PSYCHIATRY FOR LAWYERS

ALAN COOK, MD
DIRECTOR, ADULT ADMISSIONS
CENTRAL REGIONAL HOSPITAL
BUTNER /RALEIGH NORTH CAROLINA
JANUARY 2009
OUTLINE

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

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

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

- SCHIZOAFFECTIVE DISORDER
  - Involves significant mood component

- DELUSIONAL DISORDER
  - Usually non-bizarre delusions
  - Less impact on overall functioning

- SUBSTANCE-INDUCED PSYCHOSIS
  - Cocaine, marijuana, amphetamines most common

- PSYCHOSIS SECONDARY TO MOOD/COGNITIVE DISORDERS
  - Depression, Mania, Dementia syndromes

- PSYCHOSIS DUE TO MEDICAL CONDITIONS
ANTIPSYCHOTIC MEDICATIONS

- Essentially all equally efficacious
  - Exception: Clozapine for treatment resistance

- Differ with regard to side effect profile
  - Older drugs impact neuromuscular function
  - Newer drugs tend to promote metabolic problems

- Compliance problems common
  - Strategies include long acting injectable agents
MOOD DISORDERS

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

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

- Essential diagnostic component involves manic or hypomanic episode
  - Duration of symptoms important
  - Current debate whether overdiagnosed or underdiagnosed

- Often (but not necessarily) involves episodes of depression as well

- Hypomania/Mania involves elevated or irritable mood
  - Risk taking and other aberrant behavior common
  - Other biologic changes typical
    - Decreased sleep, increased energy
OTHER MOOD DISORDERS

- **DYSTHYMIA**
  - Chronic form of depression
  - Symptoms less severe

- **SUBSTANCE-INDUCED MOOD DISORDER**
  - Most common agents alcohol, cocaine

- **MOOD DISORDER DUE TO MEDICAL CONDITION**
  - Multiple associated medical problems (cancer, vascular disease, hypothyroidism, Parkinson's)
PERSONALITY DISORDERS

- Enduring, life-long pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture

- Pervasive and inflexible

- Onset in adolescence or early adulthood

- Stable over time ("stably unstable")

- Leads to distress or impairment
CLUSTER B

PERSONALITY DISORDERS

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

- **ANTISOCIAL PERSONALITY DISORDER**
  - Pattern of disregard for, and violation of, the rights of others (i.e. criminals)

- **BORDERLINE PERSONALITY DISORDER**
  - Pervasive pattern of relationship and emotional instability and marked impulsivity
SUBSTANCE USE DISORDERS

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

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

• CANNABIS
  • Most common illicit drug of abuse
  • Potency of drug ~4x since the 70’s
  • Adverse effects on health, cognition, motivation

• COCAINE
  • Extremely potent euphoric effects, short half-life and delivery system (crack) contribute to high risk for dependency in short periods of time
  • High financial costs contribute to illegal behaviors to maintain drug habit (theft, prostitution, drug sales)
PRESCRIPTION DRUGS

- **SEDATIVES/ANXIOLYTICS**
  - Benzodiazepines widely prescribed for anxiety, sleep
  - Produce intoxication and withdrawal picture similar to alcohol

- **OPIOIDS**
  - Used for both acute and chronic pain syndromes
  - Dependency will result in withdrawal that, while not fatal, is extremely unpleasant
DEMENTIA SYNDROMES

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

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

- Clinicians’ role to assess risk

- Assessment of risk factors allows accurate identification of suicidal patient, but low predictive success in determining which patient will commit suicide

- Separate acute v chronic risk, modifiable v static
- Identify protective factors
RISK FACTORS

- Major mental illness
  - Mood disorders account for ~80%
  - 10% of patients w/ Schizophrenia complete suicide

- Alcoholism/chemical dependence
  - Risk increased 5X

- Borderline Personality Disorder
  - Notorious for suicidal/parasuicidal behavior
  - 3-8% incidence completed suicide
RISK FACTORS

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

- Involves the mitigation of those risk factors that are modifiable

- Hospitalization, frequent contact with mental health often necessary during periods of increased risk
VIOLENCE

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

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

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