



Psychiatric Diagnoses

DSM-IV Diagnoses

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Child and Adolescent Diagnoses

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 - ▶ Asperger's Disorder
 - ▶ Rett's Disorder
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- 5 Special Considerations for Mood Disorders in Children and Adolescents



Schizophrenia

DSM-IV Diagnostic Criteria for Schizophrenia

- A Have two or more of the following been present for a significant portion of time during a one-month period, (less, if successfully treated)?
 - ▶ delusions
 - ▶ hallucinations
 - ▶ disorganized speech
 - ▶ grossly disorganized or catatonic behavior
 - ▶ negative symptoms such as flat affect, poverty of speech and thought, no motivation, etc. (Only one of the above is required, if the delusions are bizarre, hallucinations consist of a running commentary on the behavior or thoughts of the person, or two or more voices converse with one another.)
- B Since the onset of the disturbance has there been a deterioration of social functioning, interpersonal relations, or self care?
- C Have the signs of illness been present on a continuous basis for 6 months?
- D Have Schizoaffective Disorder and Mood Disorder with Psychotic Features been ruled out?

Treatment Planning

Specific Considerations

TREATMENT PLAN

- ◊ The diagnosis should be firmly established.
- ◊ Schizophrenia is a chronic, lifelong condition that requires numerous interventions of varying levels; the symptoms at a given point in time dictate the acute treatment plan.
- ◊ Involuntary hospitalization is commonly required in this population.
- ◊ The initial goals of treatment are:
 - ▶ Reduction of psychotic symptoms to a level that allows a lower level of care, or a return to a home environment with outpatient follow-up

- ▶ Prevention of harm to the patient, others, or property
- ▶ Development of an effective regimen of medication that:
 - Is effective in reducing the patient's psychotic symptoms
 - Has few or tolerable side effects
 - Will promote compliance with the medication
- ◊ The mainstay of initial and long-term treatment of schizophrenia is pharmacologic.

Pharmacologic management of schizophrenia

Specific considerations

- ◊ The newer antipsychotic medications should be used first.
- ◊ The older antipsychotic medications should be reserved for:
 - ▶ Stable patients who are responding well to these medications and are experiencing no major side effects
 - ▶ Patients who require IM medication for their management
 - ▶ Acute management of aggression and violence in some patients

INADEQUATE RESPONSE TO INITIAL TREATMENT

- ◊ The initial treatment should continue for 4-8 weeks before considering a change.
- ◊ If the inadequate response was with a conventional antipsychotic medication, then the patient should be switched to an atypical antipsychotic medication.
- ◊ If the inadequate response was to an atypical antipsychotic medication, then a trial on a different atypical antipsychotic medication should be initiated or the dose of the initial atypical antipsychotic medication should be optimized.
- ◊ If the inadequate response persists after several trials of conventional and atypical antipsychotic medications, the patient should be tried on clozapine.

CHOICE OF ANTIPSYCHOTIC MEDICATION SHOULD BE BASED ON:

- ◊ Acceptability to patient
- ◊ Prior drug response
- ◊ Side effect profile
- ◊ Long-term treatment planning

CLOZAPINE

- ◊ This medication should be offered to:
 - ▶ Patients whose positive symptoms do not respond to two different classes of antipsychotic medications
 - ▶ Patients with Schizophrenia or Schizoaffective Disorder who have persistent violence or other psychotic symptoms that have not responded to trial of two different antipsychotic medications
 - ▶ Patients who experience intolerable side effects to other antipsychotic medications
- ◊ The lack of response should be defined as persistent symptoms after 2, six-week trials of maximum tolerated doses of antipsychotic medications from two different chemical classes (at least one atypical).
- ◊ An adequate clozapine trial is three months at a dose between 300-800 mg per day.
- ◊ Doses should be kept to the lowest dose that produces a positive response.
- ◊ Patients who do not respond to lower doses of clozapine should have a blood level drawn and the dose slowly raised to 800 mg/day.

ADJUNCTIVE PHARMACOTHERAPIES

Depending on the specific symptoms of the patient, any of the following may be used in combination with antipsychotic medications to control these symptoms:

- ▶ Lithium: manic-like symptoms
- ▶ Benzodiazepines: anxiety, violence
- ▶ Anticonvulsants: manic-like symptoms, hostility, impulsivity
- ▶ Other antipsychotic medications in combination with clozapine
- ▶ Two atypical antipsychotic medications simultaneously
- ▶ Antidepressants: depression

ELECTROCONVULSIVE THERAPY-ECT

If a patient has not responded to antipsychotic medication medications then the patient should be considered for ECT if:

- ▶ The patient has been ill less than a year.
- ▶ The patient has been ill for more than a year, but is in an early exacerbation.
- ▶ Affective or catatonic features are prominent.

SUBSTANCE ABUSE

- ◊ All patients should be screened for substance abuse
- ◊ Substance abuse is common in this patient population, especially cocaine abuse.

Non-pharmacologic management of Schizophrenia

Specific Considerations

- ◆ Individual and Group Therapy
- ◆ Combinations of support, reality orientation, education, behavioral and cognitive skills training designed to address the specific deficits of the schizophrenic patient should be offered.
- ◆ Interpretative treatment or treatments that use regression as a therapeutic means should not be used in this patient population.
- ◆ Family Intervention
 - ▶ Offer support
 - ▶ Skills training
 - ▶ Education
 - ▶ Problem-solving skills

Discharge plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
- ◆ A specific appointment is made before discharge and patient is aware of appointment.
- ◆ Patient has means to get to appointment, and, if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Family education, if indicated, is conducted before discharge.
- ◆ Patient education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.

ANTIPSYCHOTIC MEDICATIONS AND SIDE EFFECTS

Side Effect	Least likely to cause	Most likely to cause
Sedation	Risperidone [Risperdal] Ziprasidone High potency conventional antipsychotics [such as Haldol]	Low potency conventional antipsychotics [such as Thorazine, Mellaril] Clozapine [Clorazil]
Weight Gain	Ziprasidone Risperidone [Risperdal]	Clozapine [Clorazil] Olanzapine [Zyprexa]
Extra-pyramidal Side Effects	Clozapine [Clorazil] Quetiapine [Seroquel] Olanzapine [Zyprexa] Ziprasidone Risperidone [Risperdal]	Mid- and high-potency conventional antipsychotics
Cognitive Side Effects	Atypical antipsychotics	Low-potency conventional antipsychotics
Anticholinergic Side Effects	Risperidone [Risperdal] Ziprasidone Quetiapine [Seroquel] High potency conventional antipsychotics [such as Haldol]	Low-potency conventional antipsychotics
Sexual/Reproductive system Side Effects	Quetiapine [Seroquel] Olanzapine [Zyprexa] Ziprasidone Clozapine [Clorazil]	Conventional Antipsychotics
Cardiovascular Side Effects	Risperidone [Risperdal] Olanzapine [Zyprexa] High potency conventional antipsychotics [such as Haldol] Quetiapine [Seroquel]	Low-potency conventional antipsychotics
Tardive Dyskinesia	Clozapine [Clorazil] Quetiapine [Seroquel] Olanzapine [Zyprexa] Ziprasidone	Conventional antipsychotics
Recurrence of Neuroleptic Malignant Syndrome	Olanzapine [Zyprexa] Clozapine [Clorazil] Quetiapine [Seroquel] Ziprasidone Risperidone [Risperdal]	Conventional antipsychotics



Schizoffective Disorder

DSM-IV Diagnostic Criteria for Schizoffective Disorder

- A Has there been an uninterrupted period of illness when with a Major Depressive Disorder, a Manic Episode or a Mixed Episode was concurrent with Criterion A for Schizophrenia?
- B Have delusions and hallucinations been present for at least two weeks during the same period of illness in the absence of prominent mood symptoms?
- C Have symptoms that meet the mood episode been present for a substantial portion of the illness?

Treatment Planning

Specific Considerations

DIAGNOSIS

- ◆ The accurate diagnosis of this condition is difficult due to the complexity of the symptoms, the careful delineation of the time frames of symptoms and overlapping symptomatology that must be present for this diagnosis to be made.
- ◆ The DSM-IV diagnostic criteria are somewhat nonspecific and a spectrum of diagnoses and subsets of diagnoses may be included in this disorder.
- ◆ When substance abuse, intoxication or withdrawal are part of the clinical presentation, then the diagnosis should not be made.
- ◆ The most accurate diagnosis is derived from a review of the entire course of illness and not limited to the present symptomatology.

TREATMENT

Pharmacology

Medications from many drug classes have been used in the treatment of individuals with this diagnosis and the published results have been mixed and controversial. This probably reflects the over-inclusiveness of the diagnosis, allowing patients with very different symptoms to carry the same diagnosis. These patients would respond differently to different medications.

Antipsychotic medication

- ◆ Data indicates that antipsychotic medications used alone are the best available treatment.
- ◆ Atypical antidepressants may have an advantage over the older conventional antipsychotic medication.
- ◆ No evidence to support that the use of antidepressants with antipsychotic medication is advantageous.

Antidepressant medication

- ◆ Data indicates that in this group of patients these medications are only useful once the psychosis is stabilized and the patient has a full depressive syndrome.
- ◆ Antidepressant medications seem to have little value if used when only depressive symptoms are present.
- ◆ Antidepressant medication used while the patient is actively psychotic may worsen the psychosis.

Lithium

- ◆ Its use in this group of patients is especially controversial. Some authors favor its use; others feel that the patients it benefits do not meet current criteria for Schizoaffective Disorder.
- ◆ *The Practice Guidelines for Schizophrenia* from the American Psychiatric Association states that there is some evidence to support the use of lithium; a recent review does not agree with this conclusion (See Bibliography).

Anticonvulsant medication

- ◆ No controlled data supports the use of this group of medications in this patient population.

Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
 - ▶ A specific appointment is made before discharge and patient is aware of appointment.
 - ▶ Patient has means to get to appointment, and, if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.



Brief Psychotic Disorder

DSM-IV Diagnostic Criteria

- A** Are one or more of the following present?
1. Delusions
 2. Hallucinations
 3. Disorganized speech (i. e. frequent derailment or incoherence)
 4. Grossly disorganized or catatonic behavior
- B** Has the episode lasted at least one day but not longer than one month?
1. Is there an eventual return to normal?

Treatment

Specific Considerations

- ◆ This is a time-limited disorder often associated with a significant stressor, but may occur without stressors.
- ◆ Of special concern is maintaining the safety of the patient during the psychotic episode.
- ◆ Antipsychotic medication may be required during the active phase of the illness.
- ◆ Once the episode has resolved, medication will no longer be required.
- ◆ Once the episode resolves, there should be no residual symptoms if the diagnosis is correct.
- ◆ Families and concerned friends should be reassured of the eventual return to the pre-episode status.

Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
 - ▶ A specific appointment is made before discharge and patient is aware of appointment.
 - ▶ Patient has means to get to appointment, and, if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Family education, if indicated, is conducted before discharge.
- ◆ Patient education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged, if needed.
- ◆ Case management, if indicated, is arranged.



Mood Disorders: Major Depression

DSM-IV Diagnostic Criteria for Major Depressive Episode

For children and adolescents, see Special Considerations in the section on child and adolescent disorders

One of the following must be present for at least two weeks, nearly every day, most of the day:

- ▶ Depressed mood most of the day,

OR

- ▶ Loss of interest or pleasure in most activities most of the day

At least four of the following must be present for at least two weeks, nearly every day, most of the time:

- ▶ Greater than 5% weight loss or gain; clearly increased or decreased appetite
- ▶ Insomnia or hypersomnia
- ▶ Psychomotor agitation or retardation
- ▶ Fatigue or loss of energy
- ▶ Feelings of worthlessness, inappropriate guilt or low self-esteem
- ▶ Diminished concentration or indecisiveness
- ▶ Recurrent thoughts of death or suicide

Signs/symptoms (all must be yes)

- ▶ Must result in a functional impairment and/or emotional distress.
- ▶ Must not be due to a substance abuse disorder
- ▶ Must not be due to a medical disorder

Treatment goals—acute phase of treatment

- ▶ Reduce and remove (if possible) all signs and signs/symptoms of depression
- ▶ Restore occupational and psychosocial functioning
- ▶ Reduce the likelihood of relapse and recurrence

Treatment Plan

Specific considerations

In addition to establishing the diagnosis of depression, the patient's risk for suicide must be thoroughly assessed.

- ▶ Intent
- ▶ Extent of plans
- ▶ Availability of means
- ▶ Lethality of available means
- ▶ Previous attempts
 - Number of previous attempts
 - Severity of previous attempts
- ▶ Factors that increase the risk of suicide are:
 - Psychosis
 - Severe anxiety
 - Panic attacks
 - Substance abuse

Medications

ANTIDEPRESSANT MEDICATION

- ⊕ For moderate to severe depression, antidepressant medication should be used in the initial phase of treatment, unless ECT is planned.
- ⊕ All true antidepressant medications require at least 4-6 weeks before an assessment of their effectiveness can be completed.
- ⊕ All currently available antidepressant medications are effective. Thus the selection of the specific antidepressant medication depends on:
 - ▶ Patient preference
 - ▶ Previous positive response to a specific antidepressant medication
 - ▶ Family response to a specific antidepressant medication

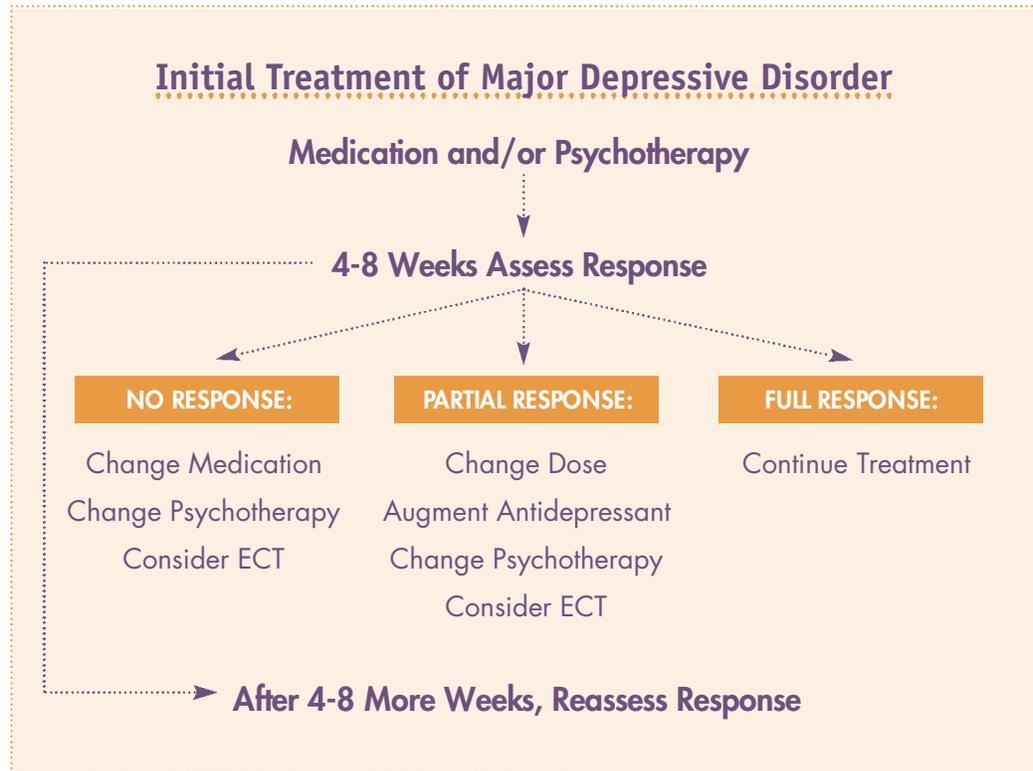
- ▶ Safety of use (lethality of overdose)
- ▶ Side effects:
 - Side effects tend to occur early in treatment (immediately to within a few days after beginning treatment)
 - Safety and tolerability of side effects
 - Management of side effects
 - Cost
- ▶ Medical disorders
- ▶ Other medications taken by the patient

IMPLEMENTATION OF ANTIDEPRESSANT MEDICATION TREATMENT

- ◊ Most antidepressant medications require starting at a low dose and increasing to a therapeutic dose over a period of days to weeks.
- ◊ Side effects, safety and compliance must be carefully monitored at this phase of treatment.
- ◊ Obtaining informed consent is recommended prior to initiating treatment.

ANTIDEPRESSANT MEDICATIONS

Generic Name	Brand Name	Start Dose (total milligrams per day)	Usual Dose (total milligrams per day)
Amitriptyline	Elavil	25-50	100-300
Bupropion	Wellbutrin	150	300
Citalopram	Celexa	20	20-60
Clomipramine	Anafranil	25	100-250
Desipramine	Norpramin	25-50	100-300
Doxepin	Sinequan	25-50	100-300
Fluoxetine	Prozac	20	20-60
Fluvoxamine	Luvox	50	50-300
Imipramine	Tofranil	25-50	100-300
Maprotiline	Ludiomil	50	100-225
Mirtazapine	Remeron	15	15-45
Nefazodone	Serzone	50	150-300
Nortriptyline	Norpramin	25	50-200
Paroxetine	Paxil	20	20-60
Phenelzine	Nardil	15	15-90
Protriptyline	Vivactyl	10	15-60
Sertraline	Zoloft	50	50-200
Trazodone	Desryl	50	75-300
Trimipramine	Surmontil	25-50	100-300
Venlafaxine	Effexor	37.5	75-225



FAILURE TO RESPOND

- ◆ If not at least moderate improvement is not observed after 6-8 weeks of treatment, a reappraisal of the treatment plan should be conducted.

Psychotherapy

- ◆ Cognitive behavioral therapy and interpersonal therapy have the best documented effectiveness in the treatment of depression.
- ◆ Psychodynamic therapy is often used in the treatment, but its effectiveness at symptom reduction has been less well studied than cognitive-behavioral therapy and interpersonal therapy.

Hospitalization

SHORT-TERM GOALS FOR ACUTE HOSPITALIZATION

- ◆ Sufficient resolution of symptoms to allow a return to home or a lower level of care:
 - ▶ Self-care acceptable

- ▶ Suicide risk has been reduced by symptom reduction and addressing external factors contributing to suicidal risk
- ▶ Medications are effective and side effects, if any, are tolerable
- ▶ Functionality in family, school, and occupational roles is improved
- ▶ Proactively to prevent recurrence of symptoms (for example, taking medications)

LONG-TERM GOALS IDENTIFIED WHILE HOSPITALIZED

- ◆ Complete sustained resolution of symptoms
- ◆ Absence of suicidal ideation
- ◆ Origins of depression explored and understood
- ◆ Higher level of adaptation attained as evidenced by:
 - ▶ Improved function in social and occupational roles
 - ▶ Understanding of factors contributing to onset of depression are used to act proactively to prevent recurrence of symptoms (for example, taking medications).

Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
 - ▶ A specific appointment is made before discharge and patient is aware of appointment.
 - ▶ Patient has means to get to appointment, and, if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Patient and family education about medications, signs of depression worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.



Bipolar Affective Disorders

DSM-IV Diagnostic Criteria for Manic Episode

For children and adolescents, see Special Considerations in the section on child and adolescent disorders

- A Has there been a distinct period of abnormally and persistently elevated, expansive or irritable mood lasting at least one week? (any duration if hospitalization is necessary)
- B During the period of mood disturbance, have three or more (four, if mood is irritable) of the following persisted and have been present to a significant degree?
 1. Inflated self-esteem or grandiosity
 2. Decreased need for sleep
 3. More talkative than usual or pressure to keep talking
 4. Flight of ideas or experiencing thoughts as racing
 5. Distractible
 6. Increased goal directed activity or psychomotor agitation
 7. Excessive involvement in pleasurable activities that have a high potential for painful consequences.
- C Is the mood disturbance severe enough to cause a marked impairment in usual activities or to require hospitalization to prevent harm to self or are psychotic features present?

DSM-IV Diagnostic Criteria for Hypomanic Episode

- A Is there evidence of a persistently elevated, expansive, or irritable mood, lasting at least 4 days that is clearly different from a normal non-depressed mood?
- B During the period of mood disturbance, have three or more (four, if mood is irritable) of the following persisted and been present to a significant degree?
 1. Inflated self-esteem or grandiosity
 2. Decreased need for sleep
 3. More talkative than usual or pressure to keep talking

4. Flight of ideas or experience that thoughts are racing
 5. Distractible
 6. Increased goal directed activity
 7. Excessive involvement in pleasurable activities that have a high potential for painful consequences
- C Is the episode a clear change from functioning when the person is not symptomatic?
- D Are the disturbance in mood and the change in functioning observable by others?
- E Is the episode not severe enough to cause marked impairment in social or occupational functioning, to result in hospitalization and are there no psychotic features?

DSM-IV Diagnostic Criteria for Bipolar I Disorder

- A Are the criteria (except for duration) met of a Manic, Hypomanic, or Major Depressive Episode?
- B Has there been at least one Manic Episode in the patient's past?
- C Are the mood symptoms causing clinically significant distress or impairment in social, occupational or other important areas of functioning?
- D Are the mood symptoms in Criteria A and B better accounted for by Schizoaffective Disorder? **Must be no.**
- E Are the mood symptoms superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder, NOS? **Must be no.**
- F Are the mood symptoms listed in Criteria A and B due to the direct effects of a substance or of a physical illness? **Must be no.**

DSM-IV Diagnostic Criteria for Bipolar II Disorder

- A Is there the presence, or is there history of one or more Major Depressive Episodes?
- B Is there the presence or history of at least one Hypomanic Episode?
- C Is the current clinical presentation and the history free of any Manic Episodes?
- D Are the mood symptoms causing clinically significant distress or impairment in social, occupational or other important areas of functioning?
- E Are the mood symptoms in Criteria A and B better accounted for by Schizoaffective Disorder? **Must be no.**
- F Are the mood symptoms superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder, NOS? **Must be no.**

Treatment

Specific Considerations

- ◆ Individuals experiencing a Manic Episode with psychotic features can be among the most aggressive and dangerous patients on a psychiatric unit.
- ◆ Settings accepting these patients must be prepared to deal promptly and effectively with the patient's behavior to insure the safety of the patient, the other patients on the unit and the staff on the unit.
- ◆ These patients may be especially lacking in insight about their disorder and deny its existence.
- ◆ Some patients enjoy the experience of mania and are reluctant to prevent its recurrence.
- ◆ The Manic Episode is usually part of the clinical picture of Bipolar I Disorder; and the Manic Episode may be followed by a Depressive Episode.
- ◆ Compliance with treatment may be especially problematic since these patients feel that nothing is wrong with them.
- ◆ Detailed education about the nature, treatment and prognosis is important for these patients and their families.
- ◆ Education of these patients enhances their ability to detect sub-clinical symptoms that may herald the onset of a Manic Episode.

- ▶ Reports of these symptoms should be taken seriously and the patient should be closely monitored.
- ▶ Reports of changed behavior in the patient by individuals who know the patient well should be taken seriously and active interventions considered.
- ◆ During Manic Episodes the patient may engage in behaviors that result in severe negative consequences (excessive spending, inappropriate sexual expression, violence, etc.)
 - ▶ Patients should seek psychiatric management at the first indication of a Manic Episode.
 - ▶ Prompt, effective psychiatric management should be instituted immediately.
- ◆ The mainstay of treatment of these patients is pharmacologic.

MEDICATIONS USED IN THE TREATMENT OF MANIC EPISODE

Generic Name	Brand Name(s)	Dose	Side Effects/ Adverse Effects	Comments
Lithium	Eskalith, Lithobid	900 – 1800 mg daily, divided into two or three doses	Increased urination, increased fluid intake, hypothyroidism, weight gain, tremor, GI distress	Effective for about 70% of Bipolars. Narrow therapeutic range. Requires serum monitoring. Serious problems with overdose
Valproate, Valproic Acid	Depakote	Start dose is 750 mg, divided into 3 doses, Increase dose to achieve 50 -100 micrograms/ml blood level	GI distress, liver toxicity	Effective for many Bipolars. Wide therapeutic range. May require serum monitoring. Requires monitoring of liver enzymes
Carbamazepine	Tegretol	400-600 mg daily, divided into 2 doses; increase by 200 mg increments to a maximum dose of 1600 mg/24hrs	Rashes, bone marrow suppression, low serum sodium, elderly more sensitive	Rarely used today.
Clonazepam	Klonopin	Dose ranges not well established	Sedation, disinhibition	Possible abuse and dependency
Tiagabine	Gabatril	Starting dose is 1 mg/day increasing slowly up to 8 -10 mg/day	Dizziness, lightheadedness, asthenia, sedation, nausea, decreased attention and concentration, confusion	Use is only as an "add-on" drug to supplement other first line treatments of Bipolar Disorder
Lamotrigine	Lamictal	Starting dose should not exceed 25mg/day and may be slowly increased to up to more than 100 mg/day. Specific doses not established	Nausea, dizziness, headache, blurred vision. Severe, serious rash may rarely occur; medication must be discontinued and not restarted.	Initial studies indicate that this medication may be a valuable addition in the treatment of mania
Gabapentin	Neurontin	Total daily doses 900 - 3000 mg given in 3 or 4 doses	Dizziness, sedation, fatigue, ataxia	Use is only as an "add-on" drug to supplement other first line treatments of Bipolar Disorder.
Topiramate	Topamax	Start at 50 mg/day; increase 50 mg/week to total therapeutic dose of 400 mg given in two doses	Asthenia	Use is only as an "add-on" drug to supplement other first line treatments of Bipolar Disorder.



Anxiety Disorders: Post-Traumatic Stress Disorder

DSM-IV Diagnostic Criteria for Post-Traumatic Stress Disorder

- A** Has the person been exposed to traumatic event in which both of the following were present?
1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or to the physical integrity of oneself.
 2. The person's response involved intense fear, helplessness, or horror.
- B** Has the traumatic event been re-experienced in one or more of the following ways?
1. Recurrent and intrusive distressing recollections of the event, including images thoughts or perceptions.
 2. Recurrent distressing dreams of the event
 3. Acting or feeling as if the traumatic event were recurring
 4. Intense psychological distress to internal or external cues that symbolize or resemble an aspect of the event.
 5. Reacting on a physical level to internal or external cues that symbolize or resemble an aspect of the event.
- C** Has there been persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, as indicated by three or more of the following?
1. Efforts to avoid activities, places or people that arouse recollections of the event
 2. Efforts to avoid thoughts, feelings or conversations that are associated with the trauma
 3. Inability to recall an important aspect of the trauma
 4. Markedly diminished interest or participation in significant activities
 5. Feelings of detachment or estrangement from others
 6. Restricted range of affect
 7. Sense of a foreshortened future

- D** Does the person have persistent symptoms of increased arousal as indicated by two or more of the following?
1. Difficulty falling or staying asleep
 2. Irritability or outbursts of anger
 3. Difficulty concentrating
 4. Hypervigilance
 5. Exaggerated startle response
- E** Have the symptoms in Criteria B, C and D been present for more than one month?
- F** Did the symptoms cause significant distress or impairment in important areas of life function?

Treatment Planning

- ◆ The patient with a diagnosis of PTSD will most often present for inpatient services when experiencing a loss of control, resulting in violent thoughts or behaviors or suicidal ideation.
- ◆ Substance-abuse-related issues may also result in a presentation for hospitalization.
- ◆ Depression may be the presenting diagnosis.
- ◆ PTSD is frequently comorbid with other disorders, and symptoms of it should be investigated.
- ◆ The initial phase of treatment is to reduce the presenting symptoms to a level that allows the patient to go to a lower level of care.

Medications

- ◆ Antidepressant medications are usually the most effective for this condition.
- ◆ Sertraline (Zoloft) has been specifically approved by the FDA for the treatment of PTSD.
- ◆ Older studies indicate that the sedating tricyclic antidepressant medications were helpful, especially Imipramine (Tofranil).
- ◆ Benzodiazepines have a negative or no effect on these patients.

Psychotherapy

- ◆ It has been a cornerstone of the treatment of this disorder.
- ◆ Usually long term outpatient psychotherapy is required.
- ◆ Numerous models of psychotherapy have been tried, with varying levels of success. The guiding principles in most treatments have been exposure to the original (or recreated) event(s) in a hierarchical fashion, and the use of social supports. There has been little systematic research on this aspect of treatment.

Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
 - ▶ A specific appointment is made before discharge and patient is aware of appointment.
 - ▶ Patient has means to get to appointment, and, if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.



Anxiety Disorders: Acute Stress Disorder

DSM-IV Diagnostic Criteria for Acute Stress Disorder

- A** Has the person been exposed to a traumatic event in which both of the following were present?
1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or to the physical integrity of oneself.
 2. The response involves intense fear, helplessness or horror.
- B** Did the person, while experiencing the event or after experiencing the distressing event, have three or more of the following dissociative symptoms?
1. A subjective sense of numbing, detachment, or absence of emotional responsiveness
 2. A reduction in awareness of his/her surroundings
 3. Derealization
 4. Depersonalization
 5. Dissociative amnesia
- C** Is the traumatic event persistently re-experienced in at least one of the following ways?
1. Recurrent images
 2. Thoughts
 3. Dreams
 4. Illusions
 5. Flashback episodes
 6. A sense of reliving the experience
 7. Distress at reminder of the traumatic event

- D Marked avoidance of stimuli that arouse recollections of the event
 1. Thoughts
 2. Feelings
 3. Conversations
 4. Activities
 5. Places
 6. People
- E Marked symptoms of anxiety or increased arousal
 1. Difficulty sleeping
 2. Irritability
 3. Poor concentration
 4. Hypervigilance
 5. Exaggerated startle response
 6. Motor restlessness
- F Does the disturbance cause significant distress or impairment in social, occupational or other important areas of functioning or impair the person's ability to pursue some necessary task?
- G Has the disturbance lasted at least two days and occurred within 4 weeks of the traumatic event?

Treatment Planning

- ◆ Many individuals with this diagnosis have experienced a disaster, natural or man-made.
- ◆ Prompt intervention (psychotherapeutic and pharmacological) may reduce the sequelae of this diagnosis and prevent PTSD.
- ◆ Most individuals will not require hospitalization.
- ◆ Individuals with pre-existing conditions or special sensitivities may require hospitalization to regain coping skills following an event resulting in this diagnosis.

Medications

- ◆ Sleep problems may be especially prominent and require medication.
- ◆ Benzodiazepines for acute anxiety have not been shown to be helpful.
- ◆ Aside from purely symptomatic relief, medications play a minor role in the management of this disorder.

Psychotherapy

- ◆ Acute intervention immediately after the event is key to reduce the psychological sequelae of the event.
- ◆ Special trauma teams may be mobilized to assist large groups of people following an event.
- ◆ For individuals requiring hospitalization, prompt assessment and intervention must occur.

Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
 - ▶ A specific appointment is made before discharge and patient is aware of appointment.
 - ▶ Patient has means to get to appointment, and, if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Patient and family education about: medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.



Eating Disorders: Anorexia Nervosa

DSM-IV Criteria for Anorexia Nervosa

- A Does the person refuse to maintain body weight at or above a minimally normal weight for age and height? (less than 85% of expected weight)
- B Is there an intense fear of gaining weight or becoming fat, even though the person is underweight?
- C Is there a disturbance in the way one's body is experienced in terms of weight or shape? Is there undue influence of body weight or shape on self-evaluation? Is there denial about the seriousness of the weight loss?
- D In post-menarcheal females, have three consecutive menstrual cycles been missed?

Treatment Planning

Specific Considerations

Pretreatment evaluation is essential for determining the appropriate level of care.

PHYSICAL PARAMETERS

- ◆ Weight
 - ▶ Rapidity of weight loss
 - ▶ Current weight as compared to age and size normative data
- ◆ Cardiac Status
 - ▶ Irregular, weak, slow pulse
 - ▶ Marked orthostatic blood pressure drop
 - ▶ Peripheral vasoconstriction
 - ▶ Q-Tc prolongation (dangerous sign)
- ◆ Metabolic Status
 - ▶ Dehydration
 - ▶ Electrolyte abnormalities
 - ▶ Low serum phosphorus
 - ▶ Hypoglycemia (rare)

DECISION TO HOSPITALIZE ON A PSYCHIATRIC UNIT IS BASED ON:

- ◆ Rapid or persistent decline in oral intake
- ◆ Decline in weight despite outpatient and partial hospitalization interventions
- ◆ Presence of additional stressors that interfere with the patient's ability to eat
- ◆ Prior knowledge of a weight at which instability is likely to occur
- ◆ Co-morbid psychiatric problems that merit hospitalization

DECISION TO HOSPITALIZE ON A PSYCHIATRIC VERSUS A MEDICAL UNIT:

- ◆ Patient's general medical status
- ◆ Skills and ability of psychiatric and medical staffs
- ◆ Availability of suitable intensive outpatient, partial and day hospitalization
- ◆ Aftercare for the patient's general medical and psychiatric problems

PSYCHIATRIC MANAGEMENT

- ◆ Establish and maintain a therapeutic alliance.
- ◆ Coordinate care with other clinicians treating the patient.
- ◆ Assess and monitor eating disorder symptoms and behavior.
- ◆ Assess and monitor patient's general medical condition.
- ◆ Assess and monitor the patient's psychiatric status and safety.
- ◆ Provide family assessment and treatment.

AIMS OF TREATMENT

- ◆ Restore patient to healthy weight, normal menses, and normal ovulation in females, and normal physical and sexual growth and development in children and adolescents.
- ◆ Treat physical complications.
- ◆ Enhance patient's motivation to cooperate in the restoration of healthy eating patterns and to participate in treatment.
- ◆ Provide education regarding healthy eating patterns and to participate in treatment.

- ◆ Correct core maladaptive thoughts, attitudes, and feelings related to the eating disorder.
- ◆ Treat associated psychiatric conditions, especially related to mood regulation, self-esteem, and behavior.
- ◆ Enlist family and school support and provide family counseling and therapy.
- ◆ Prevent relapse.

NUTRITIONAL REHABILITATION

- ◆ Inpatient
- ◆ Establish healthy target weights.
- ◆ Have expected rates of controlled weight gain (2-3 lb/week for inpatient, 0.5-1 lb. for outpatient).
- ◆ Intake should begin at about 1000-1600 cal/day and should be advanced progressively.
- ◆ Patients must be carefully observed for discarding food, vomiting, exercising frequently, or increased nonexercise activity.
- ◆ Medical monitoring during nutritional rehabilitation:
 - ▶ Vital signs (blood pressure, pulse, respiratory rate)
 - ▶ Food and fluid intake and output
 - ▶ Monitoring of electrolytes (including phosphorus)
 - ▶ Observation for rapid weight gain
 - ▶ Observation for edema and congestive heart failure
 - ▶ Observation for gastrointestinal symptoms (especially bloating and constipation.)
 - ▶ If weight is less than 70% of standard weight (severely malnourished)
- ◆ Concerns about body image, health risks associated with eating disorders and provision of general ongoing support is also part of nutritional rehabilitation.

Medications

- ◆ Psychiatric medications should not be used as the sole or primary treatment.
- ◆ After weight gain, the patient can be assessed for antidepressant medication.
 - ▶ Major Depression or Dysthymic Disorder may be present.
 - ▶ The selective serotonin re-uptake inhibitors (Prozac, Celexa, Zoloft, Paxil, Luvox) may be helpful, though the data from controlled studies are mixed.
 - ▶ Patients with evidence of Obsessive-Compulsive symptoms may also respond positively to the SSRIs.

Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
 - ▶ A specific appointment is made before discharge and patient is aware of appointment.
 - ▶ Patient has means to get to appointment, and, if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.



Disorders of Impulse Control: Intermittent Explosive Disorder

DSM-IV Diagnostic Criteria for Intermittent Explosive Disorder

- A Are there discrete episodes of failure to resist aggressive impulses that result in serious acts of assault or destruction of property?
- B Is the degree of aggression expressed during the episodes grossly out of proportion to the any precipitating psychosocial stressors?
- C Have other diagnoses and substance use/abuse been ruled out as a cause of the symptoms?

Treatment Plan

Specific considerations

- ◆ There is little literature on this disorder.
- ◆ Some authors feel this may be a variant of mania (“micromania”).
- ◆ During the episode, the patient may be markedly violent and dangerous to others.
- ◆ The episodes are usually short, 20-30 minutes.
- ◆ Usually, the patient comes to the attention of behavioral health after the episode has passed.
- ◆ Episodes may be occasionally witnessed in an inpatient setting.
- ◆ Episodes may result in arrest and/ or incarceration.

Medications

- ◆ Most psychiatric medications, and some non-psychiatric medications, have been used in the treatment of this disorder. (See Section on Bipolar Affective Disorders for more information on these medications.)

- ◆ Medications used in the treatment disorder include:
 - ▶ Lithium
 - ▶ Anticonvulsants
 - Carbamazepine [Tegretol]
 - Valproate [Depakote]
 - Clonazepam [Klonopin]
 - Gabapentin [Neurontin]
 - Lamotrigine [Lamictal]
 - Topiramate [Topamax]
 - Tiagabine [Gabatril]
 - ▶ Antidepressant Medications [See Section on Major Depressive Disorder for more information on these medications]. The selective serotonin re-uptake inhibitors have been occasionally effective.
 - Sertraline [Zoloft]
 - Paroxetine [Paxil]
 - Fluoxetine [Prozac]
 - Citalopram [Celexa]
 - Fluvoxamine [Luvox]
 - ▶ Miscellaneous
 - Antiarrhythmics
 - Propranolol [Inderal]

Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
 - ▶ A specific appointment is made before discharge and patient is aware of appointment.
 - ▶ Patient has means to get to appointment, and, if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Patient education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.



Personality Disorders: Antisocial Personality Disorder

DSM-IV Diagnostic Criteria for Antisocial Personality Disorder

- A** Is there a pattern of disregard for and a violation of the rights of others, occurring from the age of 15, as indicated by three or more of the following?
1. Failure to conform to the social norms with respect to the law, as indicated by acts that are grounds for arrest
 2. Deceitfulness, repeated lying, exploiting others for personal profit or pleasure
 3. Impulsivity or failure to plan ahead
 4. Irritability or aggressiveness as indicated by repeated physical fights
 5. Reckless disregard for the safety of others
 6. Consistent irresponsibility, failure to honor financial responsibility
 7. Lack of remorse, indifference to having hurt, mistreated, or stolen from another
- B** Is the individual age 18 years or older?
- C** Is there evidence of Conduct Disorder with onset before age 15 years?
- D** Did the antisocial behavior occur only during the course of an episode of Schizophrenia, or a Manic episode? (**Must be no for diagnosis.**)

Treatment Plan

Specific Considerations

- ◆ Personality disorders are lifelong characteristic ways of behaving, responding to stimuli, and interacting with others.
- ◆ Personality disorders are notoriously difficult to treat.
 - ▶ During periods of stress, these individuals may need to be hospitalized due to disorganized behavior, severe emotional distress, or severe acting out.
 - ▶ Individuals with this disorder are most often hospitalized when this disorder is comorbid with another disorder, frequently substance abuse.

- ▶ These individuals may feign symptomatology to be admitted to avoid the consequences of their behavior.
- ▶ Inpatient treatment is focussed on symptom reduction and behavioral containment.
- ▶ Behavioral therapy approaches may be the most effective with these patients; insight oriented psychotherapy has little or no usefulness in these patients.
- ▶ Medication is not a primary treatment for this disorder.
- ▶ Potentially addicting medications or medications that can be abused should be avoided in this patient population.
- ▶ Manipulation, splitting, and exploitation of others are often seen in the inpatient setting.
- ▶ Feigned suicidal ideation to obtain admission is common in this population.
- ▶ Occasionally, individuals with this disorder may intentionally harm themselves to obtain admissions or narcotic analgesics. The harm is rarely life threatening or based on true suicidal ideation or intent.
- ▶ Treatment options for this population should be limited and clear.

Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
 - ▶ A specific appointment is made before discharge and patient is aware of appointment.
 - ▶ Patient has means to get to appointment, and, if not, transportation is arranged
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Family education, if indicated, is conducted before discharge.
- ◆ Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.



Borderline Personality Disorder

DSM-IV Diagnostic Criteria for Borderline Personality Disorder

- A** Is there a pervasive pattern of instability of interpersonal relationships, self-image, and affects and a marked impulsivity beginning in early adulthood and present in a variety of contexts as indicated by five or more of the following?
1. Frantic efforts to avoid real or imagined abandonment
 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between the extremes of idealization and devaluation
 3. Identity disturbance as indicated by a markedly and persistently unstable self-image
 4. Impulsivity in at least two areas that are self-damaging, such as excessive spending, reckless driving, binge eating, substance abuse. (Do not include suicidal behavior in item 5).
 5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behaviors
 6. Affective instability due to marked reactivity of mood (intense episodic dysphoria, irritability, or anxiety usually lasting a few hours, but not more than a few days)
 7. Chronic feelings of emptiness
 8. Inappropriate intense anger or difficulty controlling anger (for example, frequent displays of temper, constant anger, recurrent physical fights)
 9. Transient stress-related paranoid ideation or severe dissociative symptoms

Treatment

Specific considerations

- ◆ Usually the need for inpatient treatment is the result of suicidal ideation, although brief psychotic episodes or substance abuse may be the primary reason for admission or may be co-morbid with suicidal ideation.
- ◆ Treatment of patients with borderline personality disorder may be exceptionally difficult, with many setbacks and admissions.

- ◆ Treatment plans should have highly specific behavioral goals for the patient.
- ◆ These patients may be difficult to remove from an inpatient setting with increased symptomatology developing as discharge approaches.
- ◆ Discharge should be planned well in advance and should be known by the patient.
- ◆ The manipulative behaviors of these patients may be especially problematic and require behavioral contracts.
- ◆ If possible, admission should be avoided.

Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
 - ▶ A specific appointment is made before discharge and patient is aware of appointment.
 - ▶ Patient has means to get to appointment, and, if not, transportation is arranged
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Patient and family education about medications, signs of patient's condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.