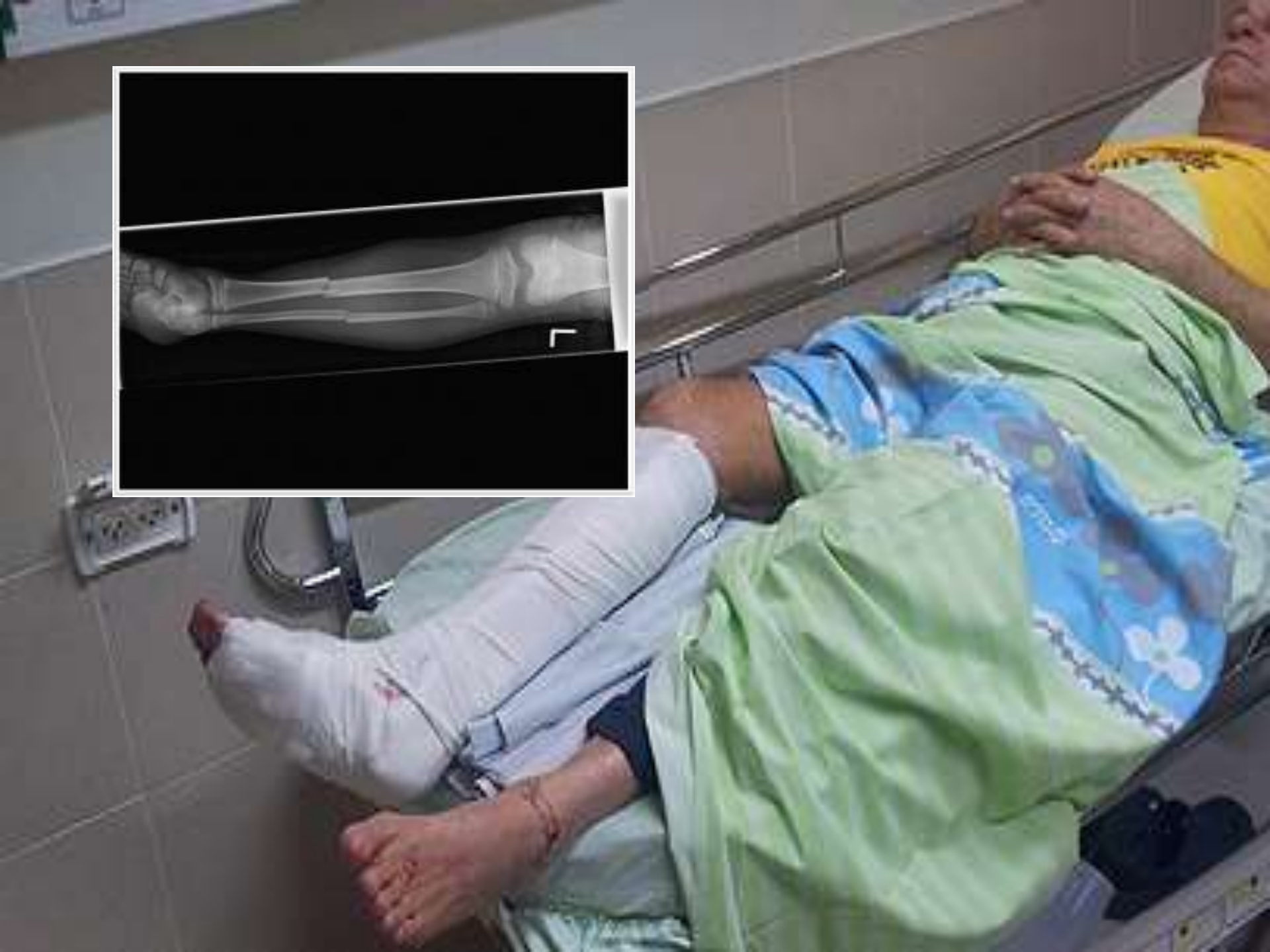
Mental Health Training.co.uk

Mental Disorders / General Psychiatry

Agenda

- **Mental Health Awareness Training – Progress Housing:**
-
- This is a short course and will address the following key areas:
- Recognising the signs and symptoms of mental illness in the general community with a key focus on tenancies that require a care-line service;
- A key focus on the different ways to support people with mental disorders. These may include depression and mood disorders, anxiety-related disorders, acute and chronic psychosis, cognitive impairments, complex personality disorders, infections and mental disorders associated with poor health and infections;
- Responding to / appropriate management of suicide-related behaviours;
- Appropriate communications skills and empathic practice – supporting individuals vulnerable to mental disorder;
- Managing conflict more effectively with a specific focus on hostile conflict / behaviours from individuals with potential psychiatric disorders or psychological problems;
- Managing potential hazards associated with mental illness;
- Understanding the importance of personal boundaries when supporting individuals with potential mental disorders and signposting tenants to the appropriate services;
- Understanding the responsibilities (and limitations) of the NHS. CMHT Crisis Teams, Social Services safeguarding policies and responsibilities, the Police and emergency services. How these services respond to mental health crises and generally support individuals vulnerable to mentally illness.
- The importance of health and safety and improving risk assessments when visiting individuals with potential forensic mental health problems;
- Escalating concerns to the statutory services and management;
- Supporting co-workers that may be vulnerable to mental disorder.



Learning Objectives

- **Learning Objectives:**
- Understand terminology to improve awareness; improve capacity to identify & support; support / interact more effectively with individuals; improve signposting to care providers and NHS organisations

- Psychiatric Disorder. The **14 major disorders** that present in primary and secondary care settings. Recognising and understanding the signs and symptoms of mental disorder from the perspective of the multiaxial model

- Understanding and recognising potential risks and the the importance of signposting

- Understanding the principles of treatment with general psychiatry

- Improved interactions and individual support for individuals with mental disorder

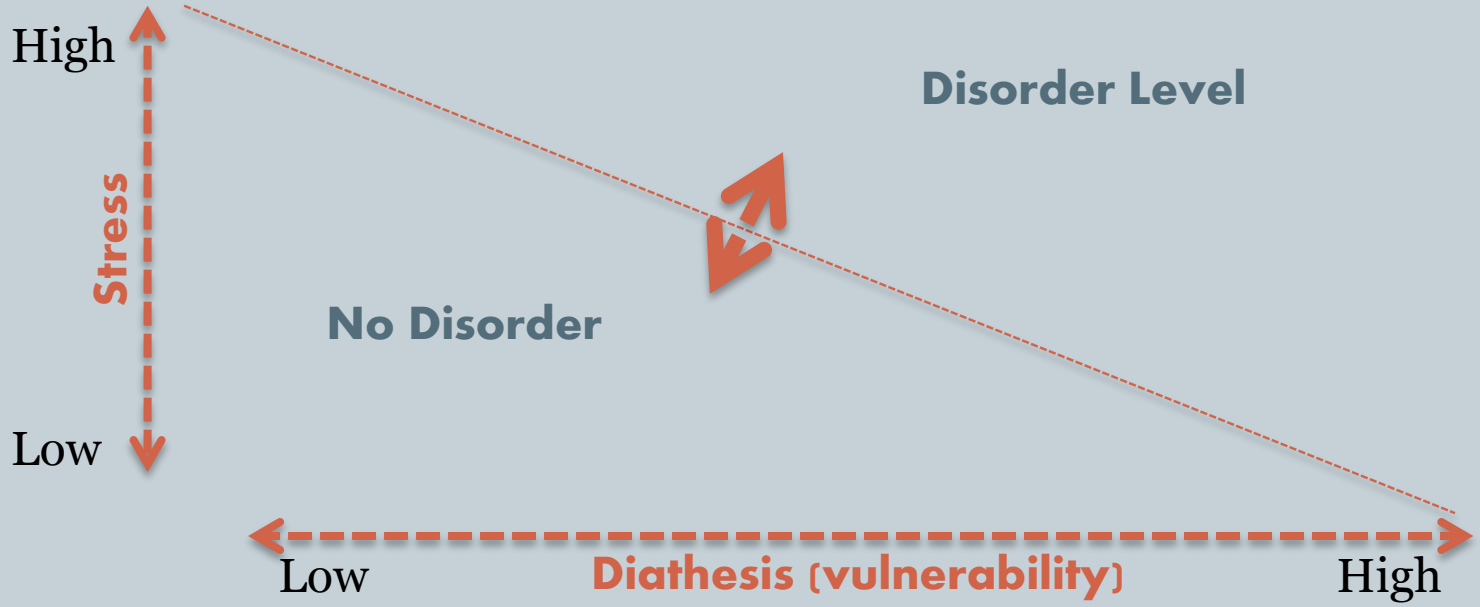
Mental Health Training.co.uk

Common Psychiatric Diagnoses

- **Disorders in today's training:**
- Stress Psychology & Psychiatry
- Axis I Disorders (acute symptoms describing a 'state' of mental disorder)
- 1) Major Depressive Episodes;
- 2) Bipolar Disorder;
- 4) Anxiety Disorders including:
  - 5) Generalised Anxiety Disorder (GAD), 6) Panic Disorder, 7) Agoraphobia, 8) Obsessive-Compulsive Disorder (OCD), 9) Post-Traumatic Stress Disorder (PTSD),
- 10) Psychosis & Schizophrenia;
- 11) Eating Disorders;
- Axis II Disorders (personality disorders describing a proposed mental 'trait' resulting in functional and social impairment)
- 12) Borderline Personality Disorder (BPD)
- (plus a potential focus on Antisocial Personality Disorder / Psychopathy)
- Axis III Disorders (Neurocognitive & Medical Disorders that may manifest in Mental Disorder)
- 13) Neurocognitive Disorders – The Dementia Syndrome
- 14) Delirium

Mental Health Training.co.uk

Diathesis Stress Model

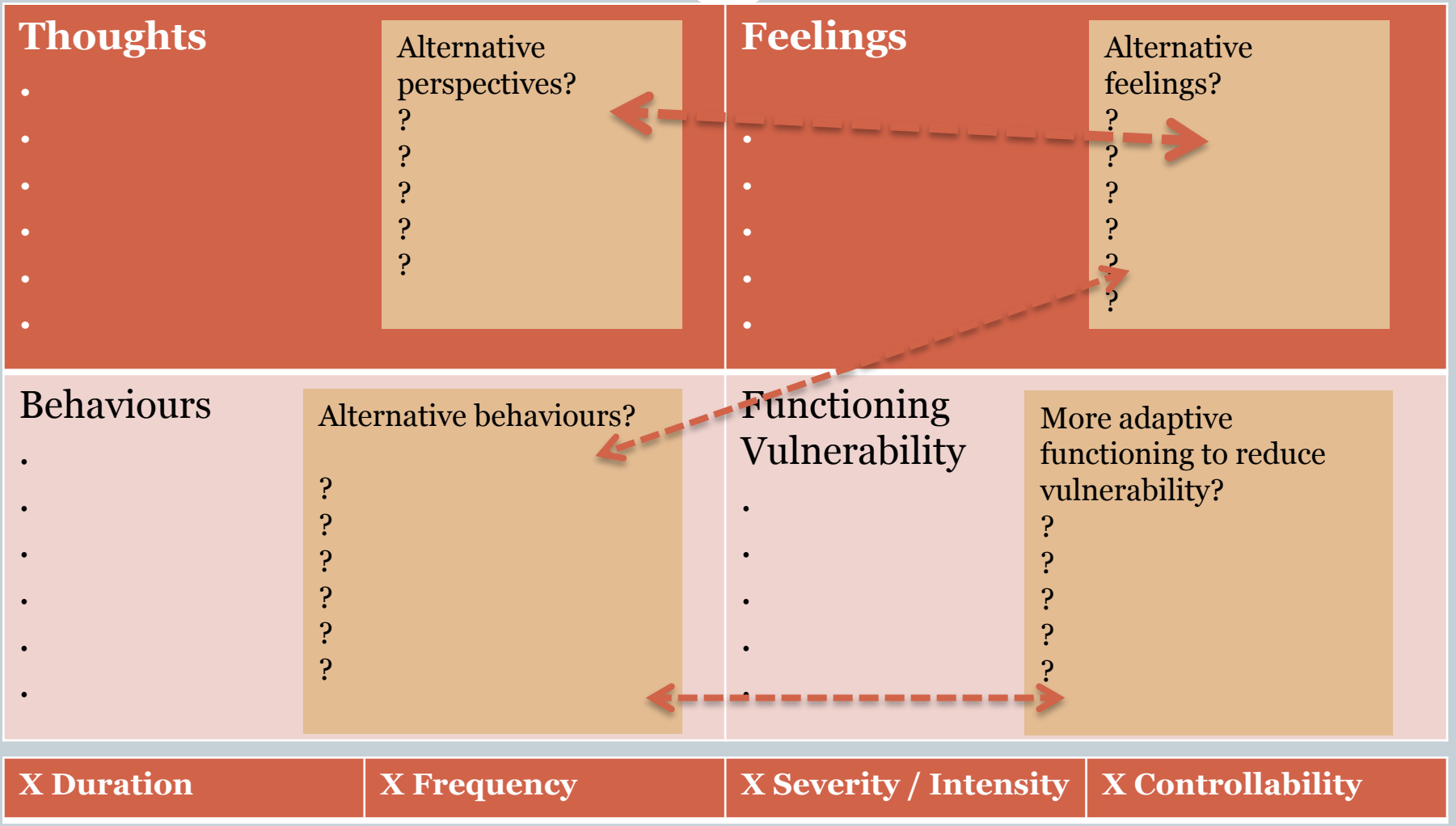


The experience of mental disorder?

Thoughts	**Feelings**
Behaviours	Functioning Vulnerability

X Duration	**X Frequency**	**X Severity / Intensity**	**X Controllability**

Cognitive Reframing



Nice Guidelines

- **NICE guidelines**
- NICE guidelines are evidence-based recommendations for health and care in England.
- They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings.
- Our guidelines help health and social care professionals to:
- prevent ill health
- promote and protect good health
- improve the quality of care and services
- adapt and provide health and social care services.

Mental Health Training.co.uk

T: 01332 362222
E: info@mentalhealthtraining.co.uk

If you have to support or signpost friends, family or colleagues with Primary & Secondary NHS care, the NICE Guidelines are invaluable. Clinical guidelines (in this case, those relevant to mental health problems), recommend (and instruct) how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management.

These guidelines are also important for health service managers and commissioners of NHS services.

In effect, these guidelines identify patient's rights. They provide patients with information and confirm their rights to services, service deadlines, medications and detail the treatment pathways that must be followed by the various NHS departments that may be involved in your care.

Please contact us directly if you need advice or support with these guidelines.

alcoholuse-disorders-diagnosis-assessment-and-management-of-harmful-drinking-and-alcohol-dependence-pdf-35109391116229

bipolar-disorder-assessment-and-management-pdf-35109814379461

borderline-personality-disorder-recognition-and-management-pdf-975635141317

chronic-fatigue-syndromemyalgic-encephalomyelitis-or-encephalopathy-diagnosis-and-management-pdf-975505810885

coexisting-severe-mental-illness-psychosis-and-substance-misuse-assessment-and-management-in-healthcare-settings-pdf-35109443184325

common-mental-health-problems-identification-and-pathways-to-care-pdf-35109448223173

delirium-prevention-diagnosis-and-management-pdf-35109327290821

depression-in-adults-recognition-and-management-pdf-975742636741

drug-misuse-in-over-16s-psychosocial-interventions-pdf-975502451653

eating-disorders-recognition-and-treatment-pdf-1837582159813

depression-in-adults-with-a-chronic-physical-health-problem-recognition-and-management-pdf-975744316357

epilepsies-diagnosis-and-management-pdf-35109515407813

generalised-anxiety-disorder-and-panic-disorder-in-adults-management-pdf-35109387756997

obsessivecompulsive-disorder-and-body-dysmorphic-disorder-treatment-pdf-975381519301

posttraumatic-stress-disorder-management-pdf-975329451205

psychosis-and-schizophrenia-in-adults-prevention-and-management-pdf-35109758952133

social-anxiety-disorder-recognition-assessment-and-treatment-pdf-35109639699397

workplace-health-longterm-sickness-absence-and-incapacity-to-work-pdf-1996184939461

Defining Health – The World Health Organisation.

- The World Health Organization (WHO) defined health in its broader sense in its 1948 constitution as "**a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.“**

- A key component of the World Health Organisation (WHO) definition of health is the notion of the capacity *to participate in community life,* rather than the traditional narrower view of health as the absence of disease.

- According to this definition, health refers to *"a state of wellbeing in which the individual is able to work productively and fruitfully, and is able to make a contribution to his or her community"* . Mental health encompasses the individual's capacity to cope with internal needs as well as external needs, such as roles within employment.

Defining good mental health

- **Hopefulness;**
- **Rational competence;**
- **Confidence to manage challenges;**
- **Energy;**
- **Decisiveness;**
- **Assertiveness;**
- **Non-judgemental / mindfulness;**
- **Rational self-worth / acceptance of self;**
- **Ability to tolerate frustration;**
- **Unconditional acceptance of others;**
- **Active;**
- **Engagement in the world;**
- **Connection with family, friends, neighbours, colleagues.**

Mental Health Recovery & Resilience

- **Attitudes & Perspectives:**
- Frustration; Negative Assumptions; Rescaling Continuums
- **Self Awareness:**
- Mindfulness; Self Discrepancy experiences (Theory); Conditional Self-Worth Cognitions;
- **Balance & Priorities:**
- Limits on self & others; Personal Limitations (control & social supports)
- **Supportive Relationships:**
- Positive – interest in others; Effective interpersonal communications

1) Major Depressive Episode

Major Depressive Episode

- **Diagnostic Criteria for Major Depressive Episode**
- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
- Note: Do not include symptoms that are clearly attributable to another medical condition.
- 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
- 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
- 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
- 4. Insomnia or hypersomnia nearly every day.
- 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- 6. Fatigue or loss of energy nearly every day.
- 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

- Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

Understanding Stress

Atypical Depression

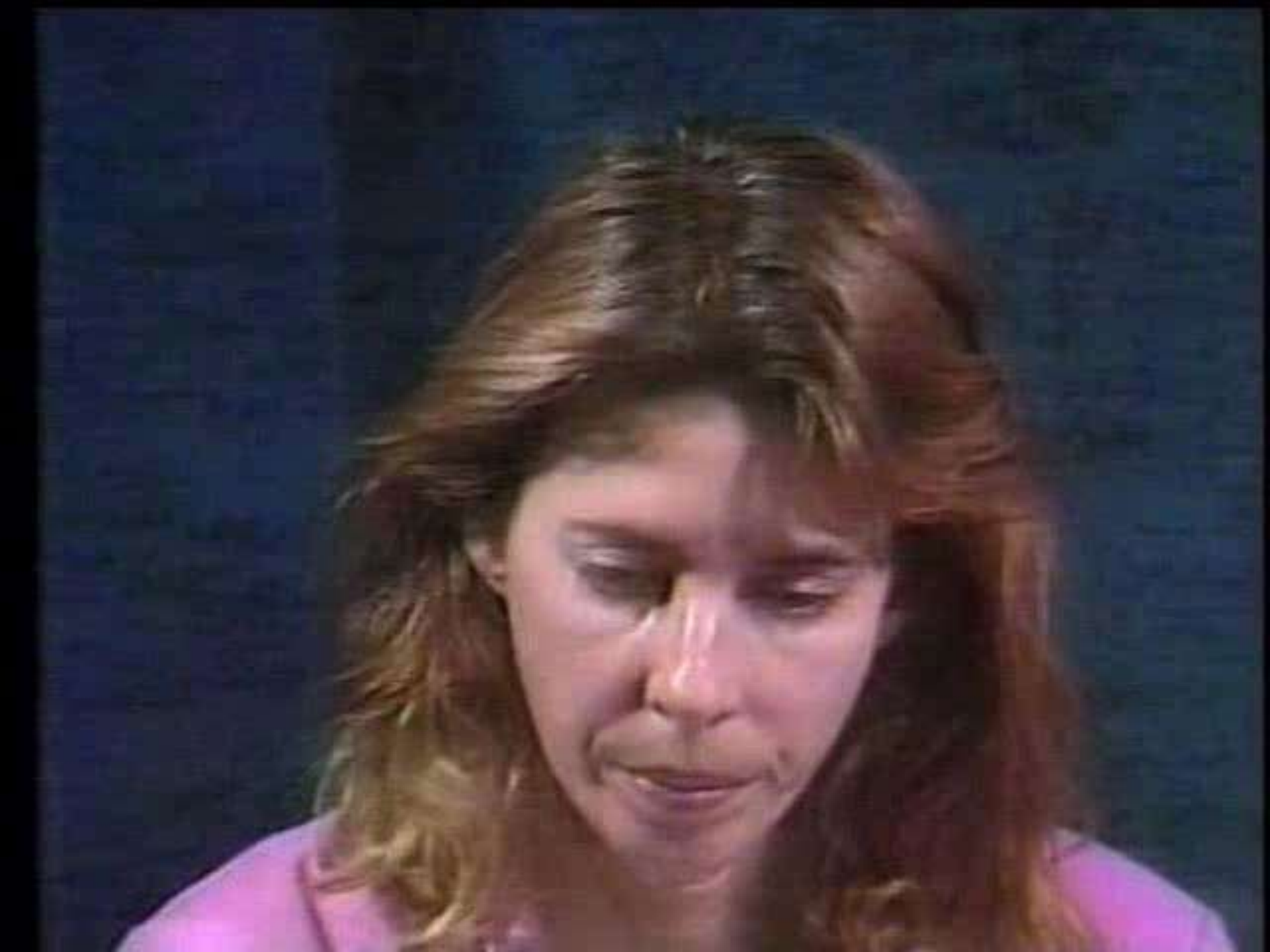
- **Atypical depression**, or **depression with atypical features** as it has been known in the DSM IV, is depression that shares many of the typical symptoms of the psychiatric syndromes major depression or dysthymia but is characterised by improved mood in response to positive events.
- In contrast, people with melancholic depression generally do not experience an improved mood in response to normally pleasurable events.
- Atypical depression also features significant weight gain or an increased appetite, hypersomnia, a heavy sensation in the limbs and interpersonal rejection sensitivity that results in significant social or occupational impairment.

The DSM-IV-TR defines Atypical Depression as a subtype of Major Depressive Disorder with Atypical Features, characterised by:

- Mood reactivity (i.e., mood brightens in response to actual or potential positive events)
- At least two of the following:
  - Significant weight gain or increase in appetite;
  - Hypersomnia (sleeping too much, as opposed to the insomnia present in melancholic depression);
  - Leaden paralysis (i.e., heavy, leaden feelings in arms or legs);
  - Long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment.

Major Depressive Symptoms

- **Common symptoms - Depression:**
  - Feeling of emptiness or worthlessness (as opposed to sadness)
  - Loss of energy and motivation for many or all everyday activities, including washing, feeding and caring for oneself
  - Pessimism and negativity about most things or everything
  - Loss of concentration
  - Loss of perspective
  - Loss of sense of self
  - Self-doubt and self-blame
  - Isolation from friends and family
  - Poor quality of sleep, with early morning waking
  - Inability to get out of bed until late morning or early afternoon
  - Thoughts of death and/or planning suicide can be common, but may be difficult to discuss



Alison is a 38 year old woman who is seeing her GP due to low mood.

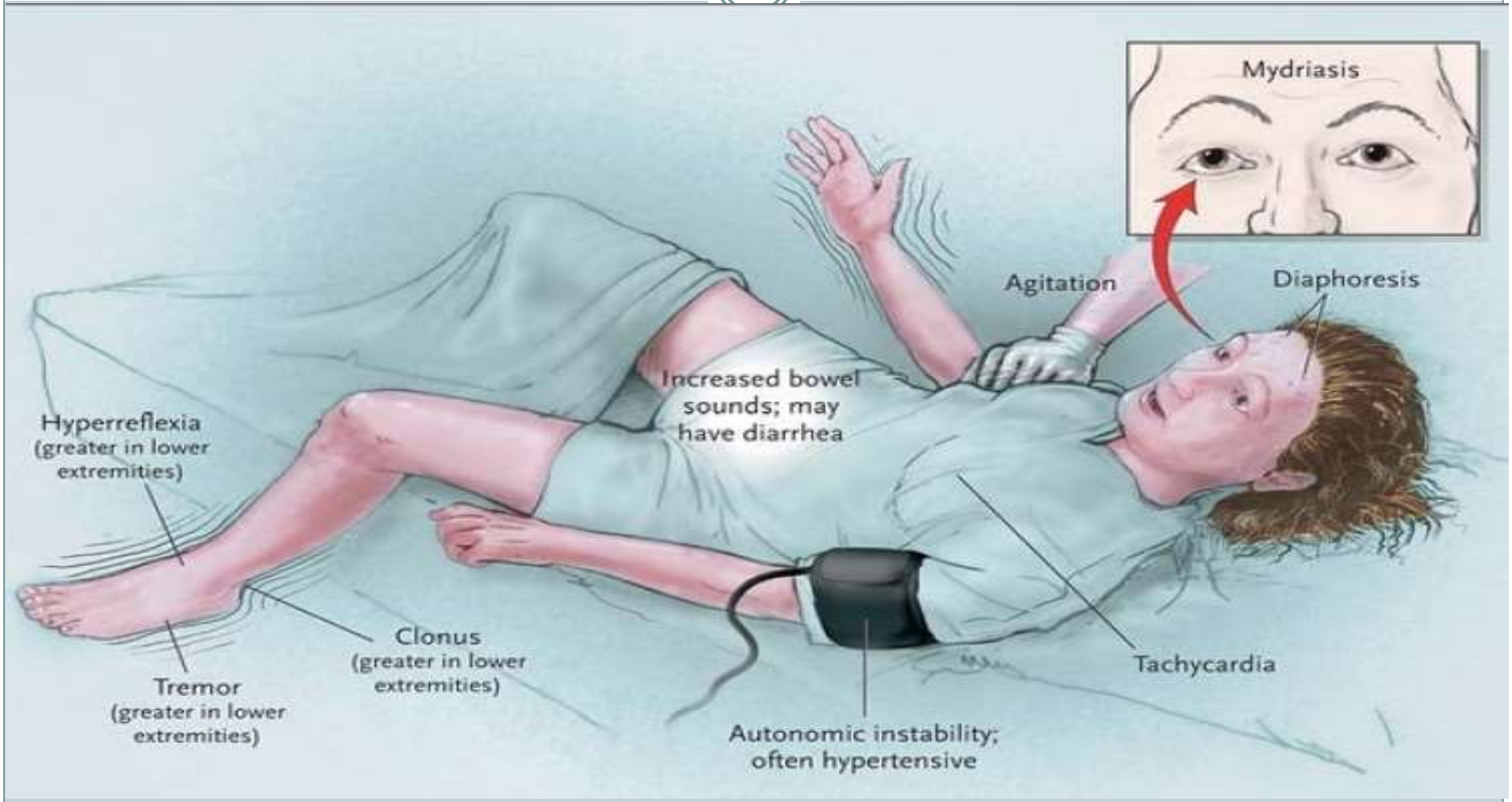
She is divorced and has two children. She works in a local supermarket.

ECT in Modern Psychiatry

Serotonin Shock Syndrome

- **15% consequence of overdose attempt;**
- **Coingestion of any of the following:**
- **Antidepressants:** Monoamine oxidase inhibitors (MAOIs), TCAs, SSRIs, SNRIs, bupropion, nefazodone, trazodone, mirtazapine,
- **Opioids:** tramadol pethidine, fentanyl, pentazocine, buprenorphine, oxycodone, hydrocodone,
- **Stimulants:** MDMA, MDA, diethylpropion, amphetamine, sibutramine, methylphenidate, methamphetamine, cocaine dextromethorphan
- **Psychedelics:** 5-Methoxy-diisopropyltryptamine, LSD
- **Herbs:** St John's Wort, Syrian rue, Panax ginseng, Nutmeg, Yohimbe
- **Others:** tryptophan, L-Dopa, valproate, buspirone, lithium, linezolid, dextromethorphan, 5-hydroxytryptophan, chlorpheniramine, risperidone, olanzapine, ondansetron, granisetron, metoclopramide, ritonavir

Serotonin Shock Syndrome



Antidepressant Pharmacotherapy

- **Selective serotonin reuptake inhibitors (SSRIs):**
- **Citalopram** (Celexa)
- **Escitalopram** (Lexapro, Cipralex)
- **Paroxetine** (Paxil, Seroxat)
- **Fluoxetine** (Prozac)
- **Fluvoxamine** (Luvox)
- **Sertraline** (Zoloft, Lustral)

- **Norepinephrine reuptake inhibitors:**
- **Atomoxetine** (Strattera)
- **Reboxetine** (Edronax)
- **Viloxazine** (Vivalan)

Antidepressant Pharmacotherapy

- **Serotonin–norepinephrine reuptake inhibitors:**
- **Desvenlafaxine** (Pristiq)
- **Duloxetine** (Cymbalta)
- **Milnacipran** (Ixel, Savella)
- **Venlafaxine** (Effexor)

- **Serotonin antagonist and reuptake inhibitors** (SARIs)
- **Etoperidone** (Axiomin, Etonin)
- **Nefazodone** (Serzone, Nefadar)
- **Trazodone** (Desyrel)

- **Norepinephrine-dopamine reuptake inhibitors:**
- **Bupropion** (Wellbutrin, Zyban)

Antidepressant Pharmacotherapy

- **Tricyclic antidepressants**
- (block the reuptake of norepinephrine and serotonin).
- **Amitriptyline** (Elavil, Endep)
- **Clomipramine** (Anafranil)
- **Doxepin** (Adapin, Sinequan)
- **Imipramine** (Tofranil)
- **Trimipramine** (Surmontil)
- **Desipramine** (Norpramin)
- **Nortriptyline** (Pamelor, Aventyl, Noritren)
- **Protriptyline** (Vivactil)

Antidepressant Pharmacotherapy

- **Monoamine oxidase inhibitor:**
- (MAOIs) inhibit the enzyme monoamine oxidase, which breaks down the neurotransmitters dopamine, serotonin, and norepinephrine. As there are potentially fatal interactions between irreversible MAOIs and certain foods (particularly those containing tyramine),
- **Isocarboxazid** (Marplan)
- **Phenelzine** (Nardil)
- **Selegiline** (Eldepryl, Emsam)
- **Tranylcypromine** (Parnate)
- **Moclobemide** (Aurorix, Manerix)
- **Pirlindole** (Pirazidol)

Differential Diagnosis - Depression

- **Autoimmune Disorders;**
- **Bacterial-viral-parasitic infection;**
- **Adjustment Disorders;**
- **Blood disorders;**
- **Chronic Fatigue Syndrome;**
- **Dietary disorders;**
- **Endocrine system disorders (Irregularities in the HPA axis, thyroid dysfunctions);**
- **Adrenal Gland disorders;**
- **Thyroid disorders;**
- **Pituitary disorders and tumours;**
- **Pancreas disorders;**
- **Post-concussion syndrome;**
- **Pseudobulbar affect (secondary to neurodegenerative diseases)**
- **Neurotoxicity & medicine contraindications;**
- **Bipolar disorder;**
- **Nutritional deficiencies;**
- **Sleep disorders.**

Screening tools – PHQ9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
TOTAL:				

10. If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation
5-9	Minimal symptoms*	Support, educate to call if worse; return in 1 month.
10-14	Minor depression ††	Support, watchful waiting
	Dysthymia*	Antidepressant or psychotherapy
	Major depression, *mild*	Antidepressant or psychotherapy
15-19	Major depression, *moderately severe*	Antidepressant or psychotherapy
≥ 20	Major depression, *severe*	Antidepressant and psychotherapy (especially if not improved on monotherapy)

‘Atypical’ Depression

Atypical Depression

- **Atypical depression**, or **depression with atypical features** as it has been known in the DSM IV, is depression that shares many of the typical symptoms of the psychiatric syndromes major depression or dysthymia but is characterised by improved mood in response to positive events.
- In contrast, people with melancholic depression generally do not experience an improved mood in response to normally pleasurable events.
- Atypical depression also features significant weight gain or an increased appetite, hypersomnia, a heavy sensation in the limbs and interpersonal rejection sensitivity that results in significant social or occupational impairment.

The DSM-IV-TR defines Atypical Depression as a subtype of Major Depressive Disorder with Atypical Features, characterised by:

- Mood reactivity (i.e., mood brightens in response to actual or potential positive events)
- At least two of the following:
  - Significant weight gain or increase in appetite;
  - Hypersomnia (sleeping too much, as opposed to the insomnia present in melancholic depression);
  - Leaden paralysis (i.e., heavy, leaden feelings in arms or legs);
  - Long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment.


Depression 1

2) Bipolar Disorder

Bipolar Disorder type I

- **Diagnostic Criteria for Bipolar 1**
- For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.:

- **Manic Episode**
- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
- B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
- 1. Inflated self-esteem or grandiosity.
- 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
- 3. More talkative than usual or pressure to keep talking.
- 4. Flight of ideas or subjective experience that thoughts are racing.
- 5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
- 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
- 7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

- Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and,
- therefore, a bipolar I diagnosis.
- Note: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder. (continued)

Bipolar Disorder (type II)

- **Diagnostic Criteria for Bipolar II**
- For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode and the following criteria for a current or past major depressive episode:

- **Hypomanic Episode**
- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.
- B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:
- 1. Inflated self-esteem or grandiosity.
- 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
- 3. More talkative than usual or pressure to keep talking.
- 4. Flight of ideas or subjective experience that thoughts are racing.
- 5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed/ed.
- 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
- 7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
- D. The disturbance in mood and the change in functioning are observable by others.
- E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
- B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
- C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
- D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).
- F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).

- Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Bipolar Mania Symptoms

- **Common symptoms - Mania:**
  - Incoherent, rapid or disjointed thinking
  - Talkative
  - Severely impaired judgement
  - Ever changing plans and ideas
  - Constant elation and/or euphoria
  - Inappropriate optimism
  - Grandiose delusions or ideas
  - Gross over-estimation of personal capability
  - Waking early and highly energised
  - Need for little sleep (less than 5 hours)
  - Promiscuous/increased sexual behaviour
  - Buying and spending freely, beyond financial means
  - Verbal aggression towards partner, relatives & friends

Bipolar Disorder - Mixed States

- **Manic / Hypomanic episode:**
- Elevated / expansive mood
- Inflated self-esteem / grandiosity
- Over talkativeness
- Pressure of Speech
- Flights of ideas / racing thoughts
- Increased energy / goal-directed activities
- Increased risky activities
- Decreased need for sleep

- **Depressed episode:**
- Prominent depressed mood
- Anhedonia
- Significant weight loss (or gain)
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Loss of energy
- Feelings of worthlessness or guilt
- Decreased concentration / indecisiveness
- Suicidal ideation

- **Episode with mixed state:**
- Three or more manic / hypomanic symptoms PLUS three or more depressive symptoms in MDE

Bipolar Disorder Classifications

- **Mild, Moderate and Severe classifications:**

- **Bipolar Type I disorder:**
- A syndrome with complete manic symptoms occurring during the episode

- **Bipolar Type II disorder:**
- Hypomania: characterised by depression and episodes of mania that don't meet the full criteria for manic syndrome

- **Hypomania:**
- Symptoms are similar to those of mania, although they do not reach the same level of severity or cause the same degree of social impairment.
- Although hypomania is often associated with an elevated mood and very little insight into it, patients do not usually exhibit psychotic symptoms, racing thoughts or marked psychomotor agitation

- **Rapid-Cycling Bipolar Disorder:**
- Occurrence of at least four episodes – both retarded depression and hypomania / mania – in a year

- **Labile:**
- A mood and / or affect that switches rapidly from one extreme to another. For example, a patient can be laughing and euphoric one minute, following by a display of intense anger and then extreme sadness in the following minutes of an interview

The Young Mania Rating Scale (YMRS)

- **The Young Mania Rating Scale (YMRS)**
- The Young Mania Rating Scale (YMRS) is one of the most frequently utilized rating scales to assess manic symptoms. The scale has 11 items and is based on the patient's subjective report of his or her clinical condition over the previous 48 hours. Additional information is based upon clinical observations made during the course of the clinical interview. The items are selected based upon published descriptions of the core symptoms of mania.

- **1. Elevated Mood**
- 0 Absent
- 1 Mildly or possibly increased on questioning
- 2 Definite subjective elevation; optimistic, self-confident; cheerful; appropriate to content
- 3 Elevated; inappropriate to content; humorous
- 4 Euphoric; inappropriate laughter; singing

The Young Mania Rating Scale (YMRS)

- **2. Increased Motor Activity-Energy**
- 0 Absent
- 1 Subjectively increased
- 2 Animated; gestures increased
- 3 Excessive energy; hyperactive at times; restless (can be calmed)
- 4 Motor excitement; continuous hyperactivity (cannot be calmed)

- **3. Sexual Interest**
- 0 Normal; not increased
- 1 Mildly or possibly increased
- 2 Definite subjective increase on questioning
- 3 Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report
- 4 Overt sexual acts (toward patients, staff, or interviewer)

The Young Mania Rating Scale (YMRS)

- **4. Sleep**
- 0 Reports no decrease in sleep
- 1 Sleeping less than normal amount by up to one hour
- 2 Sleeping less than normal by more than one hour
- 3 Reports decreased need for sleep
- 4 Denies need for sleep
-
- **5. Irritability**
- 0 Absent
- 2 Subjectively increased
- 4 Irritable at times during interview; recent episodes of anger or annoyance on ward
- 6 Frequently irritable during interview; short, curt throughout
- 8 Hostile, uncooperative; interview impossible

The Young Mania Rating Scale (YMRS)

- **6. Speech (Rate and Amount)**
- 0 No increase
- 2 Feels talkative
- 4 Increased rate or amount at times, verbose at times
- 6 Push; consistently increased rate and amount; difficult to interrupt
- 8 Pressured; uninterruptible, continuous speech
-
- **7. Language-Thought Disorder**
- 0 Absent
- 1 Circumstantial; mild distractibility; quick thoughts
- 2 Distractible, loses goal of thought; changes topics frequently; racing thoughts
- 3 Flight of ideas; tangentiality; difficult to follow; rhyming, echolalia
- 4 Incoherent; communication impossible

The Young Mania Rating Scale (YMRS)

- **8. Thought Content**
- 0 Normal
- 2 Questionable plans, new interests
- 4 Special project(s); hyper-religious
- 6 Grandiose or paranoid ideas; ideas of reference
- 8 Delusions; hallucinations
-
- **9. Disruptive-Aggressive Behaviour**
- 0 Absent, cooperative
- 2 Sarcastic; loud at times, guarded
- 4 Demanding; threats on ward
- 6 Threatens interviewer; shouting; interview difficult
- 8 Assaultive; destructive; interview impossible

The Young Mania Rating Scale (YMRS)

- **10. Appearance**
- 0 Appropriate dress and grooming
- 1 Minimally unkempt
- 2 Poorly groomed; moderately disheveled; overdressed
- 3 Disheveled; partly clothed; garish make-up
- 4 Completely unkempt; decorated; bizarre garb
-
- **11. Insight**
- 0 Present; admits illness; agrees with need for treatment
- 1 Possibly ill
- 2 Admits behavior change, but denies illness
- 3 Admits possible change in behavior, but denies illness
- 4 Denies any behavior change

Bipolar Disorder (type II)

- The child's total score is determined by adding up the highest number circled on each question. Scores range from 0-60. Extremely high scores on the P-YMRS increase the risk of having bipolar disorder by a factor of 9, roughly the same increase as having a biological parent with bipolar disorder. Low scores decrease the odds by a factor of ten. Scores in the middle don't change the odds much.
- The average scores in children studied were approximately 25 for mania (a syndrome found in patients with Bipolar-I), and 20 for hypomania (a syndrome found in patients with BP-2, BP-NOS, and Cyclothymia). Anything above 13 indicated a potential case of mania or hypomania for the group that was studied, while anything above 21 was a probable case. In situations where the odds of bipolar diagnosis are high to begin with (a child with mood symptoms with 2 parents having bipolar disorder), the P-YMRS can be extremely helpful. But for most groups of people, the base rate of bipolar disorder is unknown but low. Then, the most that a high score can do is raise a red flag (similar to having a family history of bipolar disorder).

John Riley is a 36 year old man who is seeing a psychiatrist due to concerns raised by his GP.

He works as a mechanic and lives with his parents.

Lithium Therapy

- **Lithium is sold under various brand names, including:**
- Cibalith
- Carbolith
- Duralith
- Eskalith
- Lithane
- Lithobid
- Lithonate

- **Acute Toxicity**
- Diarrhoea
- Dizziness
- Nausea
- Stomach pains
- Vomiting
- Weakness

Anticonvulsants

- **Anticonvulsants (not all approved for the treatment of Bipolar Disorder)**
- **Valproic acid (Depakine),**
- **Divalproex sodium** (Depakote),
- **Sodium Valproate** (Depacon, Epilim) –**Lamotrigine** (Lamictal)
- **Carbamazepine** (Tegretol) **Oxcarbazepine** (Trileptal) – **Oxcarbazepine**
- **Topiramate** (Topamax)
- **Riluzole** (Rilutek)
- **Gabapentin** (Neurontin)

Differential Diagnosis - Bipolar

- **Mood disorder due to general medical condition;**
- **Substance-induced mood disorder;**
- **Depression;**
- **Psychosis / Schizophrenia / Schizoaffective Disorder;**
- **Borderline Personality Disorder;**
- **ADHD;**
- **Thyroid dysfunction;**
- **Hormone imbalances**

3) Anxiety Disorders

Anxiety Disorders

- 4) Generalised Anxiety Disorder
- 5) Panic Disorder
- 6) Agoraphobia
- 7) Obsessive Compulsive Disorder
- 8) Post-Traumatic Stress Disorder

4) Generalised Anxiety Disorder

- **Diagnostic Criteria for Generalised Anxiety Disorder**
- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The individual finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months);
- Note: Only one item is required in children.
- 1. Restlessness or feeling keyed up or on edge.
- 2. Being easily fatigued.
- 3. Difficulty concentrating or mind going blank.
- 4. Irritability.
- 5. Muscle tension.
- 6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
- D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Somatic symptoms of Autonomic Arousal

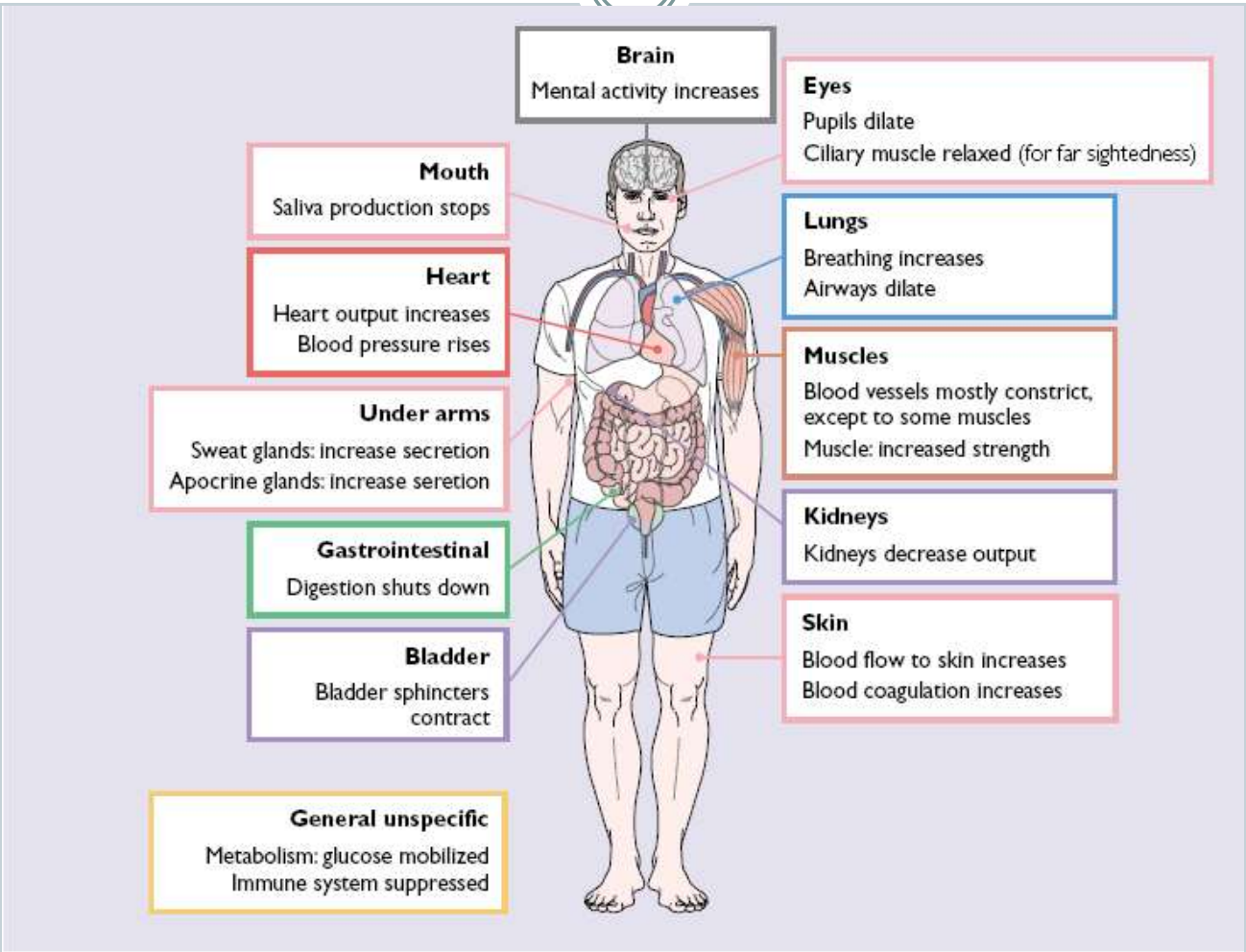


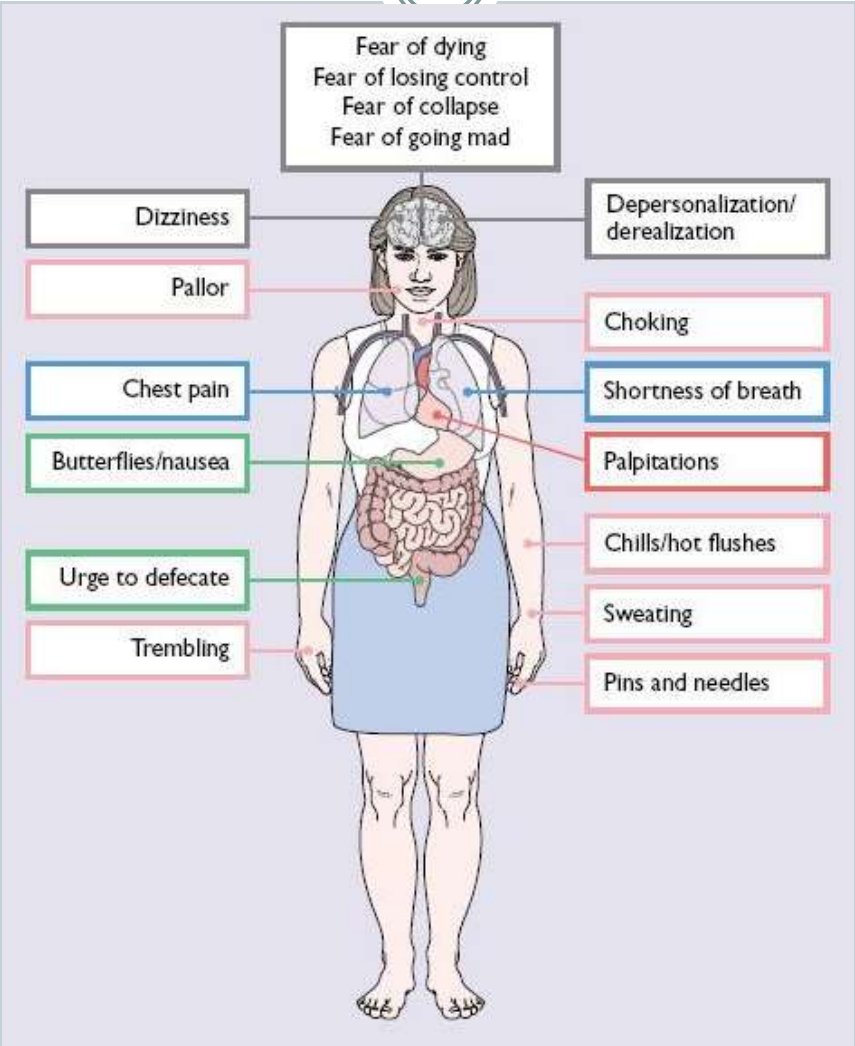
Figure 5.2 The physiologic response to 'flight or fight' stimuli

5) Panic Disorder

- **Diagnostic Criteria for Panic Disorder**
- A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur;
- Note: The abrupt surge can occur from a calm state or an anxious state.
- 1. Palpitations, pounding heart, or accelerated heart rate.
- 2. Sweating.
- 3. Trembling or shaking.
- 4. Sensations of shortness of breath or smothering.
- 5. Feelings of choking.
- 6. Chest pain or discomfort.
- 7. Nausea or abdominal distress.
- 8. Feeling dizzy, unsteady, light-headed, or faint.
- 9. Chills or heat sensations.
- 10. Paresthesias (numbness or tingling sensations).
- 11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
- 12. Fear of losing control or “going crazy.”
- 13. Fear of dying.

- Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.
- B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
- 1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).
- 2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

Somatic symptoms and complications of Panic



Julie is a 48 year old woman who is seeing her GP due to anxiety symptoms.

She is married and currently off sick from her job as a bank clerk.

6) Agoraphobia

- **Diagnostic Criteria for Agoraphobia**
- A. Marked fear or anxiety about two (or more) of the following five situations:
- 1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
- 2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
- 3. Being in enclosed places (e.g., shops, theaters, cinemas).
- 4. Standing in line or being in a crowd.
- 5. Being outside of the home alone.
- B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence).
- C. The agoraphobic situations almost always provoke fear or anxiety.
- D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.
- E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.
- F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.
- I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder—for example, the symptoms are not confined to specific phobia, situational type; do not involve only social situations (as in social anxiety disorder): and are not related exclusively to obsessions (as in obsessive-compulsive disorder), perceived defects or flaws in physical appearance (as in body dysmorphic disorder), reminders of traumatic events (as in posttraumatic stress disorder), or fear of separation (as in separation anxiety disorder).

- Note: Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual's presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

7) Obsessive-Compulsive Disorder

- **Diagnostic Criteria for Obsessive Compulsive Disorder**
- A. Presence of obsessions, compulsions, or both:
- Obsessions are defined by (1) and (2):
- 1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
- 2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).
- Compulsions are defined by (1) and (2):
- 1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g. Praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- 2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.
- Note: Young children may not be able to articulate the aims of these behaviors or mental acts.
- B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

- Specify if:
- With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.
- With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.
- With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.


BBC

8) Post-Traumatic Stress Disorder

8) Post-Traumatic Stress Disorder

- **Diagnostic Criteria for Post-traumatic stress disorder**
- Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.
- A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
- 1. Directly experiencing the traumatic event(s).
- 2. Witnessing, in person, the event(s) as it occurred to others.
- 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse).
- Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.
- B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
- 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
- 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
- 3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
- 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- 5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
- 1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

- (Continued)

8) Post-Traumatic Stress Disorder

- **Diagnostic Criteria for Post-traumatic stress disorder (continued)**
- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
- 1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
- 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," 'The world is completely dangerous," "My whole nervous system is permanently ruined").
- 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
- 4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
- 5. Markedly diminished interest or participation in significant activities.
- 6. Feelings of detachment or estrangement from others.
- 7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
- 1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
- 2. Reckless or self-destructive behavior.
- 3. Hypervigilance.
- 4. Exaggerated startle response.
- 5. Problems with concentration.
- 6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational,
- or other important areas of functioning.

- (continued)

8) Post-Traumatic Stress Disorder

- Specify whether:
- **With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
- 1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
- 2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

- Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

- Specify if:
- With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be

8) Post-Traumatic Stress Disorder

- Specify whether:
- With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

- 1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
- 2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant,
- or distorted).

- Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

- Specify if:
- With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be


EXTRA
MINUTES

9) Chronic Psychosis & Schizophrenia

9) Schizophrenia

- **Diagnostic Criteria for Schizophrenia**
- A. Two (or more) of the following, each present for a significant portion of time during a 1 -month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
- 1. Delusions.
- 2. Hallucinations.
- 3. Disorganized speech (e.g., frequent derailment or incoherence).
- 4. Grossly disorganized or catatonic behavior.
- 5. Negative symptoms (i.e., diminished emotional expression or avolition).
- B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).
- C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion
- A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

9) Schizophrenia

- **Residual Schizophrenia**
- Residual schizophrenia is diagnosed when a person has a history of prominent schizophrenic symptoms, but none of his/her current symptoms dominate the clinical presentation. In other words, s/he may still be experiencing delusions, hearing voices, or showing some signs of disorganized speech or other positive symptoms typical of schizophrenia, but the intensity has decreased significantly. The symptoms are no longer as severe as they were when s/he was acutely ill, but indicators of the disorder are still evident.
- Instead, the person may only be exhibiting some degree of odd behaviour, or his/her speech may be only mildly disorganized. S/he may also have some strange beliefs. With residual schizophrenia, if hallucinations or delusions are still part of the picture, the person doesn't have any strong emotions associated with them.
- In this type of schizophrenia, some of the negative symptoms of schizophrenia are still present. For example, s/he may still have blunted emotions, have difficulties initiating or carrying out tasks or show signs of impaired thought processes.

9) Schizophrenia

- **Residual Schizophrenia**
- Additional Diagnostic Criteria
- In order to meet the diagnosis of schizophrenia, regardless of the type, these other criteria must also have been met prior to the diagnosis of residual schizophrenia:
- A marked decline in functioning, after the onset of symptoms, in at least one of the primary aspects of the person's life (e.g., work, school, relationships, self-care).
- Signs of the disorder are present continuously for a period of at least 6 months. For at least one month of that time period (less if they subside due to effective treatment), the active-phase symptoms (e.g. delusions, hallucinations, extremely disorganized behavior, etc.) must be present.
- Schizoaffective disorder (a disorder similar to schizophrenia but with prominent mood episodes) or other mood disorder must have been ruled out.
- With the residual type of schizophrenia, it may be a transitional period which is occurring between an acute episode and a full remission. In some cases, however, the person may continue to meet the criteria for the residual type for a very long time, even years.

9) Schizophrenia

- **Hebrephrenic Schizophrenia**
- Hebephrenic schizophrenia, more commonly known as disorganized schizophrenia, is one of the subtypes of schizophrenia. It is a complex and chronic psychiatric disorder. The term “hebephrenic” is an older term which is still used in some classifications of psychiatric disorders with regards to this type of schizophrenia. The primary symptoms include significant impairment in thought processes, speech, behaviour, and emotional expression and response.
- **Characteristics and Symptoms**
- There are three prominent symptoms which are characteristic of hebephrenic schizophrenia:
- **Disorganized speech**
- Disorganized speech may be evidenced in a variety of ways. For example, when responding to a question, the person may give an answer which has little or no relevance to the question. S/he may abruptly jump from one topic to another while talking, or make up words as s/he goes along. In particularly severe cases, the person’s words may be complete nonsense, sometimes referred to as “word salad”.
- This impairment in speech is due to significant impairment in the person’s thinking. His/her thought processes are often illogical, and don’t connect very well. Hence it shows up in his/her speech.
- Hebephrenic schizophrenics often experience something known as “thought blocking”. They may stop suddenly while talking, as if the thought abruptly left them. They may express feeling as if someone or something removed the thought from their mind.

9) Schizophrenia

- **Disorganized behaviour**
- When a schizophrenic's behaviour is considered "disorganized", it may mean s/he is unable to or lacks the motivation to start or carry out a given task, such as preparing a meal or getting dressed. Their behaviour may be bizarre, such as wearing layer upon layer of clothing in the middle of summer. Or, their behaviour may be grossly inappropriate, such as acting out sexually in public. They may completely neglect personal grooming and have a very unkempt appearance.
- **Blunted or inappropriate emotional expression and response**
- A person with hebephrenic schizophrenia will often appear to have no emotions. His/her face may look completely blank, and his/her speech may be monotone. At times, s/he may have an emotional response which is completely irrelevant to the context, such as laughing or giggling suddenly, when nothing funny has occurred.

9) Schizophrenia

- **Additional Diagnostic Criteria**

1. In order to meet the diagnosis of schizophrenia, regardless of the type, these other criteria must also be met:

- A marked decline in functioning, after the onset of symptoms, in at least one of the primary aspects of the person's life (e.g., work, school, relationships, self-care).
- Signs of the disorder are present continuously for a period of at least 6 months. For at least one month of that time period (less if they subside due to effective treatment), the active-phase symptoms (e.g. delusions, hallucinations, extremely disorganized behaviour, etc.) must be present.
- Schizoaffective disorder (a disorder similar to schizophrenia but with prominent mood episodes) or other mood disorder have been ruled out.
- **Other Characteristics**
- Other characteristics often exhibited by individuals with hebephrenic schizophrenia may include poor job or school performance, social withdrawal, lack of coordination, odd postures, childlike silliness, or grimacing. While they may have hallucinations or delusions, they are not pronounced. Since they are often quite impaired, living independently may be impossible for them.

9) Schizophrenia

- **Paranoid Schizophrenia**
- Of all the types of schizophrenia, paranoid schizophrenia is probably the most frequently diagnosed. Compared to the other types of schizophrenia, delusions and / or auditory hallucinations are much more prominent. Also, the paranoid type has the best overall prognosis.
- **Characteristics and Symptoms**
- **To qualify for a diagnosis of paranoid schizophrenia, two primary criteria must be met:**
- Frequent experience of auditory hallucinations or preoccupation with at least one delusion.
- The following symptoms are not prominent: blunted or inappropriate emotional expression, disorganized behaviour, catatonic behaviour, or speech which is disorganized.
- **More About Delusions and Hallucinations**
- Delusions are firmly held beliefs which are not based in reality. An example of a delusion would be the belief that aliens have removed one's brain and replaced it with an alien brain.

9) Schizophrenia

- **More About Delusions and Hallucinations**
- In paranoid schizophrenia, the delusions often involved the belief that they are the victim or target of persecution. They may believe someone is spying on them or plotting to do them harm. The delusion may also be grandiose in nature; for example, a belief that s/he has supernatural powers or is on a mission to save the world. Other types of delusions may also occur, such as ones involving their bodies.
- Auditory hallucinations are usually experienced as voices. The voices may be talking to them or about them. Sometimes the voices comment on their activity or tell them they are in danger. The voices may also order them to do certain things, such as commit suicide or stop taking their medication. Most of the time, the hallucinations are related to the delusional beliefs.
- Other features which are typical of paranoid schizophrenia are an attitude of superiority or a tendency to be patronizing towards others. They may be aloof or argumentative. Anger and feelings of anxiety are also not uncommon. They can be very intense when interacting with others, or unusually formal.
- Typically, the paranoid schizophrenic's speech, cognitive functioning, and emotional expression are less impaired than in some of the other subtypes.

9) Schizophrenia

- **Additional Diagnostic Criteria**
- **In order to meet the diagnosis of schizophrenia, regardless of the type, these other criteria must also be met:**
- A marked decline in functioning, after the onset of symptoms, in at least one of the primary aspects of the person's life (e.g., work, school, relationships, self-care).
- Signs of the disorder are present continuously for a period of at least 6 months. For at least one month of that time period (less if they subside due to effective treatment), the active-phase symptoms (for paranoid type that would be delusions and / or hallucinations) must be present.
- Schizoaffective disorder (a disorder similar to schizophrenia but with prominent mood episodes) or other mood disorder have been ruled out.
- **Suicide and Violence**
- Paranoid schizophrenics may be prone to suicide as a result of the belief that they are persecuted or harassed. They may also attempt to harm themselves or others if they are hearing voices telling them to do so. If they have grandiose beliefs as well, they may be more inclined to become violent towards others, such as harming someone they perceive as a threat or being in their way.

9) Schizophrenia

- **Other Factors**
- People who develop paranoid schizophrenia often start having symptoms at a later age than the other types. The defining features of this disorder also tend to remain fairly stable over time.
- Compared to the other subtypes, paranoid schizophrenics are often more likely to be able to live independently and hold down a job.

9) Schizophrenia

- **Undifferentiated Schizophrenia**
- When a person is exhibiting symptoms which meet many of the symptoms of schizophrenia, but does not fully or clearly fit one of the other types of schizophrenia (paranoid, catatonic, disorganized or residual), then s/he is given a diagnosis of undifferentiated schizophrenia.
- **Symptoms and Diagnosis**
- The person with this type of schizophrenia must have at least two or more of the following symptoms:
- **Delusions**
- Firmly held beliefs which are not based in reality, and are maintained despite evidence which disproves the belief or even when practically no one else ascribes to the same belief
- **Hallucinations**
- Seeing or hearing or otherwise sensing things which aren't really there
- **Disorganized speech**
- Person can't stay on one topic, gives irrelevant responses, or his/her words make no sense at all.

9) Schizophrenia

- **Extremely disorganized or catatonic behaviour**
- Extremely unkempt appearance, bizarre dress, unresponsive to his/her surroundings, rigid posture, or exhibits bizarre or overly excited movements
- **“Negative” symptoms**
- Examples of negative symptoms as lack of emotional expression or response, or significantly impaired thinking, or is unable to initiate or carry out basic tasks)
- Also, these symptoms must be present for at least one month, unless the person was treated successfully before the end of a one month period.
- **According to the DSM-IV, the person needs to meet only one (rather than two) of the above criterion when:**
- Delusions are bizarre. Bizarre delusions would involve a belief which is completely implausible, such as believing that an alien surgically removed the person’s heart and put another one inside the person’s body in its place.
- The patient is hearing at least two voices talking to each other, or is hearing a voice which is giving an ongoing commentary on the person’s activities or thoughts.

9) Schizophrenia

- **Additional Diagnostic Criteria**
- In order to meet the diagnosis of schizophrenia, regardless of the type, these other criteria must also be met:
- A marked decline in functioning, after the onset of symptoms, in at least one of the primary aspects of the person's life (e.g., work, school, relationships, self-care).
- Signs of the disorder are present continuously for a period of at least 6 months. For at least one month of that time period (less if they subside due to effective treatment), the active-phase symptoms (e.g. delusions, hallucinations, extremely disorganized behaviour, etc.) must be present.
- Schizoaffective disorder (a disorder similar to schizophrenia but with prominent mood episodes) or other mood disorder have been ruled out.
- In the other types of schizophrenia, at least one of the above symptoms is very prominent. But in undifferentiated schizophrenia, none are prominent. However, as with all the types, it is possible that at a different point in time the individual will meet the criteria for one of the other types.

9) Schizophrenia

- **Catatonic Schizophrenia**
- Catatonic schizophrenia is quite rare, particularly in industrialized countries. It is one of the different types of schizophrenia, and is characterized by a variety of unusual symptoms, many of which are physical in nature. Catatonic symptoms may briefly be exhibited by the other schizophrenic types.
- Characteristics and Symptoms
- In order for a person to be given the diagnosis of catatonic schizophrenia, at least one of the following criteria must be prominent in terms of the overall clinical presentation (in addition to meeting the other criteria for schizophrenia):
- The person is in a stupor (i.e., is unresponsive to his/her environment or shows little or no movement or activity); if moved, s/he maintains the new position and s/he remains immobile ("waxy flexibility")
- The person engages in excessive movement which has no purpose, and is not in reaction to something external
- The person resists any type of instruction or attempt to be moved, or s/he refuses or is unable to speak ("mutism").
- The person willingly takes on a bizarre or inappropriate stance or posture, or engages in peculiar movements, pronounced grimacing or mannerisms

9) Schizophrenia

- The person senselessly repeats the words spoken to him/her (echolalia) or involuntarily imitates the movements of another person (echopraxia)
- Additional Characteristics
- While one or more of the above symptoms are the most prominent in catatonic schizophrenia, other characteristics may be present. These may include hallucinations, delusions, disorganized speech, fits of anger, social withdrawal, absence of emotional expression or response, awkward or uncoordinated movement, poor personal hygiene, inappropriate emotions, difficulties performing at work or school.
- Additional Diagnostic Criteria
- In order to meet the diagnosis of schizophrenia, regardless of the type, these other criteria must also be met:
- A marked decline in functioning, after the onset of symptoms, in at least one of the primary aspects of the person's life (e.g., work, school, relationships, self-care).
- Signs of the disorder are present continuously for a period of at least 6 months. For at least one month of that time period (less if they subside due to effective treatment), the active-phase symptoms (e.g. delusions, hallucinations, extremely disorganized behaviour, etc.) must be present.
- Schizoaffective disorder (a disorder similar to schizophrenia but with prominent mood episodes) or other mood disorder have been ruled out.

9) Schizophrenia

- **Risks**
- When someone with this diagnosis is exhibiting extreme catatonic excitement (the excessive, senseless movement mentioned above) s/he is at risk of getting injured as well as injury others around him/her. Also, individuals with catatonic schizophrenia can become malnourished and / or exhausted. They may also at risk for hyperpyrexia, which means their body temperature has become dangerously elevated. Because of these risks, it is vital that they be closely monitored and supervised until they are stabilized.
- Other Diagnostic Considerations
- When someone presents with symptoms which resemble catatonic schizophrenia, it is important that other causes, such as drugs, other substances, or a medical condition are ruled out. Until that happens, the diagnosis catatonic schizophrenia is usually only provisional.

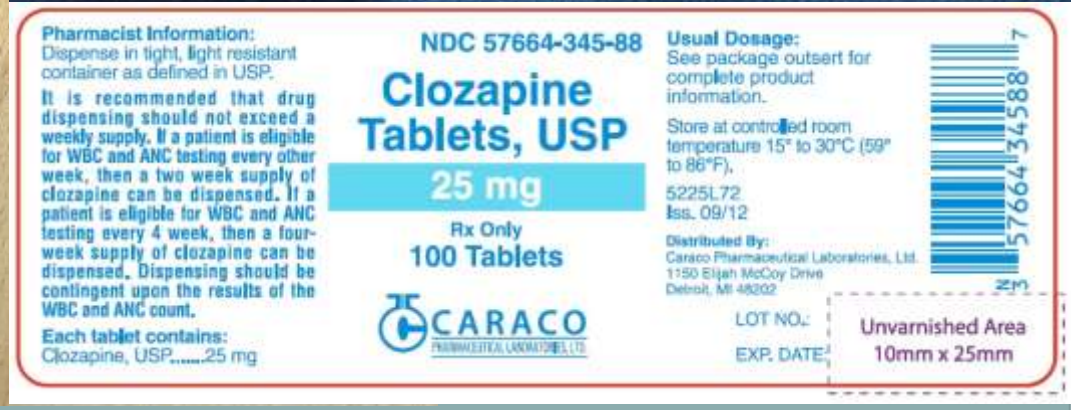

BBC FOUR


BBC FOUR

Produced with support from

Otsuka Pharmaceutical Development and Commercialization, Inc.

Antipsychotic Pharmacotherapy



Antipsychotic Pharmacotherapy

- **First-generation antipsychotics**
- **Haloperidol** (Haldol, Serenace)
- **Droperidol** (Droleptan, Inapsine)
- **Chlorpromazine** (Thorazine, Largactil)
- **Fluphenazine** (Prolixin) – Available in decanoate (long-acting) form
- **Perphenazine** (Trilafon)
- **Prochlorperazine** (Compazine)
- **Thioridazine** (Mellaril)
- **Trifluoperazine** (Stelazine)
- **Mesoridazine** (Serentil)
- **Periciazine**
- **Promazine**
- **Triflupromazine** (Vesprin)
- **Levomepromazine** (Nozinan)
- **Promethazine** (Phenergan)
- **Pimozide** (Orap)
- **Cyamemazine** (Tercian)

- **Second-generation antipsychotics (**Atypical)
- **Clozapine** (Clozaril)
- **Olanzapine** (Zyprexa
- **Risperidone** (Risperdal)
- **Quetiapine** (Seroquel)
- **Ziprasidone** (Geodon)
- **Amisulpride** (Solian)
- **Asenapine** (Saphris)
- **Paliperidone** (Invega)
- **Iloperidone** (Fanapt, Fanapta)
- **Zotepine** (Nipolept, Losizopilon, Lodopin, Setous)
- **Sertindole** (Serdolect)
- **Lurasidone** (Latuda)

- **Third-generation antipsychotics**
  Aripiprazole (Abilify)

Clozapine

- **Not a first-line choice due to side effects but seen to be effective in the treatment of treatment-resistant schizophrenia**
- Hypersalivation – (sialorrhea)
- Anticholinergic activity
- Myocarditis Myocarditis or inflammatory cardiomyopathy is inflammation of heart muscle (myocardium).*
- Tachychardia
- Weight gain and diabetes
- Agranulocytosis
- Postural / orthostatic potension (dizziness)
- Constipation
- Seizures

- Symptoms associated with myocarditis are varied, and relate either to the actual inflammation of the myocardium, or the weakness of the heart muscle that is secondary to the inflammation:
- Chest pain (often described as "stabbing" in character)
- Congestive heart failure (leading to edema, breathlessness and hepatic congestion)
- Palpitations (due to arrhythmias)
- Sudden death (in young adults, myocarditis causes up to 20% of all cases of sudden death)
- Fever

Anticholinergic side effects

- Anticholinergics will cause all the *opposite* effects of parasympathomimetics and AChEI's:

- **Eyes:**
- Mydriasis (pupil dilation)
- Dry Eye (no lacrimation)
- Accommodation for far vision
- Increases intra-ocular pressure (bad for glaucoma)

- **Digestive tract:**
- Decreased saliva production (dry mouth)
- Decreased stomach acid production (good for peptic ulcers)
- Decreased peristalsis (constipation; good for diarrhea)

- **Other effects:**
- Increased heart rate (good for cardiac insufficiency)
- Bronchodilation (good for asthmatics)
- Urinary retention (good for benign prostatic hyperplasia; large prostate)
- Again, all these are sympathetic-like effects from acetylcholine not being able to stimulate the muscarinic receptor in the parasympathetic fibers.

- **Anticholinergic Order of Sensitivity**
- Secretory (saliva, sweat, stomach acid)
- Eye
- Heart
- GI Motility

Tardive dyskinesia – or TD – is a neurological disorder resulting in involuntary, repetitive body movements.

KINECTSTUDY.COM

kinect STUDY


Dorothy
1990

BBC
FIVE
NEWS

9) Eating Disorders

Anorexia Nervosa / Bulimia Nervosa

- **Diagnostic Criteria for Anorexia Nervosa**
- A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

]

- Coding note: The ICD-9-CM code for anorexia nervosa is 307.1, which is assigned regardless of the subtype. The ICD-10-CM code depends on the subtype (see below). Specify whether:
- (F50.01) Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
- (F50.02) Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

- Specify if:
- In partial remission: After full criteria for anorexia nervosa were previously met. Criterion
- A (low body weight) has not been met for a sustained period, but either Criterion
- B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met. In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.
- Specify current severity:
- The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

- Mild: BMI>17kg/m2
- Moderate: BM116-16.99 kg/m2
- Severe: BM115-15.99 kg/m2
- Extreme: BMI < 15 kg/m2

Anorexia Nervosa / Bulimia Nervosa

- **Diagnostic Criteria for Bulimia Nervosa**
- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
- 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
- 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

- Specify if:
- In partial remission: After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time.
- In full remission: After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.

- Specify current severity:
- The minimum level of severity is based on the frequency of inappropriate compensatory behaviors (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- Mild: An average of 1-3 episodes of inappropriate compensatory behaviors per week.

- Moderate: An average of 4-7 episodes of inappropriate compensatory behaviors per week.

- Severe: An average of 8-13 episodes of inappropriate compensatory behaviors per week.

- Extreme: An average of 14 or more episodes of inappropriate compensatory behaviors per week.

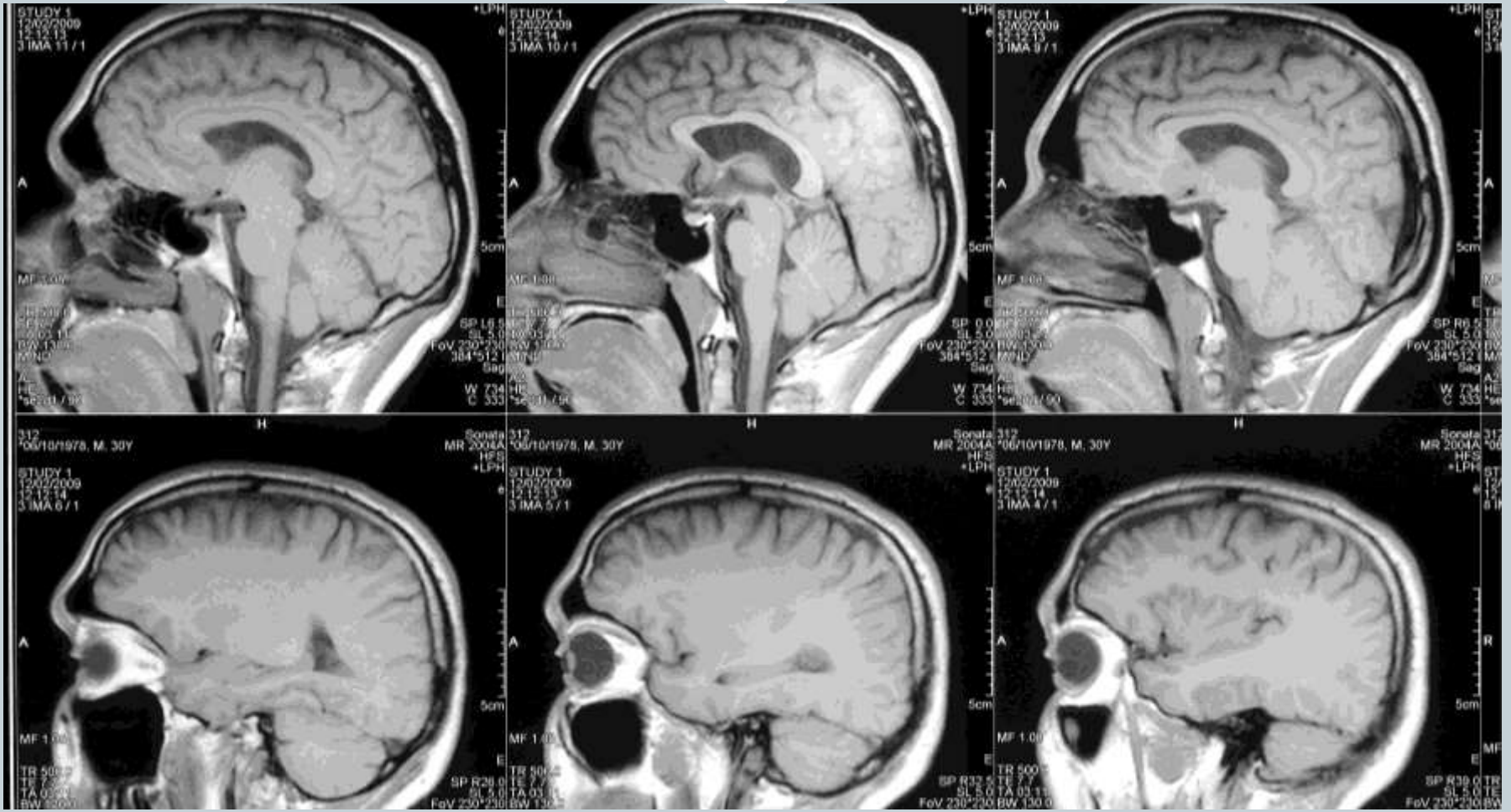
Anorexia Nervosa

Bulimia Nervosa.
Steve's Story

Bulimia Nervosa

Anorexia Nervosa.
Katie's Story

Neurocognitive Disorders



Neurocognitive Disorders

- Neurocognitive Disorder due to Alzheimer's Disease
- Neurocognitive Disorder due to Vascular Disorder
- Neurocognitive Disorder due to Frontotemporal Disorder
- Neurocognitive Disorder due to Lewy Bodies

Neurocognitive Disorders due to Alzheimer's Disease

- **Diagnostic Criteria for major to mild Neurocognitive Disorder due to Alzheimer's Disease**
- A. The criteria are met for major or mild neurocognitive disorder.
- B. There is insidious onset and gradual progression of impairment in one or more cognitive domains (for major neurocognitive disorder, at least two domains must be impaired).
- C. Criteria are met for either probable or possible Alzheimer's disease as follows:
- Probable Alzheimer's disease is diagnosed if either of the following is present; otherwise, possible Alzheimer's disease should be diagnosed.
- 1. Evidence of a causative Alzheimer's disease genetic mutation from family history or genetic testing.
- 2. All three of the following are present:
- a. Clear evidence of decline in memory and learning and at least one other cognitive domain (based on detailed history or serial neuropsychological testing).
- b. Steadily progressive, gradual decline in cognition, without extended plateaus.
- c. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline).

- **For mild neurocognitive disorder:**
- Probable Alzheimer's disease is diagnosed if there is evidence of a causative Alzheimer's disease genetic mutation from either genetic testing or family history.
- Possible Alzheimer's disease is diagnosed if there is no evidence of a causative Alzheimer's disease genetic mutation from either genetic testing or family history, and all three of the following are present:
- 1. Clear evidence of decline in memory and learning.
- 2. Steadily progressive, gradual decline in cognition, without extended plateaus.
- 3. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological or systemic disease or condition likely contributing to cognitive decline).
- D. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

Neurocognitive Disorders due to Vascular Disorder

- **Diagnostic Criteria for major to mild Vascular Neurocognitive Disorder**
- A. The criteria are met for major or mild neurocognitive disorder.
- B. The clinical features are consistent with a vascular etiology, as suggested by either of the following:
- 1. Onset of the cognitive deficits is temporally related to one or more cerebrovascular events.
- 2. Evidence for decline is prominent in complex attention (including processing speed) and frontal-executive function.
- 0. There is evidence of the presence of cerebrovascular disease from history, physical examination, and/or neuroimaging considered sufficient to account for the neurocognitive deficits.
- D. The symptoms are not better explained by another brain disease or systemic disorder.

- Probable vascular neurocognitive disorder is diagnosed if one of the following is present; otherwise possible vascular neurocognitive disorder should be diagnosed:
- 1. Clinical criteria are supported by neuroimaging evidence of significant parenchymal injury attributed to cerebrovascular disease (neuroimaging-supported).
- 2. The neurocognitive syndrome is temporally related to one or more documented cerebrovascular events.
- 3. Both clinical and genetic (e.g., cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy) evidence of cerebrovascular disease is present.

Neurocognitive Disorders due to Lewy Bodies

- **Diagnostic Criteria for major to mild Neurocognitive Disorder with Lewy Bodies**
- A. The criteria are met for major or mild neurocognitive disorder.
- B. The disorder has an insidious onset and gradual progression.
- C. The disorder meets a combination of core diagnostic features and suggestive diagnostic features for either probable or possible neurocognitive disorder with Lewy bodies. For probable major or mild neurocognitive disorder with Lewy bodies, the individual has two core features, or one suggestive feature with one or more core features.
- For possible major or mild neurocognitive disorder with Lewy bodies, the individual has only one core feature, or one or more suggestive features.
- 1. Core diagnostic features:
- a. Fluctuating cognition with pronounced variations in attention and alertness.
- b. Recurrent visual hallucinations that are well formed and detailed.
- c. Spontaneous features of parkinsonism, with onset subsequent to the development of cognitive decline.
- 2. Suggestive diagnostic features;
- a. Meets criteria for rapid eye movement sleep behavior disorder.
- b. Severe neuroleptic sensitivity.
- D. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

Neurocognitive Disorders due Frontotemporal Disorder

- **Diagnostic Criteria for major to mild Frontotemporal Neurocognitive Disorder**
- A. The criteria are met for major or mild neurocognitive disorder.
- B. The disturbance has insidious onset and gradual progression.
- C. Either (1) or (2);

- **1. Behavioral variant;**
- a. Three or more of the following behavioral symptoms:
- i. Behavioral disinhibition.
- ii. Apathy or inertia.
- iii. Loss of sympathy or empathy.
- iv. Perseverative, stereotyped or compulsive/ritualistic behavior.
- v. Hyperorality and dietary changes.
- b. Prominent decline in social cognition and/or executive abilities.

- **2. Language variant:**
- a. Prominent decline in language ability, in the form of speech production, word finding, object naming, grammar, or word comprehension.
- D. Relative sparing of learning and memory and perceptual-motor function.
- E. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

- Probable frontotemporal neurocognitive disorder is diagnosed if either of the following is present; otherwise, possible frontotemporal neurocognitive disorder should be diagnosed:
- 1. Evidence of a causative frontotemporal neurocognitive disorder genetic mutation, from either family history or genetic testing.
- 2. Evidence of disproportionate frontal and/or temporal lobe involvement from neuroimaging.
- Possible frontotemporal neurocognitive disorder is diagnosed if there is no evidence of a genetic mutation, and neuroimaging has not been performed.

Neurocognitive Disorders due Frontotemporal Disorder

- **Diagnostic Criteria for major to mild Frontotemporal Neurocognitive Disorder**
- A. The criteria are met for major or mild neurocognitive disorder.
- B. The disturbance has insidious onset and gradual progression.
- C. Either (1) or (2);

- **1. Behavioral variant;**
- a. Three or more of the following behavioral symptoms:
- i. Behavioral disinhibition.
- ii. Apathy or inertia.
- iii. Loss of sympathy or empathy.
- iv. Perseverative, stereotyped or compulsive/ritualistic behavior.
- v. Hyperorality and dietary changes.
- b. Prominent decline in social cognition and/or executive abilities.

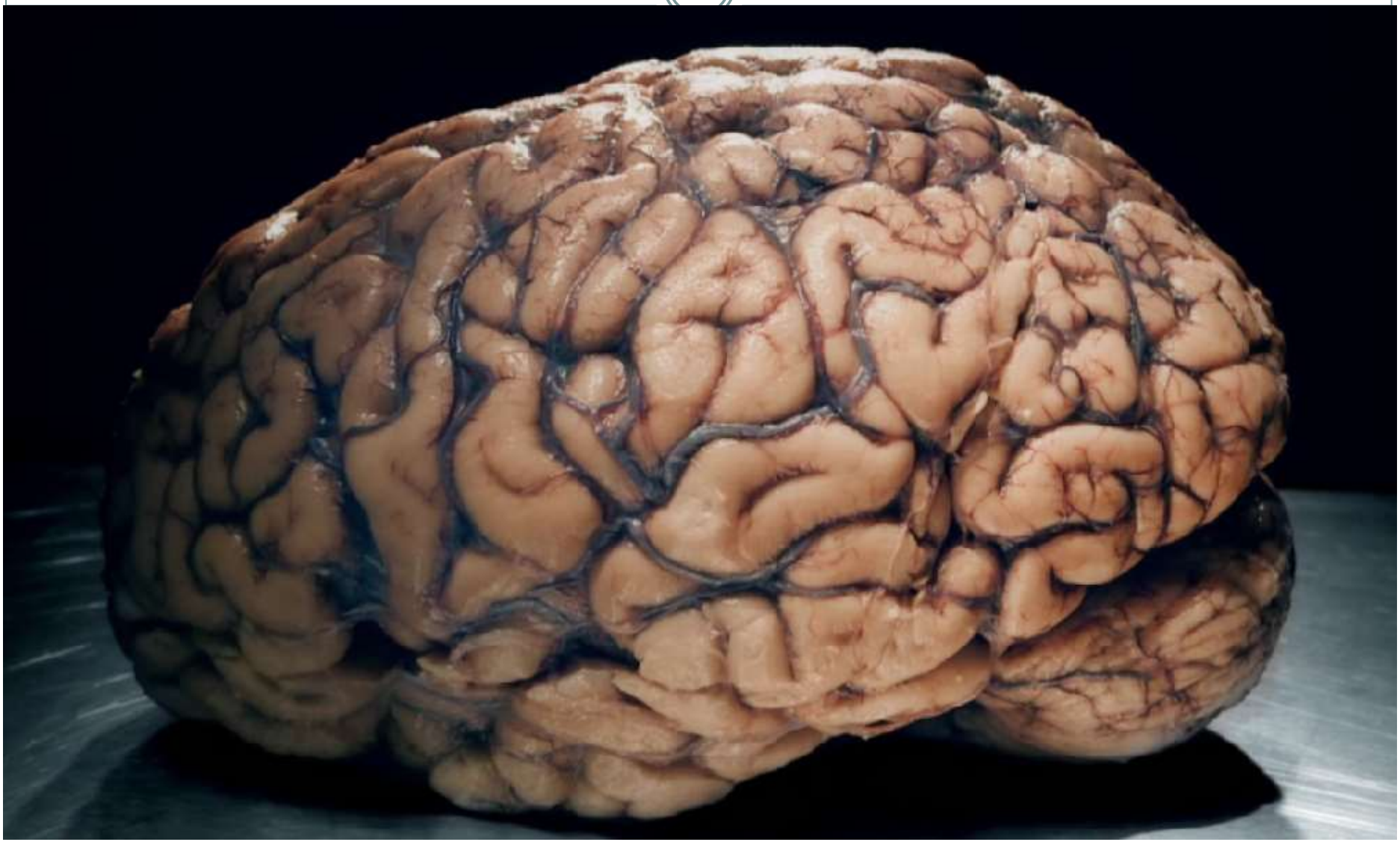
- **2. Language variant:**
- a. Prominent decline in language ability, in the form of speech production, word finding, object naming, grammar, or word comprehension.
- D. Relative sparing of learning and memory and perceptual-motor function.
- E. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

- Probable frontotemporal neurocognitive disorder is diagnosed if either of the following is present; otherwise, possible frontotemporal neurocognitive disorder should be diagnosed:
- 1. Evidence of a causative frontotemporal neurocognitive disorder genetic mutation, from either family history or genetic testing.
- 2. Evidence of disproportionate frontal and/or temporal lobe involvement from neuroimaging.
- Possible frontotemporal neurocognitive disorder is diagnosed if there is no evidence of a genetic mutation, and neuroimaging has not been performed.

Neurocognitive Disorders

- **Amnesia** (memory Impairment):
- **Aphasia** (impaired comprehension, naming, reading, writing).
- **Apraxia** (cannot perform certain movements on command or imitation -- dressing, using scissors)
- **Agnosia** (cannot recognize objects: pen, watch).
- **Ataxia** (symptom characterised by imbalance, wide-based gait)
- Disturbance in **executive functioning**

Neurocognitive Disorders



Brain imaging studies in PNES-related disorders and vulnerability traits.

- **Conversion paralysis –**
- Decreased CBF in motor areas responsible for deficit110,111 and decreased activity in motor areas during motor task115 and during movement observation.113
- Excessive activity in OFC and ACC during motor task111; excessive metabolism in right OFC compared to feigners during motor task116; decreased activity of right
- OFC compared to feigners during motor task115 and compared to feigners during no-go trials114; increased activation of left inferior frontal gyrus compared to
- feigners during motor task.115
- Decreased activity in DLPFC112 and compared to feigners during motor task.115
- Increased activity in bilateral putamen115 and increased metabolism in left putamen116 and left thalamus116 compared to feigners during motor task.
- Enhanced functional connectivity between motor-related areas and brain regions responsible for emotion processing114,118 and self-representation114 during
- motor task.
- **Conversion sensory deficit**
- Decreased CBF in contralateral basal ganglia and thalamus119 during sensory task.
- **Psychogenic tremor**
- Decreased activity at right TPJ and lower interaction between sensorimotor cortices and TPJ compared to voluntary tremor.121
- **Dissociative identity disorder**
- Increased activation in dissociated PTSD of right ACC, medial prefrontal cortex, medial frontal gyrus, medial parietal lobe and bilateral inferior frontal gyri after
- traumatic scripts.126
- Decreased CBF in bilateral OFC and superior and medial frontal regions in host states.127
- Activation of somatosensory areas and other areas responsible for negative emotional states in traumatic identity states compared to neutral identity states
- during traumatic scripts.128
- **Dissociative amnesia**
- Increased activation in DLPFC and decreased activation in hippocampus during memory retrieval of dissociated memories compared to nondissociated memories.129
- Decreased metabolism in right inferior frontal gyrus in dissociative amnesia at rest.130
- Activation of amygdala and right inferior frontal gyrus during cued recall of dissociated memories compared to nondissociated memories.131
- **Alexithymia**
- Increased metabolism in sensorimotor cortices and left insula during emotional stimuli compared to controls.132
- Decreased metabolism in ACC during emotional stimuli compared to controls.132
- Negative correlation with amygdala activation during emotional stimulation.133,134
- **Avoidance tendencies**
- Increased amygdala activation when confronted with threatening stimuli136; level of activation correlates with avoidance behaviors.135
- **Hypervigilance and somatization**
- Activation of insula and dorsal ACC correlates with interoceptive heartbeat sensitivity.137
- Increased activation in dorsal and rostral ACC, left amygdala and posterior parietal regions during threatening stimuli in PTSD compared to controls.138
- Activation of right parietal cortex during interoceptive attention to heartbeat compared to external attention in controls.141
- Activation of insula and ACC during sham mobile phone radiation in somatoform patients compared to controls.143

Common symptoms of conversion disorder

Common symptoms of conversion disorder

Sensory symptoms

Diplopia (Double Vision)
Deafness
Numbness
Blindness
Mutism

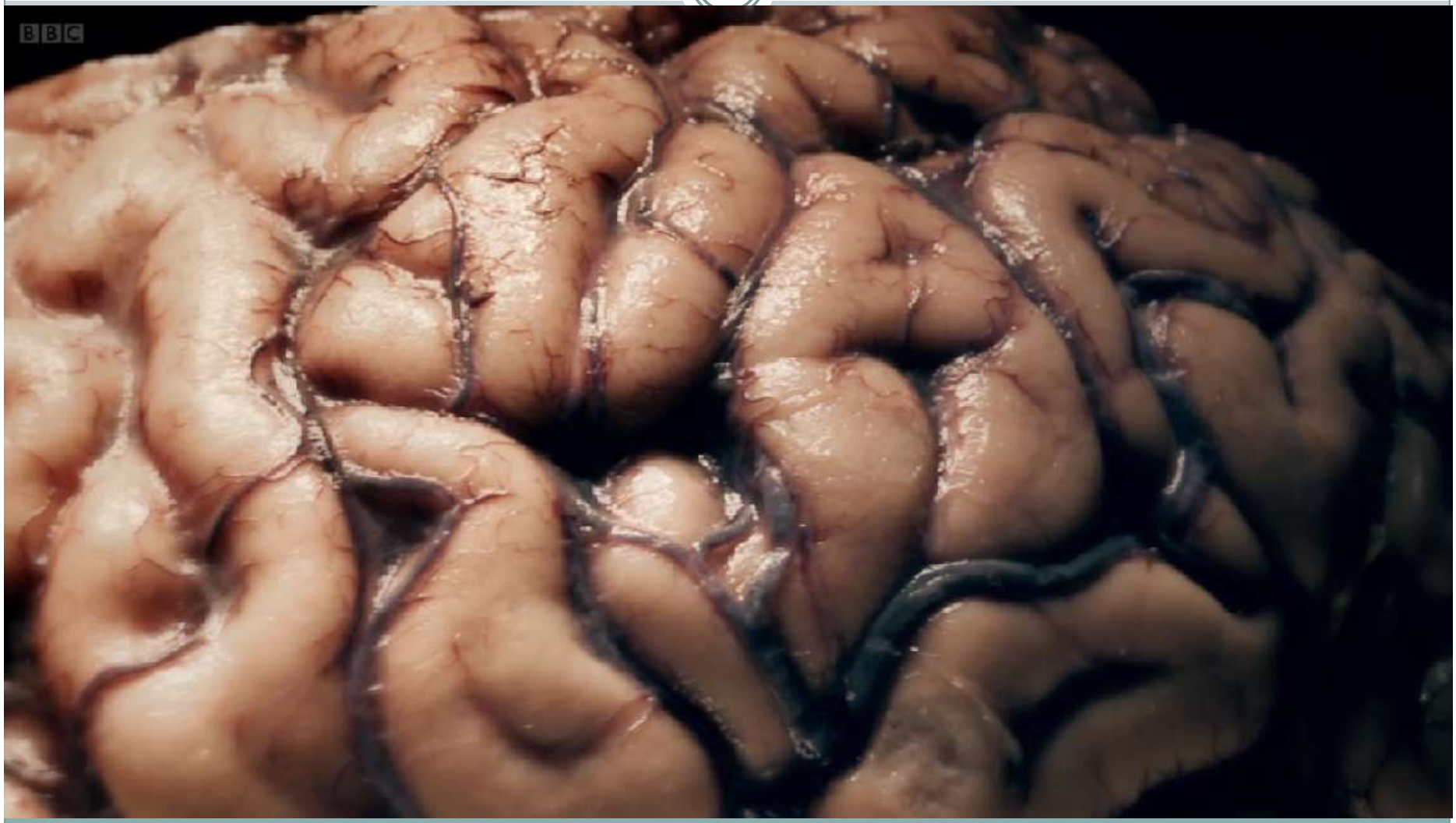
Motor Symptoms

Paralysis
Dysphasia (language disorder marked by deficiency in the generation of speech, and sometimes also in its comprehension, due to brain disease or damage)
Ataxia
Tremor
Aphonia (inability to speak through disease of or damage to the larynx or mouth)
Seizures

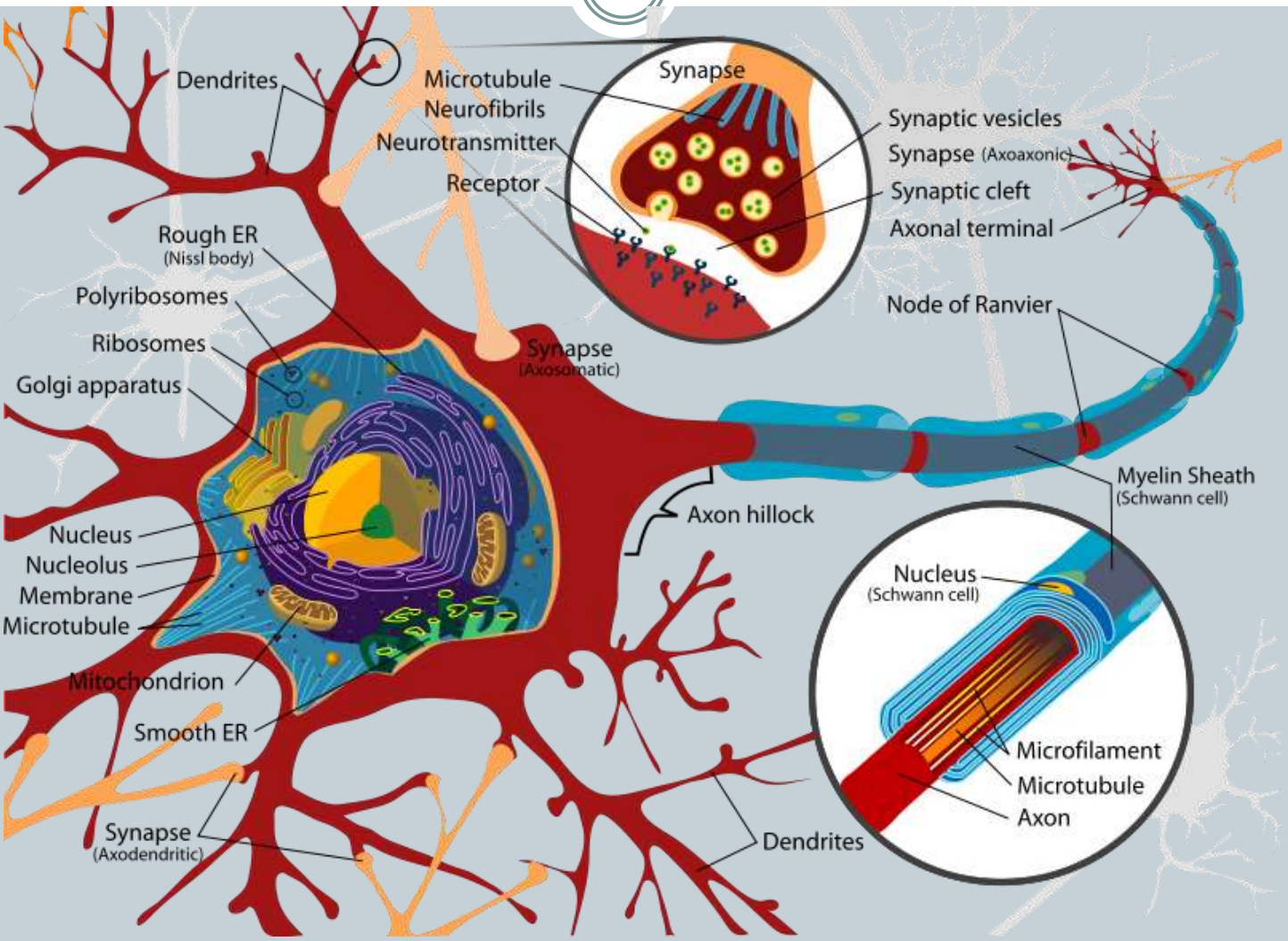
Brain imaging studies in PNES-related disorders and vulnerability traits.

- **Partial (focal) seizure**
- All seizures are caused by abnormal electrical disturbances in the brain. Partial (focal) seizures occur when this electrical activity remains in a limited area of the brain. The seizures can sometimes turn into generalized seizures, which affect the whole brain. This is called secondary generalisation.
- Partial seizures can be divided into:
- **Simple, not affecting awareness or memory**
- **Complex, affecting awareness or memory of events before, during, and immediately after the seizure, and affecting behaviour**
- **Causes**
- Partial seizures are the most common type of seizure in people 1 year and older. In people older than 65 who have blood vessel disease of the brain or brain tumors, partial seizures are very common.
- **Symptoms**
- People with complex partial seizures may or may not remember any or all of the symptoms or events during the seizure.
- Depending on where in the brain the seizure starts, symptoms can include:
- Abnormal muscle contraction, such as abnormal head movements
- Staring spells, sometimes with repetitive movements such as picking at clothes or lip smacking
- Eyes moving from side to side
- Abnormal sensations, such as numbness, tingling, crawling sensation (like ants crawling on the skin)
- Hallucinations, seeing, smelling, or sometimes hearing things that are not there
- Abdominal pain or discomfort
- Nausea
- Sweating
- Flushed face
- Dilated pupils
- Rapid heart rate/pulse
- Other symptoms may include:
- Blackout spells, periods of time lost from memory
- Changes in vision
- Sensation of déjà vu (feeling like current place and time have been experienced before)
- Changes in mood or emotion
- Temporary inability to speak

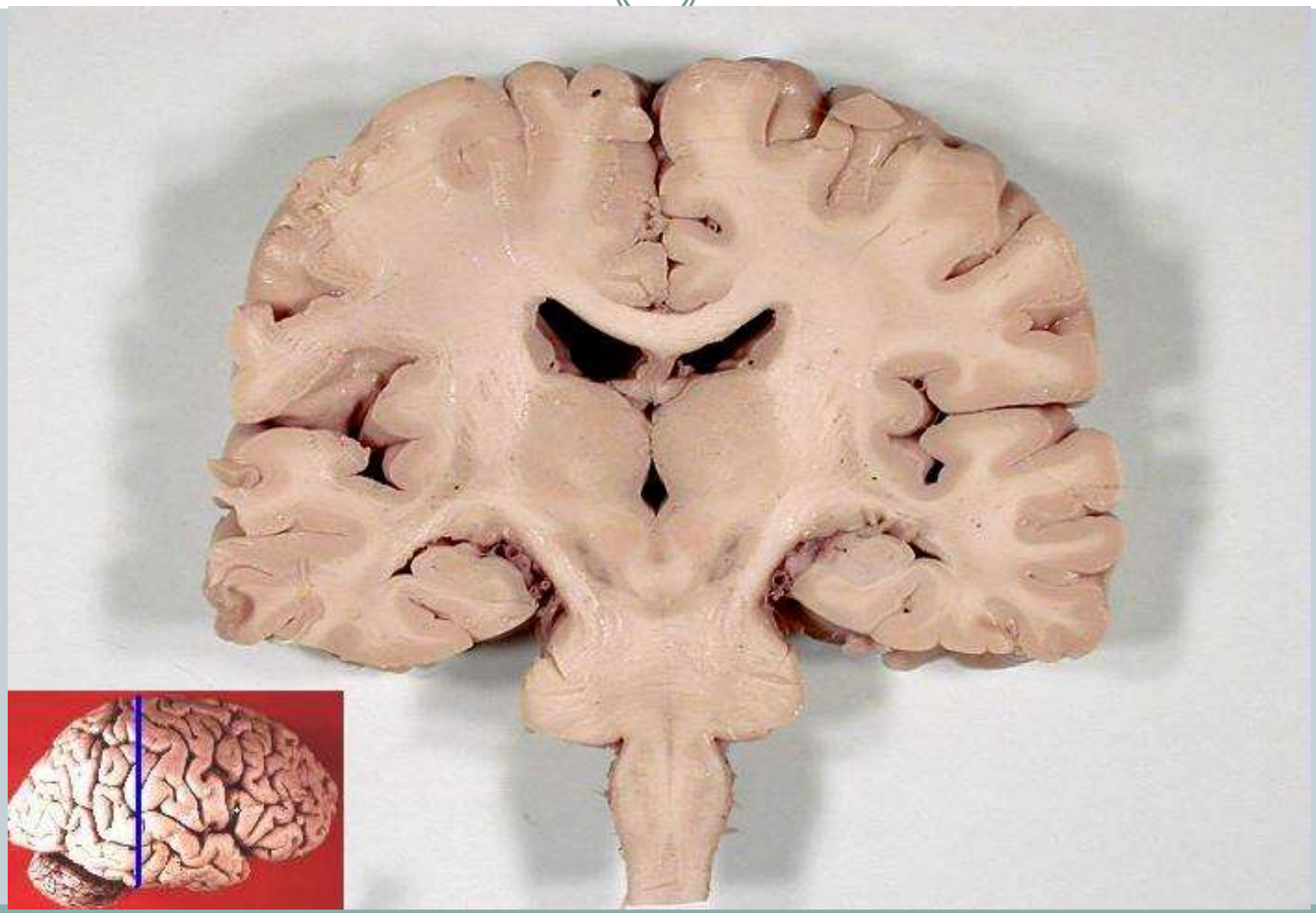
Neurocognitive Disorders



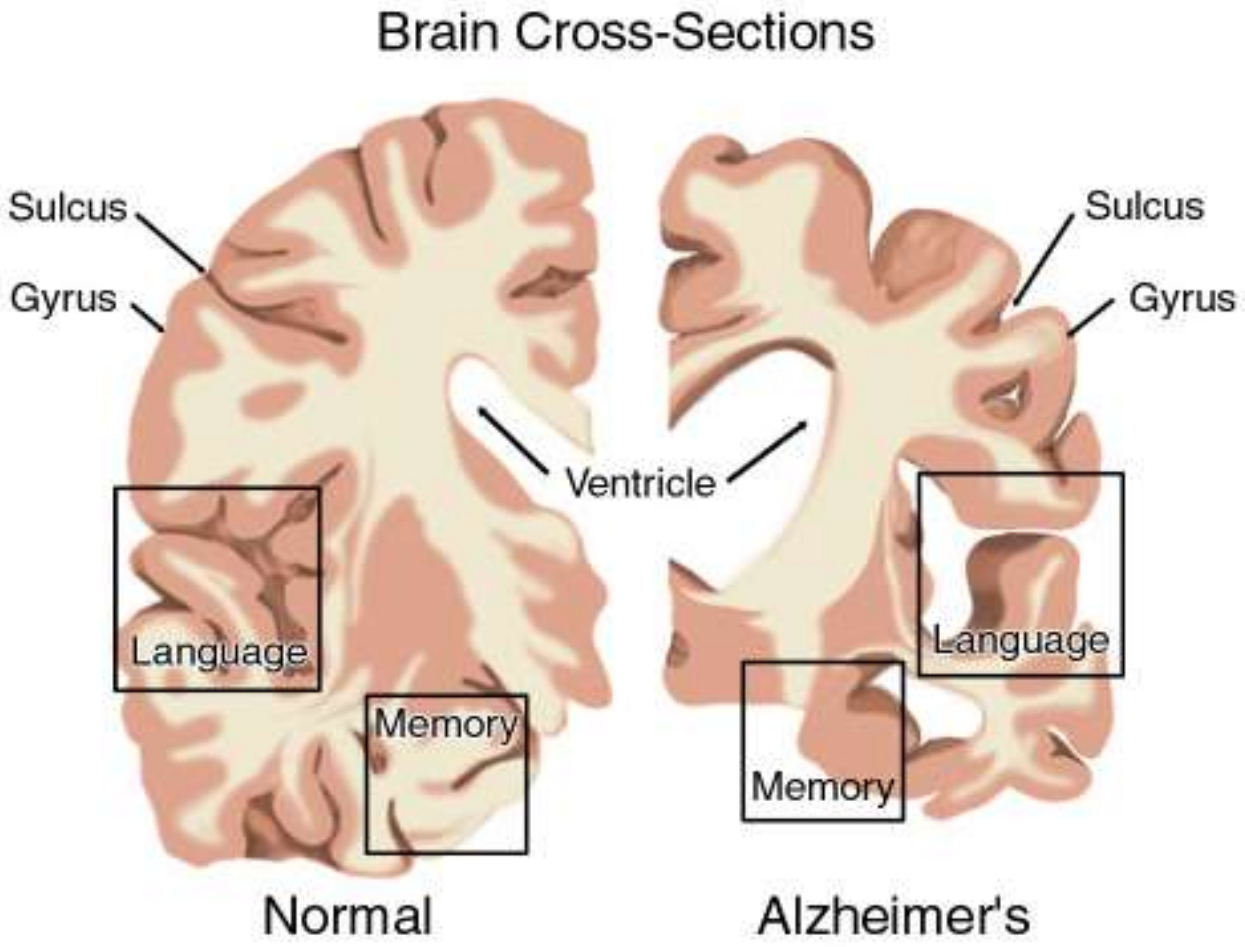
Neurocognitive Disorders



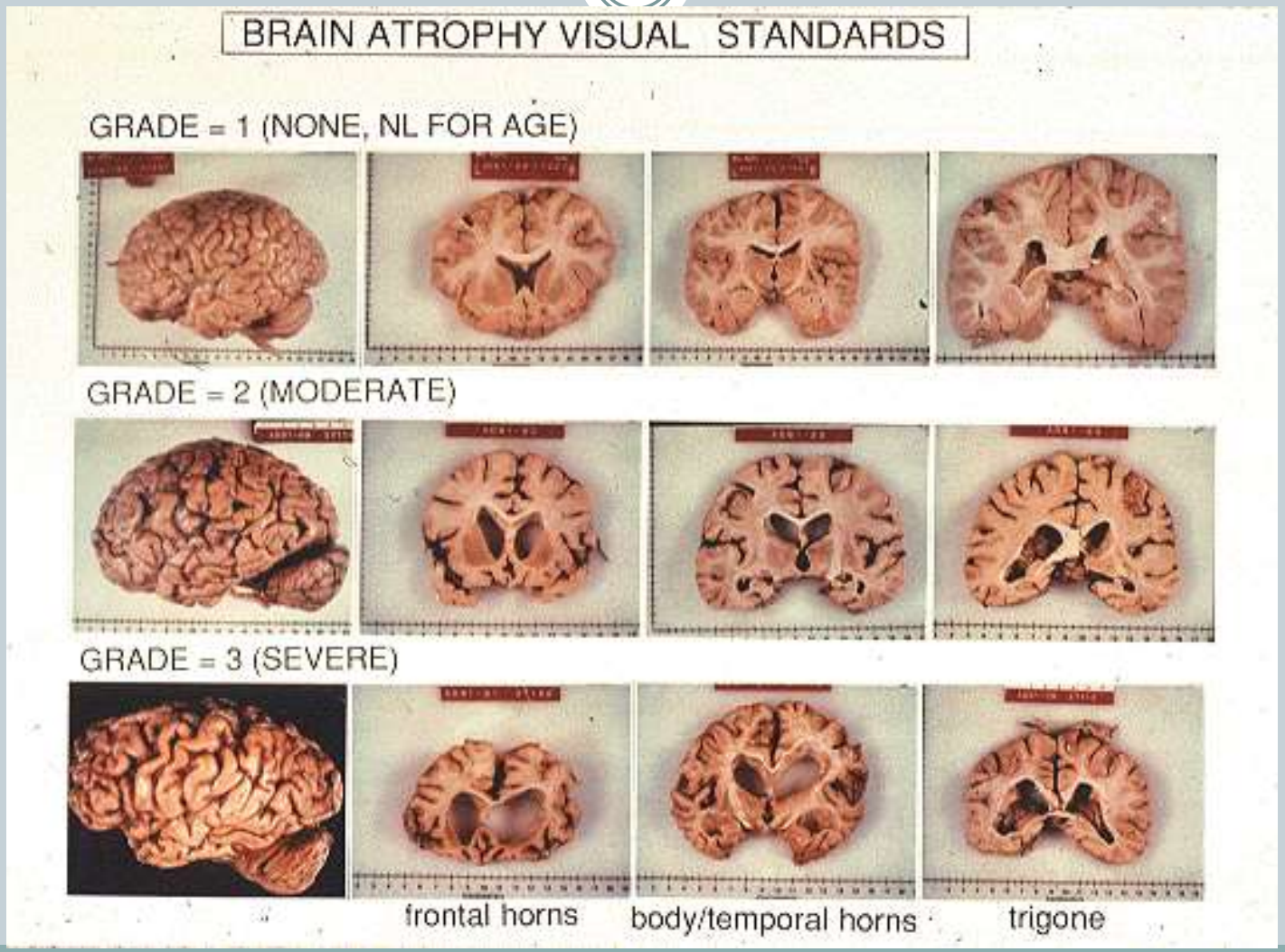
Neurocognitive Disorders



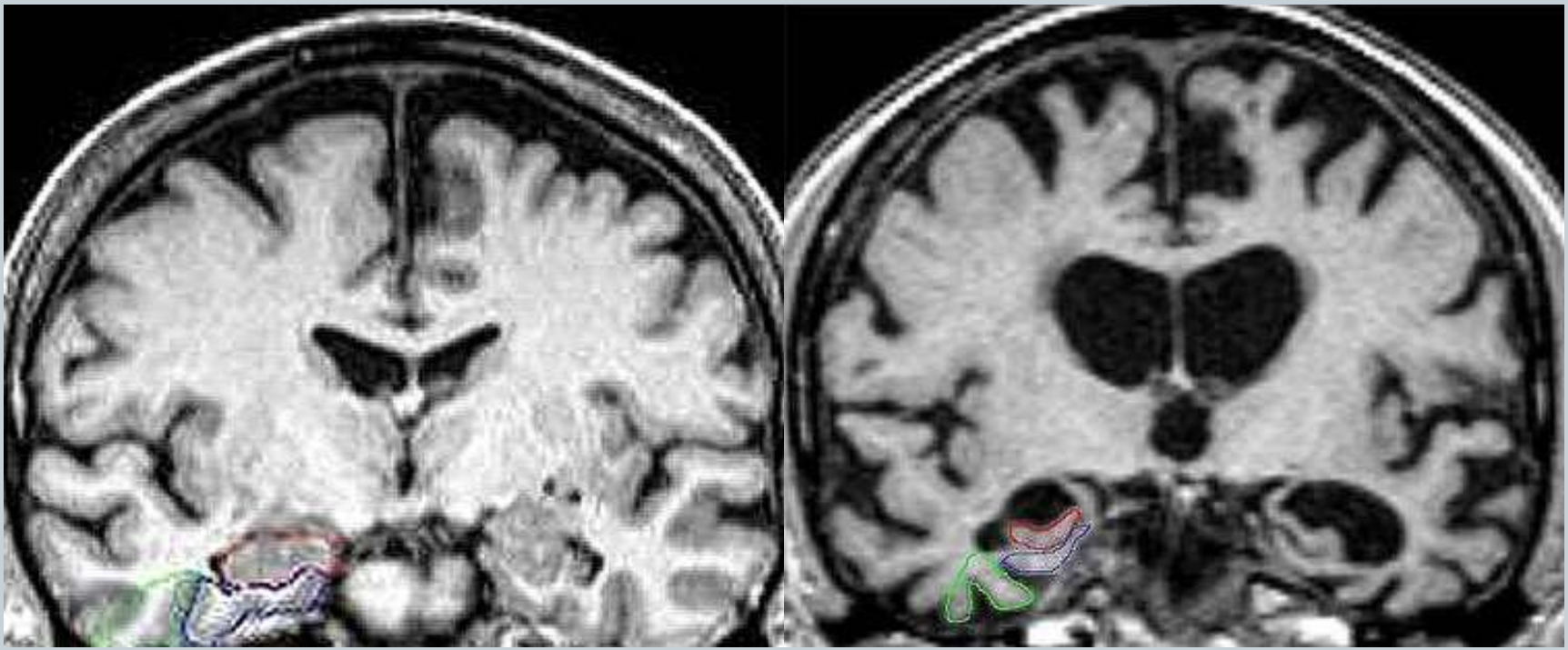
Neurocognitive Disorders due to Alzheimer's Disease



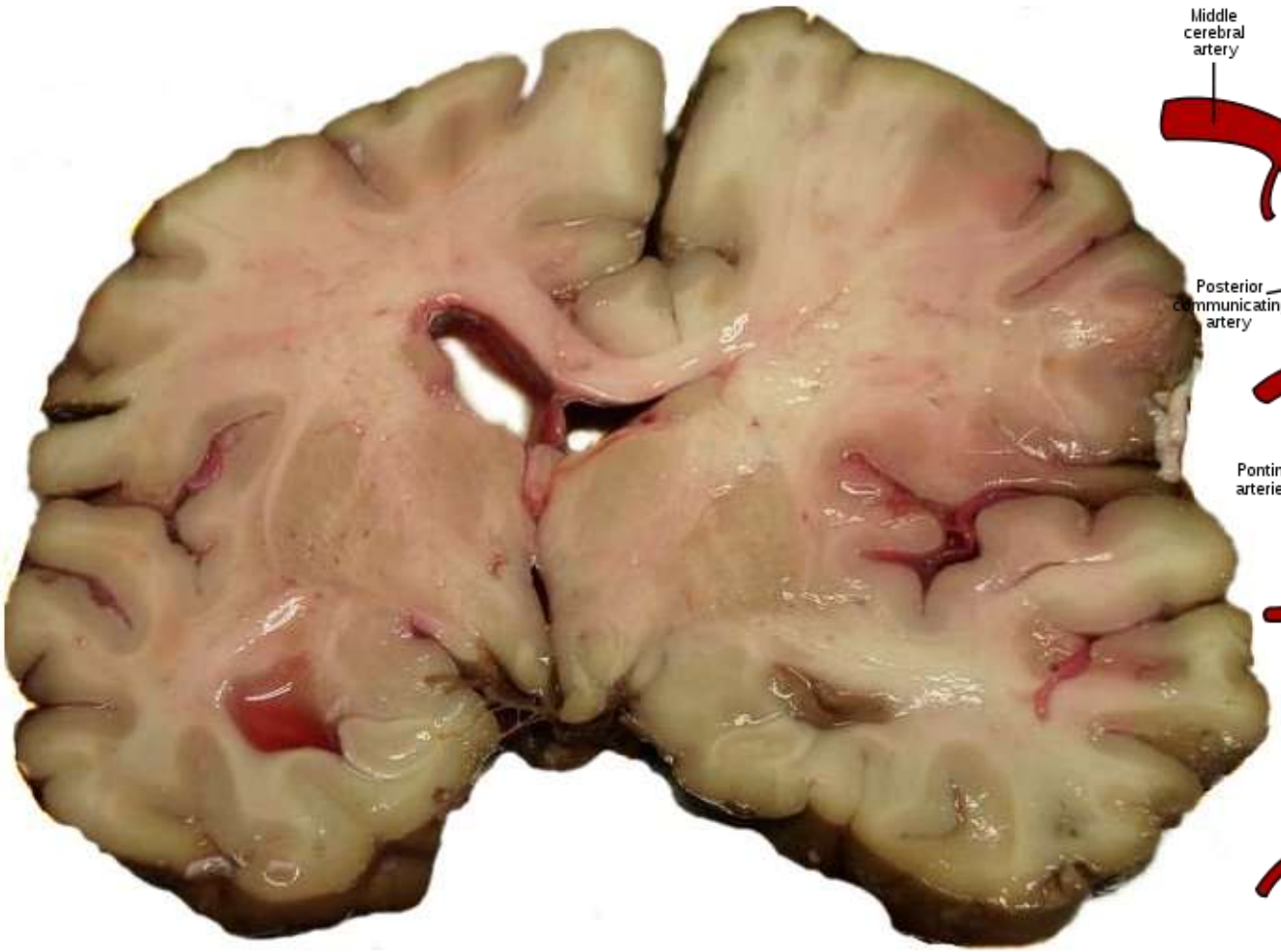
Neurocognitive Disorders due to Alzheimer's Disease

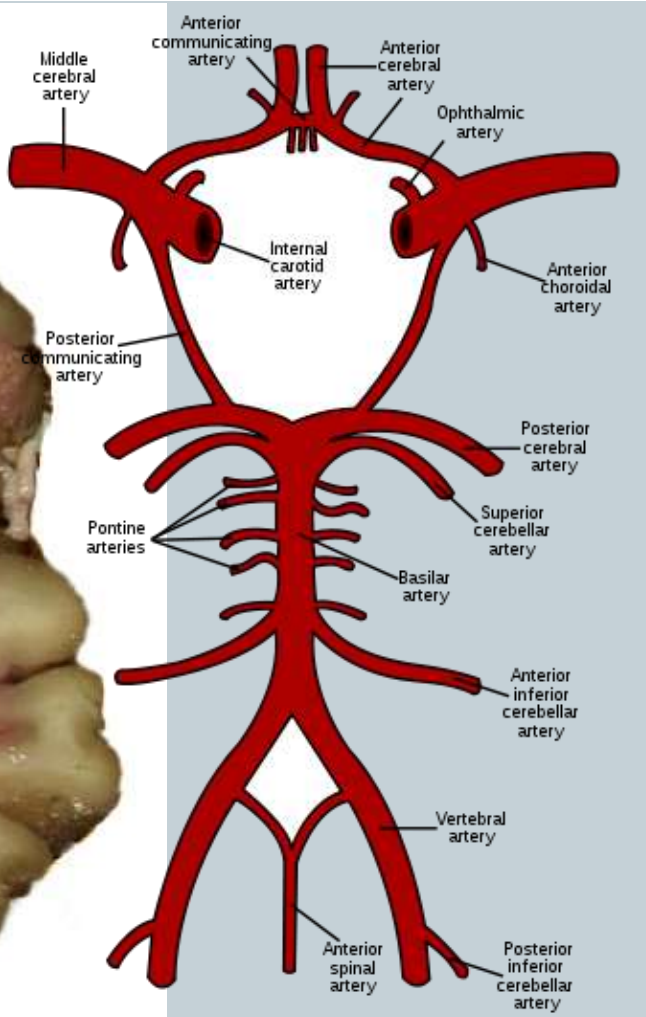


Neurocognitive Disorders due to Alzheimer's Disease



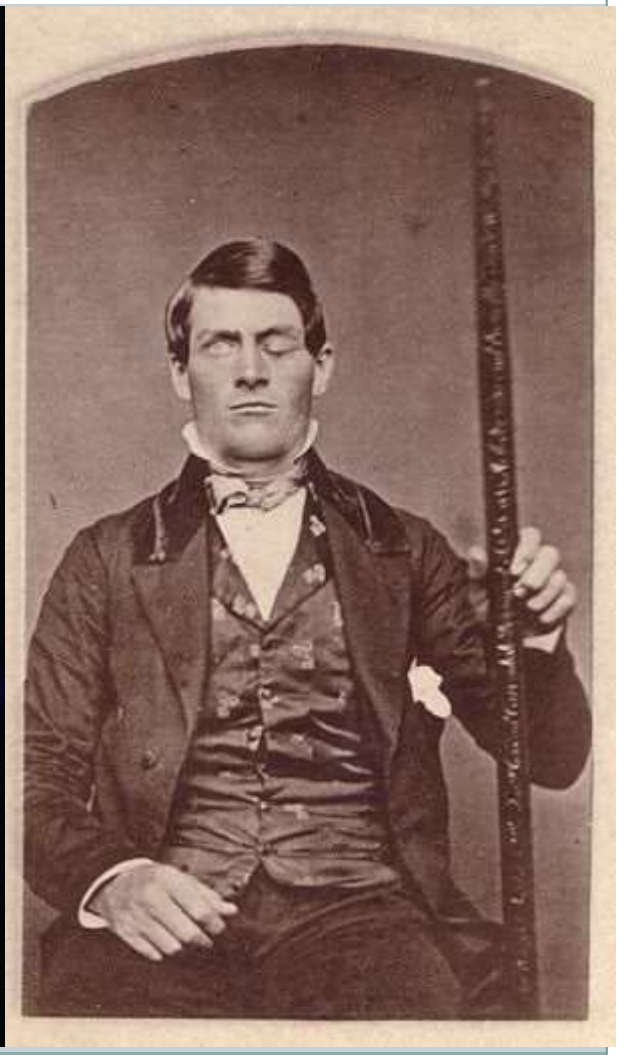
Neurocognitive Disorders due to Vascular Disorder






Ischemic & hemorragic Strokes

Phineas Gage



Phineas Gage

- *"The equilibrium or balance, so to speak, between his intellectual faculties and animal propensities, seems to have been destroyed. He is fitful, irreverent, indulging at times in the grossest profanity (which was not previously his custom), manifesting but little deference for his fellows, impatient of restraint or advice when it conflicts with his desires, at times pertinaciously obstinate, yet capricious and vacillating, devising many plans of future operations, which are no sooner arranged than they are abandoned in turn for others appearing more feasible. A child in his intellectual capacity and manifestations, he has the animal passions of a strong man. Previous to his injury, although untrained in the schools, he possessed a well-balanced mind, and was looked upon by those who knew him as a shrewd, smart businessman, very energetic and persistent in executing all his plans of operation. In this regard his mind was radically changed, so decidedly that his friends and acquaintances said he was 'no longer Gage."*

Delirium

Delirium

- **Diagnostic Criteria for Delirium**
- A. A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention)
- and awareness (reduced orientation to the environment).
- B. The disturbance develops over a short period of time (usually hours to a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day.
- C. An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception).
- D. The disturbances in Criteria A and C are not better explained by another preexisting, established, or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal, such as coma.
- E. There is evidence from the history, physical examination, or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal (i.e., due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple etiologies.
- Specify whether:
- Substance intoxication delirium: This diagnosis should be made instead of substance intoxication when the symptoms in Criteria A and C predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

Personality Disorders

Personality Disorder in the DSM / ICD

- A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.
- The following personality disorders are included in the DSM
- **Paranoid personality disorder** is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.
- **Schizoid personality disorder** is a pattern of detachment from social relationships and a restricted range of emotional expression.
- **Schizotypal personality disorder** is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.
- **Antisocial personality disorder** is a pattern of disregard for, and violation of, the rights of others.
- **Borderline personality disorder** is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.
- **Histrionic personality disorder** is a pattern of excessive emotionality and attention seeking.
- **Narcissistic personality disorder** is a pattern of grandiosity, need for admiration, and lack of empathy.
- **Avoidant personality disorder** is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
- **Dependent personality disorder** is a pattern of submissive and clinging behavior related to an excessive need to be taken care of.
- **Obsessive-compulsive personality disorder** is a pattern of preoccupation with orderliness, perfectionism, and control.

Personality Disorders

- Borderline Personality Disorder
- Antisocial Personality Disorder
- Paranoid Personality Disorder

Paranoid Personality Disorder

ICD- 10

Paranoid Personality Disorder is characterized by at least 3 of the following:

1. excessive sensitivity to setbacks and rebuffs;
2. tendency to bear grudges persistently, i.e. refusal to forgive insults and injuries or slights;
3. suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous;
4. a combative and tenacious sense of personal rights out of keeping with the actual situation;
5. recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner;
6. tendency to experience excessive self-importance, manifest in a persistent self-referential attitude;
7. preoccupation with unsubstantiated "conspiratorial" explanations of events both immediate to the patient and in the world at large.

DSM IV

Paranoid Personality Disorder is a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her;
2. is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates;
3. is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her;
4. reads hidden demeaning or threatening meanings into benign remarks or events;
5. persistently bears grudges, i.e., is unforgiving of insults , injuries, or slights perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack;
6. has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

The disorder does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects or a general medical condition.

Psychopathic Personality Disorder

Hare's PCL-R Twenty Traits

Factor 1: Primary Psychopathy

1. **Glibness and Superficial Charm** – Smooth-talking, engaging and slick.
2. **Grandiose Self-Worth** – Greatly inflated idea of one's abilities and self-esteem, arrogance and a sense of superiority.
3. **Pathological Lying** – Shrewd, crafty, sly and clever when moderate; deceptive, deceitful, underhanded and unscrupulous when high.
4. **Manipulative** – Uses deceit and deception to cheat others for personal gain.
5. **No Guilt / Remorse** - no feelings or concern for losses, pain and suffering of others, cold=hearted and un=empathic.
6. **Emotional Poverty** – Limited range or depth of feelings; interpersonal coldness.
7. **Lacks Empathy** – A lack of feelings toward others; cold, contemptuous and inconsiderate.

Factor 2: Secondary Psychopathy

1. **Needs Stimulation/Prone to Boredom** – An excessive need for new, exciting stimulation and risk-taking.
2. **Parasitic Lifestyle** – Intentional, manipulative, selfish and exploitative financial dependence on others.
3. **Poor Behavioural Controls** – Expressions of negative feelings, verbal abuse and inappropriate expressions of anger.
4. **Promiscuity** – Brief, superficial relations, numerous affairs and an indiscriminate choice of sexual partners.
5. **No Realistic Long-Term Goals** – Inability or constant failure to develop and accomplish long-term plans.
6. **Impulsiveness** – Behaviours lacking reflection or planning and done without considering consequences.
7. **Irresponsible** – Repeated failure to fulfil or honour commitments and obligations.
8. **Fails to Accept Responsibility for Own Behaviour** – Denial of responsibility and an attempt to manipulate others through this.
9. **Many Short-Term Marital Relationships** – Lack of commitment to a long-term relationship.
10. **Early Behaviour Problems** – A variety of dysfunctional and unacceptable behaviours before age thirteen.
11. **Juvenile Delinquency** – Criminal behavioural problems between the ages of 13-18.
12. **Revocation of Conditional Release** – Violating probation or other conditional release because of technicalities.
13. **Criminal Versatility** – Diversity of criminal offenses, whether or not the individual has been arrested or convicted.

Scores – 0,1,2 (Max 40 – prototypical. Qualifying – score of 30, non psychopathic criminal – 22. Normal non-criminals typically score 5))


Jeremy Kyle
Father to '15... Wife and girlfriend
pregnant again!

Borderline Personality Disorder

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

Borderline Personality Disorder

- **ICD 10 – criteria for Emotionally Unstable Personality Disorder**
- **Impulsive type:**
- The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others. At least three of the following must be present, one of which must be (2)

1. Marked tendency to act unexpectedly and without consideration of the consequences;
2. Marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticised;
3. Liability to outbursts of anger or violence with inability to control the resulting behavioural explosions;
4. Difficulty in maintaining any course of action that offers no immediate reward;
5. Unstable and capricious mood.

- **Borderline type:**
- At least three of the symptoms mentioned above must be present with at least two of the following in addition:

1. Disturbances in and uncertainty about self-image, aims and internal preferences;
2. Liability to become involved in intense and unstable relationships, often leading to emotional crisis;
3. Excessive efforts to avoid abandonment;
4. Recurrent threats or acts of self harm;
5. Chronic feelings of emptiness;
6. Demonstrates impulsive behaviour, i.e speeding, substance misuse

Antisocial Personality Disorder

- **Diagnostic Criteria for Antisocial Personality Disorder**
- A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
- 1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
- 2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
- 3. Impulsivity or failure to plan ahead.
- 4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
- 5. Reckless disregard for safety of self or others.
- 6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
- 7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
- B. The individual is at least age 18 years.
- C. There is evidence of conduct disorder with onset before age 15 years.
- D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

Dissocial Personality Disorder (ICD 10)

- **Diagnostic Criteria for Dissocial Personality Disorder**
- **The ICD-10 criteria**
- The general criteria of personality disorder (F60) must be met.
- At least three of the following must be present:
- Callous unconcern for the feelings of others.
- Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations.
- Incapacity to maintain enduring relationships, although having no difficulty to establish them.
- Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.
- Incapacity to experience guilt, or to profit from adverse experience, particularly punishment.
- Marked proneness to blame others, or to offer plausible rationalisations for the behaviour bringing the subject into conflict with
- society.
- Persistent irritability and the presence of conduct disorder during childhood and adolescence are not required for the diagnosis.

Paranoid Personality Disorder

- **Diagnostic Criteria for Paranoid Personality Disorder**
- A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
- 1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
- 2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
- 3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
- 4. Reads hidden demeaning or threatening meanings into benign remarks or events.
- 5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
- 6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
- 7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.
- B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

- Note: If criteria are met prior to the onset of schizophrenia, add “premorbid,” i.e., “paranoid personality disorder (premorbid).”

Paranoid Personality Disorder

- Mistrustful: Reluctant to presume others' goodwill.
- Suspicious: Scrutinizes the actions of others for any hint of malevolent or selfish motive.
- Vigilant: Actively scans surroundings and inspects interactions for signs of danger.
- Cynical: Believes positive expectations will be spoiled, that human nature is inherently
- selfish, and that the universe is unjust.
- Rivalrous: Actively engages in social comparison.
- Wronged: Views self as innocent victim of injustice. Sees self at short end of social comparisons.
- Jealous: Questions the loyalty of intimate associates, including spouse.
- Thin-Skinned Hypersensitive to perceived slights. Easily enraged by narcissistic injury.
- Seething: Recounts past wrongs while boiling with anger.
- Revengeful: Determined to "balance the books," through own action, if necessary.
- Guarded: Maintains self-protective posture. Indiscriminately secretive and evasive.
- Convicted: Impervious to correction by new information or information inconsistent with previous views.
- Humourless: Takes everything seriously. Especially unable to laugh at self. Brittle.
- Self-Contained: Impervious to correction based on the advice of others.
- Self-Important: Believes own experience has special significance. Personalizes neutral events.

News Front Page
World
UK
England
Northern Ireland
Scotland
Wales
Business
Politics
Health
Education
Science & Environment
Technology
Entertainment
Also in the news
Video and Audio
Have Your Say
Magazine
In Pictures
Country Profiles
Special Reports
RELATED BBC SITES
SPORT
WEATHER
CBBC NEWSROUND
ON THIS DAY
EDITORS' BLOG

Last Updated: Thursday, 4 September, 2003, 18:55 GMT 19:55 UK

E-mail this to a friend | Printable version

Swordsman sent to hospital

A man who attacked an MP and his assistant with a Samurai sword, killing the aide, has been sent to a medium secure hospital for an indefinite period.

Ashman had denied attempting to kill the MP

Robert Ashman, 52, had previously admitted the manslaughter of councillor Andrew Pennington, but denied trying to kill the Liberal Democrat MP for Cheltenham, Nigel Jones, on 28 January 2000.

Mr Pennington, died in the attack at the MP's weekly constituency surgery after being stabbed six times.

Ashman, a regular visitor to Mr Jones's surgeries, had taken his father's sword with him on the day of the attack.

After asking Mr Jones to look at a letter for him, he pulled out the three-foot long weapon and lunged at the MP with it.

High security

Mr Jones suffered serious injuries to his hands as he tried to fend off the man.

When the MP escaped and tried to run for help, Ashman turned on 39-year-old Mr Pennington, killing him.

Mr Pennington was posthumously awarded the George Medal for bravery for saving Nigel Jones's life.

SEE ALSO:
- MP's sword attacker guilty
  03 Apr 03 | England
- Debts led to breakdown
  03 Apr 03 | England
- Honour for MP's aide
  03 Apr 03 | England
- MP's attacker's 'mental disorder'
  02 Apr 03 | England
- MP's sword attacker 'aimed at heart'
  01 Apr 03 | England

RELATED INTERNET LINKS:
- The Court Service
- Liberal Democrats
- Gloucestershire Police
- Nigel Jones

The BBC is not responsible for the content of external internet sites

TOP GLOUCESTERSHIRE STORIES
- Doors open at new maternity unit
- Residents cannot reach post box
- RAF Hercules makes final journey

News feeds

Adverse Childhood Experience Study (ACE)


Actors are used to protect identities

Adverse Childhood Experience Study (ACE)

- **Key Hypothesis of Study**
- Childhood Traumas lead to a wide array of negative and social consequences
- Stressful, or traumatic experiences negatively affect childhood development that set the stage for later problems
- Study found a strong relationship between ACE score and psychiatric disorders in later life

- **Summary of findings of the ACE Study**

- Difficulties with……
- Cognitive Problems
- Psychiatric Disorder
- Relationship Problems
- Affective Problems
- Family Problems
- Traumatic Behaviour Problems
- Somatic Problems

- Alcohol Abuse
- Sexual Promiscuity
- Using Psychoactive materials and illicit Drug Use
- Over eating/ Eating Disorders
- Delinquent Behaviour

Adverse Childhood Experience Study (ACE)

Participants surveyed on 9 types of adverse childhood experiences

1. Recurrent physical abuse
2. Recurrent emotional abuse
3. Contact sexual abuse
4. An alcohol and/or drug abuser in the household
5. An incarcerated household member
6. Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
7. Mother is treated violently
8. One or no parents
9. Emotional or physical neglect

- Decade long study carried out by Kaiser Permanente, San Diego, CA
- 17,421 adult cohort

Adverse Childhood Experience Study (ACE)

- While you were growing up, during your first 18 years of life:

- 1. Did a parent or other adult in the household often or very often…
- Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?
- Yes / No If yes enter 1 _____

- 2. Did a parent or other adult in the household often or very often…
- Push, grab, slap, or throw something at you? Or Ever hit you so hard that you had marks or were injured?
- Yes / No If yes enter 1 _____

Adverse Childhood Experience Study (ACE)

- 3. Did an adult or person at least 5 years older than you ever…
- Touch or fondle you or have you touch their body in a sexual way? Or Attempt or actually have oral, anal, or vaginal intercourse with you?
- Yes / No If yes enter 1 _____

- 4. Did you often or very often feel that …
- No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?
- Yes / No If yes enter 1 _____

Adverse Childhood Experience Study (ACE)

- 5. Did you often or very often feel that …
- You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
- Yes / No If yes enter 1 _____

- 6. Were your parents ever separated or divorced?
- Yes / No If yes enter 1 _____

Adverse Childhood Experience Study (ACE)

- 7. Was your mother or stepmother:
- Often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit at least a few minutes or threatened with a gun or knife?
- Yes / No If yes enter 1 _____

- 8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
- Yes / No If yes enter 1 _____

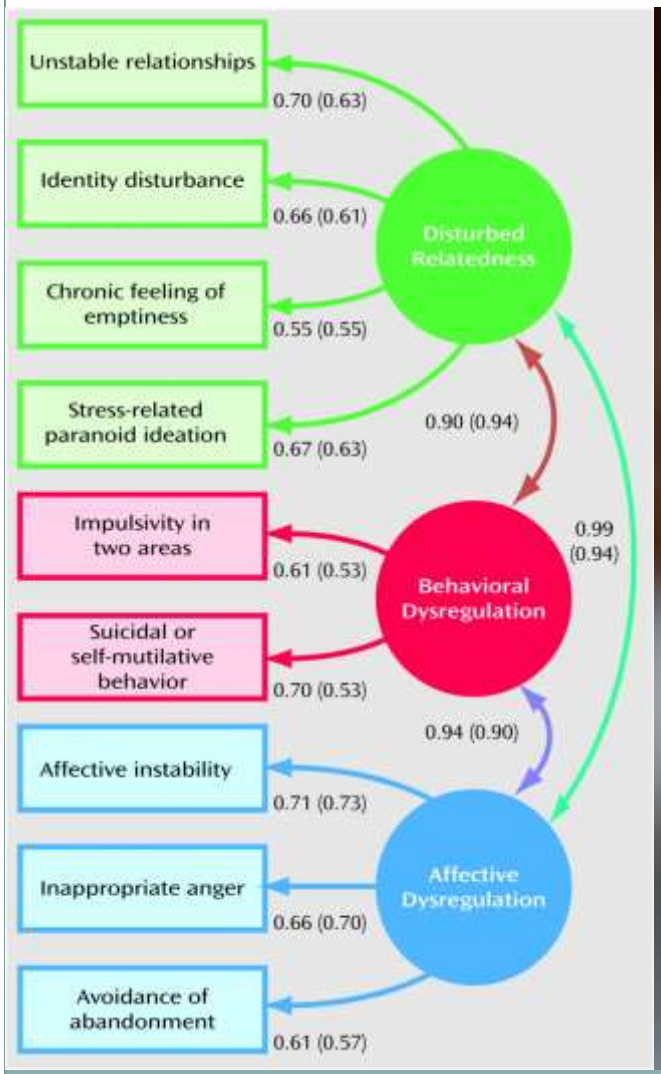
Adverse Childhood Experience Study (ACE)

- 9. Was a household member depressed or mentally ill, or did a household member attempt suicide? Or did a household member go to prison?
- Yes / No If yes enter 1 _____

- Now add up your “Yes” answers: _____

- This is your ACE Score.

Borderline Personality Disorder



Borderline Personality Disorder

- ICD 10 – criteria for Emotionally Unstable Personality Disorder

- **Impulsive type:**
- The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others. At least three of the following must be present, one of which must be (2)

1. Marked tendency to act unexpectedly and without consideration of the consequences;
2. Marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticised;
3. Liability to outbursts of anger or violence with inability to control the resulting behavioural explosions;
4. Difficulty in maintaining any course of action that offers no immediate reward;
5. Unstable and capricious mood.

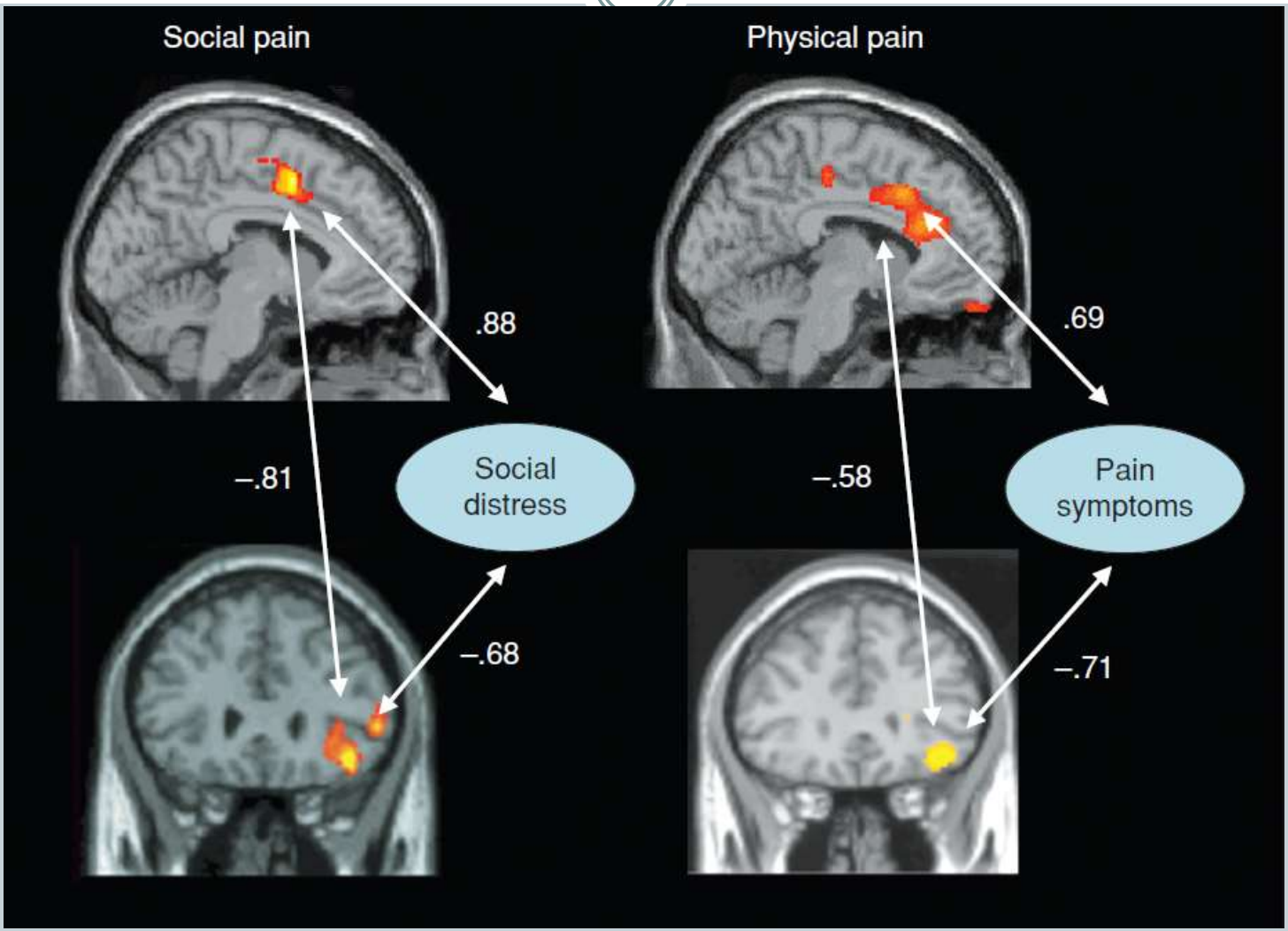
- **Borderline type:**
- At least three of the symptoms mentioned above must be present with at least two of the following in addition:

1. Disturbances in and uncertainty about self-image, aims and internal preferences;
2. Liability to become involved in intense and unstable relationships, often leading to emotional crisis;
3. Excessive efforts to avoid abandonment;
4. Recurrent threats or acts of self harm;
5. Chronic feelings of emptiness;
6. Demonstrates impulsive behaviour, i.e speeding, substance misuse

Borderline Personality Disorder

- Has had a pattern of serious substance abuse.
- Has had a pattern of sexual deviance (i.e., promiscuity or paraphilia).
- Has had a pattern of physical self-mutilation.
- Has had a pattern of manipulative suicide threats, gestures, or attempts
- (i.e., the suicidal efforts were mainly designed to elicit a “saving” response).
- Has had another pattern of impulsive behaviour.
- Has typically tried to avoid being alone or felt extremely dysphoric when alone.
- Has repeatedly experienced fears of abandonment, engulfment, or annihilation.
- Has been strongly counter dependent or seriously conflicted about giving and receiving care.
- Has tended to have intense, unstable close relationships.
- Has had recurrent problems with devaluation, manipulation, or sadism in close relationships.
- Has had recurrent problems with demandingness or entitlement in close relationships.

Social Pain in the brain



Jane is a 41 year old woman who is seeing the liaison psychiatrist following an episode of self harm.

She is unemployed and has recently split from her partner.

comments made to people
when being treated

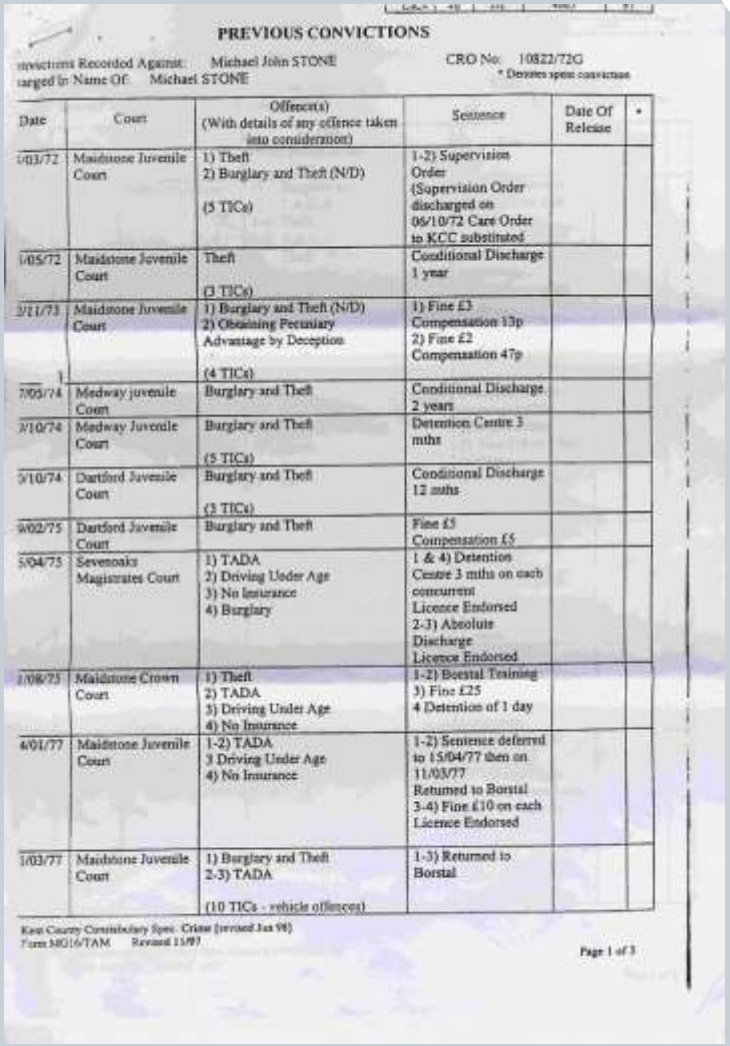
Mental Health Awareness – 22nd December 2016

- **Validation & Dialectic Practice**

- To **validate someone's feelings (and the associated behaviours)** is first to accept **someone's feelings** - and then to understand them by understanding the perspective that is creating them.
- To **validate** is to acknowledge and accept a person, a person's perspective / viewpoint and how this influences their feelings and behaviours.
- Invalidation, on the other hand, is to reject, ignore, or judge all of the above. We commonly do this in an attempt to pursue logic or defend our own viewpoints and feelings.
- Dialectic practice is a conversational style intended to resolve a conflict between two apparently contradictory ideas or statements. Establishing truths and validity on both sides rather that disapproving or disproving one argument

Antisocial Personality Disorder (Forensics)

Antisocial Personality Disorder (Forensics)



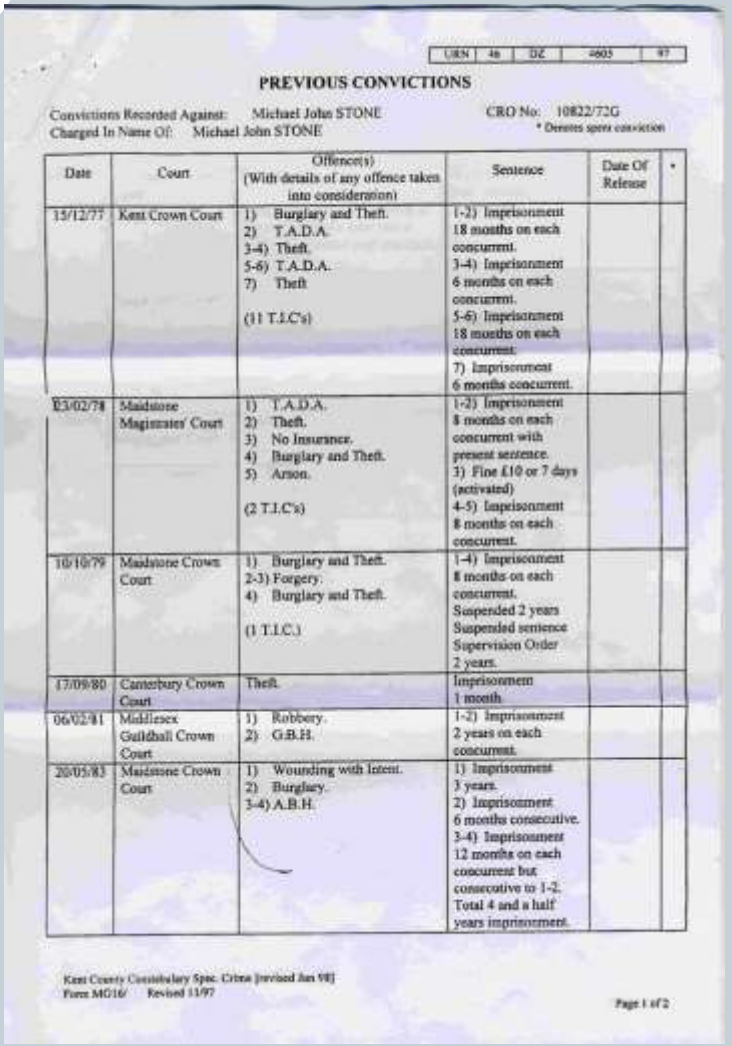
PREVIOUS CONVICTIONS

Convictions Recorded Against: Michael John STONE CRO No: 10822/72G
Charged In Name Of: Michael STONE
* Denotes spent conviction

Date	Court	Offence(s) (With details of any offence taken into consideration)	Sentence	Date Of Release	*
1/03/72	Maidstone Juvenile Court	1) Theft 2) Burglary and Theft (N/D) (5 TICs)	1-2) Supervision Order (Supervision Order discharged on 06/10/72 Care Order to KCC substituted		
1/05/72	Maidstone Juvenile Court	Theft (3 TICs)	Conditional Discharge 1 year		
2/11/73	Maidstone Juvenile Court	1) Burglary and Theft (N/D) 2) Obtaining Pecuniary Advantage by Deception (4 TICs)	1) Fine £3 Compensation 13p 2) Fine £2 Compensation 47p		
7/05/74	Medway juvenile Court	Burglary and Theft	Conditional Discharge 2 years		
3/10/74	Medway Juvenile Court	Burglary and Theft (5 TICs)	Detention Centre 3 mths		
5/10/74	Dartford Juvenile Court	Burglary and Theft (3 TICs)	Conditional Discharge 12 mths		
9/02/75	Dartford Juvenile Court	Burglary and Theft	Fine £5 Compensation £5		
5/04/75	Sevenoaks Magistrates Court	1) TADA 2) Driving Under Age 3) No Insurance 4) Burglary	1 & 4) Detention Centre 3 mths on each concurrent Licence Endorsed 2-3) Absolute Discharge Licence Endorsed		
1/08/75	Maidstone Crown Court	1) Theft 2) TADA 3) Driving Under Age 4) No Insurance	1-2) Borstal Training 3) Fine £25 4 Detention of 1 day		
4/01/77	Maidstone Juvenile Court	1-2) TADA 3 Driving Under Age 4) No Insurance	1-2) Sentence deferred to 15/04/77 then on 11/03/77 Returned to Borstal 3-4) Fine £10 on each Licence Endorsed		
1/03/77	Maidstone Juvenile Court	1) Burglary and Theft 2-3) TADA (10 TICs - vehicle offences)	1-3) Returned to Borstal		

Kent County Constabulary Spec. Crime [revised Jan 98]
Form MG16/TAM Revised 11/97

Page 1 of 3



URN 46 DZ 4605 97

PREVIOUS CONVICTIONS

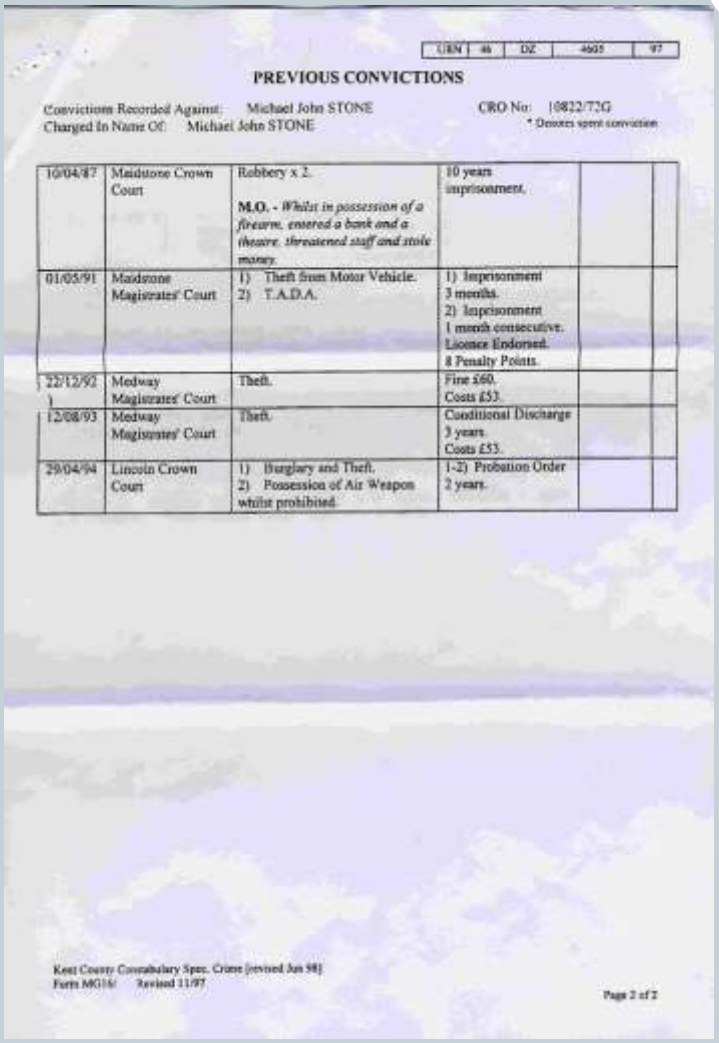
Convictions Recorded Against: Michael John STONE CRO No: 10822/72G
Charged In Name Of: Michael John STONE
* Denotes spent conviction

Date	Court	Offence(s) (With details of any offence taken into consideration)	Sentence	Date Of Release	*
15/12/77	Kent Crown Court	1) Burglary and Theft. 2) T.A.D.A. 3-4) Theft. 5-6) T.A.D.A. 7) Theft (11 T.I.C's)	1-2) Imprisonment 18 months on each concurrent. 3-4) Imprisonment 6 months on each concurrent. 5-6) Imprisonment 18 months on each concurrent. 7) Imprisonment 6 months concurrent.		
03/02/78	Maidstone Magistrates' Court	1) T.A.D.A. 2) Theft. 3) No Insurance. 4) Burglary and Theft. 5) Arson. (2 T.I.C's)	1-2) Imprisonment 8 months on each concurrent with present sentence. 3) Fine £10 or 7 days (activated) 4-5) Imprisonment 8 months on each concurrent.		
10/10/79	Maidstone Crown Court	1) Burglary and Theft. 2-3) Forgery. 4) Burglary and Theft. (1 T.I.C.)	1-4) Imprisonment 8 months on each concurrent. Suspended 2 years Suspended sentence Supervision Order 2 years.		
17/09/80	Canterbury Crown Court	Theft.	Imprisonment 1 month		
06/02/81	Middlesex Guildhall Crown Court	1) Robbery. 2) G.B.H.	1-2) Imprisonment 2 years on each concurrent.		
20/05/83	Maidstone Crown Court	1) Wounding with Intent. 2) Burglary. 3-4) A.B.H.	1) Imprisonment 3 years. 2) Imprisonment 6 months consecutive. 3-4) Imprisonment 12 months on each concurrent but consecutive to 1-2. Total 4 and a half years imprisonment.		

Kent County Constabulary Spec. Crime [revised Jan 98]
Form MG16/ Revised 11/97

Page 1 of 2

Antisocial Personality Disorder (Forensics)



URN	46	DZ	4605	97

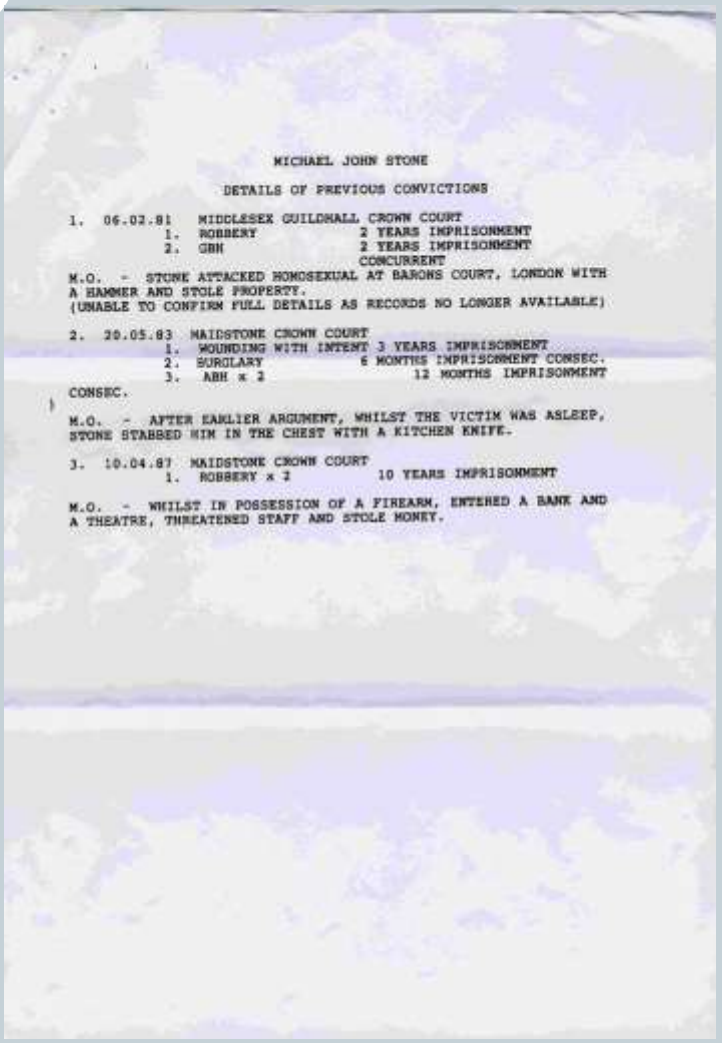
PREVIOUS CONVICTIONS

Convictions Recorded Against: Michael John STONE CRO No: 10812/72G
Charged In Name Of: Michael John STONE
* Denotes spent conviction

10/04/87	Maidstone Crown Court	Robbery x 2. **M.O.** - *Whilst in possession of a firearm, entered a bank and a theatre, threatened staff and stole money.*	10 years imprisonment.		
01/05/91	Maidstone Magistrates' Court	1) Theft from Motor Vehicle. 2) T.A.D.A.	1) Imprisonment 3 months. 2) Imprisonment 1 month consecutive. Licence Endorsed. 8 Penalty Points.		
22/12/92	Medway Magistrates' Court	Theft.	Fine £60. Costs £53.		
12/08/93	Medway Magistrates' Court	Theft.	Conditional Discharge 3 years. Costs £53.		
29/04/94	Lincoln Crown Court	1) Burglary and Theft. 2) Possession of Air Weapon whilst prohibited.	1-2) Probation Order 2 years.		

Kent County Constabulary Spec. Crime [revised Jan 98]
Form MG16 Revised 11/97

Page 2 of 2



MICHAEL JOHN STONE

DETAILS OF PREVIOUS CONVICTIONS

1. 06.02.81 MIDDLESEX GUILDHALL CROWN COURT
   1. ROBBERY 2 YEARS IMPRISONMENT
   2. GBH 2 YEARS IMPRISONMENT CONCURRENT

M.O. - STONE ATTACKED HOMOSEXUAL AT BARONS COURT, LONDON WITH A HAMMER AND STOLE PROPERTY.
(UNABLE TO CONFIRM FULL DETAILS AS RECORDS NO LONGER AVAILABLE)

2. 20.05.83 MAIDSTONE CROWN COURT
   1. WOUNDING WITH INTENT 3 YEARS IMPRISONMENT
   2. BURGLARY 6 MONTHS IMPRISONMENT CONSEC.
   3. ABH x 2 12 MONTHS IMPRISONMENT CONSEC.

M.O. - AFTER EARLIER ARGUMENT, WHILST THE VICTIM WAS ASLEEP, STONE STABBED HIM IN THE CHEST WITH A KITCHEN KNIFE.

3. 10.04.87 MAIDSTONE CROWN COURT
   1. ROBBERY x 2 10 YEARS IMPRISONMENT

M.O. - WHILST IN POSSESSION OF A FIREARM, ENTERED A BANK AND A THEATRE, THREATENED STAFF AND STOLE MONEY.

Antisocial Personality Disorder (Forensics)

- **Michael Stone report – Psychological Assessment - Forensic Psychiatric Services:**
- Stone was one of five children and suffered domestic violence as a child.
- The young Stone ended up in a children's home in Eastry, near Canterbury, but he was abused and embarked on his teenage years as a confused, frustrated and angry boy.
- He had a police record dating back to the age of 12 and his criminal career - mainly shoplifting and burglary - continued unabated into adulthood.
- In 1981 he was jailed for two years at Middlesex Crown Court for robbery and grievous bodily harm after he attacked a homosexual man with a hammer.
- Two years later he was sentenced to four-and-a-half years for wounding, assault and dishonesty after he stabbed his sleeping victim in the chest with a kitchen knife.
- In 1987 he was jailed again, this time for an armed robbery on a building society in Brighton which netted him a measly £577.
- The trial was told that Stone supplemented his income by driving around Kent and stealing lawnmowers, mobile generators, hi-fi equipment and other easily disposable goods.
- Josie Russell, who was left for the dead in the attack, later told police a man had demanded money from them before tying them up and bludgeoning them with a hammer.

Antisocial Personality Disorder (Forensics)

- ‘With regard to formal assessments it seems that Mr Stone’s IQ falls in the low / average range. His profile from the Personality Disorder Questionnaire Revised shows that of a severely personality disordered personality. He also seems to have very low self esteem. This is not surprising in the context of his childhood’.
- Dr Q –Psych(F) reviewed elements of Stone’s personality and fantasies. He recorded that Mt Stone told him that he was prone to over-reacting to situations by bottling-up anger which he released later. He described having fantasies when not taking medication, of torture, dismembering people and killing them. There was no sexual fantasies associated with his aggression and no persecutory ideas or delusions present. Mr Stone described general fears and unease over his involvement in the criminal subculture and his childhood.
- Although Stone was free in the community and had seen to have ‘capacity’, he received regular supervision from psychiatry services and drug rehabilitation services and was subject to constant supervisory contact.
- Stone was regularly involved in violent incidents and had head-butted a shopkeeper during an argument.

Antisocial Personality Disorder (Forensics)

- His psychiatric review detailed:

- - *Early history of abusive upbringing involving abuse within the family and whilst in care;*
- - *An 'institutional upbringing';*
- - *Early delinquency;*
- - *Poor educational achievement;*
- - *Early drug abuse.*

- Further diagnostic formulation was:
- 'Dissocial Personality Disorder' and mental and behavioural disorder due to multiple drug and psychoactive substances, multi-substance abuse and drug-induced paranoia.'
- Stone was also described as a 'threatening patient'
- Stone abused Heroin 2-3 times a day and smoked Cannabis 2 to 3 times a day.
- Stone's psychiatrist assessed that 'he had no remorse for his past offences and that offending was likely to continue'.
- Stone had previously been detained under S2 and S3 of The Mental Health Act 1983 but was discharged on his appeal

Antisocial Personality Disorder (Forensics)

- Stone was diagnosed with Paranoid Personality Disorder.
- Stone reported to his psychiatrist that he had fantasies of torture, killing people and dismembering them. He considered the 'violence to be a means-to-an-end'. He expressed plans to kill prison officers if he should receive a future prison sentence.
- He described how he imagined strangling his girlfriend and cutting up her body in the bath, then disposing of it in bin liners.
- Stone needed large quantities of Benzodiazepines. These were provided by community mental health support. Stone obtained more benzodiazepines by creating false identities and threatening numerous doctors.
- Psychiatrist believed that Stone satisfied the criteria for Antisocial Personality Disorder with signs of Paranoid Illness.
- Further to this Stone was drinking a quarter bottle of Vodka every other day. His poly-substance abuse included daily abuse of Benzodiazepines, Heroin, Methadone and Cocaine. Ms ZP - CPN described his:
- • "Moderate to severe agitation; • Expression of paranoid ideation; • Aggressive thoughts/intent to harm others; • Verbally voluble behaviour accompanied by irritability and anger;
- • Excessive consumption of illicit drugs i.e. heroin; • Sudden heroin withdrawal; • Physically assaultive behaviour".

Antisocial Personality Disorder (Forensics)

- Mr Stone had told Dr T –CPsych(F) that he needed large quantities of benzodiazepines to sleep and that he obtained these by threatening local doctors. He admitted previously threatening to kill and decapitate people, but said these threats were not serious and that an overreaction to them had resulted in his detention.
- Dr T –CPsych(F) described Stone in his letter as:

- *'A tough-minded man …(who).. at no point displayed any features of a psychotic illness. He had credible explanations for apparently psychotic episodes …(and)… denied ever hearing voices. The most striking abnormality was his extreme callous attitudes towards victims and anger and contempt towards several professionals involved with him'*

Antisocial Personality Disorder (Forensics)

- Ms ZP- CPN's Notes – 4th-5th July 1996

- 'Michael became agitated when recalling his present circumstances and vented anger at being forced to live in his mother's flat, finding his own uninhabitable'.

Michael focused on a previous probation officer, Mr HH - PO, whom he blames for all of his ills. In discussion, the intensity of Michael's anger increased accompanied by a series of threats, both physical and psychological, towards Mr HH - PO and his family. These consisted of threats to kill Mr HH - PO and also a campaign of intimidation accompanied by a further series of threats toward Mr HH - PO and his family, the nature of which compromised threats of retributory violence and threats to rape Mr HH - PO's wife. Michael was unaware of Mr HH - PO's address but he asserted he will soon discover this and planned to buy the house next door as a base to undertake his vendetta'

- She detected no psychotic phenomena nor any self harm or suicidal intent. Her risk assessment concluded:
- *'Due to his history of assaultative behaviour and substance abuse Michael has the potential to pose a risk to others and self. However, in the last two years his life has been relatively stable and he has cooperated fully with agencies involved in his care'*

Antisocial Personality Disorder (Forensics)

- Ms ZP- CPN's Notes – 4th-5th July 1996

- *'At 1400 hrs, I rang Rochester probation and spoke to the Senior Probation Officer to ensure they are aware of Michael's threats towards Mr HH – PO. At the same time I advised that Michael had booby trapped his house with a 10,000 volt circuit, armed himself with swords and an electric plane and also possessed two vicious dogs for his own protection. Although Michael's story is factual there are certain embellishments which would appear to give him more credibility'.*

- Joint Press Statement 23.10.98
- *'Michael Stone is a violent man. He has served many years in prison for a variety of offences including violent offences but he is not mentally ill. He has an antisocial personality disorder. He has also abused drugs over a very long period of time including cannabis, amphetamines, cocaine, benzodiazepines, methadone, heroin and alcohol. He abused different drugs in different combinations at different times. But Michael Stone is responsible for his own actions'. Personality Disorder is a deeply ingrained behaviour pattern that represents a significant departure from the way the average individual would behave. People with these personality disorders will often show a callous lack of concern for others. Some will have a tendency to resort to violence and an incapacity to experience guilt. Michael Stone's personality disorder is resistant to treatment and his abuse of illicit drugs makes his behaviour even more unpredictable.*

Human Right Act

Section 2 - MHA

Section 3 - MHA

Section 136 - MHA

Community Treatment Orders

AMHPs

Section 4

Section 5(2)

Section 5 (4)

Mental Capacity Act

MHA – Restricted Patients

MHA – The Role of The Social Supervisor

IMHAs

Mental Health Tribunals – Rights to Appeal

The role of Mental Health Administrators (MHAA)

The Purpose of Guardianship

Nearest Relatives

The Role of the Police - MHA

The Role of the Responsible Clinician - RC

MHA – 117 Aftercare