

HUMAN BEHAVIOR COURSE

BLOCK IV SYLLABUS

DISORDERS

SPECIAL TOPICS

Academic Year 2004

HUMAN BEHAVIOR COURSE 2004

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HUMAN BEHAVIOR COURSE 2004

DATES

JANUARY 8 (THURSDAY).....COURSE STARTS

FEBRUARY 19 (THURSDAY).....**MANDATORY:** FIRST SMALL GROUP

MARCH 4 (THURSDAY).....BLOCK ONE EXAM

APRIL 2 (FRIDAY).....LAST DAY TO DECLARE INTENT & TOPIC FOR PAR PROJECT

APRIL 2 (FRIDAY).....**MANDATORY:** SECOND SMALL GROUP

APRIL 7 (WEDNESDAY).....BLOCK TWO EXAM

APRIL 9 (FRIDAY).....**MANDATORY:** THIRD SMALL GROUP

APRIL 19 (WEDNESDAY).....**MANDATORY:** TORREY & FRESE LECTURE ON SCHIZOPHRENIA

APRIL 26 (MONDAY).....PAR PROJECT DUE (BONUS POINTS)

APRIL 26 (MONDAY).....BLOCK THREE EXAM

APRIL 26 (MONDAY).....**MANDATORY:** FOURTH SMALL GROUP

APRIL 28 (WEDNESDAY).....**MANDATORY:** JAMISON LECTURE ON SUICIDE & MOOD DISORDERS

MAY 5 (WEDNESDAY).....BLOCK FOUR & FINAL EXAM

MAY 15 (FRIDAY).....FINAL COURSE GRADES POSTED

HUMAN BEHAVIOR COURSE 2004

OBJECTIVES

MAIN OBJECTIVE. Introduce second-year medical students to the theory and practice of psychiatry and biopsychosocial patient care.

LEARNING OBJECTIVES.

Students should achieve the following objectives during the Human Behavior Course:

1. Learn the phenomenology and range of normal and disordered behavior, emotions, and relationships over the human life span.
2. Grasp the concept and application of the biopsychosocial model to general medical and psychiatric care.
3. Learn and practice how to create biopsychosocial formulations and management plans for patients.
4. Understand and discuss the impact of various predisposing, protective, precipitating, perpetuating, and therapeutic factors on the natural history of psychiatric disorders.
5. Rehearse prioritized differential diagnoses based on appropriate nomenclature, diagnostic categories, and criteria using patient vignettes or actual patient histories.
6. Develop a foundation of knowledge and experience in psychiatry that is applicable to medical practice and a framework for new knowledge obtained using various life-long learning strategies.

HUMAN BEHAVIOR COURSE 2004 ATTENDANCE

ABSENCES. To be excused from any mandatory activity (e.g., small groups, examinations) you must notify Dr. Engel in writing **AT LEAST 24 HOURS** prior to your absence, emergencies excepted.

ALL SMALL GROUPS ARE MANDATORY. They will meet in rooms and labs as assigned. Please see "Small Group Assignments" section of the syllabus for details. The small group sessions may be found in the main class schedule (course hours 15, 22, 27, and 36).

SOME LECTURES ARE MANDATORY. Some of the course lectures are mandatory because guest lecturers, patients, or family members of patients are volunteering their time (and in some cases traveling great distances) to speak to the class. **Mandatory lectures are bolded in the main class schedule.** To learn more about the lecturers, see the "Lecturers" section of this syllabus.

CONSEQUENCES OF MISSING MANDATORY ACTIVITIES. Role is taken at all mandatory lectures and small groups. More than one unexcused absence from the mandatory course activities (lectures plus small groups) will drop the responsible student's course grade one letter grade (e.g., drop from B to C or from C to D). A more protracted pattern of unexcused absences (i.e., more than 3) may result in a failing course grade.

HUMAN BEHAVIOR COURSE 2004 TEXT & REQUIRED READINGS

REQUIRED COURSE READINGS ARE FROM:

Cohen BJ. *Theory and Practice of Psychiatry*. Oxford University Press, New York, NY; 2003. Students should review the assigned readings prior to attending lectures. This book is lent to each student for the duration of the course. Please don't mark in these books because they will be reused.

THE REFERENCE TEXT FOR THE COURSE IS:

Hales RE, Yudofsky SC, Editors. *Textbook of Clinical Psychiatry*, 4th Edition. American Psychiatric Press, Washington, DC; 2002. This book has been issued to students and comes with a CD-ROM version of the complete *Diagnostic & Statistical Manual, Fourth Edition (Text Revision)* (DSM-IV-TR). DSM-IV-TR is the principal diagnostic manual used in clinical psychiatry. Neither these two books are required reading for the Human Behavior Course. However they are useful reference texts that provide broader and more comprehensive coverage of psychiatry than the Cohen book.

NOTE: The Hales & Yudofsky chapter on normal development (chapter 2) is *required* reading for the normal development lectures in the course that are delivered by Dr. Gemelli. This is the only exception to the rule that Hales & Yudofsky is not required reading for the course.

HUMAN BEHAVIOR COURSE 2004 SCHEDULE (V3)

Lectures are in Lecture Room D unless otherwise noted.

| PART I. | | | FUNDAMENTALS. | LECTURER |
|---------|---------------|---------------|--|----------|
| 1. | 8 Jan THU | 0730- 0745 | Course Introduction READ: Introductory Parts of the Syllabus | Engel |
| 2. | 8 Jan THU | 0745- 0820 | Global Burden of Psychiatric Disorders READ: Syllabus | Engel |
| 3. | 8 Jan THU | 0830- 0920 | Neurobiology of Psychiatric Disorders One READ: Syllabus & Cohen Ch 4 | Lacy |
| 4. | 15 Jan THU | 0730- 0820 | Neurobiology of Psychiatric Disorders Two READ: Syllabus & Cohen Ch 4 | Lacy |

| PART II. | | | DEVELOPMENT. | LECTURER |
|----------|---------------|---------------|---|----------|
| 5. | 15 Jan THU | 0830- 0920 | Suicide READ: Cohen Ch 16 | Engel |
| 6. | 22 Jan THU | 0730- 0820 | Infancy & Toddlerhood READ: Hales & Yudofsky Ch 2:67-105 | Gemelli |
| 7. | 22 Jan THU | 0830- 0920 | Infancy & Toddlerhood READ: Hales & Yudofsky Ch 2:67-105 | Gemelli |
| 8. | 29 Jan THU | 0730- 0820 | Childhood READ: Hales & Yudofsky Ch 2:67-105 | Gemelli |
| 9. | 29 Jan THU | 0830- 0920 | Childhood READ: Hales & Yudofsky Ch 2:67-105 | Gemelli |
| 10. | 5 Feb THU | 0730- 0820 | Adolescence READ: Hales & Yudofsky Ch 2:67-105 | Gemelli |
| 11. | 5 Feb THU | 0830- 0920 | Adolescence READ: Hales & Yudofsky Ch 2:67-105 | Gemelli |

| PART III. | | | ASSESSMENT | LECTURER |
|------------------|---------------|-----------|--|-----------------|
| | | | | |
| 12. | 12 Feb THU | 0730-0820 | Psychiatric Evaluation, Diagnosis, & Formulation READ: Cohen Ch 1, 2, 3 | Engel |
| 13. | 12 Feb THU | 0830-0920 | Violence READ: Cohen Ch 17 | Engel |
| 14. | 17 Feb TUE | 0730-0820 | Adult Development READ: Syllabus only | Privitera |
| 15. | 19 Feb THU | 0730-0920 | DIAGNOSIS & FORMULATION ONE TOPIC: Introduction to Diagnosis & Formulation READ: Syllabus only | Faculty |

| PART IV. | | | MAJOR DISORDERS. | LECTURER |
|-----------------|---------------|-----------|------------------------------|-----------------|
| | | | | |
| 16. | 26 Feb THU | 0730-0820 | Delirium READ: Cohen Ch 5 | Engel |
| 17. | 26 Feb THU | 0830-0920 | Dementia READ: Cohen Ch 6 | Engel |

| | | |
|---------------------|--|---|
| BLOCK 1 EXAM | | THURSDAY MARCH 4 0830-0920 [COVERS LECTURE HOURS 2-15] |
|---------------------|--|---|

| PART IV. | | | MAJOR DISORDERS (Continued). | LECTURER |
|-----------------|-----------------------|------------------|---|-------------------------|
| | | | | |
| 18. | 29 Mar MON | 0730-0820 | Psychotherapies One READ: Cohen Ch 18 | Ursano |
| 19. | 29 Mar MON | 0830-0920 | Psychotherapies Two READ: Cohen Ch 18 | Ursano |
| 20. | 31 Mar WED | 0730-0820 | Schizophrenia & Psychosis One READ: Cohen Ch 8 | Torrey Frese |
| 21. | 31 Mar WED | 0830-0920 | Schizophrenia & Psychosis Two READ: Cohen Ch 8 | Torrey Frese |
| 22. | 2 Apr FRI | 0730-0920 | DIAGNOSIS & FORMULATION II TOPIC: Gender-Related Issues READ: Syllabus only | Faculty |
| 23. | 5 Apr MON | 0930-1020 | Anxiety Disorders One READ: Cohen Ch 9 | Engel |

| PART V. | | | MAJOR DISORDERS (Continued). | LECTURER |
|---------|--------------|---------------|---|----------|
| 24. | 5 Apr MON | 1030- 1120 | Substance Use Disorders READ: Cohen Ch. 12 | Holloway |

| | | |
|-------------------------|--|---|
| BLOCK 2 EXAM | | WEDNESDAY 7 APRIL 0730-0820 [COVERS LECTURE HOURS 16-24] |
|-------------------------|--|---|

| PART V. | | | MAJOR DISORDERS (Continued). | LECTURER |
|---------|---------------|---------------|---|-------------------|
| 25. | 7 Apr WED | 0830- 0920 | Somatoform & Related Disorders READ: Cohen Ch 13 | Engel |
| 26. | 7 Apr WED | 0930- 1020 | Reactions to Stress & Trauma READ: Cohen Ch 9:273-280; Ch 7:Table 7-6; & Ch 14 | Osuch |
| 27. | 9 Apr FRI | 0730- 0920 | DIAGNOSIS & FORMULATION III TOPIC: Social & Cultural Aspects of Psychiatry READ: Cohen Ch 7 | Faculty |
| 28. | 12 Apr MON | 0730- 0820 | Eating Disorders READ: Cohen Ch 11 | Hall |
| 29. | 12 Apr MON | 0830- 0920 | Developmental Disorders & Mental Retardation READ: Cohen Ch 19 | Randall Hanson |
| 30. | 14 Apr WED | 0930- 1020 | Childhood Disorders READ: Cohen Ch 19 | Waldrep |
| 31. | 14 Apr WED | 1030- 1120 | Personality Disorders: Introduction & Cluster A Disorders READ: Cohen Ch 10 | Engel |
| 32. | 19 Apr MON | 0930- 1020 | Mood Disorders One Read: Cohen Ch 7 | Engel |
| 33. | 19 Apr MON | 1030- 1120 | Anxiety Disorders Two READ: Cohen Ch 9 | Engel |
| 34. | 21 Apr WED | 0930- 1020 | Forensic Psychiatry READ: Cohen Ch 20 | Benedek |
| 35. | 21 Apr WED | 1030- 1120 | Schizophrenia & Psychosis Three READ: Cohen Ch 8 | Engel |

| | | |
|-------------------------|--|---|
| BLOCK 3 EXAM | | MONDAY 26 APR 0730-0820 [COVERS LECTURE HOURS 25-31] |
|-------------------------|--|---|

| PART V. | | MAJOR DISORDERS (Continued). | | LECTURER |
|----------------|-----------------------------|-------------------------------------|---|-----------------|
| | | | | |
| 36. | 26 Apr MON | 0830- 1020 | DIAGNOSIS & FORMULATION IV TOPIC: The Geriatric Patient READ: Syllabus | Faculty |
| 37. | 28 Apr WED | 0930- 1020 | Mood Disorders Two READ: Cohen Ch 7 | Jamison |
| 38. | 28 Apr WED | 1030- 1120 | Mood Disorders Three READ: Cohen Ch 7 | Jamison |
| 39. | 3 May MON | 0930- 1020 | Sexual & Gender Identity Disorders READ: Cohen Ch 15 | Engel |
| 40. | 3 May MON | 1030- 1120 | Personality Disorders: Cluster B and Cluster C Disorders READ: Cohen Ch 10 | Engel |
| 41. | 4 May TUE | 0930- 1020 | Military Psychiatry READ: Syllabus | Holloway |
| 42. | 4 May TUE | 1030- 1120 | Comprehensive Review Session | Engel |

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|-----------------------|--|---|
| FINAL EXAM | | WEDNESDAY 5 MAY 0730-1030 [COMPREHENSIVE BUT EMPHASIZES LECTURE HOURS 32-42] |
|-----------------------|--|---|

HUMAN BEHAVIOR COURSE 2004

GRADING

POSTING OF GRADES. During the course, exam grades will be posted outside Dr. Engel's office, B3066.

EXAM EMPHASIS. Not all topics will receive equal emphasis on examinations. Generally, lecture topics are weighted on the exams in proportion to the amount of class time spent on them. Topics that receive a little more emphasis on exams than one might expect from the amount of course time spent on them include neuropsychiatry, mood disorders, schizophrenia, substance use disorders, disorders resulting from situational stressors, anxiety disorders, suicide and violence.

CHALLENGES TO EXAM QUESTIONS. Students will have five working days after exam grades are posted to challenge exam questions. Challenges are to be submitted electronically to the class representative, who collates them without editing into a single submission to Dr. Engel (cengel@usuhs.mil).

To successfully challenge an answer to any Human Behavior Course exam question, students must make their case based upon statements from the book, the lectures, and/or the way the question is worded. All course director decisions regarding exam question challenges are final.

EXAMINATIONS.

Block Exams: 120 points (three exams worth 40 points each)

All examinations will be administered in Lecture Room D. The format for all examinations is the same and consists of single-best-answer multiple choice and extended-matching questions.

Final Exam: 72 points

32 points on this examination will address cumulative course content. 40 points will cover the last course block only.

Small Groups (ATTENDANCE MANDATORY): 8 points (four groups worth up to 2 points each)

There are four small group sessions during the course. Any readings assigned for the small groups are testable for exam purposes. Students earn a grade from 0-2 points per small group session. Small group leaders evaluate and grade student participation (absent & unexcused=0; present=1; active in discussions=2). Student concerns or complaints regarding any small group may be addressed by email to Dr. Engel. Except for determinations regarding excused versus unexcused absences, however, small group leader grades are final. Small group evaluations of student performance can be decisive for students on the border between grades.

Bonus Points: 10 points possible

Up to 10 bonus points will be added to your final grade point average **after** letter grade cutoffs have been determined from examination and small group performance. These points can make a major difference in your overall grade. BONUS POINT ACTIVITIES ARE VOLUNTARY and amount to 'extra credit' work. Bonus points can have a significant impact on your final course grade. Bonus points are earned by successfully completing a **Psychiatry Academic Report (PAR)**, as described the corresponding section of the syllabus. Note that the PAR must be completed on time to be eligible for full credit.

FINAL COURSE GRADES.

Final grades will be disseminated to students at the end of the course. The final grade will reflect each exam score, each small group grade, and any bonus points received during the course. If you wish to have us email your final grade to you, please notify Dr. Engel or Jennifer Stecklein at or before the Final Exam.

FINAL COURSE POINT TOTAL (up to 210 points)

Block Exams (up to 120 pts) + Final Exam (up to 72 pts) + Small Group (8 pts) + Bonus Points

Dr. Engel will assign all students a preliminary course letter grade based on your course point total before bonus points are added. The ranges listed below are based on the class grades from previous years and serve as a guideline.

| CLASS STANDING RELATIVE THE MEAN IN SD | GRADE |
|--|-------|
| Greater than +1.1 SD from Class Mean | A |
| Class Mean to + 1.1 SD From Class Mean | B |
| -1.5 SD to Class Mean | C |
| -2.0 SD to -1.5 SD from Class Mean | D |
| Less than -2.0 SD from Class Mean | F |

Once the class curve and individual grade cut points have been established, bonus points are added, and the final course point total and grade are determined. Academic Awards will be based on your final course point total that includes your bonus points. A letter grade of "I" (incomplete) will be given for failure to complete required assignments, tests, or the final course evaluation.

Some years, students score very well as a group, leading to an unfairly difficult class curve. To prevent this from occurring, any student with a final course point total of 90% or greater is insured an "A", 80% or greater at least a "B", 70% or greater at least a "C", and 65% or greater at least a "D."

ACADEMIC DIFFICULTIES.

What the department will do:

- **After the Block 2 Exam.** Any student with a cumulative point total of less than -2.0 SD who is scoring less than 65% on the first two examinations must meet with Dr. Engel to discuss the situation.
- **After the Block 3 Exam.** Any student with a cumulative point total of less than -2.0 SD who is scoring less than 65% on the first two examinations will be offered a plan of remedial action. The student and the Associate Dean for Student Affairs will be notified of the potential for academic deficiency.

What you can do:

- *Don't* wait for the last minute.
- *Don't* be afraid to ask for assistance.
- *Don't* take the course lightly. We do everything we can to get students successfully 'past the finish line'. However, every year four or five people struggle to get a 'C' final grade, and one or two students struggle to get a 'D' final grade. A small percent of students have failed the course (perhaps one student in every 200 or so that take the course) and must either take it again, complete a PAR after the course is over (getting in the way of spring USMLE exams), and/or have to take an extra clinical psychiatry rotation in the fourth year. Don't be one of these students!
- Do anticipate emerging academic or scheduling problems. Meet with Dr. Engel to prevent them. Dr. Engel maintains an open door policy for students, but 'drop-in' visits may sometimes be impossible, so please request an appointment via email ahead of time (cengel@usuhs.mil). Please suggest two or three possible meeting times and wait for Dr. Engel's reply.
- Do Contact Jennifer Stecklein B3066 (295-9799 or 9796 or jstecklein@usuhs.mil) if you have any trouble contacting Dr. Engel.

DISCIPLINARY ACTIONS.

Any student who does not display consistent seriousness of purpose and effort may be denied a letter grade above a C. Small group facilitator evaluations of student performance during small group sessions can be a decisive factor for students who are on the border between the A/B, B/C, or C/D grades. Dr. Engel reserves the right to change a student's letter grade if there is sufficient evidence of inappropriate, disruptive, or unethical behavior. This includes actions disruptive to other students or to faculty.

HUMAN BEHAVIOR COURSE 2004

PAR

CONCEPT. The Psychiatry Academic Report (PAR) is an optional project that allows you to obtain bonus points toward your final course grade (see 'Grading' section in this syllabus). The objective of the project is to cultivate independent learning skills that will be critical to your continued success as a clinician and to give you a chance to pursue a topic of interest in psychiatry.

WHY DO A PAR? The biggest and most immediate benefit is on the course grade. In past years, 80% of individuals completing a PAR raised their final point total enough to come up one full letter grade for the course. A PAR can also bring departmental visibility to the students producing it. Each year, the student completing the best PAR (determined by department faculty consensus) is invited to present his or her work to the entire National Capital Area Department of Psychiatry Grand Rounds at Walter Reed Army Medical Center. There may be the opportunity for other students to similarly present their work too. This kind of visibility may be a big benefit if a student is considering psychiatry as a career. Lastly, a good PAR can support write-ups required in the third year USUHS psychiatry clerkship.

APPROACH. The PAR is an optional project that students complete individually to receive course bonus points (essentially extra credit points). **Student collaboration on PAR projects is not allowed.** In other words, the PAR is an independent project, not a group project. Any student with an innovative idea for a PAR, i.e., one that deviates from the formats described below, is encouraged to discuss his or her idea with Dr. Engel. **All topics and ideas must receive his approval in advance to be accepted for bonus points.**

SUGGESTED FORMATS. Please double-space all PARs.

Format One (Good for up to 10 bonus points): Conventional Report

This type of PAR is essentially a substantial and relatively conventional report on any topic pertaining to Psychiatry. The standards for Format One PARs are as follows:

1. Title page. Include title, author, date of completion.
2. Abstract. Summarize the paper in 250-400 words.
3. The body of the PAR should contain some appropriate visuals such as pictures, tables, or figures.
4. Length of the overall report excluding references should be 4,500-6,000 words (15-25 double-spaced pages of 12-point text with one inch margins).
5. Clinical case examples are often useful to illustrate points but they are not required.
6. PAR literature citations should emphasize primary articles from the medical or social science literature. Citing textbooks is discouraged, but published review articles are acceptable, and often textbooks can help the student to identify relevant primary literature.
 - A. A minimum of 10 and maximum of 30 literature citations is required.
 - B. Citations must be formatted in a consistent manner. The recommended format for citations may be found in the "information for authors" posted in the journal *JAMA* (see <http://jama.ama-assn.org/info/auinst.html>).

Format Two (Good for up to 10 bonus points): Book Report/Review.

Novel or biographical account that focuses on an individual with an apparent psychiatric disorder. Books may address an individual with a major axis I psychiatric disorder such as schizophrenia (many great books of this sort, for example, *Shine* or *A Beautiful Mind*) or an individual with an axis II disorder such as mental retardation or an apparent personality disorder. The resulting book report would be 3,000-4,000 words (10-15 double-spaced pages of 12-point text with one inch margins) and should focus on a specific issue relevant to psychiatry. The student should clearly state the issue they want to develop after reading the book and use 5-10 references from the medical or social sciences literature to support the discussion. Issues of relevance, for example, might include stigma, patient versus clinician perspective of psychiatric disorders, the range of disability associated with psychiatric disorders, or differential diagnosis of a particular psychiatric symptom or sign. **Students should seek course director approval or advice regarding an appropriate book before reading it for the course.** To receive bonus points, the student must read the book during the period of time

encompassing the Human Behavior Course. Students are not allowed to report on a book they have previously read.

Format Three (Good for up to 5 bonus points each, but students can do up to two for a maximum of 10 total bonus points). Movie Review.

Movies reviews should address a movie that focuses on an individual with an apparent psychiatric disorder. Movies may address an individual with a major axis I psychiatric disorder such as schizophrenia or an individual with an axis II disorder such as mental retardation or an apparent personality disorder. The resulting movie review should be 2,000-3,000 words (7-10 double-spaced pages of 12-point text with one inch margins) and should focus on a specific issue relevant to psychiatry. The student should clearly state the issue they want to develop after reading the book and use up to 5 references from the medical or social sciences literature to support the discussion. Issues of relevance, for example, might include stigma, patient versus clinician perspective of psychiatric disorders, the range of disability associated with psychiatric disorders, or differential diagnosis of a particular psychiatric symptom or sign. **Students should seek course director approval or advice regarding an appropriate movie to review before watching it for the course.** To receive bonus points, the student must watch the movie during the period of time encompassing the Human Behavior Course. Students are not allowed to report on a movie they have previously viewed.

GRADING. Dr. Engel will coordinate Department of Psychiatry faculty reviews of and grades for the completed PARs.

DUE DATES. To receive bonus points, you must submit your topic(s) to Dr. Engel on email (cengel@usuhs.mil) by **COB Friday April 2**. Any student missing this deadline cannot receive bonus points (exceptions to this rule may be made for students who discover late that they are struggling to pass the course – note that this exception will not be extended to people are otherwise passing and decide late that they want to raise their grade). A completed electronic version of the PAR must be submitted to Dr. Engel by **COB Monday April 26** (please note that this is also the date of the block 3 examination, so students are warned not to wait until the last minute to complete the PAR). PARs submitted late but before May 3 will be accepted but cannot receive more than half credit. PARs submitted after COB April 28 will not receive bonus points unless by previous arrangement with Dr. Engel (usually reserved for students struggling to pass the course or students with extenuating personal circumstances that prevent them from meeting the regular deadline).

PLAGIARISM: It is increasingly easy to plagiarize previously written reviews or reports by cutting and pasting material from the World Wide Web and other source material. All PARs are submitted to a web-based service that reviews them for evidence of plagiarism. Any student who has plagiarized all or part of their PAR will be punished to the maximum extent allowed by University policy.

HUMAN BEHAVIOR COURSE 2004

WEB

THE HUMAN BEHAVIOR COURSE WEBSITE IS AT <http://cim.usuhs.mil/ps02001/>

WEBSITE PURPOSE. The course website is a centralized repository for course materials. Content includes:

1. A homepage with recent course announcements and reminders.
2. A bulletin board for asking questions pertinent to other students.
3. Syllabus materials – for example, notices regarding modifications may be found on the site.
4. Study materials – for example, old exams.
5. Downloadable lecture slides.
6. Class curves, answers to the exams, and responses to student exam challenges.

ACCESSING THE SITE. It is recommended that you access the course website once each week. This will insure you don't miss important course announcements and other developments. Having said that, all course announcements will be sent via email at the same time it is placed on the website. Emails to the students will routinely contain a link to the course website reminding students to log in to the site. If you have any trouble linking to the site, please contact Jennifer Stecklein or Dr. Engel for assistance.

SOME OTHER INTERNET PSYCHIATRY RESOURCES.

These Internet resources may prove useful during the course or in the future. For students planning to complete the Psychiatry Academic Report (PAR) for up to five bonus points at the end of the course, these links may provide useful leads when planning for web-links to sites related to your report. There is also a website for obtaining software compatible with the Palm OS. There are many programs relevant to psychiatry that are designed to run on the students' issued palm devices.

USEFUL SITES FOR RESEARCHING THE PAR BONUS PROJECT.

PubMed.

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>

Particularly user-friendly.

Free Medical Journals.com.

<http://www.freemedicaljournals.com/>

Good for finding full text journal articles and/or abstracts of key articles from the peer-reviewed medical literature.

Evidence-Based Mental Health.

<http://www.ebmentalhealth.com>

This site covers the quarterly journal, "Evidence-Based Mental Health". The journal summarizes clinically relevant evidence of clinical utility for psychiatrists and other clinicians.

Palm, Inc. Software Site.

<http://www.handango.com/>

Go to the 'search for software' box, and enter terms like 'psychiatry', 'psychiatrist', 'mental', 'psychology', and 'psychologist' and see what comes up. Lots of inexpensive and often useful software for PDAs. Be sure to check out a shareware program called, "Eliza Pilot Psychologist".

USEFUL SITES FOR MEDICAL STUDENTS LEARNING PSYCHIATRY.

CAUTION! The accuracy of the information found on the web varies from site to site and sometimes from topic to topic within a given site. In short, the sites below are variably quality controlled, so while we endorse their general use, Dr. Engel, Dr. Privitera, and the Department of Psychiatry at USUHS do not "stand behind" the information found on them.

Emergency Psychiatry Service Handbook.

<http://www.vh.org/Providers/Lectures/EmergencyMed/Psychiatry/TOC.html>

A Virtual Hospital and a University of Iowa Hospitals and Clinics sponsored tool.

US Naval Flight Surgeon's Manual – Psychiatry.

<http://www.vnh.org/FSManual/06/SectionTop.html>

A Virtual Naval Hospital product is available for 330 page adobe file download called “Aviation Psychiatry Handbook”.

Iowa Family Practice Handbook – Psychiatry.

http://www.vh.org/navigation/vh/topics/adult_provider_psychiatry.html

Internet Mental Health – Psychiatry.

<http://www.mentalhealth.com/>

Merck Manual – Psychiatry.

<http://www.merck.com/pubs/mmanual/section15/sec15.htm>

HUMAN BEHAVIOR COURSE 2004

SMALL GROUPS

Small groups are central to the structure of the Human Behavior Course. Small groups meet for four small group sessions (see the "Schedule" or "Dates" sections of this syllabus). All of these small group meetings will take place in the rooms designated below. **SMALL GROUP SESSIONS ARE MANDATORY.**

| GROUP | STUDENT NAMES | ROOM NUMBER & STUDENT NAMES |
|----------------|---|---|
| Group A | | Room A2015 |
| | Adams, Michael Burkhardt, Gabriel Callis, William Damasco, Leo Egloff, Brian George, Jennifer Gray, Jon | Haggerty, Paul Kaesberg, Julie Matthews, Tokunbo Rabens, Clayton Schwalier, Erik Talley, William |
| Group B | | Room A2052A |
| | Adams, Thomas Barker, Patrick Dansie, Chad Faircloth, Ruth Kent, Zachary Lefringhouse, Jason Lynch, Michelle | McArthur, Conshombia Nasir, Javed Odone, James Porsi, Luke Rao, Luigi Ugochukwu, Obinna |
| Group C | | Room A2052B |
| | Afiesimama, Boma Campos, Napoleon Daschbach, Emily Harper, Stephen Ignacio, Patrick Jacobs, Justin Mack, Takman | Moore, Matthew Neiner, James Padlan, Claire Rappe, Jodie Seigh, Mark Tan, Erico |
| Group D | | Room A2053A |
| | Ajao, Michael Barna, Michael Capra, Gregory Gim, Sylvia Harris, Jason Kho, Ellie Lackey, Jeffrey | Maddox, John Martinez-Ross, Juan Palmer, Eldon Quan, Sara Redding, Shawn Shaffer, Brett |

| GROUP | STUDENT NAMES | ROOM NUMBER & STUDENT NAMES |
|----------------|--|--|
| | | |
| Group E | | Room A2053B |
| | Aldrich, Shelly Barstow, Craig Fasoldt, Jerry Gratrix, Max Jones, Ronald Lanzi, Joseph McArthur, Samuel | Neuffer, Marcus Patel, Shimul Reha, Jeffery Shayegan, Shahrooz Sundell, Zoe Royster, Don |
| Group F | | Room A2069 |
| | Allan, Nicholas Baldwin, Allister Capra, Jason Dimmer, Brian Ferguson, Katrina Gray, Kelly Hilton, William | Kitley, Charles Lee, Mary Nijjar, Upneet Paul, Michael Rice, Jason Simpson, Michael |
| Group G | | Room A2039 |
| | Angelidis, Matthew Bernzott, Stephanie Carbone, Peter Dirks, Michael Fernelius, Colby Lesperance, Richard Levy, Gary | McGill, Robert McPherson, John Payne, Kathryn Robinson, David Smith, Ryan Wright, Heath |
| Group H | | Room A2041 |
| | Arner, David Bode, David Cho, Timothy Downs, John Gregory, Leslie Hobernicht, Susan Lewis, Aaron | Mei, Jian Pederson, Aasta Rodgers, Blake Soto, Adam Tou, Kevin Wells, Nicholas |
| Group I | | Room A2045 |
| | Arnett, Gavin Brown, Jamey Cleaves, John Fick, Daryl Gudeman, Suzanne Hunsaker, John Kraus, Gregory | Lewis, Troy Messmer, Caroline Penska, Keith Rodgers, Matthew Stringer, Sarah Treffer, Christine |

| GROUP | STUDENT NAMES | ROOM NUMBER & STUDENT NAMES |
|----------------|---|--|
| | | |
| Group J | | Room A2049 |
| | Arnold, Michael Bryant, Summer Covey, Carlton Flaherty, Kathleen Gregory, Todd Liebig, Jonathan Liu, Scott | Mielcarek, Emily Phinney, Samuel Rogers, Derek Rose, David Summers, Noelle Vojta, Christopher |
| Group K | | Room A2057 |
| | Cragin, Douglas Fowler, Elizabeth Gwinn, Barbara Knudson, Todd Loveridge, Benjamin Longwell, Jason Lotridge, Jessica | Montenegro, Karla Moore, Jacqueline Pieroni, Kevin Rose, Matthew Summers, Thomas Wherry, Sean |
| Group L | | Room A2061 |
| | Bernhard, Jason Fox, David Hamele, Mitchell Luger, Richard Macian Allen, Diana Miletich, Derek Musikasinthorn, Chayanin Musser, John | Nelson, Austin Nelson, Austin Palmer, Bruce Rice, Robert Wright, Heath Vachon, Tyler |
| Group M | | Room A2065 |
| | Freeman, Benjamin Hicks, Brandi Loughlin, Carrie Lai, Tristan McDivitt, Jonathan Mosteller, David Poulin, John | Ryan, Jenny Sunkin, Jonathan Tintle, Scott White, Dennis Segura, Christopher Wilde, Matthew Weatherwax, Robert |

HUMAN BEHAVIOR COURSE 2004 LECTURERS

COURSE CONTACT INFORMATION.

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HUMAN BEHAVIOR COURSE LECTURERS.

David Benedek, MD MAJ, MC, USA

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Dr. Benedek is a member of the Walter Reed Army Medical Center staff and the National Capital Area Forensic Psychiatry Fellowship Director. He is a USU medical school graduate and completed general psychiatry and forensic psychiatry training in National Capital Area programs. Dr. Benedek was one of the first psychiatrists deployed to Bosnia and has presented his experiences there at an American Psychiatric Association annual meeting. Dr. Benedek comes from a rich family tradition in psychiatry: his mother is a past president of the American Psychiatric Association.

Charles Engel, MD, MPH LTC, MC, USA

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Dr. Engel is co-director of the Human Behavior Course with Dr. Privitera. He is a full-time member of the USU military faculty and the chief of the Deployment Health Center (formerly the Gulf War Health Center) at Walter Reed Army Medical Center, a center specializing in treatment and research related to redeployment health issues, especially unexplained illnesses such as the infamous "Gulf War Syndrome". Dr. Engel is a consultation-liaison psychiatrist and epidemiologist and served as the First Cavalry Division psychiatrist during the Gulf War. His interests include medically unexplained physical symptoms, clinical hazard communication, psychiatric practice in primary care, psychiatric research design, health services research, and teaching psychiatrists how to interpret and use research evidence.

Frederick J. Frese, III, PhD

For 15 years until his retirement in 1995, Fred Frese he served as Director of Psychology at Western Reserve Psychiatric Hospital, a state-operated facility in the Cleveland-Akron area. A member of the National Alliance for the Mentally Ill (NAMI) since 1989, Dr. Frese is currently the First Vice President of its National Board. He currently serves on the Board of the Summit County Alliance for the Mentally Ill.

Dr. Frese has given more than 300 presentations on topics related to serious mental illness in 30 states, Canada, Puerto Rico, and Washington, D.C. He has published extensively, and has been on the advisory reviewing boards of five professional journals, including Schizophrenia Bulletin. Along with his wife, Penny, he has also co-produced a widely distributed training video about coping with schizophrenia.

Dr. Frese has been a faculty member at Case Western Reserve University, Kent State, Ohio University, and Ashland Theological Seminary. He has also served as Chairperson of the Akron Area Mental Health Board. Dr. Frese was the founder and first president of Community and State Hospital Psychologists, the American Psychological Association's division for psychologists serving persons with serious mental illness. He also was on the Board of Trustees of the Ohio Psychological Association, where he served as Chair of the committee for the Mentally Ill Homeless. Additionally, he served as president of the National Mental Health Consumers' Association.

Dr. Frese served as a consultant to the Department of Veterans Affairs on a project to improve clinical practice. He has testified before congressional committees on priorities for public mental health services and is a part of the American Psychological Association Task Force for the Seriously Mentally Ill/Seriously Emotionally Disturbed.

Ralph Gemelli, MD CAPT(RET), MC, USN

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Dr. Gemelli is the founder of the USU Human Behavior Course, is a past psychiatric residency training director at National Naval Medical Center, and has been teaching the normal development portion of the course for many years. He is a psychoanalyst and is currently on the teaching faculty at the prestigious Washington Psychoanalytic Institute. He has recently published an excellent book on normal childhood development (10 copies are available for students in the library). Students consistently rate Dr. Gemelli's lectures as among the very best in the second year, and he is the recipient of numerous teaching awards. Dr. Gemelli is a Naval Academy graduate; the first Academy graduate to go directly into medical school upon completion of his Annapolis education.

Molly Hall, MD Col, MC, USAF

mhall@usuhs.mil

Dr. Hall is assigned to the Department of Psychiatry, USUHS as an associate professor. She has served in several capacities in the National Capital Area including Chief, Clinical Quality Management Division, Air Force Medical Operations Agency, Bolling AFB (1998-2000); Flight Commander, Mental Health Flight 89th Medical Group, Andrews AFB (1995-1998) and Consultant for Psychiatry to the USAF Surgeon General (1995-1999). Dr. Hall attended Yale College as a member of the first class of women and graduated magna cum laude in 1973 with Departmental Honors in Combined Sciences, Biology and Psychology. Col Hall attended Cornell University Medical College where she was elected to Alpha Omega Alpha in 1976. She joined the Air Force in 1985 and was assigned to Wright-Patterson AFB where she was the Psychiatry Residency program director until 1995. Col Hall received numerous Wright State University faculty awards, including the Career Achievement award in 1995 and was the recipient of the first annual Excellence in Medical Education award conferred by the American Psychiatric Association (APA) in 1991. She has served as a psychiatric consultant to the Astronaut Selection Board at NASA since graduating from the Aerospace Primary Course at Brooks AFB in 1990. Col Hall is a distinguished graduate of the Aerospace Medicine Course and a distinguished graduate of the Air War College Seminar. Col Hall has four children: Kate, Aaron, Hannah and Sarah and three dogs: Elsa, Bou and Merlin.

Jan Hanson, PhDjhanson@usuhs.mil

Dr. Hanson is a special educator and Research Assistant Professor of Pediatrics. She and Dr. Randall co-direct a project that involves parents of children with special needs and adults with chronic health conditions as advisors to the medical education program at USUHS. They have presented abstracts about family-centered care, involving patients and families as advisors, and the patient/physician relationship at many professional meetings. Before coming to USUHS, Dr. Hanson was Director for Research and Evaluation at the Institute for Family-Centered Care from 1992-1999. She has worked in a wide variety of educational and research settings, including special education programs for children of all ages, the DoD system of services for children with special needs, and pre-service and in-service education programs for educators and physicians. Dr. Hanson and Dr. Randall along with several parents will teach the lecture on developmental and learning disorders.

Harry Holloway, MD COL(RET), MC, USAhhollowa@impop.bellatlantic.net

Dr. Holloway is internationally respected as the dean of modern military psychiatry. He served thirty years in the US Army Medical Corps including tours in the Vietnam War, Thailand, and Walter Reed Army Institute of Research. He has around 50 publications and many scholarly works to his credit. He finished his active duty career as the first Chairman of Psychiatry at USU and later held positions as Deputy Dean and Acting Dean of the medical school and the director of life sciences at NASA. Arguably, Dr. Holloway knows more about substance abuse in the military than any other physician does. Currently, he is a co-principal investigator on a project aiming at assembling a scholarly history of substance use in the military through the year 1985. Dr. Holloway will speak to us on alcohol and other substance abuse, disorders due to traumatic events, and on military psychiatry.

Kay Redfield Jamison, PhD

Dr. Jamison is the daughter of an Air Force officer and was brought up in the Washington, D.C. area. She attended UCLA as an undergraduate and as a graduate student in psychology, and she joined the medical school faculty there in 1974. She later founded the UCLA Affective Disorders Clinic, which has treated thousands of patients for depression and manic-depression.

Dr. Jamison is now Professor of Psychiatry at the Johns Hopkins University School of Medicine. The textbook on manic-depressive illness that she wrote in association with Dr. Frederick Goodwin was chosen in 1990 as the Most Outstanding Book in Biomedical Sciences by the Association of American Publishers. She is also the author of, *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (1993), and has produced three public television specials on the subject: one on manic-depressive composers, one on Vincent van Gogh, and one on Lord Byron. In recent years she has written and spoken extensively on her own battle with bipolar disorder, publishing two award winning books, one on bipolar disorder (*An Unquiet Mind*, 1997), and one on suicide (*Night Falls Fast: Understanding Suicide*, 2000)

The recipient of numerous national and international scientific awards, Dr. Jamison was a member of the first National Advisory Council for Human Genome Research, and is currently the clinical director for the Dana Consortium on the Genetic Basis of Manic-Depressive Illness.

Timothy Lacy, MD Maj, MC, USAFtlacy@usuhs.mil

Dr. Lacy is the Malcolm Grow Medical Center site director for the National Capital Area Psychiatry Residency Program and the director of Family Practice - Psychiatry Combined Residency Program. Dr. Lacy is a graduate of Wilford Hall Air Force Psychiatry Residency Program. He is an expert on neuropsychiatry.

Charles Privitera, MD COL(RET), MC, USA

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Dr. Privitera is co-director of the Human Behavior Course with Dr. Engel. USU students know him best as the psychiatrist at the USU Student Health Center. He is a noted teacher and practitioner of family therapy who is a past USU Dean for Student Affairs. Dr. Privitera has many years of experience in academic medicine and medical student education. His parallel and complimentary roles as student counselor, mentor, and colleague make him ideally suited to teach the course lectures on adult development, the military family, and medical marriages. Dr. Privitera retired from Army medicine after a long and decorated military career.

Ginny Randall, MD COL, MC, USA

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Dr. Randall is a developmental pediatrician interested in children under three years of age with developmental disabilities such as cerebral palsy, mental retardation, and autism. She has been an Army pediatrician for 27 years, first as a general pediatrician in Alaska for 6 years, then specializing in developmental pediatrics, then doing a 9 year stretch at the Army Surgeon General's Office working on the policy and budget associated with the care of children with special needs in overseas locations. Currently, Dr. Randall is teaching pediatrics at USU and collaborating with Dr. Hanson in research involving parents of children with special needs as participants and facilitators of medical education.

E. Fuller Torrey, MD

Dr. Torrey is an internationally respected expert, clinician, and scientist specializing in schizophrenia and bipolar disorder. He is the Executive Director of the Stanley Foundation Research Programs, which supports research on schizophrenia and bipolar disorder. From 1976 to 1985, Dr. Torrey was on the clinical staff at St. Elizabeths Hospital, specializing in the treatment of severe psychiatric disorders. From 1988 to 1992, he directed a study of identical twins with schizophrenia and bipolar disorder. His research has explored viruses as a possible cause of these disorders, and he has carried out research in Ireland and Papua New Guinea. Dr. Torrey was educated at Princeton University (BA, Magna Cum Laude), McGill University (MD), and Stanford University (MA in Anthropology). He trained in psychiatry at Stanford University School of Medicine. He practiced general medicine in Ethiopia for two years as a Peace Corps physician, in the South Bronx in an OEO health center, and in Alaska in the Indian Health Service. From 1970 to 1975, he was a special assistant to the Director of the National Institute of Mental Health.

Dr. Torrey is the author of 16 books and more than 200 lay and professional papers. Some of his books have been translated into Japanese, Russian, Italian, and Polish. Dr. Torrey has appeared on national television (e.g., Donahue, Oprah, 20/20, 60 Minutes, and Dateline) and has written for many newspapers. He received two Commendation Medals from the US Public Health Service, a 1984 Special Families Award from the National Alliance for the Mentally Ill (NAMI), a 1991 National Caring Award, and in 1999 received research awards from the International Congress of Schizophrenia and from NARSAD.

Robert J. Ursano, MD Col(Ret), USAF, MC

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Dr. Ursano is a rabid Notre Dame football fan. When he is not rooting for the Fighting Irish, he serves as Professor and Chair, USU Department of Psychiatry. Dr. Ursano is an internationally respected expert on psychiatric responses to trauma who has co-authored more than 100 publications and written or edited several books. He is a psychoanalyst who has written and lectured extensively on psychotherapy, including psychotherapy for the medically ill, and he is on the editorial board of the Journal of Psychotherapy Research & Practice and Military Medicine. He completed his undergraduate education at Notre Dame. He went to medical school at Yale, but he doesn't seem to follow the Yale football team very closely.

Douglas A. Waldrep, MD LTC, MC, USA

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LTC Douglas A. Waldrep, MD, is presently assigned to the Department of Psychiatry Walter Reed Army Medical Center, Washington DC. After finishing his undergraduate education at West Point, NY and completing five years as a Field Artillery Officer in the United States Army he attended medical school on an Army scholarship at the Medical University of South Carolina, Charleston SC. He completed his General Psychiatry and Child and Adolescent Psychiatry training at Tripler Army Medical Center, Honolulu, HI. He has had the opportunity to practice in Heidelberg, Germany, Dwight D. Eisenhower Army Medical Center, Ft Gordon GA and presently at Walter Reed Army Medical Center. He has held multiple leadership positions in Army Psychiatry and is presently the Chief, Continuity Services, Assistant Psychiatry Training Director for the National Capital Area, Director of Curriculum, the site-training director for the Walter Reed Psychiatry Program as well as a member of the Center for the Study of Traumatic Stress, Uniformed Services University Bethesda, MD. He has spoken and published in the areas of adult, child and adolescent psychiatry. He is extremely happy to be married to Heda for 22 years and adores his two daughters Megan 21, 3rd year at the University of Georgia, and Caraline 14, a freshman at Sherwood High School, Sandy Spring, MD. His favorite past time is spoiling the women in his life.

**Human Behavior Course
2004**

PART IV

**MAJOR DISORDERS
(CONTINUED)**

Human Behavior Course 2004

Mood Disorders One Depressive Disorders

Charles C. Engel, MD, MPH
LTC, MC, USA
Associate Professor of Psychiatry
Uniformed Services University

HUMAN BEHAVIOR COURSE 2004

MOOD DISORDERS ONE - SLIDES

LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. Know the meaning of the terms and concepts listed in slide one to slide 3 below.
2. What is the difference between clinical depression and the everyday depression we all experience from time to time?
3. Name the different depressive disorders and whether they are very common (point prevalence > 5%), common (1-5%) or uncommon (<1%) in the general population.
4. Know whether each depressive disorder is more common in men, more common in women, or occurs in a similar proportion of men and women.
5. 3. Know the diagnostic criteria for major depressive disorder.
6. What is the difference between a major depressive episode and major depressive disorder?
7. What is the difference between dysthymic disorder and major depressive disorder?
8. What is the difference between bipolar 2 and major depressive disorder?
9. Know the subtypes of depression and the key characteristics or defining features of each.
10. Describe the pathogenesis of depression from a biological or neurophysiological perspective. What neurotransmitters, nervous system pathways, other body systems, and brain areas are involved?
11. Know the psychosocial causes of depression when considered from the psychoanalytic, object relations, cognitive, and behavioral perspectives.
12. What factors commonly predispose people to developing depression?
13. Know the basic psychotherapeutic, pharmacological, and somatic therapies used to treat depression.

Slide 1

Depression - Terms & Concepts

- ★ Depressive episode
- ★ Suicide
- ★ Mood disorder due to GMC
- ★ Substance included mood disorder
- ★ Major depressive disorder
- ★ Dysthymic disorder
- ★ Atypical depression
- ★ Seasonal affective disorder
- ★ Melancholic depression
- ★ Double depression
- ★ Premenstrual dysphoric disorder
- ★ Post-psychotic depressive disorder of schizophrenia
- ★ Post-stroke depression
- ★ Postpartum depression
- ★ Bereavement
- ★ Pseudounipolar depression
- ★ Parkinson's disease
- ★ Huntington's disease
- ★ Catatonia
- ★ Rejection sensitivity
- ★ Monoamine oxidase inhibitors
- ★ Selective serotonin reuptake inhibitors
- ★ Anger turned inward
- ★ Unconscious or symbolic loss
- ★ Internalized object representations
- ★ Psychoanalytic psychotherapy
- ★ Short-term therapies
- ★ Interpersonal psychotherapy
- ★ Cognitive therapy
- ★ Automatic thoughts
- ★ Selective abstraction
- ★ Arbitrary inference



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Depression - Terms & Concepts 2

- ★ Absolutist thinking
- ★ Magnification and minimization
- ★ Personalization
- ★ Catastrophic thinking
- ★ Collaborative empiricism
- ★ Cognitive schemas
- ★ Biogenic amine model
- ★ Monoamine theories
- ★ Non-monoamine theories
- ★ Global neurophysiologic theories
- ★ Neurophysiologic theories
- ★ Stress diathesis model
- ★ Antidepressant response versus remission
- ★ Phenelzine (Nardil)
- ★ Tranylcypromine (Parnate)
- ★ Tyramine reaction
- ★ Serotonin syndrome
- ★ Meperidine (Demerol)
- ★ Selegiline (Deprenyl)
- ★ Moclobemide
- ★ Imipramine
- ★ Amitriptyline
- ★ Doxepin
- ★ Desipramine
- ★ Nortriptyline
- ★ Secondary versus tertiary amines
- ★ Clomipramine
- ★ Antidepressant overdose
- ★ Fluoxetine
- ★ Paroxetine
- ★ Fluvoxamine
- ★ Amoxapine
- ★ Yohimbine



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Depression - Terms & Concepts 3

- ★ Cyproheptadine
- ★ Amantadine
- ★ Cytochrome P450 system
- ★ Bupropion (Wellbutrin)
- ★ Venlafaxine (Effexor)
- ★ Duloxetine (Cymbalta)
- ★ Trazodone (Desyrel)
- ★ Nefazodone (Serzone)
- ★ Mirtazepine (Remeron)
- ★ Buspirone (BuSpar)
- ★ Dextroamphetamine
- ★ Methylphenidate
- ★ Pemoline
- ★ Electroconvulsive therapy (ECT)
- ★ ECT indications
- ★ ECT complication risks
- ★ ECT adverse effects
- ★ Stages of depression treatment
- ★ Acute phase
- ★ Continuation phase
- ★ Maintenance phase
- ★ Response
- ★ Remission
- ★ Relapse
- ★ Recovery
- ★ Recurrence



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Epidemiology of Major Depressive Disorder

- ★ 12-month prevalence rate ~ 7%
- ★ Lifetime prevalence ~ 15%
- ★ Recurrence rate ~ 75%
- ★ 1-year symptom duration ~ 40%
- ★ Mania ~ 5-10%
- ★ Suicide ~ 15% lifetime occurrence



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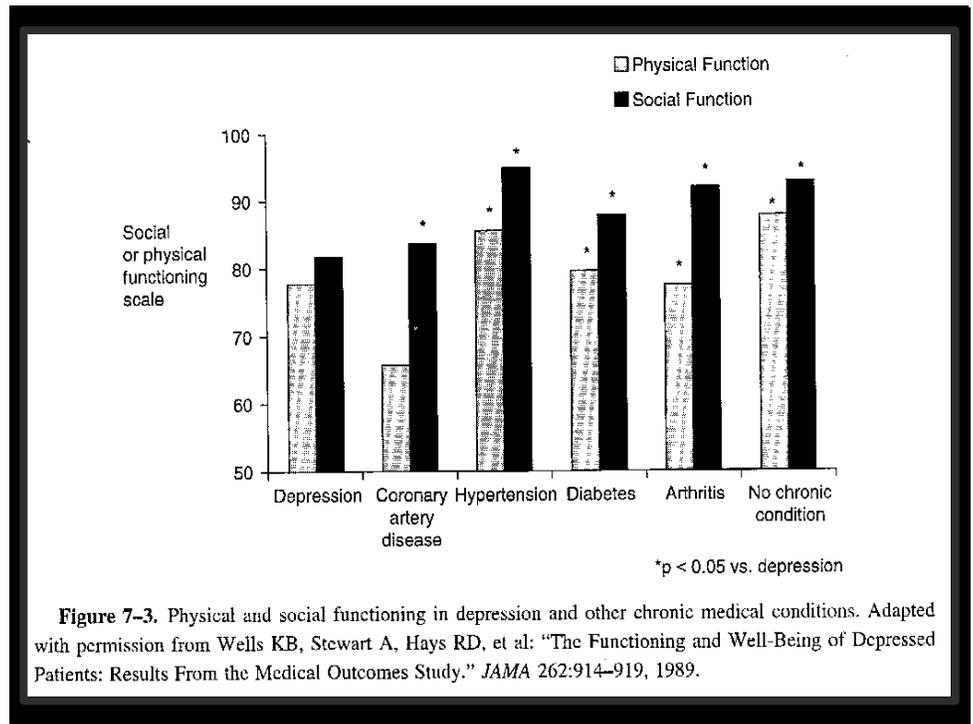
Burden of Depression

- ★ Annual cost (direct & indirect) in U.S. \$43.7 Billion
- ★ Half of depression care occurs in medical settings
- ★ A fifth of depression care occurs in specialty mental health care settings
- ★ MDD sufferers often present to their doctors with vague physical symptoms causing MDD to go undetected or untreated



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Simon, 1999; Regier et al, 1993; Regier et al, 1978



30 Leading Worldwide Causes of Disability WHO Global Burden of Disease Study *

| <u>RANK</u> | <u>DISORDER</u> | <u>DALY x 10⁴</u> |
|-------------|------------------------------------|------------------------------|
| 1 | Lower Respiratory Tract Infections | 112.9 |
| 2 | Diarrheal Diseases | 99.6 |
| 3 | Perinatal Disorders | 92.3 |
| 4 | Unipolar Major Depression | 50.8 |
| 5 | Ischemic Heart Disease | 46.7 |
| 16 | War Injuries | 20.0 |
| 17 | Self-Inflicted Injuries | 19.0 |
| 19 | Violence | 17.5 |
| 20 | Alcohol Use | 16.7 |
| 22 | Bipolar Disorder | 14.3 |
| 26 | Schizophrenia | 12.8 |
| 28 | HIV | 11.2 |
| 29 | Diabetes Mellitus | 11.1 |
| 30 | Asthma | 10.8 |



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* Murry, Lopez. *Lancet* 1997; 349:1436-42

Health Care Costs Among Employees of a Major US Corporation in 1995

TABLE 2. Health Care Costs Incurred by 15,153 Employees of a Major U.S. Corporation Who Filed Health Claims in 1995

| Disorder | Cost of Mental Health Care ^a | | | Cost of Non-Mental-Health Care ^d | | | Total Health Care Cost ^e | | |
|-----------------------------|---|---|--------|---|---|--------|-------------------------------------|---|--------|
| | Mean (dollars) ^b | Difference From Depression ^c | | Mean (dollars) ^b | Difference From Depression ^c | | Mean (dollars) ^b | Difference From Depression ^c | |
| | | t | p | | t | p | | t | p |
| Depressive disorder (N=412) | 1,341 | | | 3,032 | | | 4,373 | | |
| Diabetes (N=203) | 29 | -22.6 | <0.001 | 4,341 | 2.98 | 0.03 | 4,371 | 0.00 | 1.00 |
| Heart disease (N=715) | 38 | -31.5 | <0.001 | 4,080 | 3.34 | 0.01 | 4,117 | -0.80 | 0.97 |
| Hypertension (N=689) | 107 | -29.9 | <0.001 | 3,558 | 1.65 | 0.56 | 3,666 | -2.18 | 0.25 |
| Back problems (N=349) | 38 | -26.8 | <0.001 | 3,337 | 0.83 | 0.96 | 3,376 | -2.66 | 0.08 |
| All others (N=12,785) | 24 | -39.2 | <0.001 | 925 | -8.27 | <0.001 | 949 | -13.2 | <0.001 |

^a Proportion of variance explained by the model: R²=9.9% (df=14,360 for each t test).

^b Adjusted for age, sex, race, income, geographic region, education, salary, and tenure with the corporation.

^c Adjusted costs compared with t tests; p values calculated by using the Tukey method of post hoc comparisons.

^d Proportion of variance explained by the model: R²=6.0% (df=14,360 for each t test).

^e Proportion of variance explained by the model: R²=6.5% (df=14,360 for each t test). Calculated as separate model; therefore, may not represent exact sum of mental and non-mental-health costs.



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Druss, Rosenheck, and Sledge, Aug 2000 Am J Psychiatry

Sick Days and Total Employer Costs Among Employees of a Major US Corporation in 1995

TABLE 3. Sick Days and Total Cost Incurred by Employees of a Major U.S. Corporation Who Filed Health Claims and Had Work Data Available in 1995

| Disorder | Sick Days (N=9,398) ^a | | | Total Per Capita Health and Disability Costs (N=9,398) ^d | | | Total Costs to the Corporation (million dollars) ^e |
|-----------------------------|----------------------------------|---|--------|---|---|--------|---|
| | Mean ^b | Difference From Depression ^c | | Mean (dollars) ^b | Difference From Depression ^c | | |
| | | t | p | | t | p | |
| Depressive disorder (N=412) | 9.86 | | | 5,415 | | | 2.2 |
| Diabetes (N=203) | 7.17 | -2.91 | 0.04 | 5,472 | 0.10 | 1.00 | 1.1 |
| Heart disease (N=715) | 7.47 | -3.27 | 0.01 | 5,523 | 0.24 | 1.00 | 3.9 |
| Hypertension (N=689) | 5.39 | -6.26 | <0.001 | 3,732 | -3.88 | 0.002 | 2.6 |
| Back problems (N=349) | 7.21 | -2.90 | 0.04 | 4,388 | -1.96 | 0.36 | 1.5 |
| All others (N=12,785) | 3.32 | 3.31 | <0.001 | 1,292 | -11.3 | <0.001 | 16.6 |

^a Proportion of variance explained by the model: R²=6.0% (df=8,922 for each t test).

^b Adjusted for age, sex, race, income, geographic region, education, salary, and tenure with the corporation.

^c Adjusted costs compared with t tests; p values calculated by using the Tukey method for post hoc comparisons.

^d Proportion of variance explained by the model: R²=8.6% (df=8,922 for each t test).

^e Per capita cost multiplied by number of employees with disorder. Because each total represented only one measurement, tests of statistical significance of differences among total costs across diseases were not performed.



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Impact of Comorbidity of Depression & Medical Disorders Among Employees of a Major US Corporation in 1995

TABLE 4. Impact of Comorbidity of Depressive Disorder and Four General Medical Disorders Incurred by Employees of a Major U.S. Corporation Who Filed Health Care Claims in 1995

| Disorder | Health Care Cost ^a | | | Sick Days ^d | | | Total Per Capita Health and Disability Costs ^e | | |
|--|-------------------------------|---|--------|------------------------|---|--------|---|---|--------|
| | Mean (dollars) ^b | Difference From All Others ^c | | Mean ^b | Difference From All Others ^c | | Mean (dollars) ^b | Difference From All Others ^c | |
| | | t | p | | t | p | | t | p |
| Diabetes, heart disease, hypertension, or back problems only (N=1,956) | 3,853 | 22.9 | <0.001 | 6.64 | 12.50 | <0.001 | 4,646 | 20.2 | <0.001 |
| Depressive disorder only (N=312) | 3,417 | -8.61 | <0.001 | 8.79 | 3.19 | 0.01 | 4,675 | 8.4 | <0.001 |
| Both (N=100) | 7,407 | 6.73 | <0.001 | 13.48 | 5.44 | <0.001 | 7,906 | 8.9 | <0.001 |
| All others (12,785) | 949 | | | 3.32 | | | 1,292 | | |

^a Proportion of variance explained by the model: R²=6.7% (df=14,362 for each t test).

^b Adjusted for age, sex, race, income, geographic region, education, salary, and tenure with the corporation.

^c Adjusted costs compared with t tests; p values calculated by using the Tukey method for post hoc comparisons.

^d Proportion of variance explained by the model: R²=6.0% (df=8,924 for each t test).

^e Proportion of variance explained by the model: R²=8.5% (df=8,924 for each t test).



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Druss, Rosenheck, and Sledge, Aug 2000 Am J Psychiatry

Hidden Burden to Primary Medical Care

| Number of Symptoms | Number of Patients | Psychiatric Disorder N (%) | | |
|---------------------------|--------------------|----------------------------|----------|----------|
| | | Anxiety | Mood | Any |
| <i>Physical (N=1000)</i> | | | | |
| 0-1 | 215 | 2 (1) | 5 (2) | 16 (7) |
| 2-3 | 225 | 17 (7) | 27 (12) | 50 (22) |
| 4-5 | 191 | 25 (13) | 44 (23) | 67 (35) |
| 6-8 | 230 | 68 (30) | 100 (44) | 140 (61) |
| 9+ | 130 | 68 (48) | 84 (80) | 113 (81) |
| <i>Somatoform (N=900)</i> | | | | |
| 0 | 654 | 68 (10) | 107 (16) | 102 (25) |
| 1-2 | 143 | 42 (29) | 60 (42) | 74 (52) |
| 3-5 | 87 | 35 (40) | 40 (46) | 77 (89) |
| 6+ | 49 | 40 (55) | 34 (68) | 45 (94) |



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Kroenke et al. Arch Fam Med 1994; 3:774

Special Populations

- ★ Postpartum
- ★ Elderly
- ★ Medically ill
- ★ Children & adolescents



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Risk Factors

- ★ Childhood adversities
- ★ Current life events & stressors
- ★ Lack or loss of social support
- ★ Chronic medical illness
- ★ Family history ~ nature *and* nurture
- ★ Personality ~
insecure, worried, introverted, stress sensitive, obsessive, unassertive,
dependent
- ★ Postpartum ~ period of vulnerability
- ★ Menopause ~ no relationship to risk



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TABLE 9-12. Concordance rates for mood disorders in monozygotic and dizygotic twins

| Study | Monozygotic twins | | Dizygotic twins | |
|------------------------|------------------------------|-----------------|------------------------------|-----------------|
| | Concordant pairs/total pairs | Concordance (%) | Concordant pairs/total pairs | Concordance (%) |
| Luxenberger 1930 | 3/4 | 75.0 | 0/13 | 0.0 |
| Rosanoff et al. 1935 | 16/23 | 69.6 | 11/67 | 16.4 |
| Slater 1953 | 4/7 | 57.1 | 4/17 | 23.5 |
| Kallmann 1954 | 25/27 | 92.6 | 13/55 | 23.6 |
| Harvald and Hauge 1965 | 10/15 | 66.7 | 2/40 | 5.0 |
| Allen et al. 1974 | 5/15 | 33.3 | 0/34 | 0.0 |
| Bertelsen 1979 | 32/55 | 58.2 | 9/52 | 17.3 |
| Totals | 95/146 | 65.1 | 39/278 | 14.0 |

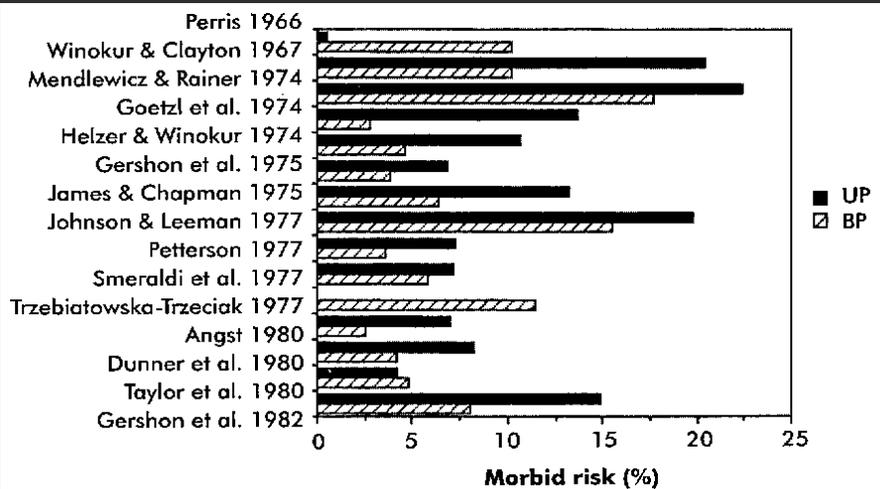
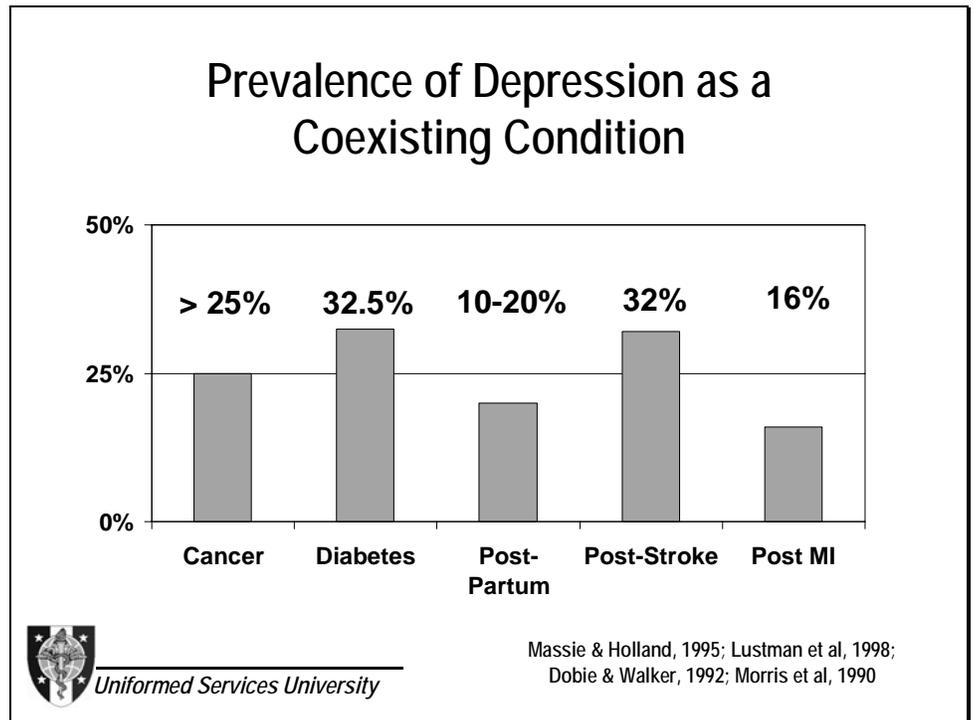
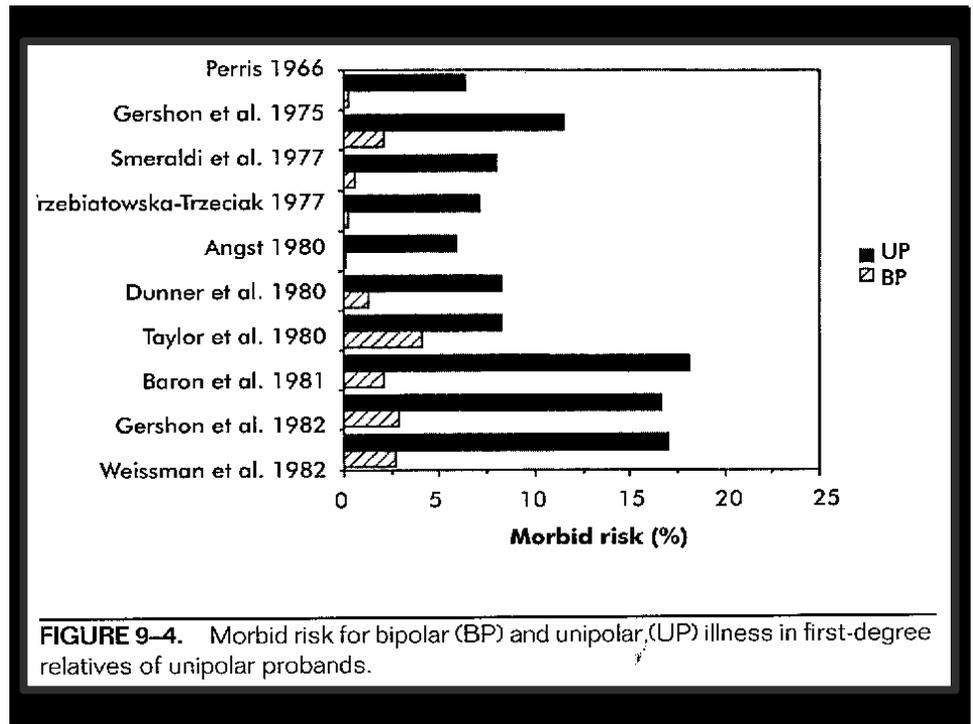


FIGURE 9-3. Morbid risk for bipolar (BP) and unipolar (UP) illness in first-degree relatives of bipolar probands.



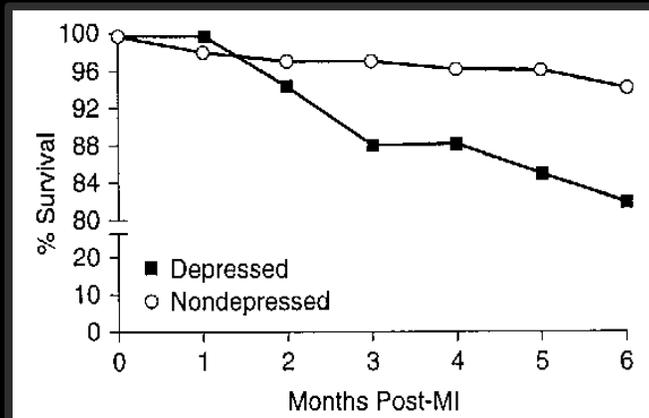


Figure 7-4. Mortality after myocardial infarction with and without comorbid depression. Reproduced with permission from Frasure-Smith N, Lesperance F, Talajic M: "Depression Following Myocardial Infarction: Impact on Six-Month Survival." *JAMA* 270:1819-1825, 1993. Copyrighted 1993, American Medical Association.

Table 7-9. Depressive Symptoms in Widows and Widowers Versus a Married Comparison Group*

| | PERCENTAGE | | | |
|---------------------------|-----------------------|------------------------|------------------------|--|
| | 2 Months (n = 350) | 13 Months (n = 286) | 25 Months (n = 274) | Married Comparison Group (n = 126) |
| Trouble sleeping | 57 | 29 | 26 | 14 |
| Feeling blue | 40 | 25 | 17 | 2 |
| Trouble concentrating | 20 | 13 | 9 | 2 |
| Poor appetite | 19 | 8 | 6 | 0 |
| Anhedonia | 18 | 15 | 8 | 2 |
| Thoughts of death/dying | 15 | 11 | 10 | 1 |
| Feelings of guilt | 12 | 8 | 5 | 0 |
| Feelings of worthlessness | 8 | 6 | 6 | 0 |
| Thoughts of ending life | 2 | 3 | 1 | 0 |

*The widows and widowers have significantly higher percentages of each depressive symptom at each point in time than the comparison group.

Source: Adapted from Zisook S, Shuchter SR, Sledge PA, et al: "The Spectrum of Depressive Phenomena after Spousal Bereavement." *J Clin Psychiatry* 55 (suppl 4), 29-36, 1994. Copyright 1994, Physicians Postgraduate Press. Adapted by permission.

Table 7-7. DSM-IV-TR Classification of Mood Disorders (in DSM-IV-TR, Adjustment Disorder Constitutes a Separate Category)

DEPRESSIVE (UNIPOLAR) DISORDERS

Major Depressive Disorder

One or more major depressive episodes (i.e., at least 2 weeks of depressed mood or anhedonia and at least four other depressive symptoms)

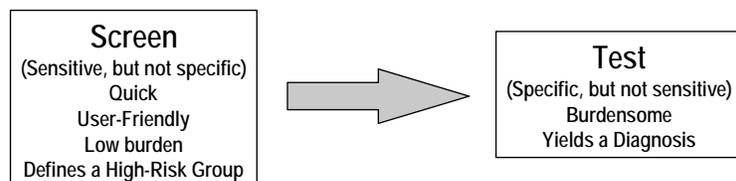
Dysthymic Disorder

At least 2 years of depressed mood along with associated symptoms, but without meeting the full criteria for major depressive episode (two rather than four additional symptoms)

DEPRESSIVE DISORDER NOT OTHERWISE SPECIFIED (NOS)

Getting an Efficient History

Use a Multi - Stage Sequence



PRIMary care Evaluation of Mental Disorders (PRIME-MD)*

During the PAST MONTH, have you OFTEN been bothered by...

- 1 ...little interest or pleasure in doing things?
- 2 ...feeling down, depressed, or hopeless?

* Spitzer RL, Williams JBW, Kroenke K, et al. JAMA 1994; 272:1749-1756.



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'The Five Minute Screening Interview'*

- ★ 'Have you been feeling SAD, BLUE, DOWN, or DEPRESSED?
- ★ 'Have you LOST INTEREST in, or get LESS PLEASURE from, the things you used to enjoy?

*Zimmerman, M. Diagnosing DSM-IV Psychiatric Disorders in Primary Care Settings: An Interview Guide For the Nonpsychiatrist Physician. Psych Products Press; 1994



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Major Depressive Disorder DSM-IV Diagnostic Criteria

- ★ Five or more symptoms (all day every day for at least two weeks)
- ★ Symptoms must include either ~
 - Depressed mood or
 - Diminished interest or pleasure in activities
- ★ Other symptoms ~
 - Significant weight loss or gain when not dieting
 - Insomnia or hypersomnia
 - Psychomotor retardation or agitation
 - Fatigue or loss of energy
 - Feelings of worthlessness or inappropriate guilt
 - Diminished ability to think or concentrate
 - Recurrent thoughts of death or suicidal ideation



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Symptoms of a Major Depressive Episode

- S sleep disturbance
- I loss of interest (anhedonia)
- G guilty ruminations
- E decreased energy
- C decreased concentration
- A altered appetite
- P psychomotor changes
- S suicidal (or morbid) ideation



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Always Assess Suicidality!

“Often people who are depressed have some troubling thoughts like they’d...

- ★ just as soon stay in bed or not wake up;
- ★ be better off dead; or
- ★ like to hurt or kill themselves

Ever have any thoughts like that? Tell me about them...”



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Suicide Assessment (Continued)

If the patient has ideas of suicide, ask them about:

- ★ A plan?
- ★ Feasibility of the plan?
- ★ Level of patient intent to carry out the plan?
- ★ Past history of attempts?
- ★ People who can support them?



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Table 21-3. Organic causes of depression.

| | |
|--|---|
| <p>Medications</p> <p>Analgesics (eg, indomethacin, opiates)</p> <p>Antibiotics (eg, ampicillin)</p> <p>Antihypertensive agents (eg, propranolol, reserpine, α-methyldopa, clonidine)</p> <p>Antineoplastic agents (eg, cycloserine, vincristine, vinblastine)</p> <p>Cimetidine</p> <p>L-Dopa</p> <p>Insecticides</p> <p>Mercury, lead</p> <p>Oral contraceptives</p> <p>Sedative-hypnotics (eg, barbiturates, benzodiazepines, chloral hydrate, phenothiazines)</p> <p>Substances of abuse</p> <p>Alcohol</p> <p>Cocaine</p> <p>Opiates</p> <p>Neurologic disease</p> <p>Chronic subdural hematoma</p> <p>Dementias</p> <p>Huntington's disease</p> <p>Migraine headaches</p> <p>Multiple sclerosis</p> <p>Normal pressure hydrocephalus</p> <p>Parkinson's disease</p> <p>Strokes</p> <p>Temporal lobe epilepsy</p> <p>Wilson's disease</p> <p>Infectious disease</p> <p>Brucellosis</p> <p>Encephalitis</p> <p>HIV</p> <p>Infectious hepatitis</p> <p>Influenza</p> <p>Mononucleosis</p> <p>Subacute bacterial endocarditis</p> <p>Syphilis</p> <p>Tuberculosis</p> <p>Viral pneumonia</p> | <p>Neoplasms</p> <p>Bronchogenic carcinoma</p> <p>CNS tumors</p> <p>Disseminated carcinomatosis</p> <p>Lymphoma</p> <p>Pancreatic cancer</p> <p>Metabolic and endocrine disorders</p> <p>Addison's disease</p> <p>Anemia</p> <p>Apathetic hyperthyroidism</p> <p>Cushing's disease</p> <p>Diabetes</p> <p>Hepatic disease</p> <p>Hypokalemia</p> <p>Hyponatremia</p> <p>Hypoparathyroidism</p> <p>Hypopituitarism (Sheehan's disease)</p> <p>Hypothyroidism</p> <p>Pellagra</p> <p>Pernicious anemia</p> <p>Porphyria</p> <p>Thiamine, vitamin B₁₂, and folate deficiencies</p> <p>Uremia</p> <p>Collagen-vascular conditions</p> <p>Giant cell arteritis</p> <p>Rheumatoid arthritis</p> <p>Systemic lupus erythematosus</p> <p>Cardiovascular conditions</p> <p>Chronic heart failure</p> <p>Hypoxia</p> <p>Mitral valve prolapse</p> <p>Miscellaneous</p> <p>Chronic pyelonephritis</p> <p>Pancreatitis</p> <p>Peptic ulcer disease</p> <p>Postpartum depression</p> |
|--|---|

Major Depressive Disorder Subtypes

- ★ Melancholic features
- ★ Atypical features
- ★ With psychotic features
- ★ Seasonal Affective Disorder (SAD)
- ★ "Double depression"



TABLE 9–8. DSM-IV-TR diagnostic criteria for melancholic features specifier*Specify if:*

With Melancholic Features (can be applied to the current or most recent Major Depressive Episode in Major Depressive Disorder and to a Major Depressive Episode in Bipolar I or Bipolar II Disorder only if it is the most recent type of mood episode)

- A. Either of the following, occurring during the most severe period of the current episode:
- (1) loss of pleasure in all, or almost all, activities
 - (2) lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens)
- B. Three (or more) of the following:
- (1) distinct quality of depressed mood (i.e., the depressed mood is experienced as distinctly different from the kind of feeling experienced after the death of a loved one)
 - (2) depression regularly worse in the morning
 - (3) early morning awakening (at least 2 hours before usual time of awakening)
 - (4) marked psychomotor retardation or agitation
 - (5) significant anorexia or weight loss
 - (6) excessive or inappropriate guilt

TABLE 9–9. DSM-IV-TR diagnostic criteria for atypical features specifier*Specify if:*

With Atypical Features (can be applied when these features predominate during the most recent 2 weeks of a current Major Depressive Episode in Major Depressive Disorder or in Bipolar I or Bipolar II Disorder when a current Major Depressive Episode is the most recent type of mood episode, or when these features predominate during the most recent 2 years of Dysthymic Disorder; if the Major Depressive Episode is not current, it applies if the feature predominates during any 2-week period)

- A. Mood reactivity (i.e., mood brightens in response to actual or potential positive events)
- B. Two (or more) of the following features:
- (1) significant weight gain or increase in appetite
 - (2) hypersomnia
 - (3) leaden paralysis (i.e., heavy, leaden feelings in arms or legs)
 - (4) long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment
- C. Criteria are not met for With Melancholic Features or With Catatonic Features during the same episode.

TABLE 9-7. Types of major depressive episode

Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with others.

Moderate: Symptoms or functional impairment between "mild" and "severe."

Severe, Without Psychotic Features: Several symptoms in excess of those required to make the diagnosis, and symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

Severe, With Psychotic Features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood congruent or mood incongruent.

Mood-congruent psychotic features: Delusions or hallucinations whose content is entirely consistent with the typical depressive themes of personal inadequacy, guilt, disease, nihilism, or deserved punishment.

Mood-incongruent psychotic features: Delusions or hallucinations whose content does not involve typical depressive themes of personal inadequacy, guilt, disease, death, nihilism or deserved punishment. Included are symptoms such as persecutory delusions (not directly related to depressive themes), thought insertion, thought broadcasting, and delusions of control.

Biological Markers

- ★ Depression is a clinical diagnosis
- ★ Dexamethasone suppression test
- ★ Thyroid releasing hormone
- ★ Neuroimaging studies
- ★ Functional imaging studies
- ★ Sleep studies



Pathogenesis Biological Theories

- ★ **Monoamines theories**
serotonin, norepinephrine, dopamine & related receptors
- ★ **Non-monoamine theories**
glucocorticoid, neurotrophic, excitatory amino acid, endocrine
- ★ **Global neurophysiologic theories**
dysregulation of circadian rhythms or neuronal electrolyte balance
- ★ **Neurophysiologic theories**
Prefrontal cortex, cingulate gyrus, basal ganglia, temporal lobes



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Pathogenesis Psychosocial Theories

- ★ **Loss and Grief**
- ★ **Psychoanalytic**
- ★ **Interpersonal**
- ★ **Cognitive**
- ★ **Learned helplessness**
- ★ **Behavioral**



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Treatment Options

- ★ Overall response rate ~ 85%
- ★ Psychotherapies
 - Cognitive-behavioral therapy (CBT)
 - Interpersonal therapy (IPT)
- ★ Antidepressant medications ~ SSRI, NRI, DNRI, SNRI, TCA, MAOI, stimulants, others
- ★ Other somatic therapies
 - Electroconvulsive Therapy (ECT)
 - Bright light therapy (“chronotherapy”)
 - Transcranial magnetic stimulation
 - Vagal nerve stimulation



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Recommendations for management of depression

1. A hopeful, optimistic tone should be established at the initial interview.
 - The severity of the depressive syndrome should be assessed, remembering that there may be individual and cultural differences in the way depression is experienced and expressed.
 - Extensive psychological probing should not be attempted when the patient is deeply depressed.
 - Suicidal risk should be determined initially and reassessed frequently.
2. Severe to moderate depression should be treated aggressively with somatic therapy.
 - Severely depressed or suicidal patients may require hospitalization.
 - Severely depressed outpatients may need frequent (e.g., twice-weekly) brief (e.g., 10- to 15-minute) contacts for support and medication management until their depression lifts.
 - Most patients will require at least 16–20 weeks of maintenance medication following an initial episode and thereafter should be given a trial of decreasing or discontinuing the medication. If symptoms reemerge, medication should be reinstated.
3. The clinician should determine whether psychosocial stressors are present that are contributing to the depressed mood and should counsel the patient on ways to cope with them.
4. Depressed patients tend to “get down” on themselves because they have been depressed; the clinician should help the patient learn to abandon negative or self-deprecating attitudes toward his or her depression through cognitive-behavioral therapy or other psychotherapeutic techniques.

Table 7-10. Typical Automatic Thoughts with Depression

| <i>Automatic Thought</i> | <i>Definition</i> |
|---|--|
| Selective abstraction ("mental filter") | Drawing a conclusion based on only a small portion of the data |
| Arbitrary inference | Drawing a conclusion based on inadequate data or ignoring contradictory data |
| Absolutist ("all or none") thinking | Rigid dichotomies; patient is all good or all bad, perfect or completely flawed, a success or a total failure, etc. |
| Magnification and minimization | Overvaluing flaws, negative life events, or future bad outcomes, while undervaluing strengths, positive events, or potential good outcomes |
| Personalization | Taking blame or self-criticizing for events that are outside of one's control |
| Catastrophic thinking | Predicting the worst possible outcome while ignoring more likely events |

Table 7-13. Adaptive and Maladaptive Schemas

| <i>Adaptive Schemas</i> | <i>Maladaptive Schemas</i> |
|--|---|
| No matter what happens, I can manage somehow | I must be perfect to be accepted |
| If I can work at something, I can master it | If I choose to do something, I must succeed |
| I'm a survivor | I'm a fake |
| Others can trust me | Without a woman, I'm nothing |
| I'm lovable | I'm stupid |
| People respect me | No matter what I do, I won't succeed |
| I can figure things out | Others can't be trusted |
| If I prepare in advance, I usually do better | I never can be comfortable around others |
| I like to be challenged | If I make a mistake, I'll lose everything |
| There's not much that can scare me | The world is too frightening for me |

Source: Reproduced with permission from Wright JH, Beck AT: "Cognitive Therapy." *American Psychiatric Press Textbook of Psychiatry*, 3rd Edition. Edited by Hales, RE, Yudofsky SC, Talbott JA. Washington, DC, American Psychiatric

Antidepressants By Presumed Mechanism of Action

MAO INHIBITORS

Irreversible Inhibitors of MAO-A and -B

- Phenelzine (Nardil)
- Tranylcypromine (Parnate)

Reversible Inhibitors of MAO-A (RIMAs)

- Moclobemide

TRICYCLIC ANTIDEPRESSANTS

Tertiary Amine Tricyclics

- Imipramine (Tofranil)
- Amitriptyline (Elavil)
- Doxepin (Sinequan)
- Trimipramine (Surmontil)
- Clomipramine (Anafranil)

Secondary Amine Tricyclics

- Desipramine (Norpramin)
- Nortriptyline (Pamelor)
- Protriptyline (Vivactil)
- Maprotiline (Ludionil)

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS):

- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Fluvoxamine (Luvox)
- Citalopram (Celexa)
- Escitalopram (Lexapro)

SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR (NRI)

- Reboxetine (Vestra)

DOPAMINE-NOREPINEPHRINE REUPTAKE INHIBITOR (DNRI)

- Bupropion (Wellbutrin)

SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITOR (SNRI)

- Venlafaxine (Effexor)
- Duloxetine (Cymbalta)

SEROTONIN (5-HT₂) ANTAGONIST/REUPTAKE INHIBITORS

- Trazodone (Desyrel)
- Nefazodone (Serzone)

SEROTONIN (5-HT₂ AND 5-HT₃) ANTAGONIST AND ALPHA-2 ANTAGONIST

- Mirtazepine (Remeron)

SEROTONIN (5HT_{1A}) PARTIAL AGONIST

- Buspirone (BuSpar)

MONOAMINE RELEASING AGENTS ("STIMULANTS")

- Dextroamphetamine (Dexedrine)
- Methylphenidate (Ritalin, Concerta, Metadate)
- Pemoline (Cylert)
- Amphetamine Mixture (Adderall)

Table 21-5. Common clinical uses of antidepressants.

| Major Indications | Secondary Indications |
|--|--|
| Major depressive disorder Dysthymia Bipolar disorder, depressed type Panic disorder (with or without agoraphobia) | Obsessive-compulsive disorder ¹ Generalized anxiety disorder Social phobia Bulimia nervosa Attention-deficit/hyperactivity disorder ² Diabetic polyneuropathy ¹ Chronic pain syndromes ¹ Sleep disorders Enuresis ³ |

¹ Mainly serotonergic antidepressants.

² Especially tricyclic antidepressants such as imipramine and desipramine.

³ Specific for the use of imipramine in children.

Table 21-10. Predictors of antidepressant response.

| Positive Predictors | Negative Predictors |
|--|---|
| Vegetative symptoms (anorexia, weight loss, middle and late insomnia) Diurnal mood variation Psychomotor agitation or retardation Autonomous and pervasive symptoms Acute onset Family history of depression Dose of imipramine (or equivalent dose of another heterocyclic) above 125-150 mg/day Blood levels of desipramine (or imipramine and desipramine) above 200 ng/mL, and nortriptyline between 50 and 150 ng/mL | Coexistence of other significant psychiatric disturbances (particularly with hysterical or externalizing features) Chronic symptoms Psychotic features Hypochondriacal concerns or predominant somatic features Previous drug trial failure(s) History of sensitivity to adverse reactions |

What Drug Should I Use? *Selecting an Agent*

- ★ Prior response (pt or family)
- ★ Side-effect profile
- ★ Age
- ★ Medical status
- ★ Medication interactions
- ★ Other psychiatric disorders
- ★ Cost
- ★ Patient preference



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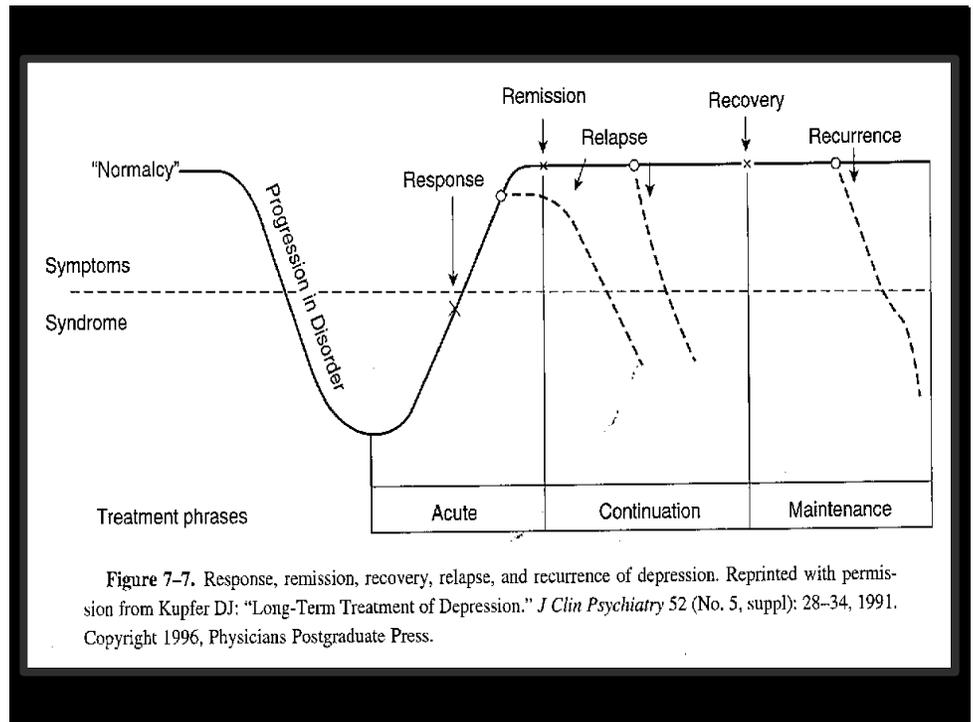


Table 7-17. Side Effects of Various Antidepressants, by Receptor Activity

| <i>Receptor</i> | <i>Side Effects</i> |
|------------------|---|
| Histamine (H-1) | Sedation, weight gain, hypotension, delirium |
| Ach muscarinic | Dry mouth/eyes, blurred vision, urinary retention, constipation, memory impairment, delirium, resting tachycardia |
| Alpha-1 | Orthostatic hypotension, reflex tachycardia, potentiation of antihypertensive effect of prazosin |
| Alpha-2 | Block antihypertensive effect of clonidine, methyl dopa, guanfacine |
| 5HT ₂ | Anxiety, insomnia, ejaculatory dysfunction, hypotension |
| 5HT ₃ | Nausea, cramps, diarrhea |

Table 7-19. SSRIs and the Cytochrome P450 System

| <i>Isoenzyme</i> | <i>Inducers</i> | <i>Inhibitors</i> | <i>Main Drug Interactions</i> |
|------------------|------------------------------|---|---|
| 1A2 | Tobacco, charbroiled foods | Fluvoxamine, grapefruit juice, flavinoids, ciprofloxacin, norfloxacin | Theophylline, clozapine, haloperidol, olanzapine, propranolol, caffeine |
| 2D6 | | Fluoxetine, paroxetine | Tricyclics, codeine |
| 2C | | Fluoxetine, fluvoxamine | Phenytoin, diazepam |
| 3A4 | Carbamazepine, phenobarbital | Nefazodone, fluoxetine, fluvoxamine, ketoconazole, cimetidine, erythromycin | Terfenadine, astemizole, cisapride, ziprasidone, carbamazepine, alprazolam, triazolam |

Table 7-15. Comparison of Mechanism of Action of Different Antidepressants

| <i>Mechanism</i> | <i>Tertiary TCA</i> | <i>Secondary TCA</i> | <i>SSRI</i> | <i>Bupropion</i> | <i>Venlafaxine</i> | <i>Nefazodone</i> | <i>Mirtazapine</i> |
|---------------------------|---------------------|----------------------|-------------|------------------|--------------------|-------------------|--------------------|
| 5HT uptake inhibition | <i>Yes</i> | No (slight) | <i>Yes</i> | No | <i>Yes</i> | <i>Yes</i> | No |
| 5HT ₂ blockade | No (slight) | No | No | No | No | <i>Yes</i> | <i>Yes</i> |
| 5HT ₃ blockade | No | No | No | No | No | No | <i>Yes</i> |
| NE uptake inhibition | <i>Yes</i> | <i>Yes</i> | No | <i>Yes</i> | <i>Yes</i> | No | No |
| Alpha-1 NE blockade | No (slight) | No | No | No | No | <i>Yes</i> | No |
| Alpha-2 NE blockade | No | No | No | No | No | No | <i>Yes</i> |
| Histamine-1 blockade | <i>Yes</i> | No | No | No | No | No | <i>Yes</i> |
| Acetylcholine blockade | <i>Yes</i> | <i>Yes (mild)</i> | No | No | No | No | No |

Italics indicate clinically significant differences.

Adherence to Antidepressant Medication

Table 3. Factors Associated With Discontinuing Use of the Initial Antidepressant Medication Within 3 Months of Starting Treatment: Results of Multivariate Model*

| Variable | Odds Ratio (95% Confidence Interval) |
|--|---|
| Communication factors reported by patients | |
| Told how long to continue with medication? | |
| ≥6 mo | 1.00 (Referent) |
| <6 mo | 3.12 (1.21-8.07) |
| Duration not specified | 1.02 (0.52-2.00) |
| Discussed adverse effects with physician during treatment? | |
| No | 1.00 (Referent) |
| Yes | 0.49 (0.25-0.95) |
| No adverse effect experienced | 1.82 (0.78-4.24) |
| Adverse effects | |
| Experienced ≥ 1 moderately or extremely bothersome adverse effect? | |
| No | 1.00 (Referent) |
| Yes | 2.94 (1.51-5.71) |
| Clinical factors | |
| Depression symptoms were reported improved at 3 months? | |
| No | 1.00 (Referent) |
| Yes | 0.40 (0.20-0.82) |
| Had ≥3 office visits within 3 months? | |
| No | 1.00 (Referent) |
| Yes | 0.40 (0.19-0.82) |
| Marital status | |
| Married | 1.00 (Referent) |
| Never married | 1.74 (0.80-3.76) |
| Separated, divorced, or widowed | 2.83 (1.49-5.39) |

*Odds ratio and 95% confidence intervals compare the 79 patients who discontinued therapy with the 268 who continued it.

Table 21–12. Alternative therapies for treatment-resistant depression.^{1,2}

- Augmentation of TCAs or MAOIs with
 - Sleep deprivation [I]
 - Lithium [I]
 - Thyroid hormone [III]
 - L-Tryptophan [III]
 - Psychostimulants (amphetamine, methylphenidate)—in combination with TCAs only [III]
 - Carbamazepine [II]
- TCA/MAOI combination (use with extreme care) [II]
- ECT (reserved primarily for severe intractable depression or when the patient is acutely suicidal) [I]
- Phototherapy or light therapy [II]
- Psychostimulants alone (reserved largely for treatment in elderly depressed patients) [III]
- Psychotherapy (cognitive-behavioral and interpersonal psychotherapy) alone or in combination with TCAs [II]

¹ Modified and reproduced, with permission, from American Psychiatric Association: Practice guidelines for major depressive disorder in adults. *Am J Psychiatry* 1993;150(Suppl):4.

² [I] indicates recommended with substantial clinical confidence; [II] indicates recommended with moderate clinical confidence; [III] indicates options that may be recommended on the basis of individual circumstances. MAOI, monoamine oxidase inhibitor; TCA, tricyclic antidepressant.

Table 21–13. Relative contraindications to electroconvulsive therapy.

| |
|--|
| Conditions with increased intracranial pressure |
| Intracerebral hemorrhage |
| Pheochromocytoma |
| Recent myocardial infarction |
| Space-occupying intracerebral lesions (except for small, slow growing tumors without edema or other mass effect) |
| Unstable vascular aneurysms or malformations |

Human Behavior Course 2004

Anxiety Disorders

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HUMAN BEHAVIOR COURSE 2004

ANXIETY DISORDERS TWO - SLIDES

LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. Know the meaning of the terms and concepts listed in slide one and two below.
2. Describe what is known about the neurobiological mechanisms of anxiety and the various anxiety disorders.
3. What medications may be used to treat generalized anxiety disorder?
4. What medications may be used to treat panic disorder?
5. What medications may be used to treat agoraphobia?
6. What medications may be used to treat social phobia?
7. What medications may be used to treat specific phobia?
8. What medications may be used to treat obsessive-compulsive disorder?
9. What types of anxiety responds to beta-adrenergic blockers?
10. Know the pharmacologic properties of the major benzodiazepine agents (e.g., adverse effects, mechanism of action, half-life, time to onset).
11. Contrast buspirone to the benzodiazepine agents.

Slide 1

Terms & Concepts 3

- ★ Stereotactic surgery
- ★ GABA
- ★ Serotonin
- ★ Norepinephrine
- ★ Dopamine
- ★ Locus ceruleus
- ★ Yohimbine
- ★ Clonidine
- ★ Lactate infusion
- ★ Flumazenil
- ★ Fenfluramine
- ★ Carbon dioxide inhalation
- ★ Bicarbonate infusion
- ★ Fear circuit



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Drugs & Drug Classes To Know

Relevant Drugs

- ★ Lorazepam (Ativan)
- ★ Midazolam (Versed)
- ★ Alprazolam (Xanax)
- ★ Flurazepam
- ★ Temazepam
- ★ Quazepam
- ★ Triazolam
- ★ Zolpidem (Ambien)
- ★ Zaleplon (Sonata)
- ★ Diazepam (Valium)
- ★ Venlafaxine
- ★ Mirtazepine

Relevant Drugs (Continued)

- ★ Nefazodone
- ★ Clomipramine
- ★ Buspirone

Relevant Drug Classes

- ★ Selective Serotonin Reuptake Inhibitors
- ★ Benzodiazepines
- ★ Tricyclic Agents
- ★ Monoamine Oxidase Inhibitors



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Theoretical Explanations -Biological-

- ★ Autonomic nervous system (ANS) dysregulation
- ★ Panic attack inducers
 - Sodium lactate infusion
 - Carbon dioxide inhalation
 - Bicarbonate infusion
 - Centrally mediated hypoxia response?



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Theoretical Explanations -Biological-

- ★ Monoaminergic hypothesis
 - Locus ceruleus
 - Anxiety & depression are linked phenomena
 - Antidepressants also treat anxiety
- ★ Gamma-aminobutyric acid (GABA)
GABA receptor is site of benzodiazepine action



Types of Anxiety Symptoms

- ★ Free-floating - steady tension and worry
- ★ Panic – sudden, intense anxiety
- ★ Phobic – fear of an object or situation
- ★ Obsessions – recurrent, intrusive, and unwanted anxiety producing thoughts



Specific Disorders

- ★ Anxiety disorder due to a general medical condition
- ★ Substance induced anxiety disorders
- ★ Primary anxiety disorders
- ★ Anxiety as a symptom of other psychiatric disorders



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Anxiety Disorder Due to a General Medical Condition*

- ★ Thyroid Disease (hypo- or hyper-)
- ★ Hypoglycemia
- ★ Vitamin B-12 Deficiency
- ★ Cardiac Dysrhythmias
- ★ Endocrine Tumors (pheochromocytoma)
- ★ Primary or metastatic brain tumors



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* See Table 9-1 in Cohen for detailed list (page 250)

Substance-Induced Anxiety Disorders

- ★ Virtually all substances of abuse may cause anxiety:
 - Intoxication
 - Withdrawal
- ★ Many prescription medications cause anxiety



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Substance-Induced Anxiety Disorders

- ★ Patients with primary anxiety disorders sometimes 'self-medicate':
 - Alcohol
 - Other drugs
- ★ Substances can cause:
 - Generalized anxiety
 - Panic attacks
 - Obsessive-compulsive symptoms



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Substance-Induced Anxiety Disorders

- ★ Vitamins: niacin, ginseng
- ★ OTCs: alcohol, diet pills, ephedra, cough/cold, laxatives, caffeine
- ★ Prescriptions: thyroid meds, theophylline, hypoglycemics, beta-agonists, antidepressants
- ★ Illicit: cocaine, amphetamines, PCP, LSD, MDMA, psilocybin mushrooms, ketamine, etc



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Table 22-2. Differential diagnosis of anxiety disorders.

| Medical Illnesses | Substance Use/Abuse | Psychiatric Disorders |
|---|--|--|
| Cardiac Angina Arrhythmias Congestive failure Infarction Mitral valve prolapse Paroxysmal atrial tachycardia Endocrinologic Hyperthyroidism Cushing's disease Hyperparathyroidism Hypoglycemia Premenstrual syndrome Neoplastic Carcinoid Insulinoma Pheocromocytoma Neurologic Huntington's disease Meniere's disease Migraine Multiple sclerosis Seizure disorder Transient ischemic attack Vertigo Wilson's disease Pulmonary Asthma Embolism Obstruction Obstructive pulmonary disease Other Porphyrria Uremia | Prescription or over-the-counter drug use Antidepressants Fenfluramine/phentermine Psychostimulants (eg, methylphenidate, amphetamine) Steroids Sympathomimetics Substance abuse Alcohol/sedative withdrawal Caffeine Hallucinogen Stimulant abuse (eg, cocaine) | Adjustment disorders Affective disorder Dissociative disorders Personality disorders Somatoform disorders Schizophrenia (and other psychotic disorders) |

Generalized Anxiety Disorder

- ★ Excessive worry or anxiety about events or life activities (school, work, relationships)
- ★ Occurs most days over 6 months or longer
- ★ Includes at least three of the following:
 - Feeling restlessness, “keyed up,” or on edge
 - Easy fatigue
 - Poor concentration
 - Irritability
 - Muscle tension or weakness
 - Sleep disturbance



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Generalized Anxiety Disorder 3 Common Pharmacotherapies

Buspirone

Imipramine

Venlafaxine

Benzodiazepines



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Panic Disorder

- ★ Panic attacks: one or more
 - Symptoms – palpitations, SOB, sweating, dizziness, choking, trembling, chest discomfort, feeling of impending doom
 - Uncued – no identifiable environmental precipitant
- ★ At least a month of worry
- ★ NOT due to disease, substance, or medication
- ★ May occur with or without agoraphobia



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Panic Disorder 4 Induction of Attack

- ★ Lactate infusion
- ★ Bicarbonate infusion
- ★ CO₂ inhalation
- ★ Caffeine
- ★ Nicotine



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Panic Disorder 5 Common Pharmacotherapies

SSRIs
Imipramine
Benzodiazepines (acutely)



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Obsessive-Compulsive Disorder

- ★ Obsessions: recurrent intrusive thoughts
 - Contamination fears & excessive doubt are most common
 - Often violent or sexual themes
- ★ Compulsions: repetitive behaviors or rituals
 - Checking & washing are most common
 - Counting
 - Repeating
 - Arranging
 - Hoarding



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Obsessive-Compulsive Disorder 3 Common Pharmacotherapies

SSRIs

Clomipramine

Most respond, but only partially



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Phobic Disorders

- ★ An irrational fear of some stimulus that causes
 - Disabling avoidance, or
 - Anxiety or panic when the feared stimulus cannot be avoided
- ★ Insight is typically preserved



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Phobic Disorders 2

- ★ Social phobia – fear of embarrassing one-self in a social or performance situation
- ★ Specific phobias – fear of...
 - Animals or insects
 - Natural environment (e.g., heights)
 - Situational (e.g., flying)
 - Blood or Injection
- ★ Agoraphobia – fear of places or situations from which escape might prove difficult or embarrassing



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Phobic Disorders 4 Common Pharmacotherapies

- ★ Specific - none
- ★ Social –
 - Beta blockers (must anticipate)
 - SSRIs – paroxetine is FDA-approved



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Differential Diagnosis

- ★ General medical conditions?
- ★ Substance use or misuse?
- ★ Which type of anxiety disorder?
 - Anxiety in "attacks"?
 - Traumatic event?
 - Specific stimulus?
 - Obsessions or compulsions?
 - Recent stressor?



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Treatment

- ★ GMC: optimize treatment of the underlying illness
- ★ Substance-induced:
 - Discontinue or taper the substance
 - May require a taper (CNS depressants) or more intensive rehab
- ★ Primary anxiety disorders:
 - Psychopharmacologic
 - Psychotherapeutic
 - Patient education



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Treatment 2

- ★ Anxiety as a symptoms of depression
Underlying illness (antidepressants work for both)
- ★ Anxiety as a symptom of schizophrenia
 - Behavioral protocols for compulsions
 - Benzodiazepines often used along with the antipsychotic medication
 - Education



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Conclusions

- ★ Anxiety is universal
- ★ Anxiety disorders are common
- ★ First, think D-S-M (disease, substances, meds)
- ★ Treatment typically includes combined behavioral or cognitive behavioral therapies, psychoactive medication, and patient education



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Human Behavior Course 2004

Forensic Psychiatry

David Benedek, MD
LTC, Medical Corps, US Army

Director, National Capital Area Forensic
Psychiatry Fellowship
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Uniformed Services University

HUMAN BEHAVIOR COURSE 2004

FORENSIC PSYCHIATRY - SLIDES

LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. What are the forensic clinician's main ethical obligations?
2. Describe how the process and goals of clinical assessment are different from the process and goals of forensic assessment.
3. Compare and contrast the meaning of 'competence' versus 'capacity'. Use examples.
4. What is medical decision-making capacity? List and describe the factors to be considered when medical decision-making capacity is assessed.
5. Describe requirements for civil commitment.
6. What are the elements of medical malpractice?
7. Contrast the terms 'confidentiality' and 'privilege'. Are there exceptions to doctor-patient confidentiality? What are the most common examples?
8. What is the 'insanity defense'? Describe key historical standards for this defense.
9. Discuss the duty that psychiatrists have to protect third parties from harm by dangerous psychiatric patients.
10. What are the elements of informed consent?

Slide 1

Forensic Psychiatry – Terms & Concepts

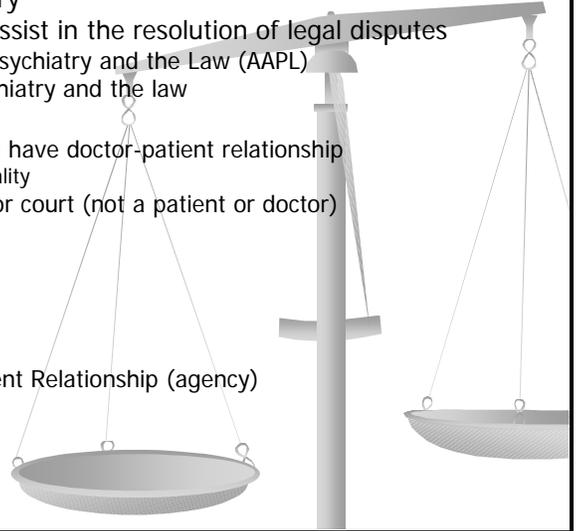
- ★ agency
- ★ fiduciary responsibility
- ★ criminal law
- ★ civil law
- ★ legislative law
- ★ criminal responsibility
- ★ insanity
- ★ malpractice
- ★ dual agency
- ★ adversarial process
- ★ functional capacity
- ★ decision-making capacity
- ★ competence
- ★ disability
- ★ civil commitment
- ★ involuntary treatment
- ★ narrative truth
- ★ historical truth
- ★ informed consent
- ★ confidentiality
- ★ privilege



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Forensic Psychiatry

- Sub-specialty of psychiatry
- Psychiatric expertise to assist in the resolution of legal disputes
 - American Academy of Psychiatry and the Law (AAPL)
 - Interface between psychiatry and the law
- Expert vs. Fact Witness
 - Expert witness does not have doctor-patient relationship
 - Absence of confidentiality
 - Referral from attorney or court (not a patient or doctor)
 - Prepare for courtroom
 - Curriculum vitae (CV)
 - Objectivity essential
- Evaluations
 - Often a team approach
 - Absence of Doctor-Patient Relationship (agency)
 - DSM IV-TR
 - Collateral sources



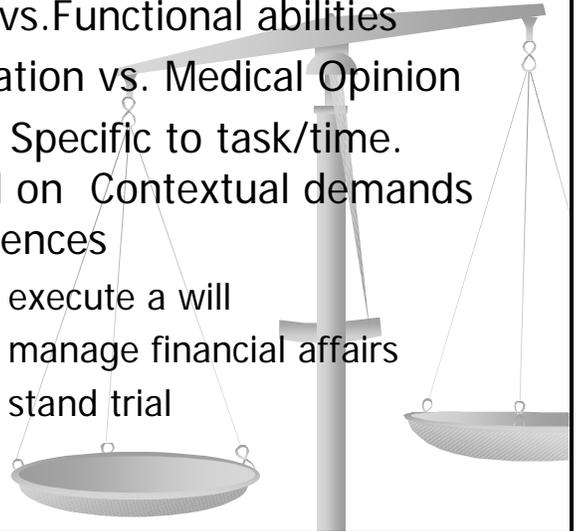
Ethical Issues

- Obligation to the court, not the patient
- Limits of confidentiality
- Evaluator, not treater
- Reliability of opinion
- Role in Death Penalty cases
- Military psychiatry has many similar issues



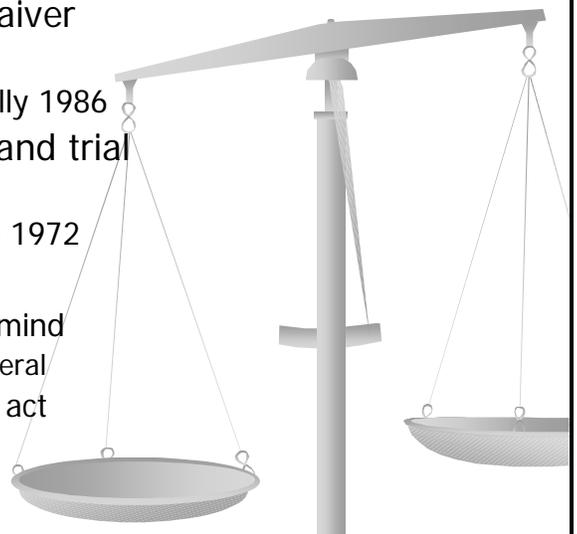
Competence vs. Capacity

- Legal Question vs. Functional abilities
- Legal Determination vs. Medical Opinion
- Competence is: Specific to task/time. therefore based on Contextual demands and causal influences
 - Competence to execute a will
 - Competence to manage financial affairs
 - Competence to stand trial



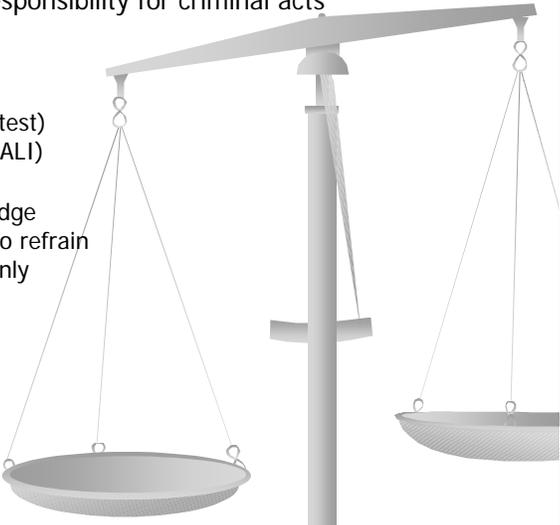
Criminal Forensic Psychiatry

- Confession and waiver
 - Miranda rights
 - Colorado v Connelly 1986
- Competence to stand trial
 - Dusky v US 1960
 - Jackson v Indiana 1972
- Guilt
 - Mens Rea--guilty mind
 - specific and general
 - Actus reus--guilty act



Insanity

- Insane defendants lack responsibility for criminal acts
- How is insanity defined?
- Insanity standards
 - M'Naghten—cognitive
 - Durham 1954 ("product test)
 - American Law Institute (ALI)
- Two "prongs"
 - Cognitive prong--knowledge
 - Volitional prong--ability to refrain
 - UCMJ--cognitive prong only
- Controversial diagnoses
- Other options
 - Diminished capacity
 - Guilty but mentally ill



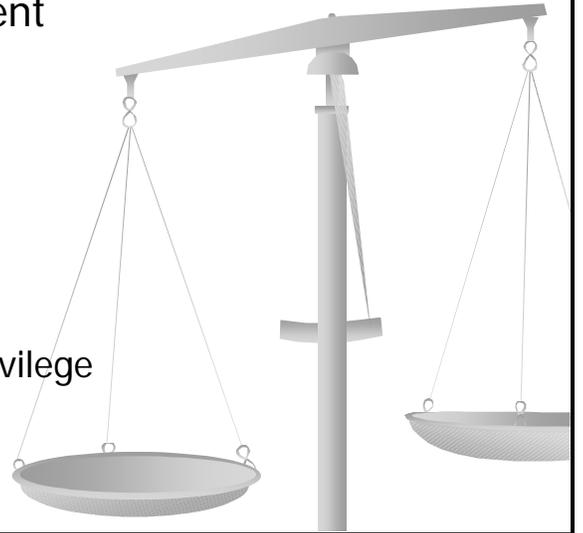
Confidentiality and Privilege

- Confidentiality--right of patient to have communications undisclosed without authorization
 - Statutory Exceptions
 - child abuse
 - competency
 - dangerousness to self or others
 - intent to commit a crime
- Testimonial privilege--statutorily created rule of evidence that permits the patient to prevent the psychiatrists from disclosing it
 - Similar exceptions



Informed Consent

- Informed Consent
 - Competency
 - Information
 - Voluntariness
- Exceptions
 - Emergencies
 - Incompetency
 - Therapeutic privilege
 - Waiver



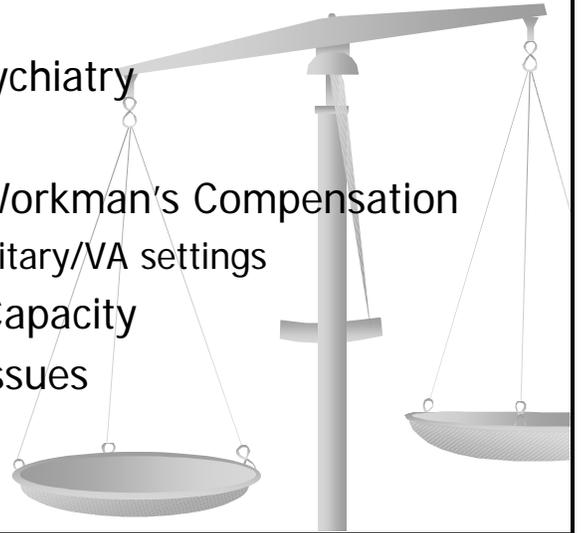
Malpractice

- Malpractice
 - A *tort*
 - negligence
 - liability--4 "D's"
 - duty
 - deviation
 - damages
 - direct causation



Other Topics

- Presentencing
- Correctional Psychiatry
- Personal Injury
- Disability and Workman's Compensation
 - Disability in military/VA settings
- Testamentary Capacity
- Child-Related Issues



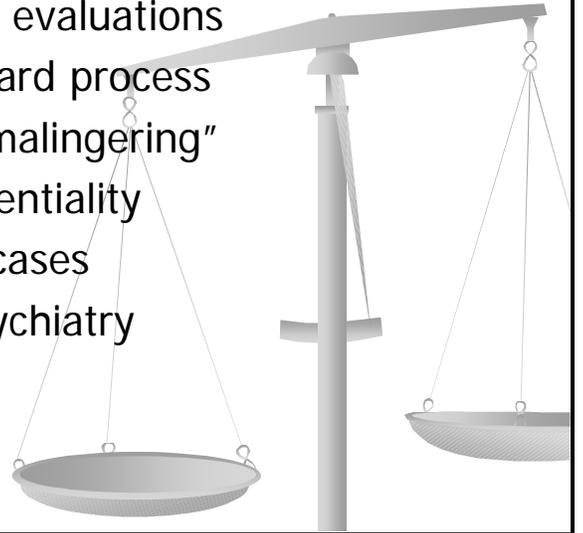
Other Topics

- Civil Commitment--standards
- Guardianship and Conservatorship
- Right to Refuse Treatment
 - Lessard v Schmidt 1972
 - "rotting with their rights on"
- Duty to Protect
 - Tarasoff v Regents of the University of California 1976
- Sex offender laws
 - Kansas v Hendricks 1997



Military Psychiatry and Forensics

- Fitness for duty evaluations
- The medical board process
- Evaluation of "malingering"
- Limits of confidentiality
- Sexual assault cases
- Correctional psychiatry
 - GITMO



**Human Behavior Course
2004**

**Schizophrenia & Psychosis Three
Therapeutics**

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HUMAN BEHAVIOR COURSE 2004
SCHIZOPHRENIA & PSYCHOSIS THREE - SLIDES

TO BE DISTRIBUTED

**Human Behavior Course
2004**

DIAGNOSIS & FORMULATION IV
The Geriatric Patient

SMALL GROUP DISCUSSION FOUR

HUMAN BEHAVIOR COURSE 2004

VIGNETTE 4:1 - "PSYCHOTIC P SERGEANT MAJOR"

Chief Complaint: Mr. C is 67-year-old retired Army command sergeant major and combat veteran. You are the medicine resident on call and Mr. C's general internist for many years just hospitalized him but there is no clinic admission note to tell you the exact reason for admission, only an admission order stating the admission diagnosis as "R/O Psychosis." Mrs. C, his wife of 46 years, tells you tearfully that she is exhausted and confused by his strange behavior over the past week. You've never met Mr. & Mrs. C before today, and he is not saying anything to you now even though Mrs. C reassures you that he is fully able to speak.

History of the Present Illness: Mr. C has been in declining health for last 10 years or so from chronic obstructive pulmonary disease suffered as a consequence of many years of heavy cigarette smoking. The pace of that decline has increased markedly over the past year. During most of that time Mr. C has been wheelchair bound and on supplementary home oxygen therapy. Mrs. C tells you that it has been very difficult for Mr. C to cope with his disability. He has always been a fiercely independent man, and received "a chest full of awards" during his 31 years of military service including two silver stars and a bronze star with v-device for his valorous service and acts of heroism in the Korean War and the Vietnam War. Mrs. C tells you that there have been three distinct declines she has noted over the past year, two of those declines occurring in the past month. There have been no unusual stressors, she says, but each decline has manifest as changes in the way Mr. C thinks and acts. Mrs. C has noticed him becoming more reclusive, isolative, and secretive. Especially over the past week, Mr. C has become very suspicious and is "filled with wild ideas that everyone, even me, is out to get him." He rarely sleeps from what she observes, choosing instead to stay in his room (they sleep separately) nearly day and night. When she wakes up to check on him in the early hours of the morning, the lights are always on, his television volume is up, and she can hear him talking as though someone were in the room with him. She says he has continued to eat and drink pretty well and shows no inability to speak to her whenever they talk at meals or in their day-to-day dealings around the house. She has noted no major changes in his nutritional or weight status.

With some persuasion from Mrs. C., Mr. C agrees to talk with you "but only on unclassified matters." The command sergeant major denies any major change whatsoever in his health or his baseline level of physical symptoms over the past few weeks. When asked about his sleep patterns, he explains, "you would stand watch too, if you knew what I know...what's gonna go down here...then again, maybe you know" and then refused to elaborate further.

Past Psychiatric History: There is no history of psychiatric problems that Mrs. C knows about, but she recalls that Mr. C was "dark, quiet, and moody" for many months after returning from a year in Vietnam in the early 1970s.

Family Psychiatric History: Mr. C has a sister who was treated once for depression.

Habits: 50 pack-year smoking history, but quit smoking 7 years ago. No other evidence of substance misuse.

Social & Developmental History: Remarkable for a history of consistent success in the military, a masters degree in administration that he earned while on active duty, and his long and stable relationship with Mrs. C that dates back to shortly after his graduation from high school. Those who have worked with and under Mr. C have high praise for him as a person, soldier, and leader. Your conversation with Mrs. C offers clear evidence of her devotion to her husband and her ongoing support. Indeed, she seems overwhelmed with guilt and sadness at the moment because she is having doubts about her ability to continue caring for Mr. C and the thought of turning his care over to someone less committed to him than she is "tears [her] up inside." She has had many acquaintances over their years together, but she has no close social supports besides Mr. C and this is making it difficult for her to cope effectively now.

Past Medical History: COPD, moderate to severe. Past oral corticosteroid treatment but none now. History of lung reduction surgery in the past with mild to moderate improvement in COPD symptoms. History of two ICU stays over the past two years with brief intubations required to stabilize him.

Medicines: Supplemental home O₂, albuterol inhaler, and oral theophylline.

HUMAN BEHAVIOR COURSE 2004
VIGNETTE 4:1 - DISCUSSION QUESTIONS

1. Your time is limited – you have two more patients awaiting admission.
 - A. What mental status examination findings do you need?

 - B. What physical examination findings are you interested in?

 - C. What further laboratory testing results do you want?

2. What is the patient's DSM-IV multiaxial diagnosis/diagnoses? Why?

3. Now that you have the history and the diagnosis, survey the current clinical situation for the biopsychosocial predisposing, precipitating, and perpetuating factors (consider the admission as the focal event):
 - A. Predisposing factors?

 - B. Precipitating factors?

 - C. Perpetuating factors?

4. Devise a biopsychosocial management plan for Mr. C.
 - A. Biological management?

 - B. Psychological management?

 - C. Social management?

VIGNETTE 4:2 - "DISTRESSED VET WITH PARKINSON'S"

Chief Complaint: A 74 year-old married African-American man, Mr. A., is referred for psychiatric consultation because he is hearing voices and has recently developed a firm belief that he is being observed.

History of Present Illness: Nine years ago, he developed Parkinsonian symptoms. He has been treated with sinemet (a combination medication containing both carbidopa and levodopa) for the past four years. His dosage was increased two months ago to 25-250 mg four times daily from three times daily due to gradual worsening of Parkinsonian symptoms. One month ago, due to worsening of symptoms, benztropine 1 mg twice daily was added with subsequent improvement in his Parkinsonian tremor.

Two weeks ago, the patient's wife noticed that the Mr. A began to express suspicions that people were observing them and bugging the telephone. After a couple of days, his beliefs became firm and unshakable. Two days ago he said he could hear someone outside the house door demanding to come in and threatening to murder Mr. A and his wife. The patient's wife corroborates that Mr. A and she are not in trouble with anyone, and there was no one behind the door at the times Mr. A said he heard the visitor.

Past Medical History: The patient was struck in the head by a falling crate while on duty in Iwo Jima in 1945. He was unconscious for six hours and had a slow recovery of short-term memory, though by the time he was flown back to CONUS, he had no clinically detectable memory deficits. His wife says, however, that "he never was the same after that," being impulsive, occasionally physically violent, and not able to control his temper well enough to hold down jobs more than one year at a time. She also complains that he "has had trouble keeping his mind on things ever since then" and "sometimes gets mentally paralyzed trying to solve simple problems." For the past five years, both the patient and wife notice increasingly impaired short-term, but not long-term memory. He has hypertension, first diagnosed at age 50, and has a sixty pack-year smoking history.

Review of Systems: Aside from the signs and symptoms detailed in the history of present illness, the patient complains of constipation, trouble getting urine stream started and stopped, and dizziness.

Past Psychiatric History: Impulse control problems, concentration problems, short-term memory deficit, as above. No formal history of psychiatric treatment. Mrs. A. describes him as a moderate drinker ("one high-ball most days; he used to drink two").

Social History: Married for 53 years; his wife is 72 years old and functions independently in spite of mild congestive heart failure and well-managed hypertension. Mr. A has two grown children who live in other states, but who are emotionally close to their parents and visit whenever they can.

Personal History: The patient's father died of tuberculosis when the patient was twelve years old. He is the oldest of seven children; he has four brothers and two sisters. His mother never remarried. The patient dropped out of school at age 16 to support the family, and joined the Marines in 1942.

Current Medications: Sinemet 25-250 mg. four times daily, benztropine (cogentin) 1 mg. p.o. twice daily, and hydrochlorothiazide 25 mg. twice daily.

Physical Examination: Significant for very mild action tremor, slow speech, mild bradykinesia, and mild general stiffness. Pupils were 9 mm. bilaterally and responsive to light. Heart rate was 96, blood pressure 160/90. Oral mucosa was dry.

Mental Status Examination: Slow responses to questions, suspicious mood, delusions, and auditory hallucination present as per HPI. Speech slow. No suicidal or homicidal ideation. No aphasia evident. Oriented to person and year. Thought he was in "a sanitarium." Gave date as January 23, 1953. Was able to recall his activities during World War II, and was able to recall three of three words right after they were said to him. However, he could not recall any of them at 3 minutes. Performed poorly on tests of attention and concentration.

HUMAN BEHAVIOR COURSE 2004
VIGNETTE 4:2 - DISCUSSION QUESTIONS

1. Place this patient's clinical data into a biopsychosocial formulation.
 - A. Biological Predisposition
 - B. Psychological Predisposition
 - C. Social Predisposition
 - D. Biological Precipitants
 - E. Psychological Precipitants
 - F. Social Precipitants
 - G. Biological Perpetuators
 - H. Psychological Perpetuators
 - I. Social Perpetuators
2. Describe the common behavioral and emotional sequelae of traumatic head injury (see pp. 1687-1689 in your textbook). How does this match Mr. A's clinical presentation, particularly the pattern of Parkinsonism, increasing short-term memory problems, and psychosis?
3. How are dopaminergic neurotransmitter systems important in motoric and behavioral function? (Review textbook pp. 20-21)
4. How are cholinergic neurotransmitter systems important in motoric and behavioral function? (Review textbook pp. 21-22)

5. What might be done to address this patient's new clinical problems?
 - A. Biological management?

 - B. Psychological management?

 - C. Social management?

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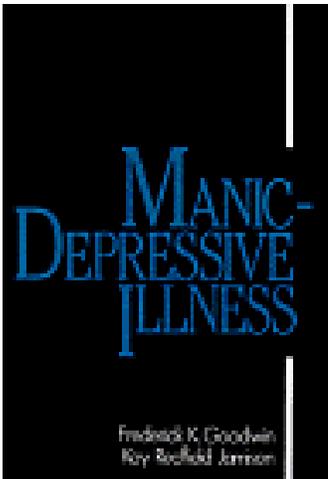
Mood Disorders Two & Three

Kay Redfield Jamison, PhD

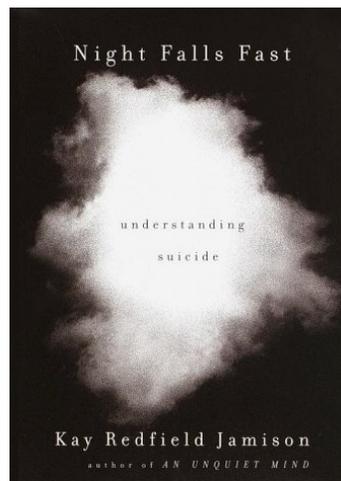
**Professor of Psychiatry
Johns Hopkins University**

Kay Redfield Jamison, PhD

Dr. Jamison is the daughter of an Air Force officer and was brought up in the Washington, D.C. area. She attended UCLA as an undergraduate and as a graduate student in psychology, and she joined the medical school faculty there in 1974. She later founded the UCLA Affective Disorders Clinic, which has treated thousands of patients for depression and manic-depression.

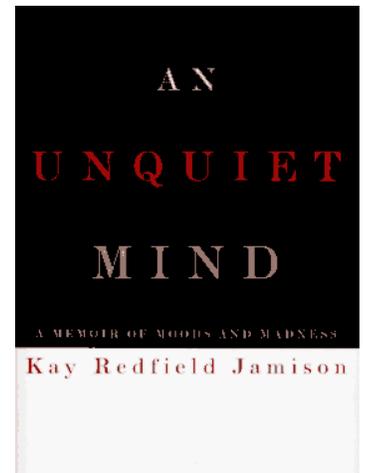


Dr. Jamison is currently Professor of Psychiatry at the Johns Hopkins University School of Medicine. The Association of American Publishers chose the textbook on manic-depressive illness that she wrote with Dr. Frederick Goodwin in 1990 as the Most Outstanding Book in Biomedical Sciences. She is also the author of, *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (1993), and has produced three public television specials on the subject: one on manic-depressive composers, one on Vincent van Gogh, and one on Lord Byron. In



recent years she has written and spoken extensively on her own battle with bipolar disorder, publishing two award winning books, one on bipolar disorder (*An Unquiet Mind*, 1997), and one on suicide (*Night Falls Fast: Understanding Suicide*, 2000)

The recipient of numerous national and international scientific awards, Dr. Jamison was a member of the first National Advisory Council for Human Genome Research, and is currently the clinical director for the Data Consortium on the Genetic Basis of Manic-Depressive Illness.



HUMAN BEHAVIOR COURSE 2004
MOOD DISORDERS TWO & THREE - SLIDES

LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. Know the meaning of the terms and concepts listed in slide one below.
2. What are the diagnostic features of acute mania (a manic episode)?
3. What is the difference between mania and hypomania?
4. Name the different cyclic mood disorders and know whether they are very common (point prevalence > 5%), common (1-5%) or uncommon (<1%) in the general population.
5. Know whether each cyclic mood disorder is more common in men, more common in women, or occurs in a similar proportion of men and women.
6. Know the prognosis and prognostic features of the bipolar disorders. How does the prognosis of bipolar disorder differ from schizophrenia?
7. What are the diagnostic features of bipolar I disorder?
8. What are the diagnostic features of bipolar II disorder? How are bipolar I and bipolar II disorders different?
9. What are the diagnostic features of cyclothymic disorder? How does cyclothymic disorder differ from bipolar I and II disorders?
10. What are the diagnostic features of mood disorder due to a general medical condition?
11. What are the diagnostic features of substance-induced mood disorder?
12. What diseases can cause mood disorders?
13. What medications can cause mood disorders?
14. What substances of abuse can cause mood disorders? The intoxication or withdrawal state (or both)?
15. What is the difference between bipolar 2 disorder and major depressive disorder?
16. Describe the pathogenesis of depression from a biological or neurophysiological perspective. What neurotransmitters, nervous system pathways, other body systems, and brain areas are involved?
17. Know the basic psychotherapeutic, pharmacological, and somatic therapies used to treat the cyclic mood disorders.
18. Is there a role for ECT in bipolar disorder? If so, what is it?

NOTE: Dr. Jamison Did Not Use Slides Last Year

**Human Behavior Course
2004**

Sexual & Gender Identity Disorders

**Charles C. Engel, MD, MPH
LTC, MC, USA
Associate Professor of Psychiatry
Uniformed Services University**

HUMAN BEHAVIOR COURSE 2004
SEXUAL & GENDER IDENTITY DISORDERS - SLIDES

TO BE DISTRIBUTED.

Human Behavior Course 2004

Personality Disorders Two

Charles C. Engel, Jr., MD, MPH
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HUMAN BEHAVIOR COURSE 2004
PERSONALITY DISORDERS TWO - SLIDES

LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. Know the meaning of the terms and concepts listed in slide one and slide two below.
2. What are the cluster B personality disorders? What are the similarities across disorders within this cluster of disorders?
3. Which of the cluster B disorders are 'very common' (point prevalence > 5%), 'common' (1-5%) or 'uncommon' (<1%) in the general population.
4. Know whether each cluster B personality disorder is more common in men, more common in women, or occurs in a similar proportion of men and women.
5. What are the diagnostic features of borderline personality disorder? Describe its pathogenesis from the perspective of both form and function.
6. What are the diagnostic features of antisocial personality disorder? Describe its pathogenesis from the perspective of both form and function.
7. What are the diagnostic features of narcissistic personality disorder? Describe its pathogenesis from the perspective of both form and function.
8. What are the diagnostic features of histrionic personality disorder? Describe its pathogenesis from the perspective of both form and function.
9. What types of medications, if any, are useful for cluster B personality disorders?
10. What types of psychosocial treatments are useful for cluster B personality disorders?
11. What are the cluster C personality disorders? What are the similarities across disorders within this cluster of disorders?
12. Which of the cluster C disorders are 'very common' (point prevalence > 5%), 'common' (1-5%) or 'uncommon' (<1%) in the general population.
13. Know whether each cluster C personality disorder is more common in men, more common in women, or occurs in a similar proportion of men and women.
14. What are the diagnostic features of obsessive-compulsive personality disorder? Describe its pathogenesis from the perspective of both form and function.
15. What is the difference between obsessive-compulsive personality disorder and obsessive-compulsive disorder?
16. What are the diagnostic features of dependent personality disorder? Describe its pathogenesis from the perspective of both form and function.
17. What are the diagnostic features of avoidant personality disorder? Describe its pathogenesis from the perspective of both form and function.
18. What is the difference between schizoid personality disorder and avoidant personality disorder?
19. What types of medications, if any, are useful for cluster C personality disorders?
20. What types of psychosocial treatments are useful for cluster C personality disorders?

Personality Disorders: Cluster B Disorders



Cluster A: "Eccentric or odd"

Paranoid Schizotypal
Schizoid

Cluster B: "Dramatic, emotional, or erratic"

Histrionic Antisocial
Narcissistic Borderline

Cluster C: "Anxious or fearful"

Avoidant Dependent
Obsessive-Compulsive



Antisocial Personality Disorder

- ★ Pervasive pattern of disregard or a violation of the rights of others
 - Repeatedly performing acts that are grounds for arrest
 - Deceitfulness
 - Impulsivity or failure to plan ahead
 - Reckless disregard for safety of self or others



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Antisocial Personality Disorder

- ★ Consistent irresponsibility
- ★ Lack of remorse
- ★ Individual is at least 18 years old
- ★ Evidence of Conduct Disorder with onset before age 15 years



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Antisocial Personality Disorder

CALLOUS MAN *

C-onduct disorder before 15 yo; now 18 yo or older

A-ntisocial acts that are grounds for Arrest

L-acunae (lacks a superego)

L-ies frequently

O-bligations are not honored (financial, occupational, etc.)

U-nstable (can't plan ahead; impulsive)

S-afety of self & others is ignored

M-oney: child and spouse are not supported

A-ggressive, Assaultive

N-ot occurring during schizophrenia or mania



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* From DSM-IV Personality Disorders
Explained. Robinson D. 2000

Antisocial PD Differential

- ★ Substance-related Disorders
- ★ Manic episode of Bipolar Disorder
- ★ Narcissistic Personality Disorder
- ★ Histrionic Personality Disorder
- ★ Adult Antisocial Behavior



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Antisocial PD Epidemiology

Prevalence:

- ★ General population:
 - 3% in men;
 - 1% in women

- ★ Clinical Settings: depends on pt population:
higher in substance abuse, prison & forensic settings



Antisocial PD Etiology

- ★ more common among 1^o relatives of those with the disorder
- ★ biological relative of persons with APD at greater risk to have
 - somatization Disorder
 - substance-Related Disorders
- ★ environmental factors also involved (e.g. , modeling by parents & peers)



Antisocial PD in Med/Surg Settings

Patient's experience of illness --

- ★ Sense of fear may be masked by increased hostility or entitled stance

Problem behaviors --

- ★ Irresponsible, impulsive, or dangerous health behavior, without regard to consequences to self or others
- ★ Angry, deceitful, or manipulative behavior



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Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Antisocial PD in Med/Surg Settings

Common problematic HCP reactions --

- ★ Succumbing to pt's manipulation
- ★ Angry, punitive reaction when manipulation is discovered



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in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Antisocial PD in Med/Surg Settings

Management Strategies --

- ★ carefully, respectfully investigate pt's concerns and motives
- ★ communicate directly
- ★ avoid punitive reactions to pt.
- ★ set clear limits in context of medically indicated interventions



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Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Borderline Personality Disorder

- ★ Instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood
- ★ Frantic efforts to avoid real or imagined abandonment
- ★ Pattern of unstable and intense interpersonal relationships
- ★ Markedly and persistently unstable self-image or sense of self



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Borderline Personality Disorder

- ★ Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- ★ Affective instability due to a marked reactivity of mood
- ★ Chronic feelings of emptiness
- ★ Inappropriate, intense anger or difficulty controlling anger
- ★ Transient, stress-related paranoid ideation or severe dissociative symptoms



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Borderline Personality Disorder

I RAISED A PAIN *

I-identity disturbance

R-relationships are unstable

A-bandonment is frantically avoided

I-mpulsivity

S-uicidal gestures

E-emptiness as a description of inner selves

D-issociative symptoms



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* From DSM-IV Personality Disorders Explained. Robinson D. 2000

Borderline Personality Disorder

I RAISED A PAIN * (Continued)

A-ffective instability

P-aranoid ideation

A-nger is poorly controlled

I-dealization of others, followed by devaluation

N-egativistic - undermine their efforts & those of others

* From DSM-IV Personality Disorders
Explained. Robinson D. 2000



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Borderline PD Differential

- ★ Mood Disorders
- ★ Histrionic Personality Disorder
- ★ Narcissistic Personality Disorder
- ★ Antisocial Personality Disorder
- ★ Dependent Personality Disorder



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Borderline PD Epidemiology

★ Prevalence:

- General population: 2%
- Psychiatric Inpatients: 20%
- Psychiatry Outpatients: 10%
- Constitutes 30-60% of clinical populations with PDs

★ Gender:

- Women comprise 75% of those dx'ed with BPD



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Borderline PD Etiology

- ★ BPD is 5x more common in 1^o family members of those with BPD
- ★ Often there is childhood history of physical or sexual abuse
- ★ Potential genetic predisposition towards dyscontrol of mood & impulses



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Borderline PD in Med/Surg Settings

Patient's experience of illness --

- ★ Terrifying fantasies about illness
- ★ Feels either completely well or deathly ill

Problem behaviors --

- ★ Mistrust of physicians & delay in seeking care
- ★ Intense fear or rejection & abandonment
- ★ Abrupt shifts from idealizing to devaluing caregivers; Splitting
- ★ Self-destructive threats & acts



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Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Borderline PD in Med/Surg Settings

Common problematic HCP reactions --

- ★ Succumbing to pt's idealizing & splitting
- ★ Getting too close to pt, causing overstimulation
- ★ Despair at pt's self-destructive behaviors
- ★ Temptation to punish pt angrily



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in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Borderline PD in Med/Surg Settings

Management Strategies --

- ★ Don't get too close to pt
- ★ Schedule frequent periodic check-ups
- ★ Provide clear, non-technical answer to questions to counter scary fantasies
- ★ Tolerate periodic angry outbursts, but set limits
- ★ Be aware of pt's potential for self-destructive behavior
- ★ Discuss feelings with coworkers & schedule multidisciplinary meetings



Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Histrionic Personality Disorder

Pervasive pattern of excessive emotionality
and attention-seeking behavior

- ★ Uncomfortable if he or she is not the center of attention
- ★ Inappropriate sexual seductiveness or provocative behavior
- ★ Rapidly shifting and shallow expression of emotions
- ★ Uses physical appearance to draw attention



Histrionic Personality Disorder

- ★ Style of speech that is excessively impressionistic
- ★ Self-dramatization, theatrical, and exaggerated expression of emotion
- ★ Suggestible
- ★ Considers relationships to be closer than they actually are



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Histrionic Personality Disorder

I CRAVE SIN *

I-nappropriate behavior: seductive or provocative

C-enter of attention

R-elationships are seen as closer than they really are

A-ppearance is most important

V-ulnerable to the suggestions of others

E-xaggerated emotional expression

S-hallow, shifting emotions

I-mpressionistic speaking style which lacks detail

N-ovel situations are sought



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* From DSM-IV Personality Disorders Explained. Robinson D. 2000

Histrionic PD Differential

- ★ Borderline Personality Disorder
- ★ Narcissistic Personality Disorder



Histrionic PD Epidemiology

Prevalence:

- ★ General population: 2.0-3.0%
- ★ Inpatient Psychiatry Settings: 10%-15%
- ★ Outpatient Psychiatry Clinics: 10%-15%

Gender:

- ★ At least 2/3 are women
- ★ May reflect the ratio of females within the respective clinical setting



Histrionic PD Etiology

Genetic contribution:

- ★ There may be a genetic predisposition towards sensation seeking & impulsivity

Possible psychosocial contributions:

- ★ Tendency of family to emphasize, value, or reinforce attention seeking behaviors



Histrionic PD in Med/Surg Settings

Patient's experience of illness --

- ★ Threatened sense of attractiveness & self-esteem

Problem behaviors --

- ★ Overly dramatic; tendency to draw HCP into excessively familiar relationship
- ★ Overemphasis on feeling states; inadequate focus on symptoms & their management
- ★ Tendency to somatize
- ★ May say things they think their physician wants to hear



Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Histrionic PD in Med/Surg Settings

★ Common problematic HCP reactions:

- Performing excessive or inadequate work-up
- Allowing too much emotional closeness & losing objectivity
- Frustration with patient's dramatic or vague presentation



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in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Histrionic PD in Med/Surg Settings

★ Management Strategies:

- Show respectful & professional concern for feelings, with emphasis on objective issues
- Avoid excessive familiarity



Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Narcissistic Personality Disorder

Pervasive pattern of grandiosity, need for admiration, and lack of empathy

- ★ Grandiose sense of self-importance
- ★ Preoccupied with fantasies of unlimited success
- ★ Believes that he or she is "special" and unique and can only be understood by other special or high-status people
- ★ Requires excessive admiration



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Narcissistic Personality Disorder

- ★ Sense of entitlement
- ★ Interpersonally exploitative
- ★ Lacks empathy
- ★ Often envious of others
- ★ Arrogant, haughty behaviors and attitudes



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Narcissistic Personality Disorder

A FAME GAME *

A-dmiration is required in excessive amounts

F-antasizes about unlimited success, beauty, brilliance, etc.

A-rrogant

M-anipulative

E-nvious of others

G-randiose sense of self importance

A-ssociated with famous people

M-e first attitude

E-mpathy lacking

* From DSM-IV Personality Disorders Explained. Robinson D. 2000



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Narcissistic PD Differential

- ★ Antisocial Personality Disorder
- ★ Histrionic Personality Disorder
- ★ Borderline Personality Disorder
- ★ Obsessive-Compulsive Personality Disorder
- ★ Bipolar Disorder, mania or hypomania
- ★ Substance-Related Disorders



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Narcissistic PD Epidemiology

Prevalence:

- ★ General population: 1%
- ★ Psychiatric population: 2%-16%

Gender:

- ★ Of those diagnosed with NPD, 50%-75% are men



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Narcissistic PD Etiology

Genetic contribution:

- ★ No genetic data

Possible psychosocial contributions:

- ★ Cultural hypothesis: Western society has become overly self-centered
- ★ Psychodynamic hypotheses: Unempathic, neglectful, or devaluing parents



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Narcissistic PD in Med/Surg Settings

Patient's experience of illness:

- ★ Illness may increase anxiety related to doubts about personal adequacy

Problem behaviors:

- ★ Demanding, entitled attitude
- ★ Excessive praise toward HCP may turn to devaluation, in effort to maintain sense of superiority
- ★ Denial of illness or minimization of symptoms



Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Narcissistic PD in Med/Surg Settings

Common problematic HCP reactions:

- ★ Outright rejection of pt's demands, resulting in pt distancing self from HCP
- ★ Excessive submission to patient's grandiose stance



Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Narcissistic PD in Med/Surg Settings

Management Strategies:

- ★ Generous validation of pt's concerns, with attentive but factual responses to questions
- ★ Allow pts to maintain sense of competence by rechannelling their "skills" to deal with illness, obviating need for devaluation of HCP

Feder & Robbins, in Behavioral Medicine in Primary Care: A Practice Guide. Feldman & Christensen (eds.) 1998



Personality Disorders: Cluster C Disorders



Cluster A: "Eccentric or odd"

Paranoid Schizotypal
Schizoid

Cluster B: "Dramatic, emotional, or erratic"

Histrionic Antisocial
Narcissistic Borderline

Cluster C: "Anxious or fearful"

Avoidant Dependent
Obsessive-Compulsive



Avoidant Personality Disorder

- ★ Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation
- ★ Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection
- ★ Unwilling to get involved with people unless certain of being liked
- ★ Shows restraint within intimate relationships because of the fear of being shamed or ridiculed



Avoidant Personality Disorder

- ★ Preoccupied with being criticized or rejected in social situations
- ★ Inhibited in new interpersonal situations because of feelings of inadequacy
- ★ Views self as socially inept, personally unappealing, or inferior to others
- ★ Unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing



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Avoidant Personality Disorder

AURICLE *

A-voids activities

U-nwilling to get involved

R-estrained within relationships

I-nhibited in interpersonal relations

C-riticism is expected within social relationships

L-ower than others (in own view)

E-mbarrassment is the feared emotion



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* From DSM-IV Personality Disorders Explained. Robinson D. 2000

Avoidant PD Differential

- ★ Social Phobia, Generalized Type
- ★ Panic Disorder with Agoraphobia
- ★ Dependent Personality Disorder
- ★ Schizoid Personality Disorder
- ★ Schizotypal Personality Disorder
- ★ Paranoid Personality Disorder



Avoidant PD Epidemiology

Prevalence:

- ★ General population: 0.5%-1%
- ★ Outpatient Psychiatry Clinics: 10%

Gender:

- ★ Occurs equally in men & women



Avoidant PD Etiology

- ★ Substantial heritability with introversion, social anxiety, shyness, & inhibition
- ★ Parents could contribute through overprotection, excessive cautiousness, or inculcation of low self esteem in child with respect to social desirability



Dependent Personality Disorder

- ★ Pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation
- ★ Difficulty making everyday decisions
- ★ Needs others to assume responsibility for major areas of his or her life
- ★ Difficulty expressing disagreement
- ★ Difficulty initiating projects or doing things on his or her own



Dependent Personality Disorder

- ★ Goes to excessive lengths to obtain nurturance and support from others
- ★ Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for oneself
- ★ Urgently seeks another relationship as a source of care and support when a close relationship ends
- ★ Unrealistically preoccupied with fears of being left to care care of oneself



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Dependent Personality Disorder

NEEDS PUSH *

N-eedy - has others assume responsibility for major portions of life

E-xpression of disagreement with others is limited

E-xcessive need for nurturance & support

D-ecision making is difficult

S-elf-motivation is lacking

P-reoccupied by fears of being left on own

U-rgently seeks another relationship when close one ends

S-elf-confidence lacking

H-elpless when alone

* From DSM-IV Personality Disorders Explained. Robinson D. 2000



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Dependent PD Differential

- ★ Mood Disorders
- ★ Panic Disorder
- ★ Agoraphobia
- ★ Borderline Personality Disorder
- ★ Histrionic Personality Disorder
- ★ Avoidant Personality Disorder



Dependent PD Epidemiology

Prevalence:

- ★ Among the most prevalent
- ★ General population: 2%-4%
- ★ Psychiatric patients: 5%-30%

Gender:

- ★ Controversial



Dependent PD Etiology

- ★ Insecure attachment to parent & helplessness may be generated through parent via clinging on parent's part or infantilization
- ★ May be an interaction between anxious temperament of child with an insecure attachment to parent



Dependent PD in Med/Surg Settings

Patient's experience of illness:

- ★ Fear that illness will lead to abandonment & helplessness

Problem behaviors:

- ★ Dramatic & urgent appeals for medical attention
- ★ Angry outbursts at HCP if not responded to
- ★ Pt may contribute to prolonged illness or encourage medical procedures in order to get attention
- ★ May abuse substances & medications



Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Dependent PD in Med/Surg Settings

Common problematic HCP reactions:

- ★ Inability to set limits to availability leading to burnout
- ★ Hostile rejection of pt

Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998



Dependent PD in Med/Surg Settings

Management Strategies:

- ★ Provide reassurance & make frequent periodic checkups
- ★ Be consistently available to provide firm realistic limits to availability
- ★ Enlist other members of team to provide support
- ★ Help pt obtain outside support systems
- ★ Avoid hostile rejection of pt.

Feder & Robbins, in Behavioral Medicine
in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998



Obsessive-Compulsive Personality Disorder

- ★ Preoccupation with orderliness, perfectionism, & mental and interpersonal control, at the expense of flexibility, openness, & efficiency
- ★ Preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
- ★ Shows perfectionism that interferes with the task completion



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Obsessive-Compulsive Personality Disorder

- ★ Reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
- ★ Adopts a miserly spending style towards both self and others; money is viewed as something to be hoarded for future catastrophes
- ★ Shows rigidity and stubbornness



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Obsessive-Compulsive Personality Disorder

- ★ Excessively devoted to work and productivity to the exclusion of leisure and friendships
- ★ Overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values
- ★ Unable to discard worn-out or worthless objects even when they have no sentimental value



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Obsessive-Compulsive PD

PERFECTION *

P-reoccupied with details, rules, plans

E-motionally restricted

R-eluctant to delegate tasks

F-rugal

E-xcessively devoted to work

C-ontrols others

T-ask completion hampered by perfectionism

I-nflexible

O-verconscientious about morals, values, ethics, etc.

N-ot able to discard belongings; hoards objects



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* From DSM-IV Personality Disorders Explained. Robinson D. 2000

Obsessive-Compulsive PD Differential

- ★ Obsessive-Compulsive Anxiety Disorder
- ★ Narcissistic Personality Disorder
- ★ Antisocial Personality Disorder
- ★ Schizoid Personality Disorder



O/C PD Epidemiology

Prevalence:

- ★ General population: 2%
- ★ Inpatient Psychiatry Settings: 3%-10%

Gender:

- ★ Men diagnosed 2x as often as women



Obsessive-Compulsive PD Etiology

- ★ Heritability for obsessional and conscientiousness traits
- ★ Psychoanalytic theories:
 - Unconscious guilt or shame
 - Need to maintain an illusion of infallibility to defend against feelings of insecurity
 - Identification with authoritarian parents
 - Excessive, rigid control of feelings & impulses



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O/C PD in Med/Surg Settings

Patient's experience of illness:

- ★ Fear of losing control of bodily functions & over emotions
- ★ Feelings of shame & vulnerability

Problem behaviors:

- ★ Anger about disruption of routines
- ★ Repetitive questions & excessive attention to detail
- ★ Fear of relinquishing control to health care team



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in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

O/C PD in Med/Surg Settings

Common problematic HCP reactions:

- ★ Impatience & cutting answers short
- ★ Attempts to control treatment planning



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in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

O/C PD in Med/Surg Settings

Management Strategies:

- ★ Thorough history taking & careful dx'ic workups are reassuring
- ★ Give clear & thorough explanations
- ★ Do not overemphasize uncertainties about treatments
- ★ Avoid vague & impressionistic explanations
- ★ Treat pt as an equal partner; encourage self-monitoring & allow pt participation in treatment



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in Primary Care: A Practice Guide.
Feldman & Christensen (eds.) 1998

Human Behavior Course 2004

Military Psychiatry

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HUMAN BEHAVIOR COURSE 2004

MILITARY PSYCHIATRY - SLIDES

LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. List the areas of expertise military psychiatrists must have to practice their specialty.
2. Describe the approach military psychiatrists use in the battlefield to prevent psychiatric casualties.
3. Describe aspects of psychological trauma and trauma treatment that are important to the military psychiatrist.
4. What are the key ethical dilemmas in combat and disaster psychiatry?
5. List factors associated with adverse psychosocial reactions to combat (i.e., combat stress reactions)
6. What group or individual level psychosocial factors predict resilience in combat?
7. Know the treatment of choice for combat stress reaction.
8. Know the role of medications for combat stress reaction.
9. Know the main names that have been used in the US for combat stress reactions since the Civil War.
10. List the important goals of the military psychiatrist during combat.
11. Describe technological trends that will likely impact on the practice of combat psychiatry in the 21st century?
12. What are the arguments for and against “psychological debriefing” (also known as “critical incident stress debriefing”) as an early intervention for people who have experienced severe psychological trauma? There is some evidence psychological debriefing may cause harm. In theory, how might that happen?
13. Know the psychiatric disorders commonly associated with military deployments
14. List key signs and symptoms that occur in an individual with a combat stress reaction?

Military Psychiatry – Terms & Concepts

- ★ primary prevention
- ★ secondary prevention
- ★ tertiary prevention
- ★ induction
- ★ retention
- ★ command consultation
- ★ contaminated environment
- ★ traumatic stress
- ★ combat stress
- ★ transition states
- ★ autonomic arousal
- ★ post-traumatic growth
- ★ trauma mediators
- ★ training
- ★ experience
- ★ leadership
- ★ torture
- ★ sexual assault
- ★ prisoner of war
- ★ respite
- ★ medicalization
- ★ forward treatment
- ★ frontline psychiatry
- ★ critical incident stress debriefing
- ★ combat stress reaction
- ★ battle fatigue
- ★ shell shock
- ★ neurasthenia
- ★ soldier's heart
- ★ irritable heart
- ★ buddy aid
- ★ stigmatization
- ★ "PIES"



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Military Psychiatry – Terms & Concepts

- ★ combat stress response
- ★ stigma
- ★ wounded
- ★ diazepam
- ★ amytal



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A Medical Officer & Military Psychiatrist

- **Absolute commitment**
- **Full commitment to both medical and military professional values**
- **Ethical & medical/legal sophistication**
- **Military, medical & psychiatric knowledge**
- **Physically & mentally fit**
- **Accepts exposure to extreme environments**

Military Psychiatrist

- **Advises on fitness for general and special duty**
- **Supports fitness for duty**
- **Restores fitness for duty**
- **Recommends return to or removal from duty**
- **Serves as practitioner, special staff and commands special units**

Military Psychiatrist

Knowledge of:

- **Military performance demands**
- **Administrative and forensic issues**
- **Epidemiology**
 - **Of military operations**
 - In war
 - In operations other than war (e.g. In peace keeping)
 - In garrison and training
 - **Of disasters**

Biopsychosocial Issues Military Psychiatry

The modification of doctrine, training, and practice to meet community, technological, and tactical requirements requires knowledge of

- **Bio-** (environmental stresses microbiology, fitness etc.)
 - **Psycho-** (education, beliefs, etc.)
 - **Social-** (cohesion, diversity, etc.)
- Parameters.

Psychiatric Issues in a Military Context

- Research & evaluation
- Consultation and referral
- Psychiatric prevention using public health model
 - Primary prevention (↓ incidence)
 - Secondary prevention (↓ prevalence)
 - Tertiary prevention (↓ disabilities)

Psychiatric Issues in a Military Context

- **Screening**
 - Induction standards,
 - During training and
 - Evaluate for duties
- **Rx – program:**
 - In-unit (command consultation),
 - Out-pt and
 - In-pt
 - » Retention and discharge

Psychiatric Issues in a Military Context

- **Psychiatric problems of mass casualties (burns, severely injured and problems of medical staff)**
- **Causes of behavioral dysfunction in austere, dangerous, contaminated environments**
- **Knowledge of socio-cultural influences**

Military Psychiatry Addresses

- **Endemic psychiatric disorders,**
- **Psychiatric disorders associated with deployment and combat,**
- **Mass casualties: triage & management,**
- **Practice with special populations (E.G. Intelligent personnel, Custodians of WMD, Pilots),**
- **Occupational operational psychiatry for all in armed forces.**

Stresses Of Deployment

- **Loss of social supports**
- **“Culture shock”**
- **Change in relationship**
- **with loved ones & family**
- **Economic problems**
- **Exposure to new stresses**
- **Exposure to new toxins & infections.**

Stresses Of Deployment

- **New microbial environment**
- **Opportunity for access to alcohol, illicit sex and drugs**
 - **Easier**
 - **New forms of alcoholic drinks & drugs**
- **Cultural challenges**

Diagnoses Associated With Deployment

- **Adjustment Disorders**
- **Various Character and Behavioral Disorders**
- **Malingering & Factitious Disorder**
- **Anxiety Disorders**
- **Affective & Mood Disorders**
- **Substance abuse and dependency**
- **Previously disguised disorders**
 - E.G. PTSD, & Panic Disorder

Deployment Problems: Treatments

- **Treat on site, usually do not evac, refer to psychiatrist as needed:**
- **Crisis management**
- **Reassurance & supportive psychotherapy**
- **Cognitive behavioral therapy**
- **Symptomatic management**
- **Do not excessively pathologize the patient's condition and**
- **Do understand the suffering of the patient!**

Deployment Problems: Treatments

- **Anxiolytic & antidepressants drugs (e.g. SSRIs) may be helpful for treatment of specific syndromes & symptom relief.**
- **Exceptions that may require evac**
 - **Psychotic or manic symptoms,**
 - **Severe depression**
 - **Complex dx issues**
 - **Suicidal or homicidal threat**
 - **Primary diplomatic or other special missions.**

Deployment: The high risk family

- **Few social supports**
 - **The young isolated spouse**
 - **No extended family support**
 - **Poor support from the unit**
- **Physically and psychiatrically ill spouse or child**
- **The failing marriage**
 - **Most report strengthened marriage**
 - **But failing marriages not helped**

Deployment Problems: the Return

- More problems on return than with departure
- Problem of shifting power dynamics in marital/significant other relationship
 - Children and role of returning spouse
 - New independence of spouse
 - Absence makes the heart grow fonder of someone else
- Unrealistic expectations

Effect on Marriage

40% +

29% 0

23% -

Effect on Positive Career Commitment

NCO and Officer

to Neutral

E1 to E5

to Negative

The slide features a dark background with a white border. At the top, the text "Effect on Positive Career Commitment" is written in a bold, white, sans-serif font. Below this, a rounded rectangular box contains the text "NCO and Officer" underlined, followed by "to Neutral", "E1 to E5" underlined, and "to Negative".

TRAUMA: PSYCHIATRIC CONSEQUENCES

Extreme demands associated with

- Battles
- Terrorist actions
- Criminal actions
- Technological and natural disasters
- Result in consequences

The slide has a white background with a black border. The title "TRAUMA: PSYCHIATRIC CONSEQUENCES" is centered in a bold, black, sans-serif font. Below the title, the text "Extreme demands associated with" is followed by a bulleted list of five items: "Battles", "Terrorist actions", "Criminal actions", "Technological and natural disasters", and "Result in consequences".

COMBAT STRESSES: EXAMPLES

- **Extreme environmental exposure**
- **Chronic fear of mutilation and death**
- **Horror**
- **Failure, letting your buddies down**
- **Fear of displaying fear**

Mediators of the Consequences of Trauma

- **Physical injury & disease**
- **Psychologically overwhelmed**
- **Extreme psychophysiological arousal – sense of being physiologically overwhelmed**
- **Fail socio-cultural expectations**
- **Disruption of social supports**
- **Failure command and med care**

Transition States

Psychological states that occur when there is a catastrophic alteration of the environment.

(e.g. Extreme autonomic arousal & Dissociation)

Consequences of Trauma

- **Transient manifest changes in alerting and autonomic functions,**
- **Acute disorders,**
- **Chronic disorders & complaints of undefined causes,**
- **Growth**

Consequence of the Response to Trauma

Potential for reorganization of the perception of one's "self" & of one's sense of personal and social identity.

Trauma Mediators [Biopsychosocial]

- **Previous trauma**
(↑risk)
- **Successful training** (↓risk)
- **Experience managing response to disasters facilitates successful performance** (↓risk)

Note the paradox

Trauma Mediators [Biopsychosocial]

- **Leadership**
- **Unit/Community Factors
(Cohesion Versus Disorganization)**
- **Physical Conditioning**
- **Equipment that Works**
- **Good Preventative Medicine**

The Stresses of War & Battle

- **Destruction of social supports**
- **Destruction of expectations**
- **Physiological exhaustion, poor nutrition, infection**
- **Exposure to toxins, and injury and wounding**
- **Battle death, and injustice seem unending**

Combat Stresses: Examples

- **Death, mutilation & injury of colleagues,**
- **Chronic illness and nagging, untreated injury,**
- **Perform acts contrary to conventional moral sanctions,**
- **Separation from family and roots
(Communication with those at home important – mail, e-mail ,etc helps).**

Combat Stresses: Transcendental factors

**Threatened loss of
faith in:**

- **Leadership**
- **Nation**
- **Belief in the eternal verities**

Trauma Mediators [Biopsychosocial]

Biology-genetics

- **Illness**
- **Genetically mediated**
- **Endocrine-autonomic mechanisms**

Neuro-psychological

- **Learning and conditioning (learned helplessness?)**
- **Dissociation**

Increased Risk In Combat Deployed

- **Organic mental syndromes**
- **Mood and Anxiety Disorders**
 - **Major Depression**
 - **Bipolar Disease**
 - **Phobic Disorders**
 - **Generalized Anxiety Disorder**
 - **Panic Disorder**
- **Adjustment Disorder**
- **Dissociative Disorders**

Factors that Shape the Response to Trauma

- **Physical injury and disease,**
- **Psychophysiological change & Psychological change**
- **Act together - cohesion**
- **A potential reorganization of personal outlook**

Prevention

- **Screening,**
- **Buddy care,**
- **Manage social supports,**
- **Educate about disaster stress, &**
- **Educate health care providers concerning effective responses to victims prior to the casualty generating event.**

Prevention

- **Training**
- **Experience**
- **Leadership**
- **Manage meaning**
- **Manage exposure**
- **Manage fatigue**

Those most exposed to horror of trauma are at higher risk.

Intensity of horror related to nature of events, the number of exposures to very intense events, and influenced by expectation.

Respite helps!

Increased Risk in the Combat Deployed

- **Factitious disorder**
- **Adjustment disorder**
- **Malingering**
- **Acute Stress Disorder**
- **PTSD**
- **Post concussion syndrome (also occurs with PTSD)**
- **Complex substance abuse**

Higher Risk Groups

- **Combat personnel**
- **Rear area personnel (when attacked)**
- **Previously psychologically traumatized**
- **Perpetrator of torture or atrocity**

Higher Risk Groups

- **Untrained and inexperienced**
- **Refugees**
- **Very young and very old**
- **The wounded and injured**
- **Professional rescue teams**
- **Medical personnel**
- **Survivor of multiple losses of significant others**

Higher Risk Groups

- **Those perceiving self as failing others,**
- **Those tortured and sexually assaulted, male or female, &**
- **Torturers or murders.**

Recovery Environment

- **Provide respite**
 - Must be designed to be appropriate to the deployment, the mission, and the actions of the enemy
 - Safe, socially and personally supportive
- **Holding environment**
Do no harm - No 2° injury

Recovery Environment: Military Style

- "Critical incident debriefing" this technique has not been demonstrated to be efficacious. –
 - Many military trained to use CISD
- "Forward treatment"
May be buddy aid & medics aid in modern combat.
Avoid stigmatization

Recovery Environment

In combat the central concept of psychiatric care has been:

- **Provide respite [Cognitive behavioral support or psychpharm intervention ??]**
&
- **Expect recovery &**
- **Expect return to duty with 1 unit or in combat area.**

Maybe impossible on modern battle field.

Psychiatric Casualty Classification

- **According to the severity of the service person's loss of functional capacity &**
- **Non-diagnostic terms like "combat stress response" are used.**

Management Policy for Psych Casualties

- **Physical illness & injury is evaluated in the initial triage process &**
- **Reevaluated throughout the evac chain;**
- **DSM Dx is not permitted in the forward area;**
- **Initial treatment must be brief & simple.**

Incidence

- **Highest with high intensity battles lasting for prolonged periods**
- **Rates of occurrence vary between 1 in 20 physical casualties in elite units**
- **To 1 in 2 or 1 to 1 physical casualties in an intense land combat engagement**

Incidence

- **Lower on ships at sea and in surrounded units**
[Casualties may appear when ships reach port.]
- **Rear area soft target have highest rate of casualties when attacked**
- **Operational fatigue in air ops may relate to sortie rate.**

Management Policy for Psych Casualties

- **If impairment, is extreme or persistent evacuate to rear areas.**
- **A DSM-4 diagnosis will be developed after evacuation.**
- **Treatment is provided at all levels mostly by non-mental health personnel. Avoid stigma.**
- **Wounded are at higher psychiatric risk.**
- **Return to duty possible at all levels.**

FORENSIC ISSUES IN COMBAT

- **Those commit atrocities at increased psychiatric risk.**
- **Those who commit crimes may use psychiatric claims to avoid responsibility.**
- **Other issues include**
 - **Malingering and factitious disorders**
 - **Civil/tort (damage claims)**
 - **Disability determination.**

Medications for Acute Psychiatric Casualties

- **Sedation or extreme agitation - a diazepam**
- **To facilitate recall or treatment (amytal interview ?)**
- **Other “chemical” restraint in forward area to control agitation & psychotic symptoms?**

Presentations: Recovery Phase After The Battle

- **Startle or anxiety**
- **Withdrawal**
- **Dissociative sx or sy**
- **Insomnia**
- **Depression**
- **Substance abuse**
- **Somatic complaints**
- **"Hallucinations"**
(intrusive re-experiencing)

Risk: Interpersonal Violence

- **Risk of suicide and murder lower in the services but matters of great command concern. Make psychiatric referral non-stigmatizing.**
- **Inter-personal violence in family by family members against family members is serious. Make psychiatric referral non-stigmatizing.**
- **Supporting the prevention & management a major task for mil med & mil psychiatry.**
- **Make seeking psychiatric care non-stigmatizing.**