BEHAVIOURAL DISORDERS: DIAGNOSTIC CRITERIA

DIAGNOSIS:

- Priority initially is to promptly stabilise the patient and evaluate their major complaint
- After stabilisation, the patient needs medical clearance evaluation ➔ used to determine whether the patient has a medical condition that causes or exacerbates the psychiatric illness or to find illnesses or injuries that are coincident to the patient's illness
- FORMULATING A SPECIFIC DIAGNOSIS IS NOT AS IMPORTANT AS DETERMINING WHETHER THE PATIENT IS HARMFUL TO SELF OR OTHERS

MULTIAXIAL DIAGNOSTIC SYSTEM:

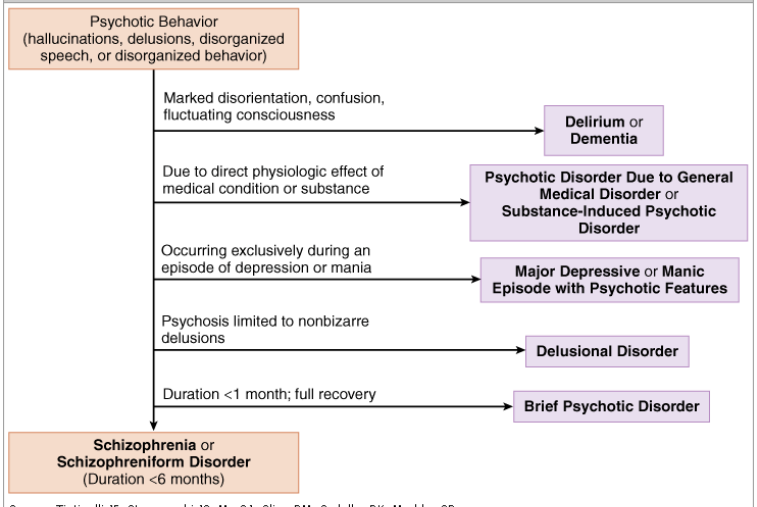
- DSM IV diagnoses are made on a multiaxial system in which axis refers to a different domain of information

Table 284-1 Multiaxial Psychiatric Assessment

Axis I	Mental disorders
	Clinical and other psychiatric conditions that may be a focus of clinical attention
Axis II	Personality disorders and mental retardation
Axis III	General medical conditions
	Medical conditions that are relevant to the understanding or management of the case
Axis IV	Psychosocial and environmental problems
Axis V	Global assessment of functioning

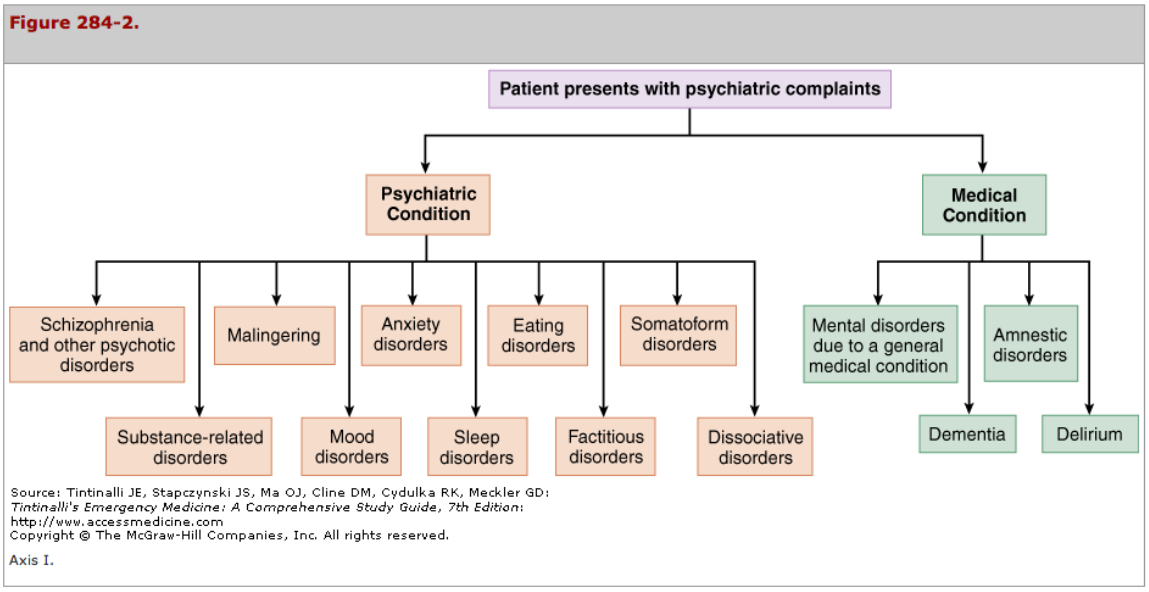
- See below for an example of a decision tree for evaluating acute psychosis ➔ others exist in DSM-IV for mental disorders due to medical condition, substance-induced disorders, mood disorders, anxiety disorders and somatoform disorders

Figure 284-1.

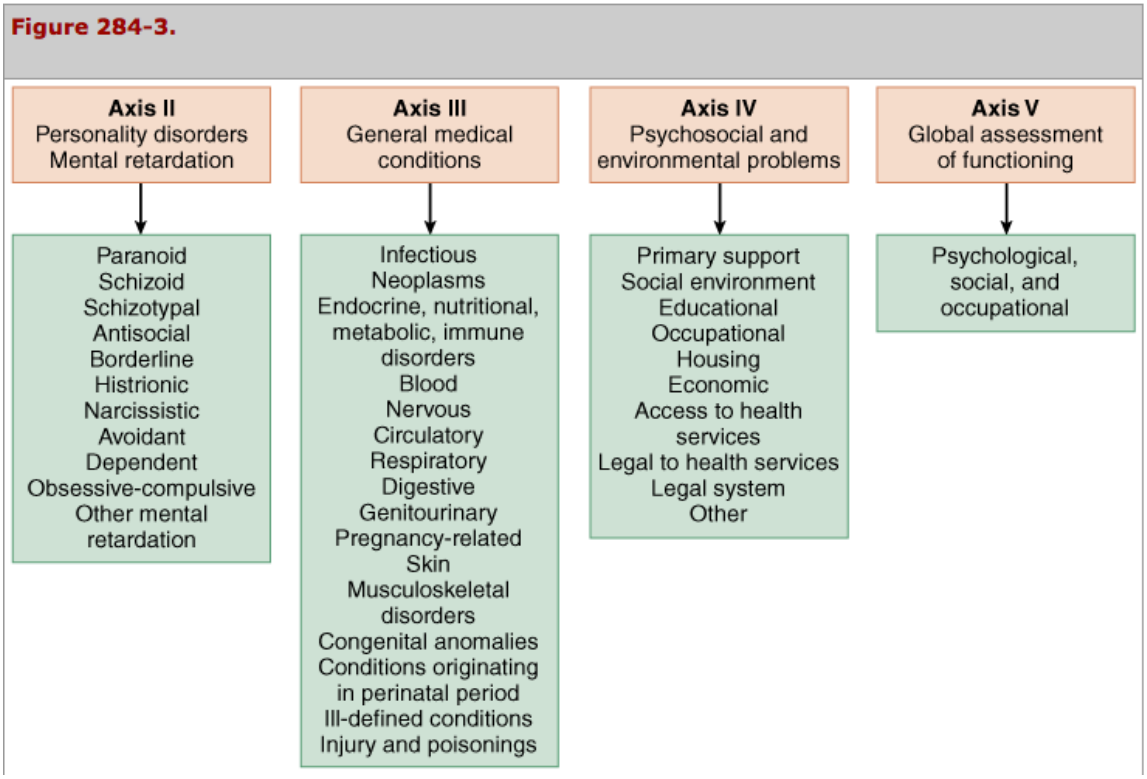


Decision tree for evaluating psychosis.

- Axis I ➔ the clinical syndromes of mental disorders (see below)



- Conditions listed under axis II are the personality disorders and developmental disorders (including mental retardation)
- Axis II encompasses general medical conditions that could be relevant to the understanding or management of their psychiatric illness
- Axis IV consists of psychosocial and environmental stressors or problems
- Axis V relates to the patient's current overall functioning using global level of functioning scale



PSYCHIATRIC SYNDROMES (AXIS I DISORDERS)

- **MAJOR CATEGORIES INCLUDE:**
  - Delirium
  - Dementia
  - Amnestic disorders
  - Mental disorders due to medical conditions
  - Substance related
  - Schizophrenia and other psychotic illness
  - Mood/anxiety/somatoform/dissociative/factitious/malingering/eating and sleeping disorders

DEMENTIA, DELIRIUM AND OTHER COGNITIVE DISORDERS:

- DEMENTIA:
  - A pervasive disturbance of cognitive functioning in several areas ➔ including memory, abstract thinking, judgment, personality and other higher cortical functions such as language
  - IF CLOUDING OF CONSCIOUSNESS IS PRESENT ➔ DELIRIUM OR INTOXICATION IS SUPERVENING
  - Memory disturbance is usually the earliest sign
  - Incidence ~3%, 1.8% cases being undiagnosed
  - Primary cause is Alzheimer or vascular dementia
  - Diagnosis is challenging in patient's with coexistent Schizophrenia
  - Onset is slow and gradual, and patients often only present to ED when some acute worsening has occurred
  - Early in the course of dementia, anxiety, depression or psychosis may dominate the clinical picture
  - Demented persons are also prone to unrecognised physical illness
  - Common causes of potentially reversible dementia:
    - Metabolic and endocrine disorders
    - Polypharmacy
    - Depression ➔ "dementia of depression"
      - A relatively acute onset, prominent mood changes, and vegetative disturbances such as loos of appetite/weght, sleep disturbance, expression of guilt, suicidal ideation
      - Treatment of the mood disorder may improve cognitive function
- DELIRIUM:
  - Characterised by global impairment in cognitive function but is distinguished from dementia in TWO MAJOR WAYS:
    - CLOUDING OF CONSCIOUSNESS
    - REDUCTION IN AWARENESS OF THE EXTERNAL ENVIRONMENT:
      - Difficulty sustaining attention ➔ varies from degrees of alertness ranging from drowsiness to stupor, and sensory misperception
  - Long list of causes of delirium

    - Typical acute course with rapid deterioration in hours or days
    - FLUCTUATING SEVERITY ➔ over course of hours
    - Extreme changes in psychomotor activity ➔ restlessness and hyperactivity to stupor
    - Visual hallucinations are common
- AMNESTIC DISORDERS:
    - Typically unable to learn new information or to recall information that is already learned
    - Causes include:
        - Brain trauma
        - Stroke
        - Carbon monoxide poisoning
        - Substance abuse
        - Chronic nutritional deficiency

MENTAL DISORDERS DUE TO GENERAL MEDICAL CONDITION:

- Terminology ➔ e.g. major depression due to hypothyroidism
- Relies on evidence from patient history, physical examination and laboratory results indicative of a causative medical condition

SUBSTANCE-RELATED DISORDERS:

- Due to ingestion of a drug of abuse or alcohol, side effects of a prescribed or OTC medications or toxic exposure
- Incidence of substance use disorder in ED ~27%
- INTOXICATION:
    - When ingestion of specific exogenous substance produces MALADAPTIVE BEHAVIOUR AND IMPAIRMENT OF JUDGMENT, PERCEPTION, ATTENTION, EMOTIONAL CONTROL AND THE PATIENT DOES NOT DISPLAY FEATURES OF DELIRIUM, DEMENTIA OR HALLUCINOSIS ➔ **DIAGNOSIS OF INTOXICATION CAN BE MADE**
    - Urine drug screen, BAL, drug levels useful in evaluating patients with new-onset psychiatric symptoms or altered mental status without known cause
- WITHDRAWAL:
    - Can follow cessation or reduction in use of a substance of abuse
    - Diagnosis is made on identification of typical symptoms and evidence of recent use of a substance in a pattern sufficient to produce withdrawal when the amount ingested is decreased or stopped
    - Specific withdrawal patterns depend on the agent

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS:

- These illnesses are marked by the presence of psychotic symptoms, primarily delusions and hallucinations

- DELUSIONS ➔ FIXED FALSE BELIEFS THAT ARE NOT AMENABLE TO ARGUMENTS OR FACTS TO THE CONTRARY AND THAT ARE NOT SHARED BY OTHERS OF SIMILAR CULTURAL BACKGROUND
    - PERSECUTORY → one believes they are being attacked, followed, harassed, conspired against
    - GRANDIOSE → those that involve themes of special powers or abilities
    - BIZARRE → absurd content, e.g. one's thoughts are controlled by aliens
- HALLUCINATION →FALSE PERCEPTIONS EXPERIENCED IN A SENSORY MODALITY AND OCCURRING IN CLEAR CONSCIOUSNESS
    - AUDITORY ➔ most common
    - Followed in order of frequency by:
        - Visual
        - Tactile
        - Olfactory
        - Gustatory
            - The presence of non-auditory hallucinations suggests a MEDICAL, NOT PSYCHIATRIC, cause of psychosis

SCHIZOPHRENIA:

- Affects ~1% of the world population
- Essential features:
    - Deterioration in function
    - CHARACTERISTIC **POSITIVE SYMPTOMS:**
        - Hallucinations
        - Delusions
        - Disorganised speech
        - Disorganised behaviour
        - Catatonic behaviour
    - **NEGATIVE SYMPTOMS:**
        - Blunted affect
        - Emotional withdrawal
        - Lack of spontaneity
        - Anhedonia
        - Attentional impairment
    - LOOSE ASSOCIATIONS ➔ loss of normal logical connections between one thought and the next → rambling speech, disjointed/nonsensical
    - These symptoms must be present for at least one month and their must be a relative absence of a mood disorder for definitive diagnosis
- Symptoms usually begin in late adolescence or early adulthood
    - Often marked by childhood shyness, oddness or eccentric behaviour, school difficulties or paranoid behaviours
    - Prodromal phase ➔ gradual deterioration of function is noted
- Schizophrenic individuals seldom seek care on their own, due to lack of insight
- Common reason for ED presentation is worsening of psychosis resulting from stress or nonadherence to the medication regimen, suicidal behaviour, EPSE

    - Also, their poor judgment and disorganisation may lead to disregard for medical problems, so attention must be given to their physical status as well as to the psychiatric complaint
- TREATMENT:
    - TYPICAL (older generation) ANTIPSYCHOTICS:
        - E.g. haloperidol
        - Reduce severity of positive symptoms (delusions/hallucinations)
        - Less affective against negative symptoms (lack of volition, blunting of emotion, anhedonia, inattention)
            - These symptoms result in long-term impairment of social functioning and self-care
    - NEWER ATYPICAL ANTIPSYCHOTICS:
        - E.g. aripiprazole, quetiapine, risperidone, olanzapine, clozapine and ziprasidone
        - Seem to have a greater effect in improving negative and positive symptoms with better side effect profile, improved cognition and less risk of tardive dyskinesia

SCHIZOPHRENIFORM DISORDER:

- When patient meets criteria for schizophrenia but symptoms have been present for <6 months
- Rapid onset over a few days and good premorbid functioning are more common than in schizophrenia

BRIEF PSYCHOTIC DISORDER:

- Some individuals may become acutely psychotic after exposure to an extremely traumatic life experience
- If it has been present for less than 4 weeks, it is termed BRIEF PSYCHOTIC DISORDER

<u>MOOD DISORDERS:</u>

- Most prevalent of the major psychiatric disorders, affecting about 10-15% of the general population at some point in their life
- Major cause of completed suicide
- Mood, or affective, disorders DIFFER FROM THE NORMAL EXTREMES OF SADNESS AND HAPPINESS in that characteristic clusters of psychological and vegetative symptoms (depressive or manic symptoms) are present and FUNCTIONING IS IMPAIRED
- THESE DISORDERS TEND TO BE EPISODIC, WITH PERIODS OF REMISSSION AND NORMAL FUNCTION

MAJOR DEPRESSION:

- MAJOR FEATURES:
    - Persistent sad or depressed (dysphoric) mood or pervasive loss of interest in usual activities for at least 2 weeks

- Associated psychiatric symptoms ➔ guilt over past deeds, self-reproach, feelings of worthlessness or hopelessness, inability to experience please (anhedonia), recurrent though of death or suicide
- VEGETATIVE SYMPTOMS:
  - IEe. those that involve physiologic functioning
  - Loss of appetite and weight
  - Sleep disturbance
  - Fatigue
  - Inability to concentrate
  - Psychomotor agitation or retardation
- Screening mneumonic shown below:

Table 284-2 In SAD CAGES: A Screening Mnemonic for Major Depression	
In	Interest
S	Sleep
A	Appetite
D	Depressed mood
C	Concentration
A	Activity
G	Guilt
E	Energy
S	Suicide

- More common in women and in persons with a family history of depression or suicide
- Often superimposed on other mental disorders
- Primary mood disorders tend to display more biologic features, are more familial and respond better to antidepressant treatment
- Lifetime risk of suicide is 15% in those with major depression
- OFTEN RECURRENT

BIPOLAR DISORDER:

- Previously known as MANIC-DEPRESSION
- Characterised by occurrence of mania cycling with periods of depression
- Mania:
  - Essential disturbance is one of elation or irritability
  - They “feel on top of the world”
  - Expansive, energetic
    - This state is PRECARIOUS ➔ they can quickly become argumentative, hostile, irritable, sarcastic, especially when their plans are thwarted
  - Vegetative signs of mania:
    - Decreased need for sleep
    - Increased activity
    - Rapid and pressured speech
    - Racing thoughts
  - May have grandiose idea

    - Poor judgment in spending money and sexual behaviour
    - Poor insight and deny anything is wrong
- Bipolar disorder divided into types I and II, based on the presence of mania (type I with mania, type II not)
- No gender propensity
- Onset is usually 3rd-4th decade
- Complications:
    - Suicide
    - Substance use
    - Marital and occupational disruptions
- Depressive episodes are more frequent than manic episodes

DYSTHYMIC DISORDER:

- More chronic and less evere from of depressive illness
- Depressed mood present for most of the day, more days than not, for two years
- Psychotic features absent
- Patients often have lifelong gloomy and pessimistic outlook
- Major depression may be superimposed

ANXIETY DISORDERS:

- Characterised by apprehension, fears and excessive worry dominate the psychological life of the individual
- Pathologic degrees of anxiety are accompanied by AUTONOMIC ACTIVITY:
    - Sweating
    - Tachycardia
    - Dizziness
        - Out of proportion to real danger or threat
- Diagnosis of a primary anxiety disorder should be made by exclusion of other causes
- Diagnosed in 4-8% of general population

PANIC DISORDER:

- Recurrent attacks of severe anxiety
- Panic attack consists of sudden extreme surge of anxiety and dread accompanied by autonomic signs, including palpitations/tachycardia/SOB/chest tightness

GENERALISED ANXIETY DISORDER:

- When anxiety attacks are absent but the patient complains of PERSISTENT WORRY, TENSION OR FREE-FLOATING ANXIETY → Generalised anxiety disorder is diagnosed
- Lasts at least 6 months, characterised by apprehensive worrying, muscle tension, insomnia, irritability, distractability

PHOBIC DISORDERS:

- Unusual presentation to ED

- In phobias, the anxiety disorders are RECOGNISED AS EXCESSIVE and occur when the patient is exposed to a specific situation which then leads to avoidance of the stimulus THAT INTERFERES WITH THE PATIENT'S LIFE

OTHER ANXIETY DISORDERS:

- POST-TRAUMATIC STRESS DISORDER:
  - Reaction to a severe psychosocial stressor (usually life-threatening)
  - Symptoms involve repetitive and intrusive memories of the event, nightmares, emotional numbing, survivor guilt
  - Anxiety and depression commonly supervene
- OBSESSIVE-COMPULSIVE DISORDER:
  - A mental disorder in which the patient experiences intrusive thoughts or images that cannot be eliminated from the mind
  - To control the obsessive thoughts, the individual may engage in compulsive behaviour or rituals
  - When the obsessions and compulsions occupy a great deal of time, the patient may become significantly disabled and seek help

SOMATOFORM DISORDERS:

- Many patients have particular complaints or symptoms for which no medical explanation exists
- When a physical cause has been clearly eliminated and the complaint is NOT delusional or occurring in the context of depression or anxiety disorder ➔ then somatoform disorder can be considered
- When the complaint involves a loss of function (usually in the neurologic system, e.g. paralysis, blindness or numbness) and psychologic factors are deemed aetiologic, A CONVERSION DISORDER MAY BE PRESENT
  - This diagnosis should be made with extreme caution, if at all in the ED, because many patients diagnosed with conversion disorder often end up developing signs of a physical disorder that explain the symptoms
- SOMATISATION DISORDER:
  - Wide variety of complaints that have no apparent medical cause
  - Often lead to unnecessary diagnostic and surgical intervention
  - Prototypical patient is a middle-aged woman who describes a "POSITIVE REVIEW OF SYSTEMS" IN A DRAMATIC AND CONFUSING WAY
- HYPOCHONDRIASIS:
  - Fears of serious illness

DISSOCIATIVE DISORDERS:

- Comprise a group of uncommon and poorly understodod conditions
- Central features is SUDDEN ALTERATION IN THE NORMAL INTEGRATION OF IDENTITY AND CONSCIOUSNESS
- Often occurs under severe stress
- Rarely permanent
- DISSOCIATIVE AMNESIA
- DISSOCIATIVE FUGUE:

    - Loss of memory and assumption of a new identity accompanied by travel away from home
- Difficult to distinguish form malingering
- Always rule out medical illness and drug intoxication must be excluded

FACTITIOUS DISORDER:

- Characterised by physical or psychological symptoms that are exhibited in order to assume a sick role

MALINGERING:

- Intentional invention or exaggeration of physical or psychological symptoms for external gain
    - Avoid work or obtain drugs

EATING DISORDERS:

- See later discussion

SLEEP DISORDERS:

- Primary dyssomnias are disorders related to initiation or maintenance of sleep or excessive sleep:
    - Primary insomnia
    - Primary hypersomnia
    - Circadian rhythm sleep disorder
    - Narcolepsy
- Parasomnia ➔ abnormal sleep behaviour ➔ nightmares, sleep terrors and sleepwalking

PERSONALITY (AXIS II) DISORDERS):

- PERSONALITY ➔ an enduring pattern of perceiving, relating to and reacting to one's environment and to other people
- When a pattern of behaviour is lifelong, is not limited to periods of illness and causes significant impairment in social and occupational functioning or considerable distress, then A PERSONALITY DISORDER IS PRESENT
- Most patients who are diagnosed with a personality disorder lack a clear awareness of how their behaviour alienates others or aggravates their own stress
- There are ten personality disorders:
    - Paranoid
    - Schizoid
    - Schizotypal
    - Antisocial
    - Borderline
    - Histrionic
    - Narcissistic
    - Avoidant
    - Dependent
    - Obsessive compulsive

- The personality disorder with a disproportionate share of ED visits is ANTISOCIAL PERSONALITY DISORDER:
    - Continuous pattern of maladaptive behaviour displaying disregard for the rights of others in a variety of ways ➔ criminal behaviour, fighting, lying, abuse and neglect of dependents and spouses, financial irresponsibility, recklessness, inability to sustain enduring attachments to others
    - Management of the antisocial patient in ED is OFTEN FRUSTRATING, but anger toward the patient can be minimised and the interaction hastened along by setting firm limits on behaviour, focusing on the chief complaint and providing the patient with necessary information about the medical problem at hand