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Welcome to *Mindcafe*

The organisers and writers of *Mindcafe* are proud to bring you our very first edition of this exciting e-publication; designed to keep you up to date with Psychiatric and Psychological research and opinion from around the world. *Mindcafe's* research review service comes from our own experience that it is hard to find the time to find various quality research articles on a regular basis. Our service will summarise and provide commentary on quality intellectual material from a variety of sources and minds, not just journals. We wish to make CME a more stimulating and simple exercise.

Mindcafe's unique strengths are that there is a large diversity of writers and topics every month, to do with the mind (and sometimes body). There will be issues released ten months per year, missing December and January. We think you will find it easier to absorb far more quality information in a short stimulating read with our publication, than from other sources. It will be invaluable for article selection, for Journal Clubs around the country. We believe CME should not be mind-numbingly dull.

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If you have seen an article you think would be useful to our fraternity, and wish to summarise and comment on it for *Mindcafe*, please contact me. We encourage you to recommend *Mindcafe* to colleagues if you find it useful. Simply tell them to visit the website and register their details to receive our free research review service.

Ranil Gunewardene FRANZCP
Clinical Director/ Medical Superintendent/ Director *Mindcafe*

Sexual Compulsivity and Addiction; Fact or Fantasy?

A four hour seminar on sex addiction seemed a great way to start my APA experience in New York, the city that caters for every urge, in a country where pornography is one of its last remaining exports. Dr Pat Carnes, the lead presenter, has many decades of experience in this field, and is the author of the self help book *"Out of the Shadows, Understanding Sexual Addiction"*. He believes the "digitalisation of sex" via the internet, with its easy access to extremely high levels of stimulation has caught a wave of people who would otherwise not have had sexual compulsivity, or at least of the same severity, similar to gaming machines in the local club. I was hooked!

The area is also at the centre of a major shift in understanding and classification. In DSM-V we saw pathological gambling move into the new category of Substance Related and Addictive Disorders, recognising that addiction and compulsive behaviour can occur without a physical substance being ingested, leading to the term behavioural or process addiction. The listing of internet gaming disorder as a condition for further study has added further recognition, while also opening up debate about the status of compulsive shopping, exercising, eating, and non-gaming forms of problematic internet use.

While sexual addiction is not currently a listed diagnosis, the shifts described above may pave the way for such recognition in the future. Sex addiction can be described as a "pathological relationship with a mood altering experience". It seems to mirror brain changes now being observed in other addictions, noting pathological activation of brain areas linked to reward, mediated by an enhanced dopamine response when the substance or behaviour is contemplated and then acted upon. Carnes believes these brain changes can be induced by exposure to high levels of stimulation or risk taking behaviour early in life, pointing to the ages of 12-16 as crucial in this regard. (Good luck to those of us with teenage boys!) Not surprisingly given this shared vulnerability, most people with sex addiction tend to have multiple addictions, and trauma is a common predisposing factor.

His proposed criteria borrow much from the substance dependence area. They include a loss of control over sexual urges and behaviour which escalate over time, and is often inconsistent with the person's values. There are efforts to stop which prove unsuccessful, much time is spent engaging in the behaviour or recovering/repairing and repeated compulsions can occur with small triggers. There is a need for ever increasing eroticism and even the risk of getting caught. The person progressively becomes less able to fulfil professional or personal obligations and relationships, and they continue despite the harm generated. They are preoccupied with their behaviour, including preparations for it, and have psychological withdrawal symptoms if they are unable to engage in it with their usual frequency. Behaviours are triggered by numerous antecedent states including boredom, the alleviation of distress, as a reward, and attempts to fill intimacy voids.

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Interesting clinical pearls include the gender differences. Males almost exclusively have only two symptom domains; internet

pornography and the use of escorts or prostitutes. Females have a broader array of compulsive behaviour, and sometimes seem more focused on the pursuit of love rather than sex. They are better at not getting caught and tend to have more shame. Interestingly sex addicts are not good at sex! The behaviour often attempts to mask physical or psychological inadequacies that will need addressing in treatment. The cost of the syndrome was shown powerfully by two video interviews with male sufferers, one with sex addiction that migrated from early substance abuse, and another married with high levels of concealed pornography and escort use , while attempting to run a business. Both were in the early stage of recovery but had suffered greatly.

Regarding management, two screening tools have been developed. These are the PATHOS with three positive items from six suggesting the syndrome. It was published in the Journal of Addiction Medicine in 2011. A more complete tool is the Sexual Addiction Screening Test- Revised (SAST-R), available at sexhelp.com. There is a comprehensive treatment program for sex addiction at The Meadows hospital in Arizona, but what can we do if we are brave and interested enough to find these symptoms in our patients?

Unsurprisingly treatment is biopsychosocial, and patients do seem to benefit greatly from the initial recognition and interest in their symptoms as a clinical concern. Comorbidity should be treated such as depression or anxiety states, as well as the treatment or exclusion of other illnesses with abnormal sexual behaviour that is not sex addiction such as a manic episode. Naltrexone may offer some value but there is little clinical experience in this area. Multiple addictions should be detected and addressed, as each addiction tends to retard progress on another. There should be a gentle exploration of predisposing factors, with a higher incidence of sufferers coming from families described as "rigid", or "disengaged" as well as having insecure attachment. Motivational interviewing can be employed to assess and foster willingness to change. There should be a 90 day period of sexual abstinence during which CBT can identify specific triggers, and behaviour's including exercise, meditation, mindfulness and yoga are encouraged. A 12 step program was highly recommended, with groups such as SLAA (sex and love addiction anonymous) operating in Sydney. Finally there was the long path of addressing sexual inadequacy and relationship repair, as well as designing a relapse prevention plan. The goal is to allow the affected individual to be meaningfully sexual in whatever their current life context is.

I was left with many questions, including where the overlap lay with various personality pathologies, and what are we doing to the sexual lives of so many of our patients on dopamine modulating drugs? I felt that even if I screened broadly for sexual addiction and use the concept so my patients can discuss it without feeling judged, I will have advanced my recognition and basic treatment of this complex area, including being open to other emerging behavioural addictions. The seminar has been running for the last 4 APA's and will return in 2015. I would highly recommend it as a fascinating alternative to a more "bread and butter" APA afternoon.

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Melatonin for delirium?

Delirium is common, expressly in hospital settings. The main goal of treatment of delirium is the underlying cause. But the distress, psychotic symptoms and behavioural consequences of delirium need effective management in and of themselves. Regrettably, our management strategies are all too often suboptimal, with consequent disruption for the patient, and disruption of other patients and staff; there is also the risk of injury from injury or aggression.

In terms of medication management for controlling delirium, we usually rely on atypical antipsychotics, yet these agents carry a risk of stroke in the elderly and also extrapyramidal side effects: akathisia in particular can be very unpleasant and worsen agitation. Also, some such agents have the propensity to cause postural hypotension; and some have inherent anticholinergic properties that can, theoretically at least, exacerbate the delirium itself.

Hence, alternative pharmacological strategies for the management of delirium are most welcome. One potential such set of agents is those that target the melatonergic system: this holds heuristic appeal given the extent of sleep-wake cycle disturbance in delirium. A systematic review (de Jonghe et al, 2010) found four randomised trials and five case series of melatonin in 330 dementia patients: seven of the nine studies showed positive effects for circadian rhythms in those receiving melatonin, leading the authors to query whether it could be useful in delirium.

So, what about trying to prevent delirium in high-risk patients? An article in the April 2014 issue of JAMA Psychiatry (Hatta et al, 2014) reports a randomised placebo-controlled trial of the melatonin agonist ramelteon (8mg at night for 7 nights) in intensive care and acute care wards of four university hospitals and one general hospital in Japan. Eligible patients were those aged 65-89 years and admitted due to 'serious medical problems' (eg. stroke, myocardial infarction). Sixty-seven patients were randomised: 33 to active treatment. Ramelteon patients had a much lower risk of delirium (3% vs. 32%; p=0.003); the effect was robust to controlling for a number of potentially confounding variables. Limitations of the study include lack of generalisability in that 1126 patients were screened and 1056 excluded; and the final number of participants was rather small, especially if one considers that it was conducted across five sites. Also, ambient light and general environmental stimuli would have been very difficult to control for in acute hospital settings.

De Rooij and colleagues (2014), in an editorial that accompanies the Hatta et al (2014) article, point to two other relevant randomised controlled trials in which melatonin was effective in reducing the risk of delirium in vulnerable medical and surgical patients.

We all know that one of the hallmarks of delirium is circadian rhythm disturbance. Whether these promising findings for melatonin and ramelton are related to sleep entrainment is not clear: indeed, Hatta and colleagues (2014) suggest that it might be that perturbations of melatonin transmission actually play a pathogenic role in delirium.

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References:

- *De Rooij SE, van Munster BC, de Jonghe A (2014). Melatonin prophylaxis in delirium: Panacea or paradigm shift? JAMA Psychiatry 71, 364-365.*
- *De Jonghe A, Korevaar JC, van Munster BC, de Rooij SE (2010). Effectiveness of melatonin treatment on circadian rhythm disturbances in dementia: are there implications for delirium? In J Geriatr Psychiatry 25, 1201-1208.*
- *Hatta K, Kishi Y, et al. (2014). Preventive effects of ramelteon on delirium: A randomised placebo-controlled trial. JAMA Psychiatry 71, 397-404.*

The Good, the Borderline and the Bipolar: can we tell the difference? Part 1

Highlights from the American Psychiatric Association 167th Annual Meeting 3-7 May 2014, New York City NY, USA.

Borderline Personality Disorder is relatively common in mental health settings, with a prevalence of up to 43% of inpatient presentations and 20% of psychiatric outpatients[1]. However, the condition can be difficult to diagnose and distinguish from other major mental illnesses due to the overlap of symptoms, diagnostic criteria and other factors such as a general reluctance of clinicians to stigmatise patients with a diagnosis of a personality disorder as opposed to other diagnostic labels. Some particularly difficult overlap symptoms include behavioural disturbances associated with impulsivity and self harm, emotional dysregulation which manifests in disturbed mood states such as depression and hypomania and psychotic states which can often be difficult to classify in terms of phenomenology[2, 3]. As a result of these diagnostic difficulties, patients may be afforded treatment strategies that may be ineffective at best or harmful at worst. The importance of distinguishing borderline personality disorder from other illnesses and in particular bipolar disorder, was the focus a several symposia at the most recent Annual Meeting of the American Psychiatric Association.

Professor Mark Zimmerman, of Brown Medical School, Rhode Island Hospital and the director of the Methods to Improve Diagnostic Assessment and Services (MIDAS) Project, asserted in his talk "Borderline Personality and the Over-diagnosis of Bipolar Disorder" that Bipolar Disorder is significantly over-diagnosed. This was based on data obtained through comparing 700 psychiatric patients who had a self-reported or previous diagnosis of bipolar disorder with formal assessment through the MIDAS project with the Structured Clinical Interview for DSM disorders (SCID) and the Family Research Diagnostic Criteria (FH-RDC)[4].

They found that about 20% of patients had a self report of a prior bipolar diagnosis but only 43% had this confirmed on the SCID. They also found that there were three times as many patients whose previous diagnosis of bipolar disorder was invalidated as there were patients who were newly diagnosed by the SCID - evidence, Professor Zimmerman argued, of significant bipolar over-diagnosis. The validity of the SCID diagnosis of bipolar disorder was strengthened by its correlation with positive family history in those who were diagnosed. He postulated that some of the reasons that lead to the over-diagnosis of bipolar disorder include a lack of validity of diagnostic processes, including antidepressant induced mania/hypomania as a diagnosis of bipolar disorder, "direct to consumer advertising" to patients who then present to doctors for a diagnosis of bipolar disorder (possibly more of a North American phenomenon than in Australia?), the inappropriate use of screening questionnaires as diagnostic instruments, the tendency of doctors to favour a diagnosis that can be treated with medication as opposed to psychotherapy, and peer-driven "campaigns" to increase and encourage diagnostic recognition of patients who may be "on the bipolar spectrum".

Professor Zimmerman was critical in particular of the use of screening questionnaires to diagnose bipolar disorder. In a study he conducted in 2011[5] he found that in 20 studies of one particular screening tool, the Mood Disorders Questionnaire, there was a positive predictive value of only 43.1% in the general population and 38.8% in psychiatric outpatients – in other words, the majority who screen positive for bipolar disorder do not in fact have the condition. He asserts that screening tools are misused in over-diagnosing bipolar disorder in academic settings also to draw wrong conclusions about bipolar disorder[6].

In the same study from the MIDAS data[4] his group found that those who were more likely to have been over diagnosed with bipolar disorder included those with current symptoms of PTSD and past eating disorders ($P<0.05$) but the most robust predictor of over diagnosis were those with borderline personality disorder ($P<0.01$). 8 out of 9 DSM-IV criteria for borderline personality disorder were associated with the over diagnosis of bipolar disorder, the exception being the presence of dissociation.

If it is true then that bipolar disorder is indeed over-diagnosed, at the expense of the accurate diagnosis of patients with borderline personality disorder, the clinical ramifications may be significant. Patients who have borderline personality disorder may not be receiving right treatment at best, being denied evidence based psychotherapy, but also possibly receiving harmful treatment at worst in the form of psychotropic medication with significant side effect burdens. Given the difficulties inherent in distinguishing the two conditions, how can a clinician tell the difference? Further highlights from the APA Annual Meeting in part 2 of this article in the August issue of *Mindcafe* will explore this dilemma.

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References for this article are listed on page 04.

A psychosocial perspective on risk factors for psychosis

'Trauma and Psychosis: Well-Researched, Full of Implications, Still Controversial?' was the title of the keynote address from Jim Van Os at the recent RANZCP 2014 Congress in Perth. After hearing the address, and having a look at the references cited, the answer to Jim's question must surely be 'full of implications'. Most psychiatrists are comfortable with the notion that childhood adversity (CA) is associated with an increased risk of non-psychotic disorders in later life – it has been estimated using data from the National Comorbidity Survey Replication (NCS-R) that having a history of childhood adversity might predict the later onset of about 32% of anxiety disorders, 26% of mood disorders and 21% of substance use disorders[1]. Notably, the influence was strongest for onset in childhood, followed by adolescence and then adulthood (e.g. 57% of childhood onset mood disorders, decreasing to 20% of mood disorders with onset after age 30 years), and the greater the 'dose' (number) of CAs the greater the risk. The size of the risk is of interest, but doesn't surprise.

What is more challenging to the prevailing view (although it might appear to those with longevity in the field to be more in the line of 'everything old is new again') is the idea that environmental stresses, most particularly in the form of CA, might make a significant contribution to the risk of psychosis. The Bradford Hill criteria for causation include evidence of a strong and consistent association, specificity, a temporal association, and dose-response relationship. Evidence for all of these is available (though limited for specificity).

The literature examining the link between CA and psychosis is robust. Varese et al[2] found 18 prospective cohort studies and large population-based cross-sectional studies to include in their meta-analysis, with all research designs finding significant associations and similar odds ratios (2.75-2.99) for the likelihood that patients with psychosis had been exposed to CA. The estimated population attributable risk was 33% (16%–47%): that is, had there not been significant CA, there would have been 33% fewer cases of psychosis. There was no specific relationship with individual types of CA or trauma, and the risk appeared to be for psychotic symptoms, rather than schizophrenia, which is interesting. Bentall et al [3], in contrast, did find specific associations for institutional care and physical abuse with paranoia, and physical and sexual abuse with auditory verbal hallucinations in individuals with a positive score on the Psychosis Screening Questionnaire in a large UK epidemiological survey. A hypothesis was raised that sexual abuse may specifically impair source monitoring (i.e. an individual's external source rather than as a product of the individual's own mind), thus linking with auditory verbal hallucinations, whereas growing up outside a family setting (e.g., institutional care) may impact on attachment styles, thus predisposing to paranoia. Paranoia might be expected to be even more closely linked to experiences of deliberate harm caused by others.

High rates of subclinical psychotic experiences have been reported in both clinical and community adolescent samples (e.g. McGorry et al[4]) and only a minority progress to persistent psychotic illness. Data from a Dutch prospective cohort study identified that developmental problems, life events before age 16 years and exposure to trauma between ages 11 and 16 years all significantly predicted both persistence and increase in psychotic symptoms with a dose-response pattern[5]. If you look up just one article to read, make it this one!

What mechanisms may be at play? Several lines of evidence suggest that CAs that are interpersonal and/or involve an intention to harm may be more pathogenic[6], and that at least some of the pathological effect of these experiences may be that they give rise to cognitive biases that predispose an individual who is experiencing unusual symptoms to attach a particular meaning to them. For example, Lovatt et al[7] found that, given similar frequency and severity of psychotic symptoms, it was an appraisal of the symptoms as having been deliberately caused by others that predicted whether an individual was unwell enough to be in treatment – those in the non-clinical group were more likely to regard their symptoms as somehow normal and benign.

What are the implications for practice? Firstly, early psychosis intervention services might pay more attention to individuals with a history of CA or trauma. Perhaps even more importantly, early (and later!) interventions should include those targeting the lasting effects of early adverse experiences. Such effects might include disturbances of attachment, poor problem-solving and coping skills, low distress tolerance and limited emotional coping skills, and limited social and communication skills (including negotiating and assertiveness). CBT to address identified cognitive biases might also be helpful.

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References for this article are listed on page 04.

Difficulties in emotion regulation across the spectrum of eating disorders.

***Comprehensive Psychiatry,* 55(3), 565–571.**
Brockmeyer, T., Skunde, M., Wu, M., Bresslein, E., Rudofsky, G., Herzog, W. & Friederich, H-C.(2014).
http://www.sciencedirect.com/science/article/pii/S0010440X1300357X

It has been commonly thought that emotional regulation difficulties are a trans-diagnostic factor across the spectrum of eating disorders. Previous research has supported impaired ability to experience and differentiate emotions and also attenuate and modulate emotional arousal in Anorexia Nervosa, Bulimia Nervosa and Binge-Eating Disorder. Despite this, there is a lack of research examining the potential differences in emotional regulation within the spectrum of eating disorders.

Of those that have examined differences within sub-types, there have been varied findings ranging from no differences found to poorer emotional awareness in individuals with Anorexia Nervosa when compared with Bulimia Nervosa.

This study compared female-only groups comprising of eating disorder patients (n=120) and healthy controls (n=89) with an age range of 17 to 61 years old. The eating disorder subgroups comprised of groups formally diagnosed with Anorexia Nervosa (Restricting type), Anorexia Nervosa (Binge/Purge type), Bulimia Nervosa and Binge-Eating Disorder. The healthy control groups were split into a normal-weight and an over-weight control group.

Unsurprisingly, the study found that all individuals in the eating disorder groups reported greater emotional regulation difficulties than the control groups. This was found in both experiencing and differentiating emotions and attenuation and modulation of emotions, thus replicating previous research. It was also found that individuals with Binge-Eating Disorder reported less emotional regulation difficulties than the other eating disorder subtypes. Additionally, Bulimic-type subtypes (such as Anorexia Nervosa – Binge/Purge subtype, Bulimia Nervosa and Binge-Eating Disorder) reported higher levels of impulse control difficulties than Anorexia Nervosa-Restricting-type. Whilst no significant differences in emotional regulation difficulties were found between the Anorexia Nervosa subtypes, the Binge/Purge subtype reported more impulse control difficulties.

Emotional dysregulation, whilst being a transdiagnostic feature of eating disorders, is also common in clients presenting with many other mental health issues. Additionally, it is uncommon for clients to present with an eating disorder in isolation of other psychopathology. Particularly in the adolescent and young adult population, clients may lack the awareness and skills to manage their emotions, and thus benefit from treatment plans that involve these skills such as the identification of emotions, and the association of emotions to their behaviour.

This study provides further support of emotional regulation deficits as a trans-diagnostic feature of eating disorders and supports the notion that eating disorder subtypes may show a different pattern of emotional regulation difficulties.

This is beneficial from both a diagnostic and treatment perspective. It provides support for the addition or emphasis of emotional regulation skills training to existing treatment plans and allows for the adaptation of current treatments to eating disorder subtypes, such as Dialectical Behavioural Therapy for Bulimia Nervosa and Binge-Eating Disorder (Safer, Telch & Chen, 2009). It also supports the development and evaluation of new treatments for disorder-specific difficulties.

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References: Brockmeyer, T., Skunde, M., Wu, M., Bresslein, E., Rudofsky, G., Herzog, W. & Friederich, H-C.(2014). Difficulties in emotion regulation across the spectrum of eating disorders. Comprehensive Psychiatry, 55(3), 565–571.

Telch,C.F., Chen, E.Y. & Safer, D.L. (2009). Dialectical Behavior Therapy for Binge Eating and Bulimia. New York: Guildford Publications.

References from page 03. The Good, the Borderline and the Bipolar: can we tell the difference? Part 1

1. Lieb K, Sanarini MC et al. Borderline Personality Disorder. The Lancet 2004;364: 453-461

2. Magill CA. The Boundary Between Borderline Personality Disorder and Bipolar Disorder: Current Concepts and Challenges. The Canadian Journal of Psychiatry. 2004; 49:551-556

3. Yee L, Korner AJ, MCswiggan S, Mears RA, Stevenson J. Persistent hallucinosis in Borderline Personality Disorder. Comprehensive Psychiatry 2006; 46:147-154

4. Zimmerman M, Ruggero CJ, Chelminski I, Young D. Is bipolar disorder overdiagnosed? The Journal of Clinical Psychiatry 2008; 69:935-940

5. Zimmerman M, Galione JN. Screening for bipolar disorder with the Mood Disorders Questionnaire: A Review. Harvard Review of Psychiatry 2011; 19(5): 219-228

6. Zimmerman M. Miuse of the Mood Disorders Questionnaire as a case-finding measure and criticw of the concept of using a screening scale for bipolar disorder in psychiatric practice. Bipolar Disroders 2012; 14:127-134

References from page 03. A psychosocial perspective on risk factors for psychosis

1. *Green JG, McLaughlin KA, Berglund PA, Gruber MJ, Sampson NA, Zaslavsky AM, et al. Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: associations with first onset of DSM-IV disorders. Archives of General Psychiatry. [Research Support, N.I.H., Extramural Research Support, Non-U.S. Gov't]. 2010 Feb;67(2):113-23.*
2. *Varese F, Smeets F, Drukker M, Lieverse R, Lataster T, Viechtbauer W, et al. Childhood Adversities Increase the Risk of Psychosis: A Meta-analysis of Patient-Control, Prospective- and Cross-sectional Cohort Studies. Schizophrenia Bulletin. 2012 July 1, 2012;38(4):661-71.*
3. *Bentall RP, Wickham S, Shevlin M, Varese F. Do Specific Early-Life Adversities Lead to Specific Symptoms of Psychosis? A Study from the 2007 The Adult Psychiatric Morbidity Survey. Schizophrenia Bulletin. 2012 July 1, 2012;38(4):734-40.*
4. *McGorry PD, McFarlane C, Patton GC, Bell R, Hibbert ME, Jackson HJ, et al. The prevalence of prodromal features of schizophrenia in adolescence: a preliminary survey. Acta Psychiatrica Scandinavica. [Research Support, Non-U.S. Gov't]. 1995 Oct;92(4):241-9.*
5. *Wigman JTW, van Winkel R, Raaijmakers QAW, Ormel J, Verhulst FC, Reijneveld SA, et al. Evidence for a persistent, environment-dependent and deteriorating subtype of subclinical psychotic experiences: a 6-year longitudinal general population study. Psychological Medicine. 2011 Nov 2011;41(11):2317-29.*
6. *van Nierop M, Lataster T, Smeets F, Gunther N, van Zelst C, de Graaf R, et al. Psychopathological Mechanisms Linking Childhood Traumatic Experiences to Risk of Psychotic Symptoms: Analysis of a Large, Representative Population-Based Sample. Schizophrenia Bulletin. 2014 March 1, 2014;40(Suppl 2):S123-S30.*
7. *Lovatt AD, Mason ODD, Brett CPD, Peters EPM. Psychotic-Like Experiences, Appraisals, and Trauma. Journal of Nervous & Mental Disease. 2010;198(11):813-9*

Psychotherapy at the APA

The author attended multiple psychotherapy-oriented lectures and workshops at this year's American Psychiatric Association Congress in New York, May 2014.

SUMMARY POINTS

1. *No single therapy is associated with positive outcomes in all cases.*
2. *There are multiple treatments which have been found to be effective for the same core problems.*
3. *A good Therapeutic Alliance has been identified to be principally related to a good outcome, regardless of modality.*
4. *Psychodynamic Psychotherapy has an expanding evidence base, and there are new approaches to its use that have a simpler, and yet more multimodal perspective.*

What was said at the conference?

The APA has a reputation for often being too biologically focused; however the psychotherapies were certainly well represented, and even appeared to show a level of maturity and pragmatism in how they were presented. Summers & Barber held a workshop providing an overview of the evidence base and use for psychodynamic psychotherapy. Much was made of the issue of therapeutic alliance, and echoing Bordin's 1979 statement of "… we can speak of the working alliance as including three features: an agreement on goals, an assignment of task or a series of tasks, and the development of bonds." Rather than simple motherhood statements, these were directly represented in Barber's 2000 study identifying that the therapeutic alliance independently predicted improvement in an 88 patient study on depression, amongst several other studies. What was most remarkable was their idiosyncratic contribution to the field in terms of considering formulating cases around six key concepts, or "Core Psychodynamic Problems". These ranged from a fear of abandonment to panic anxiety, and notably each core problem was structured around a well-established school of thought – from ego psychology to object relations. In doing so they presented a structured approach to eclectic dynamic psychotherapy, which is not a mean feat.

This tendency to pragmatic integration continued with Glen O Gabbard's lectures regarding the evidence base and sensible approaches to the psychotherapies. One of his first lectures involved a significant level of apologies for the Association-enforced title of "How I became Me", and his legendary humility showed in how he simultaneously apologised for being asked to discuss his own biography, but provided a valuable insight into the development of a psychotherapist and an educator. There was a note of concern, though, as he admitted to observing that psychodynamic psychotherapy had a shrinking role in the public sector, and numerous questions from the audience comprised basic patient-related questions from trainees, suggesting the limited access that many American trainees had to supervision. A later lecture discussed the increasing neurobiological correlates with psychotherapy, such as insights into procedural memory and the evidence of improved serotonergic transmission following successful therapy.

A key point was Gabbard's review of the therapies for borderline personality disorder, and how he pointed out that there were now six independently designed therapies that all had Level II evidence for effectiveness in BPD. He queried why this was, particularly given the grossly different theoretical models they utilised, but offered the suggestion that all the therapies built on therapeutic alliance, and provided patients with a plausible means of understanding themselves, which itself may be where the change came from. The notion of plausibility of an intervention rather than the inherent higher "truth" of the psychotherapy would have been heretical in recent times, but it was surprising to see it repeated by multiple proponents throughout the conference.

Gunderson, who had workshops and multiple lectures regarding his approach to borderline personality, also took the pragmatic stance, particularly pointing out that effective engagement of a personality disordered individual was possible without highly specialised training, and in itself yielded better outcomes. He presented newer research showing improved functioning with his "Good Psychiatric Management" treatment method, formerly called "General Psychiatric Management". One admires his restraint in not referring to it as "Gunderson Psychiatric Management".

On the other end of the spectrum was Kernberg and his associates describing object relations theory and its implications. A workshop on narcissistic personality disorder was notable for the mysterious omission of any case studies verifying the reintegration of the personality, which is supposed to be the hallmark of the object relations approach. Whilst it is easy to denigrate a therapy that took (as per the proponents at the workshop) about 10 years to yield change, Kernberg's lecture on Love and Anger demonstrated that the object relations model provided a beautiful means of conceptualising the human mind. Accuracy and independent verification are separate issues, but the art of psychiatry in terms of understanding the un-understandable continues.

At the end of the conference, an academic forum attended by Gabbard had a wry note at the excellent turnout to the review of personality disorders, particularly at such a late stage in the conference. Discussing obsessive compulsive personality disorders and key features of treatment, he was notably critical of Item 5 on the DSM-IV (and now DSM-V) listing. The same enthusiasm for treatment however came with himself and subsequent speakers, particularly a remarkable resident program with intensive dynamic psychotherapy.

The conference as a whole left myself with a renewed enthusiasm and willingness for open reflection regarding psychotherapy and how it works. There has not been any doubt as to whether it works, but the doubt as to why it works has been previously ignored. The improved willingness to confront this issue from multiple leaders in the field is reassuring. On the other side of the globe, Mary Taggart's keynote address at the RANZCP's congress in Perth identified attachment and mentalisation as common features associated with improved patient functioning, regardless of modality of therapy. It was fortuitous, as one considers that a good therapeutic alliance is essentially good attachment that facilitates mentalisation. Perhaps we are approaching a paradigm where psychodynamic psychotherapy is actually dynamic.

How does this relate to my personality disordered patient?

1. When evaluating the progress of a psychotherapy (whether you are delivering it or not), one can determine its effectiveness by how well the therapist engages the patient, and how likely the patient feels that the therapy makes "sense".
2. If providing dynamic psychotherapy, consider using Summers & Barber's "Six Core Psychodynamic Problems" approach in order to suggest with theoretical modality is most likely to help understand and benefit your patient. ("Psychodynamic Therapy: A Guide to Evidence-Based Practice" from Amazon Kindle)
3. If not providing dynamic psychotherapy, consider using Gunderson's "Good Psychiatric Management" approach as a simpler but still evidence-based means of reducing negative events. (ISBN-10: 1585624608)
4. Do not stick too slavishly to any single theoretical modality, as this can interfere with the therapy outcome – a dynamic approach using multiple theories is always better.

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The author is reviewing the following article and at the same time posing the question: Could early weight management intervention help with adherence to prescribed anti-psychotics and reduced risk of chronic disease?

Nutrition and mental health research: Where to from here?

Elisabeth Isenring PhD, Bhsc, Adv APD
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"It is apparent from the literature that there is an urgent need for effective nutrition and exercise interventions for the users of mental health services"

Introduction

The prevalence of overweight and obesity is higher in people with mental health issues than in the general population. Increased abdominal obesity is associated with decreased insulin sensitivity, (which can lead to impaired glucose tolerance), elevated LDL's and triglycerides, elevated blood pressure and thus associated risk of cardiovascular disease.

Metabolic disturbance is a factor to consider when someone is started on antipsychotic medication. Overweight and obesity are important modifiable risk factors. The potential for stigma associated with weight gain can also lead to reduced quality of life and increased risk of depression which may in turn impair adherence to medication prescription.

There are a number of biological and non-biological factors that contribute to anti-psychotic induced weight gain and anticipation of this is important. Although it is very difficult to separate the role of medication, genetics, role of hormones, presenting clinical condition and lifestyle on the high prevalence of metabolic disturbances, acknowledging and addressing each contributor can lead to improved outcome.

Non-biological factors include age, gender, smoking, diet, physical activity level and socio-economic status.

Patients with mental health issues such as Schizophrenia or Schizoaffective disorder are often prescribed large and varied doses of medication. JW Newcomer identifies Olanzapine and Clozapine as the second-generation atypical antipsychotics, which cause the most significant weight gain in his 2005 literature review. Addressing weight gain prevention strategies for patients starting on atypical antipsychotic medication such as Olanzapine and Clozapine could contribute to improved outcomes.

Symptomatic improvement of Schizophrenia or Schizoaffective disorder is a priority, but weight gain can have a great effect on body image and mobility, not to mention the increased risk of chronic diseases such as diabetes mellitus or cardiovascular disease.

Lifestyle modification can be addressed to a certain extent in a psychiatrist/ medical consultation, but for at risk patients, a Dietetic referral is wise. Techniques such as mindful eating, portion control, improving diet quality, healthy cooking methods and healthy take away options could be addressed. Good nutrition is associated with improved feeling of well being, even in something as simple as a higher fibre diet inducing regular bowel movements.

Typical Dietetic consultation considerations:

- Baseline assessment
- Diagnosis
- Anthropometry (weight, height, BMI, waist circumference)
- Pathology (such as, but not limited to fasting blood glucose, HbA1c, fasting lipids- Cholesterol, LDL, HDL, triglycerides.)
- Baseline BP
- Medical history (including family history)
- Social history (eating is very often influenced by who we are with at the time)
- Medication (risk of weight gain, side effects, drug-nutrient interactions)
- Skills (cooking and food preparation, access to equipment)
- Current eating habits, food choices, disordered eating
- Barriers to healthy eating (skills, knowledge, budget)
- Teaching plan dependent on education level
- Establishing shared goals
- Review as required, re-check anthropometry and pathology
- Referral on to other Allied Health Professionals such as Exercise Physiologists

Lifestyle modification

Dietary advice to include

1. Teaching of the Australian Guide to Healthy Eating as appropriate
2. Limiting saturated fat and trans fatty acids and switching for unsaturated fats from fish, legumes, nuts and vegetables
3. Increasing fibre from fruit, vegetables, grains and legumes
4. Including lean and varied protein sources
5. Limiting salt to <6g/day (2400mg) by avoiding adding salt to foods and choosing lower salt foods
6. Reducing processed foods and soft drink
7. Limiting alcohol <2 standard drinks/day for men and < 1 standard drink/day for women
8. A moderate reduction in calories may be indicated to avoid potential weight gain and metabolic disturbances
9. Tailor advice for individuals allowing for food preferences, budget, skill etc.
10. Eating awareness skills to include spacing of meals, slowing down eating, recognition of sensory qualities of food, avoiding distractions whilst eating
11. Build up physical activity levels slowly

Demonstration of the positive impact of Dietetic intervention in an In-Patient setting is beautifully illustrated by Amanda Clark's (Advanced APD) 'opt in' program at Currumbin Clinic on the Gold Coast. The program provides nutritionally balanced meals, which are portion controlled. Her findings indicate significant reduction in unwanted weight gain during an average 4-week stay.

http://www.greatideas.net.au/media/wysiwyg/PERFECT.pdf

Summary

Research indicates choice of medication is the strongest predictor of risk of weight gain, however it is really important to acknowledge lifestyle modification as a way of empowering patients to have greater control of their health outcomes. Minimising weight gain associated with anti-psychotropic medication will help in reducing chronic disease risk and well being status.

Conclusion

Greater collaboration between mental health professionals, allied health professional (Dietitians, Exercise Physiologists), GP's and Endocrinologists, in addition to close monitoring of individual measurements to provide more holistic care for these patients would seem prudent.

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