MIND MATTERS: August / September 2013

Clinical Psychology Forum

THE ROLE OF THE CLINICAL PSYCHOLOGIST IN PRIVATE PSYCHIATRIC HOSPITALS

During the past 20 years hospital psychiatry has changed drastically - the length of stay has decreased and alternatives to inpatient treatment have increased (http://books.google.co.za/books/about/Textbook_of_Hospital_Psychiatry.html?id=EC2hz).
Steven S. Sharfstein's clinical and administrative guide to the practice of hospital psychiatry, titled Textbook of Hospital Psychiatry (American Psychiatric Publication, 2009), written by 70 national experts, includes the role of the clinical psychologist within the psychiatric hospital setting.

In South Africa we have a growing number of private psychiatric facilities which cater for an ever-growing population of psychiatric patients. Clinical psychologists, in line with the HPCSA's scope of practice regulations, play a direct role together with psychiatrists in diagnosing and treating psychiatrically hospitalized patients. In SA the service is out-sourced and funded by the patient's own means. The psychiatrist traditionally assesses the treatment plan and requirements of the patient, following which a referral to a clinical psychologist is made; or the psychiatrist and clinical psychologist work together to admit an existing patient. The clinical psychologist then proceeds to provide psychotherapy for the patient, usually on a daily basis, in an individual psychotherapeutic setting and according to his or her own choice of therapeutic orientation. Some facilities offer psycho-educative and other group programs. The question is how we can offer more group programs to this community, based on our training and expertise.

Looking at psychological services in other world facilities (http://www.mclean.harvard.edu; http://www.menningerclinic.com/; http://www.rogershospital.org; http://swedishcovenant.org; http://www.ashahospital.org; http://www.johnmunroehospital.co.uk), we find that clinical psychologists are often employed by the institution. Research and internship programs are an integral part of the psychology departments of hospitals. Registered clinical psychologists render evidence-based services to assist in individual healing and to normalize functioning.

Formulation-based models, i.e., cognitive behavioral, psychosocial and cognitive analytic models, are cited as employed modalities. Psychological and neuropsychological assessment play a significant role during the diagnostic phase. Assessments include developmental, intelligence, personality, memory, diagnostic and ADD assessments. Various mental and physical health problems are addressed in group settings, including medication compliance, weight management, anger management, cognitive and memory impairment, pain management, coping skills development, relaxation training and family support groups. Staff supervision/training and debriefing may be included in the role of the clinical psychologist.

According to the Textbook of Hospital Psychiatry, possible psychological group interventions might ideally include:

Out-patient and day treatment programs
Milieu-based programs based on behavior modification

Software programs
Activity programs offering a blend of physical and mental tasks
Eating disorder programs
Didactic training groups
Milieu or social learning programs
Nicotine addiction programs
Self help programs
12-Step alcoholism treatment programs
Leisure activity structured groups
Family psycho-education programs
Step down programs
Adolescent/Child specific programs

Various research and application opportunities are proposed by these themes, in which clinical psychologists could adjust to the realities of service needs by finding creative ways to become more active in psychiatric hospital care settings, thereby supplementing or significantly enhancing their traditional role of longer term individual psychotherapy.

PSYCHIATRIC MEDICATIONS IN PRIMARY CARE SETTINGS

The principles of prescribing psychiatric medication begins with the identification of a diagnosis. Once the diagnosis is made the specific symptoms must be targeted. The specific symptoms may be those central to the diagnosis/disorder (i.e. low mood) or distressing symptoms to the patient (i.e. low libido) or those that cause functional impairment (i.e. impaired concentration).

Before prescribing any medication, psycho-education should be provided to the patient, his/her family; spouse; (employer/s) or other caretakers. Psycho-education should, if possible, be done in the presence of the patient's psychologist/therapist. Studies show that the most important aspect for a patient to be compliant to his/her medication is their perception of their physician's interest in their wellbeing.

Medication should always be taken initially at the lowest dosage and titrated up slowly especially in dealing with patients with panic disorders, as they are very sensitive to medication. Patients should be informed that they should take their medication daily on the same time of the day for a certain amount of months. They should only under the supervision of their physician very slowly discontinue taking their medication.

Patients should be provided with practical information such as possible common side-effects and how to try to prevent it. For instance: take Fluoxetine in the mornings early to prevent insomnia after breakfast to prevent GIT disturbances. Warning patients about the side effects of, i.e., benzodiazepines that may cause drowsiness is important before prescription. Continuous monitoring of thyroid functioning of those on lithium and ECG for patients on high doses of tricyclic antidepressants is necessary. Potential uncommon lethal side-effects should be reported, especially if the patient can still prevent it in early stages, for example Steven-Johnson Syndrome (very uncommon, one in a thousand) side effect with Lamotrigine starts with a skin rash. The patient knows then to stop immediately and to contact the emergency doctor.

Medical disorders require adjustment to psychiatric medications. Due to their psychotropic actions, herbal and dietary considerations are also assessed as part of the overall evaluation.

Psychiatric medications are classified into antidepressants, anxiolytics, antipsychotics and mood stabilizers. These can then be sub-divided in terms of more specific neurotransmitter actions.

- **Antidepressants**

  The first AD's developed were the Tricyclic antidepressants (TCAs) and the Monoamine oxidase inhibitors (MAOIs), but due to their side-effect profile researchers aimed to develop more selective antidepressants.

Tryptanol	Anafranil	Prothiaden
Tofranil	Emdalen	Aventy
Surmontil	Ludiomil	Lantanon

  Monoamine Oxidase Inhibitors (MAOIs) may constitute irreversible agents (which require avoidance of some foods such as cheese and drugs such as pethidine). The more recent reversible agents do not require a specific diet, although side effects such as insomnia and agitation may occur.

Parnate	Aurorix

  The Selective Serotonin reuptake inhibitors (SSRIs); SNRIs; NDRIs and the Noradrenaline reuptake inhibitors were introduced.

A new class of antidepressants also targets the melatonin system as well as serotonin receptors, i.e. Agomelatine.

Among the Selective Serotonin Reuptake Inhibitors (SSRIs), Fluoxetine was the first to not affect the cholinergic system. On the other hand, side effects such as nausea, weight change and delayed ejaculation often occur.

Cipramil	Cipralex	Prozac
Luvox	Aropax	Zoloft

Side effects such as inhibition, insomnia and vertigo can occur with Selective Noradrenaline Reuptake Inhibitors (NRIs) such as Edronax and Strattera.

Serotonin-Noradrenaline Reuptake Inhibitors (SNRIs) such as Efexor have fewer anti-cholinergic effects but higher instances of increased blood pressure. Sibutramine may be used for the treatment of obesity.

Serotonin Antagonist and Reuptake Inhibitors (SARIs), i.e., Molipaxin, are used to counteract the sexual side effects of serotonin reuptake inhibitors.

Noradrenergic and Specific Serotonergic Antidepressants (NaSSAs), i.e., Remeron, results in increased noradrenergic neurotransmission. Remeron has limited sexual side effects but can result in weight gain.

- **Antipsychotics**

Antipsychotics are divided into typical and atypical groups. These agents treat psychotic disorders, manic episodes, Tourette's syndrome, behavioral disturbances associated with dementia, and others. Typical antipsychotics are dopamine-2 blockers. They act on striatal dopaminergic pathways, and are effective for hallucinations and delusions; while atypical agents include serotonin-2 antagonists, which cause less cognitive impairment and act on limbic and cortical dopaminergic pathways. They are effective for symptoms such as social withdrawal and amotivation.

Largactil	Etomine	Fluanxol
Serenace	Neulactil	Trilafon
Orap (not available)	Stemetil	Sparine
Elgonyl	Melleril (blackboxed)	Stelazine
Solian	Leponex	Zyprexa
Seroque	Risperdal	

- **Anxiolytics**

These agents are used for sedation. They include barbiturates, which are less prescribed due to their high risk of dependency. Benzodiazepines are still generally used although antidepressants are considered more acceptable for the treatment of the anxiety disorders. Benzodiazepines decrease anxiety and increase sedation, cognitive slowing and muscle relaxation. Lorazepam and clonazepam are effective in treating panic disorder. Non-benzodiazepine GABA Agonists such as Stilnox, Imovane and Zopimed induce mild sedation and have less potential for dependence. Azapirones such as Buspar have been used for GAD and cause fewer side effects.

Librium	Urbanol	Rivotril
Traxene	Valium	Rohypnol
Delmadorm	Solatran	Mogadon
Demetrin	Dorme	Alzam/Xanor
Lexotan	Ativan	Dormonoct
Serepax	Normison	Dormicum
Halcion		

- **Mood Stabilisers**

  Lithium was the first-used stabilizing agent. Side effects include hypothyroidism, diuresis, and an increase in white blood cell count. Anticonvulsants such as the widely used agent Valproate alone or with Lithium have seemed to be useful. Continued life-long medication is required, as discontinuation may cause lack of response to the particular treatment.

Tegretol	Neurontin	Lamictin
Topamax	Epilim	Convulex

- **Other Agents**

  Dopaminergic agents such as Ritalin are used for ADHD, narcolepsy, restless leg syndrome and dyskinesia. "Ritalin is a psychostimulant that displaces dopamine and noradrenaline from presynaptic nerve terminals and inhibits their reuptake" (p 19).

  Noradrenergic agents such as beta-blockers treat performance anxiety, Tourette's disorder, opioid withdrawal, etc.

  Serotonergic agents target migraine, early onset alcoholism and gastrointestinal dysfunction.

  Cholinergic agents are used to treat dementia, Alzheimer's and Parkinson's disease.

  Histaminic agents have had a positive effect on GAD.

  Glutamatergic agents are used for Alzheimers and alcohol dependence.

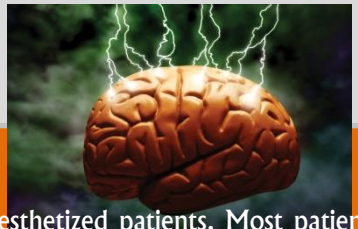
  Hormones/Peptides such as thyroid hormone treat refractory bipolar disorder; estrogens treat post-partum depression; melatonin is used for circadian rhythm disorder and desmopressin for enuresis.

  Herbs/dietary remedies have increasingly been applied although appropriate studies may be lacking. St John Wart (which may, like antidepressants, precipitate mania) has proved effective in mild to moderate cases of depression. Ginkgo, kava, ginseng and yohimbine are increasingly included in pharmacotherapy guidelines.

Resource

Stein, D.J., Seedat, S., Niehaus, D.J., Pienaar, W. and Emsley, R. Psychiatric Medication in Primary Care - Algorithms and guidelines. Mental Health Information Centre, Dept of Psychiatry, University of Stellenbosch, 2005.

(With appreciation to psychiatrist, dr Renata du Preez, for technical editing and additional information)



Electroconvulsive Therapy (ECT)

ECT is a form of psychiatric treatment in which seizures are electrically induced in anesthetized patients. Most patients who receive ECT suffer from major depression and have either not responded to medication trials, or have not tolerated medications, or have severe or psychotic symptoms, or are acutely suicidal or homicidal, or have clear symptoms of agitation or stupor. ECT is sometimes indicated for patients who suffer from manic episodes, but only when there are specific contraindications to all available pharmacological approaches. Some patients with acute schizophrenia with positive symptoms, catatonia or affective symptoms also benefit from ECT treatment.

Because patients and their families are often apprehensive about ECT, the psychiatrist will explain benefits, possible adverse effects, and alternative treatments to them. Through this process the psychiatrist obtains documented informed consent. The process usually includes a discussion of the disorder the patient is suffering from, its natural course, and the option of receiving no treatment.

Most psychiatrists or psychiatric hospitals will have printed literature and videotapes about ECT that may be useful in obtaining informed consent. The use of involuntary ECT today is rare.

Brain imaging techniques are increasingly being used to compare the effects of psychotherapy and psychopharmacological treatment methods. Psychotherapy, according to neuroimaging studies, received on it's own show changes in brain function. PET studies indicate that CBT can lead to regional metabolic changes in depressed and OCD patients. Psychotherapy may furthermore modify the dysfunctional neural circuitry associated with anxiety disorders. It appears that each form of treatment effects distinctive changes in different brain areas, often overlapping. Treating clinical depression requires patient specific approaches. Dr Helen Mayberg on the forefront of biomedical MDD research states that "Depression is unlikely a disease of a single gene, brain region, or neurotransmitter system. Rather, the syndrome is conceptualized as a systems disorder with a depressive episode viewed as the net effect of failed network regulation under circumstances of cognitive, emotional or somatic stress".

Some studies have found that certain psychotherapies have been proven to be as effective as psychopharmacology for acute depression. CT has been reported to be more effective in relapse prevention and less expensive than psychopharmacology after the eighth month of treatment.

To read more on these articles by Dichter G. & Smoski M. (2008) and Barclay L. (2004): http://www.psychiatrictimes.com/articles/effects-psychotherapy-brain-function; http://www.medscape.com/viewarticle/466497.

International Conferences: 2014

IUPSYS Website

http://www.iupsys.net/index.php/conferences--congresses/calendar-of-psychology-conferences-around-the-world

American Psychological Association

http://www.conferencealerts.com/topic-listing.php?page=1&ipp=All&topic=Psychology

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Please forward any comments or requests to cpf@healthman.co.za

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CPF AGM and CPD Presentation

General Meetings will be held in various areas, along with two CPD presentations. The first, on **Prescribed Minimum Benefits (PMB's) and Clinical Psychology**, will be presented by Gerhard Grundling. The second presentation will be led by William Griffith, titled **Suicide: A Therapeutic Reality**.

4 CPD Points available

14 September 2013 @ 08:30 – 13:00
Cape Town – The Townhouse Hotel

28 September 2013 @ 08:30 – 13:00
Bloemfontein – Villa Bali, Brandhof

9 November 2013 @ 08:30 – 13:00
Durban – Venue to be confirmed

For more information contact Joey Hanekom : cpf@healthman.co.za

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