 - scolding / physical punishment may briefly control child's behavior but eventually may decrease child's sense of security and self-esteem.
 - threats to leave / send child away are damaging.
- problem that does not change in 3-4 mo should be reevaluated; mental health consultation may be indicated.

Time-out procedure - **child must sit alone in dull place** (corner or room other than child's bedroom, with no television or toys, which is not dark or scary) for **brief period** - good approach to altering unacceptable behavior.

- best used when children are aware that their actions are incorrect or unacceptable (typically this is not case until **age 2 yr**).
- do not use in group settings (like daycare) → harmful humiliation.
- apply when child misbehaves in way that is known to result in time-out!
- misbehavior is explained to child, who is told to sit in time-out chair (or is led there if necessary).

- child should sit in chair **1 min for each year of age** (max 5 min).
 - child who gets up from chair before allotted time is returned to chair, and time-out is restarted.
 - child who gets up repeatedly may need to be held in chair (not in one's lap) - talking and eye contact are avoided.
 - if child stays in chair but does not quiet down before allotted time, time-out is restarted.
- when it is time for child to get up, caregiver asks reason for time-out without anger and nagging; child who does not recall correct reason is briefly reminded.
- soon after time-out, caregiver should praise child's good behavior, which may be easier to achieve if child is started in new activity far from scene of inappropriate behavior.

CIRCULAR BEHAVIORAL PATTERN

- negative parental reaction to child's behavior causes adverse response from child, which in turn leads to continued negative more forceful parental reaction.

- how pattern may be interrupted:
 - a) ignore behavior that does not disturb others (e.g. refusal to eat)
 - b) use distraction / temporary isolation to limit behavior that cannot be ignored (public tantrums).

TEMPER TANTRUM

- **violent emotional outburst** (shouting, screaming, crying, thrashing about, rolling on floor, stomping, and throwing things).

- child may become **red in face** and hit or kick.
- some children **voluntarily hold breath** for few seconds and then resume normal breathing (unlike breath-holding spells).
- usually appear toward end of 1st yr, are most common at age 2 ("terrible twos") to 4, and are infrequent after age 5 (**if tantrums are frequent after age 5**, they may persist throughout childhood!).
- causes (combination of **child's personality**, struggle for **autonomy**, immediate **circumstances**, and **developmentally normal behavior**) - frustration, tiredness, hunger, desire to seek attention, obtain something, or avoid doing something.
 - parents often blame themselves for temper tantrums (because of imagined poor parenting).
 - underlying mental / physical / social problem rarely may be cause (but is likely if tantrums last > 15 min or occur multiple times each day).
- to stop tantrum, parents should ask child simply and firmly to do so.
 - if child does not stop and if behavior is sufficiently disruptive → remove child physically from situation (**time-out can be very effective**).

BONDING, ATTACHMENT

Attachment - **child's affective relationship with parents**.

- like bonding, develops over time.
- no critical phase for development (attachment may be formed at any time throughout life cycle).

Bonding - **parent's affective relationship with child**.

- bonding develops over time; bonding commences long before birth of child and is apparent in parents' attitudes, fantasies, and wishes for child.
- at time of delivery, mother experiences **unique psychological state ("window")** - close contact with infant in delivery room fosters ideal bonding; maternal behavior typically begins with touching of infant's fingers and palms followed by central caressing + eye contact is also made; paternal behavior is quite similar.
 - **skin-to-skin contact** between parent and child is beneficial psychologically and physiologically.
- assessment of bonding:
 - 1) ask parents **when and how name was chosen** for child (suggests when they began planning for new arrival; name may have special meaning).
 - 2) ask what sort of **dreams and fantasies parents had** about child **during pregnancy**.
 - 3) ask **how parents' relationship toward each other changed during pregnancy**.
 - **husband often assumes maternal role** toward his wife when she is pregnant; if, however, he begins abusing her, has affairs, or grows distant or uninvolved, more difficult relationship between parents and new baby is likely.
 - 4) ask about **early reactions to child in delivery room and in nursery**; ambivalence of parents concerning their child may be communicated behaviorally (distinguish ambivalence from uncertainty, anxiety, and lack of confidence, all of which are normal reactions to childbirth and are particularly common to first-time parents).
 - 5) ask parents **of whom child reminds them**.
 - 6) **mental health of parents** (mental problems can distort way parent perceives, responds to, and interacts with child).

N.B. special problems are posed if **newborn spends extra time in nursery / ICU** due to illness (family should be evaluated before discharge to ensure that child will receive adequate care – risk of abandonment); prophylaxis:

- 1) transport mother to tertiary care center before delivery.
- 2) if infant is transported to another hospital, father should travel immediately to referral center to keep close contact with infant and bring photographs and information back to mother.
- 3) visitation should be available 24 hours day.

No neonate, even one on respirator, is too ill for parents to see and touch!!!
- 4) strong line of communication should be established between medical staff and parents.
- 5) parents stay overnight in hospital before discharge.

DISORDERS of bonding and attachment

1. **Hospitalism** - extreme failure of any affective relationship to develop.
 - affected infants suffer from: susceptibility to infection, apathy, retarded development, failure to thrive.
 - treatment - parents should be counseled **to spend time with newborn**:
 - 1) **mandatory visitation** of baby by parents **of at least 12 consecutive hours**.
 - 2) **nursing support** when parents have questions.
 - 3) **psychiatric intervention** when parents' grief over child's prematurity / illness is contributing to lack of parental involvement.
 - 4) **follow-up** in special clinic for premature infants.
 - 5) referral to **child protective agency** if parents cannot demonstrate bond to their child or when they do not understand their child's needs.
 - 6) **foster home** placement to protect child while attempts are made to correct parental deficits.
2. **Anaclitic depression** results when attachment relationship is disrupted during sensitive phase of development (e.g. 18-36 months).
3. **Child abuse** may occur if parents have not adequately bonded with child (premature infants are at increased risk).
4. **Vulnerable child syndrome** – child has been ill and have recovered, but parents continue to treat him as though he is still vulnerable; children later show variety of psychological traits resulting from **parental overprotectiveness** (hypochondriasis, hyperactivity, separation anxiety, learning difficulties).

- **management - reassurance** - inform parents that child has recovered and is doing well (surprisingly, parents may not realize this, and their attitude toward child may change with this reassurance).
 - *if reassurance fails* → **psychotherapy for parents**.
 - *if child has internalized this sense of fragility and vulnerability* → **psychotherapy for child** (affective distance between parents and child is increased, and age- appropriate autonomy of child is reinforced).

5. **Separation anxiety** derives from ambivalent / insecure attachments formed during infancy.

THUMB SUCKING

- more common in girls.
- normal at transitional periods in child's life (e.g. at bedtime, at times of separation from parents).
- chronic thumb sucking after 3½ years → changes in dentition.
- if persists into grade-school years - suggests underlying individual or family pathology (e.g. can be sign that child is insecure or withdrawn); H: behavior modification.
 - coating thumb with astringent agents is of limited benefit.

ADOLESCENT PROBLEMS

- adolescents have no more psychiatric illness than any other age group; mistaken assumption that psychopathology is typical in adolescence leads to both over- and underdiagnosis (if all teenagers are "disturbed," disturbance is normal).
- variety of disorders increase in incidence during adolescence (e.g. anorexia nervosa, adult schizophrenia, depression).
- special problems in psychotherapy of adolescents:
 - 1) **labile allegiances** - adolescents love therapist one day and hate her next day.
 - 2) **labile moods** because of great hormonal / psychological turbulence.
 - 3) **communication difficulties** - adolescents may not be comfortable with verbal communication but are too old for communication through play; some adolescents **communicate by means of their behavior** (e.g. driving recklessly to signify anger or depression).
 - 4) **overprotective parents** may meddle in adolescent's treatment; adolescent should be seen at his/her own request, even if this may be contrary to wishes of parents; when parents are involved in adolescent treatment, confidentiality of relationship between physician and adolescent still is paramount.

Identity disturbances

- adolescents struggle to achieve stable identity; problems result when this aspect of development breaks down.
- 1. **Identity diffusion** - adolescent has poor sense of himself and is easily swayed by opinions of others.
- 2. **Peer-related disorders** - adolescents persuaded to do dangerous things (e.g. become sexually promiscuous, take drugs, drink alcohol, drive recklessly) to identify with their peer groups.

Adult sexual development

- in adolescence, adult sexual functioning is achieved, and sexual preferences are solidified.
- **homosexual behaviors** are found commonly in early adolescence; if occur consistently throughout adolescence, however, they usually represent true homosexual preference.
- **paraphilias** usually begin or heighten in adolescence.

Separation

- adolescents negotiate emancipation from their family, and redefine parent-child and sibling roles and boundaries.
- psychosis becomes evident in many **schizophrenics** when they first leave home.
- battle over food is actually struggle for autonomy and independence in many **anorectics**.
- separation can trigger depressive feelings and even **major depressive** episode in individuals so predisposed.
- many adolescents feel that only through conflict will they be able to emancipate successfully → **mobilization of aggression** on part of adolescent, and intrafamily fighting.
- **incest** can develop to prevent child from emancipating.
- **obstinacy** may signify emancipation problem because child refuses to take responsibility for himself.

BIBLIOGRAPHY for ch. "Psychiatry" → follow this [LINK >>](#)