Clinical Psychology

Alan J Banaszynski, DC, MSW, LCSW

Research and Powerpoint presentation assistance provided by:

Dr. Christine Schutz Ph.D.

WHY IT MATTERS

- MANDATED REPORTER

DEFINITION

an individual who holds a professional position (as of social worker, physician, teacher, chiropractor, clergy, or counselor) that requires him or her to report to the appropriate state agency cases of child abuse that he or she has reasonable cause to suspect.

CATEGORIES

- Children
- Elderly
- Domestic Violence

Mental Illness PREVALENCE- At any given time 1 out of 6: cross-section

Prevalence(%) of Psychiatric Disorders in the USA

Disorder	Lifetime	12mos
Psychiatric	48.0	29.5
Affective	19.3	11.3
Major Depression	16.2	6.6
Anxiety Disorder	24.9	17.2
Substance Abuse	26.6	11.3

Goldberg, R.J. The Care of the Psychiatric Patient 3rd ed. 2007

Child Abuse Federal Guidelines

- **The Child Abuse Prevention and Treatment Act (CAPTA)—Federal Guidelines**
- Under the Federal Child Abuse Prevention and Treatment Act (CAPTA) passed in 1974, all 50 states have passed laws mandating the reporting of child abuse and neglect.
- CAPTA provides a foundation for the States by identifying a minimum set of acts or behaviors that characterize physical abuse, neglect and sexual abuse.
- These laws vary from state to state.
- Each state is responsible for:
  - providing its own definition of child abuse and neglect.
  - describing the circumstances and conditions that obligate mandated reporters to report known or suspected child abuse.
  - providing definitions for juvenile/family courts when to take custody of the child.
  - specifying the forms of maltreatment that are criminally punishable.
- Mandated Reporting Laws change from time to time. You should consult your local Child Protective Services for the most current statute, if you have any questions or concerns about your responsibilities. See below for links to resources for information.

State Law examples

- **Missouri law**, at 210.110.(1) RSMo., defines "abuse" as:
- ". . . any physical injury, sexual abuse, or emotional abuse inflicted on a child other than by accidental means by those responsible for the child's care, custody, and control, except that discipline including spanking, administered in a reasonable manner, shall not be construed to be abuse.

- **Missouri law**, at 210.110.(12) RSMo., defines "neglect" as:
- ". . . failure to provide, by those responsible for the care, custody, and control of the child, the proper or necessary support, education as required by **law**, nutrition or medical, surgical, or any other care necessary for the child's well-being."

- A child is any person, regardless of physical or mental condition, under eighteen years of age. Section 210.110.(4).

- **MANDATED** REPORTERS (210.115 RSMo.)
- The following individuals must report child abuse: (1) Teachers, principals, and other school officials; (2) Health care professionals (physicians, medical examiners, coroners, dentists, chiropractors, optometrists, podiatrists, residents, interns, nurses, hospital or clinic personnel); (3) Mental health professionals; (4) Social workers; (5) Day care/child-care workers; (6) **Law** enforcement officials (police officers, juvenile officers, probation/parole officers, jail or detention facility personnel) (8) Ministers; (10) Other persons with responsibility for the care of children.

Failure To Report

- **MISSOURI** **Class A misdemeanor.**
- **Michigan** **Civil and Criminal Liability**

Mandated reporters, who fail to file a report of suspected child abuse or neglect, will be subject to both civil and criminal liability. In a civil action, the mandated reporter may be held liable for all damages that any person suffers due to the mandated reporter's failure to file a report. In a criminal action, the mandated reporter may be found guilty of a misdemeanor punishable by imprisonment for up to 93 days and a fine of $500.

Signs or Symptoms

- **Physical Abuse** Unexplained recurrent injuries or burns
  Improbable excuses or refusal to explain injuries
  Wearing clothes to cover injuries, even in hot weather
  Refusal to undress for gym
  Bald patches
  Chronic running away
  Fear of medical help or examination
  Self-destructive tendencies
  Aggression towards others
  Fear of physical contact—shrinking back if touched
  Admitting that they are punished, but the punishment is excessive (such as a child being beaten every night to "make him/her study")
  Fear of suspected abuser being contacted

Signs or Symptoms (cont.)

- **Sexual Abuse**

-Being overly affectionate or knowledgeable in a sexual way inappropriate to the child's age
-Medical problems such as chronic itching, pain in the genitals, venereal diseases
-Other extreme reactions, such as depression, self-mutilation, suicide attempts, running away, overdoses, anorexia
-Personality changes such as becoming insecure or clinging
-Regressing to younger behavior patterns such as thumb sucking or bringing out discarded cuddly toys
-Sudden loss of appetite or compulsive eating
-Being isolated or withdrawn
-Inability to concentrate
-Lack of trust or fear someone they know well, such as not wanting to be alone with a babysitter
-Starting to wet again, day or night/nightmares
-Become worried about clothing being removed
-Suddenly drawing sexually explicit pictures
-Trying to be "ultra-good" or perfect; overreacting to criticism

Child Abuse vs Corporal Punishment

- **Corporal punishment** is the deliberate infliction of pain intended to punish a person or change his/her behavior.
- How do you discern between the two as a professional?
- Does the state I intend to practice in allow some form of corporal punishment?

Where the states stand on corporal punishment: Legal=23

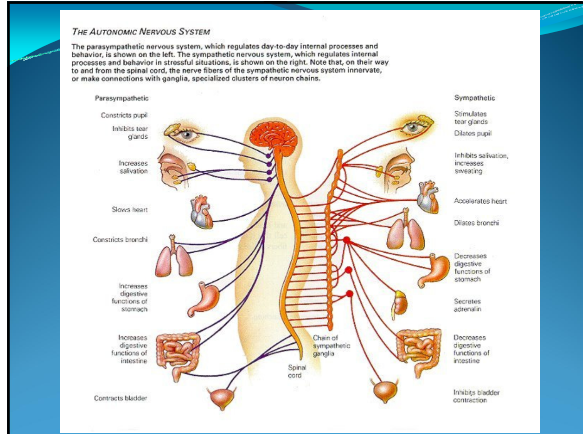
Alabama--Legal
Alaska--Illegal
Arizona--Legal
Arkansas--Legal
California--Illegal
Colorado--Legal
Connecticut--Illegal
Delaware--Illegal
District of Columbia--N/A
Florida--Legal
Georgia--Legal
Hawaii--Illegal
Idaho--Legal
Illinois--Illegal
Indiana--Legal
Iowa--Illegal
Kansas--Legal
Kentucky--Legal
Louisiana--Legal
Maine--Illegal
Maryland--Illegal
Massachusetts--Illegal
Michigan--Illegal
Minnesota--Illegal
Mississippi--Legal
Missouri--Legal
Montana--Illegal
Nebraska--Illegal
Nevada--Illegal
New Hampshire--Illegal
New Jersey--Illegal
New Mexico--Legal
New York--Illegal
North Carolina--Legal
North Dakota--Illegal
Ohio--Legal
Oklahoma--Legal
Oregon--Illegal
Pennsylvania--Legal
Rhode Island--Restricted*
South Carolina--Legal
South Dakota--Illegal
Tennessee--Legal
Texas--Legal
Utah--Illegal
Vermont--Illegal
Virginia--Illegal
Washington--Illegal
West Virginia--Illegal
Wisconsin--Illegal
Wyoming--Legal

Theories of Illness/Wellness

- Biopsychosocial
- Biomedical
- Energy
- Chiropractic/Holistic

Components of Emotion

1. Physical arousal or lowering
2. Feelings of pleasure or pain
3. Cognitive appraisal
4. Emotional Expression
5. Environmental consequences or inputs



Defense Mechanisms

1. Denial
2. *Repression*
3. *Suppression*
4. Displacement
5. Sublimation
6. Projection
7. Intellectualization
8. Rationalization
9. Regression
10. Reaction-formation

Classic Developmental Theories

- Behavioral Theories
- Cognitive Theories
- Developmental Theories
- Humanist Theories

Psychoanalytic View of Development

Age	Freud	Erikson
1st yr	Oral stage	Infancy: **Trust vs. Mistrust**
1-3	Anal Stage	Early Childhood: **Autonomy vs. Shame & Doubt**
3-5	Phallic Stage	Preschool: **Initiative vs. Guilt**
6-11	Latency Stage	School Age: **Industry vs. Inferiority**
12-18	Genital Stage	Adolescence: **Identity vs. Role Confusion**
18-35		Young Adult: **Intimacy vs. Isolation**
36-60		Middle Age: **Generativity vs. Stagnation**
61+		Later Life: **Integrity vs. Despair**

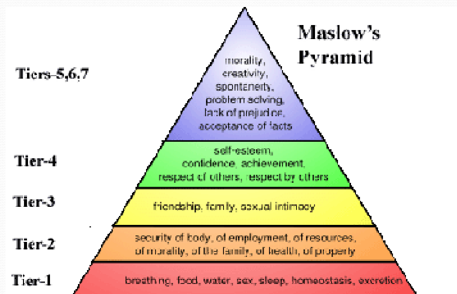
Erikson's Stages of Psychosocial Development

Stage	Basic Conflict	Important Events	Outcome
Infancy (birth to 18 months)	Trust vs. Mistrust	Feeding	Children develop a sense of trust when caregivers provide reliabilty, care, and affection. A lack of this will lead to mistrust.
Early Childhood (2 to 3 years)	Autonomy vs. Shame and Doubt	Toilet Training	Children need to develop a sense of personal control over physical skills and a sense of independence. Success leads to feelings of autonomy, failure results in feelings of shame and doubt.
Preschool (3 to 5 years)	Initiative vs. Guilt	Exploration	Children need to begin asserting control and power over the environment. Success in this stage leads to a sense of purpose. Children who try to exert too much power experience disapproval, resulting in a sense of guilt.

Erikson's Stages of Psychosocial Development

School Age (6 to 11 years)	Industry vs. Inferiority	School	Children need to cope with new social and academic demands. Success leads to a sense of competence, while failure results in feelings of inferiority.
Adolescence (12 to 18 years)	Identity vs. Role Confusion	Social Relationships	Teens needs to develop a sense of self and personal identity. Success leads to an ability to stay true to yourself, while failure leads to role confusion and a weak sense of self.
Young Adulthood (19 to 40 years)	Intimacy vs. Isolation	Relationships	Young adults need to form intimate, loving relationships with other people. Success leads to strong relationships, while failure results in loneliness and isolation.
Middle Adulthood (40 to 65 years)	Generativity vs. Stagnation	Work and Parenthood	Adults need to create or nurture things that will outlast them, often by having children or creating a positive change that benefits other people. Success leads to feelings of usefulness and accomplishment, while failure results in shallow involvement in the world.
Maturity(65 to death)	Ego Integrity vs. Despair	Reflection on Life	Older adults need to look back on life and feel a sense of fulfillment. Success at this stage leads to feelings of wisdom, while failure results in regret, bitterness, and despair.

Hierarchy of Needs



Stress Reduction Methods

- Cultivating Relaxation Response
- Progressive Relaxation
- Biofeedback
- Guided imagery
- Exercise
- Focused attention/mindfulness

Biopsychosocial Model

Components

1. Cartesian Model – Ascending Nociceptive Input from the periphery
2. Gate Control Theory – descending modulation that inhibits or facilitates nociception.
3. "Central Processes"
   - -neurological(as described above)
   - -affective
   - - cognitive

"Central Processes" defined

- NEUROLOGICAL (cont'd)
- Liebenson-less than 20% of back pain is caused by structural factors.
- Nociception - the neural processes of encoding and processing noxious stimuli. It is the afferent activity produced in the peripheral and central nervous system by stimuli that have the potential to damage tissue. This activity is initiated by nociceptors, (also called pain receptors), that can detect mechanical, thermal or chemical changes, above a set threshold. Once stimulated, a nociceptor transmits a signal along the spinal cord, to the brain.

The Other 80 %...........????? From the Patients Perspective

- Affective - refers to the experience of feeling or emotion.
- Cognitive – (Cognition) refers to one's ability to perceive, interpret, understand, and process information, given a healthy growth environment.
- Liebenson – "perception of pain is heavily influenced (both by nociception and) by one's attitudes, beliefs, and social environment".

Social Environment/Information Overload

A. Biomedical model limitations/failures (Liebenson)

1. Overemphasis on structural diagnosis
2. Over prescription of bed rest
3. Overuse of Surgery

B. Biomedical Model Complicating Factors

4. overemphasis on pharmaceutical management
5. insurance based acute care focus
6. Societal psychological mindset =no pain means no problem

Overemphasis on structural diagnosis

- Overuse of diagnostic imaging, MRI, etc. to rule out serious diseases/ "**Red Flags**"(tumors, infections, etc.)
- Structural Pathologies *that can only be identified with imaging* are misrepresented as being strongly correlated with symptoms during the ROF. (herniated discs, arthritis, etc.)
- The occurrence of false positives
  - -28 to 50% of asymptomatic individuals—low back
  - -Possibly as high as 75%--cervical spine
  - -false-positives/future problems

Overuse of Surgery

- Bigos and Battie – only appropriate for 2% of the population, and it's inappropriate use can have a great impact on increasing the chance of chronic pain disability.
- Bush – (1992) 86% of patients with clinical sciatica and radiologic evidence of nerve root entrapment were treated successfully by aggressive conservative management

Surgical intervention

- ***Almost*** Certain Surgical Criteria
  - Cauda Equina Syndrome
  - Paresis (partial loss of movement)tothat is rapidly progressive despite a trial is conservative care of four weeks and three months

Rand Corporation

- Surgical indications for disc herniation or stenosis
  - Painting lower limb with positive imaging major either neurological findings ***after restricted activity for more than six weeks***
    - **minor neurological findings(two or more)**
      - Asymmetric DTR
      - Positive ipsilateral straight leg raise (SLR)
      - Sciatica
      - Dermatomal sensory deficits
      - **Major neurological findings**
        - Progressive unilateral leg weakness
        - Positive contralateral SLR test

Abnormal Illness Behavior

LaRocca 1991 in his presidential address to the Cervical Spine Research Society's annual meeting—
•If pathology is a major cause of symptoms
•And prescribed/***appropriate*** treatment patient doesn't recover
•Then incorrectly assume psychogenic and label as such

- Acute pain
  - Painful stimuli
  - Nociception
  - Tissue injury

→

- Chronic pain
  - SMALL PORTION

Chronic Pain.. continued

- Locomotor pain = impaired function(functional disorder)
  - Nonspecific/idiopathic (**not** injury related)
    - Long-term physiologic compensatory behaviors (Innate)
    - Muscle/joint dysfunction plus chronic soft tissue irritation equals pain generation
    - Acute-care protocols (most office setups) are doomed to failure because:
      - they are injury-site specific
      - Acute pain requires reduced activity whereas chronic pain requires controlled, biomechanical, rehabilitative, increased activity levels

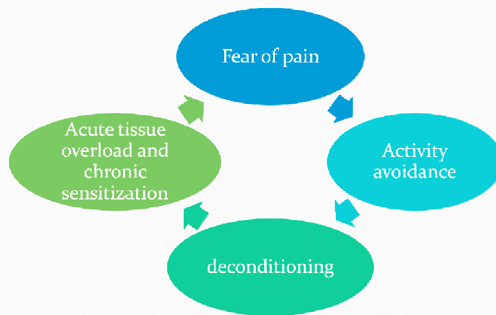
Chronic Pain…. continued

- Dysfunctional Compensatory Pathology
  - Innate helped the body survive **with limitations**
  - Excessive scar tissue development, restricted motion, chronic subluxation, increased pain perception, decreased activity, physiologic recruitment, all contribute to the following:
    - Excess strain/"wear and tear" on the anatomy usually away from the initial injury site
    - Secondary strain becomes primary pain generator
    - Overuse of normal healthy tissue causes breakdown/injury
    - define chronic illness

Chronic Pain… continued

- (slide 29) Remaining Factors
  - Affective
    - Anxiety
    - Depression
  - Cognitive (coping)
    - Fear –avoidance behavior
    - Ignoring stop rules
    - Catastrophising the low back problem
      - Ruptured disc
      - Degenerative arthritis

Fear-Avoidance Behavior



Ignoring "Stop" Rules

- An arbitrary set of rules set up by the chronic pain patient to help them make the decision to stop certain activities because they generate/initiate pain.
  - The list intends to grow as your body continues to be deconditioned
  - A weakened muscular system creates a perpetual cycle where less activity triggers pain which then forces chronic pain suffer to become less active.
  - Soon they feel trapped because minimal activity generates pain

"Catastrophising"

- Nothing relieves pain
- Increased pharmaceutical use coupled with less pain relief(tolerance)
- An expanding list of "things I can't do anymore because of the pain"
- No one can help me……..then it must be serious
  - Ruptured disk
  - (serious, irreparable)degenerative arthritis
  - They must've missed something life-threatening

Keys to Recovery 7 R's (Liebenson)

- Rule out (red flags)
- Reassurance(Klassen – 43% see doctor just for this)
- Reactivation (formulas :50/50)
- Relieve pain
- Reevaluation
- Rehabilitate/recondition/reeducate
- Refer

Cognitive behavioral therapy

- **Cognitive behavioral therapy** (**CBT**) is a psychotherapeutic approach that aims to solve problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure.

Stereotyping: A Definition

Stereotyping can be defined as the process by which people use social categories (e.g. race, sex) in acquiring, processing, and recalling information about others.

Stereotyping beliefs may serve important functions - organizing and simplifying complex situations and giving people greater confidence in their ability to understand, predict, and potentially control situations and people.

Stereotyping: Risks

Can exert powerful effects on thinking and actions at an implicit, unconscious level, even among well-meaning, well-educated persons who are not overtly biased.

Can influence how information is processed and recalled.

Can exert "self-fulfilling" effects, as patients' behavior may be affected by providers' overt or subtle attitudes and behaviors.

Stereotyping: When Is It in Action?

Situations characterized by time pressure, resource constraints, and high cognitive demand promote stereotyping due to the need for cognitive 'shortcuts' and lack of full information.

What is the Evidence that Physician Biases and Stereotypes May Influence the Clinical Encounter?

Van Ryn and Burke (2000) - study conducted in actual clinical settings found that doctors are more likely to ascribe negative racial stereotypes to their minority patients. These stereotypes were ascribed to patients even when differences in minority and non-minority patients' education, income, and personality characteristics were considered.

Finucane and Carrese (1990) - Physicians more likely to make negative comments when discussing minority patients' cases.

What is the Evidence that Physician Biases and Stereotypes may Influence the Clinical Encounter (cont'd)?

Rathore et al. (2000) – found that medical students were more likely to evaluate a white male "patient" with symptoms of cardiac disease as having "definite" or "probable" angina, relative to a black female "patient" with objectively similar symptoms.

Abreu (1999) – found that mental health professionals and trainees were more likely to evaluate a hypothetical patient more negatively after being "primed" with words associated with African American stereotypes.

Findings

Racial and ethnic disparities in health care exist and are associated with worse outcomes.

They occur in the context of broader historic and contemporary social and economic inequality in many sectors of American life.

Many sources – including health systems, health care providers, patients, and utilization managers – contribute to racial and ethnic disparities in health care.

Listening Skills

Don't fake understanding
Don't tell the patient how he/she feels
Vary your response
Focus on the feelings and understanding
Choose the most accurate feeling word
Develop vocal empathy
Strive for concreteness and relevance
Provide non-dogmatic but firm responses
Reflect the patient's resources

Key Behaviors for Active Listening (Pretending to care will get you nowhere!)

1. MAKE and MAINTAIN EYE CONTACT
2. Use nonverbal listening behaviors (appropriate body language and show empathy)
3. Use door openers and open questions to encourage the speaker
4. Clarify vague and uncertain questions
5. Determine the feeling and content messages
6. Paraphrase the message, both feeling and content
7. Obtain confirmation of your paraphrase

Handling Defensiveness in Yourself and Others

1. Listen carefully and paraphrase by reflecting both the person's content and feeling messages (repeat if necessary)
2. Verify your perceptions by asking for clarifications
3. Continue to treat the person with respect in spite of his/her words
4. Appeal to common goal of healing and getting well.
5. Make "I" statements when expressing thoughts and feelings
6. Focus on behaviors and actions, not on personality traits

Suicide in the U.S.: Statistics NIMM(National Institute of Mental Health)

- **What are the risk factors for suicide?**
- Research shows that risk factors for suicide include:
- depression and other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders). More than 90 percent of people who die by suicide have these risk factors.
- stressful life events, in combination with other risk factors, such as depression. However, suicide and suicidal behavior are not normal responses to stress; many people have these risk factors, but are not suicidal.
- prior suicide attempt
- family history of mental disorder or substance abuse
- family history of suicide
- family violence, including physical or sexual abuse
- firearms in the home, the method used in more than half of suicides
- incarceration
- exposure to the suicidal behavior of others, such as family members, peers, or media figures.

Suicide in the U.S.: Statistics ......cont. NIMM(National Institute of Mental Health)

- Research also shows that the risk for suicide is associated with changes in brain chemicals called neurotransmitters, including serotonin. Decreased levels of serotonin have been found in people with depression, impulsive disorders, and a history of suicide attempts, and in the brains of suicide victims
- **Are women or men at higher risk?**
- Suicide was the eighth leading cause of death for males and the sixteenth leading cause of death for females in 2004.[1]
- Almost four times as many males as females die by suicide

Suicide in the U.S.: Statistics ……cont. NIMM(National Institute of Mental Health)

- In 2004, suicide was the third leading cause of death in each of the following age groups. Of every 100,000 young people in each age group, the following number died by suicide:
- Children ages 10 to 14 — 1.3 per 100,000
- Adolescents ages 15 to 19 — 8.2 per 100,000
- Young adults ages 20 to 24 — 12.5 per 100,000

Causes of Death Number of Deaths Rate per 100,000

- **15-24 years (released 1/16/08 by Center for Disease Control)**
- **1: Accidents and adverse effects 13,872 38.3 . . . Motor vehicle accidents All other accidents and adverse effects**
- **2: Homicide and legal intervention**
- **3: Suicide**
  4: Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues
- **5: Diseases of heart 6 Human immunodeficiency virus infection 420 1.2 7 Congenital anomalies 387 1.1 8 Chronic obstructive pulmonary diseases and allied conditions 230 0.6 9 Pneumonia and influenza 197 0.5 10 Cerebrovascular diseases 174 0.5 . . . All other causes (Residual) 3,940 10.9**

Prevalence(%) of Psychiatric Disorders in the USA

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Mental health problems among young doctors: an updated review of prospective studies. (a little too close to home???)

- Harv Rev Psychiatry. 2002 May-Jun;10(3):154-65.
- Tyssen R, Vaglum P.
- Department of Behavioural Sciences in Medicine, Faculty of Medicine, University of Oslo, Oslo, Norway. reidar.tyssen@basalmed.uio.no
- Previous studies have shown the medical community to exhibit a relatively high level of certain mental health problems, particularly depression, which may lead to drug abuse and suicide. We reviewed prospective studies published over the past 20 years to investigate the prevalence and predictors of mental health problems in doctors during their first postgraduate years. We selected clinically relevant mental health problems as the outcome measure. We found nine cohort studies that met our selection criteria. Each of them had limitations, notably low response rate at follow-up, small sample size, and/or short observation period. Most studies showed that symptoms of mental health problems, particularly of depression, were highest during the first postgraduate year. They found that individual factors, such as family background, personality traits (neuroticism and self-criticism), and coping by wishful thinking, as well as contextual factors including perceived medical-school stress, perceived overwork, emotional pressure, working in an intensive-care setting, and stress outside of work, were often predictive of mental health problems.

Neurotransmitters/Depression

- Pharmaceutical
- **Selective Serotonin (Serotonin Specific) Reuptake Inhibitors** (SSRI's)
  - Paxil
  - Prozac
  - Zoloft
  - Celexa/Lexapro
  - Cymbalta

  All of these inhibit serotonin from being dissipated while in the synapse so the brain can use it again.

Neurotransmitters/Depression

- **Serotonin**-controls many vital human functions
  - Major help in regulation of: hunger, thirst, mood, breathing, sleep, confidence, perspective, self esteem, empathy, attitude
  - Diet needs: Tryptophan, B-complex, 5HTP

  Tryptophan-major foods: cottage cheese, basil leaves, yogurt, eggs, Lean meat, nuts, beans, fish, and cheese.

  specific cheeses-Cheddar, Gruyere, Swiss

  avoid blue cheese,processed(amines)

  B-Complex (B6) …converts tryptophan into serotonin

  -Folate-broccoli, cabbage, asparagus, spinach, Kale

  -Folic acid-whole grain breads and cereals

  5HTP:(5 hydroxytryptophan)

Folate Sources

Folate is abundant in many vegetables and legumes, all of which are members of the World's Healthiest Foods. Excellent sources of folate include spinach, asparagus, turnip and mustard greens, broccoli, cauliflower, beets, celery, cabbage, zucchini, lentils, and Brussels sprouts. Very good sources include squash, cucumber, black beans, pinto beans, and garbanzo beans.

B-Vitamins/depression

B1- Thiamin
B2- Riboflavin/Niacin
B6- Pyrodoxine/Folacin

B12- Cobalomine

Mental Health Treatment Facts

- 50% of people with mental health disorders first diagnosed by PCP
- 40% of patients seeing PCP have a diagnosable mental health disorder
- 85% of patients with anxiety or depressive disorders sought help from PCP
- Only 19% received adequate treatment

Legal Issues/Precautions (weighing the issues)

- Commitment to Care/Practitioner Limitations
- The Right to Treatment/The Right to Refuse Treatment
- Chiropractic claims/Verifiable Research
- Abandonment-be careful what you promise
- Competency
- Malpractice
- Confidentiality

Role of Portal of Entry Doctor

- Complete evaluation
- How do I Know if there is a need for mental health services-preliminary findings
  - History

Role of Portal of Entry Doctor

- Complete evaluation
- Determine the need for mental health services-preliminary diagnosis
- Explain the purpose
- Obtain a release of information
- Make the referral directly
- Followup on compliance

Assessment

- Mental Status Exam
  - Presentation
  - State of Consciousness
  - Attention
  - Speech Orientation
  - Mood & Affect
  - Form of thought

Mental Status Exam Contin.

- Thought Content
- Perceptions
- Judgment
- Memory
- Intellectual Functioning

Methods of Assessment

- Psychological Assessment
- EEG
- Computed tomography CT
- Magnetic resonance imaging MRI
- Positron Emission Tomography PET
- Single-photon emission computed tomography SPECT

Psychiatric Problems in Medical Care

- Fatigue
- Insomnia
- Chronic medical conditions
- Myocardial infarction
- Generalized anxiety
- Elderly

Psychiatric Problems in Medical Care (con.)

- Depression
- Panic Disorder
- Somatization Disorder
- Substance Abuse
- Psychosocial

Basic Theories of Counseling and Psychotherapy

Psychoanalysis
Existential-Humanistic
Reality Therapy
Behavior Therapy
Cognitive-Behavior Therapy
Family Systems

Psychoanalysis

- Individual Psychology, Self psychology Object Relations"
- Childhood determines later life psychological issues
- Treatment long-term, expensive
- Methods: Passive, Free association, dream analysis

Principles of Existential-Humanistic Approach

- Capacity of self-awareness
- Freedom and responsibility
- Search for meaning, purpose ,values goals
- Anxiety is a condition of living

Existential Humanistic Therapists

- Existential Therapy- Victor Frankl Meaning, purpose, and love
- Person Centered Therapy- Carl Rogers
  Unconditional positive regard
- Gestalt Therapy-Fritz Perls
  Experiential here and now

Reality Therapy

- Problems due to unsatisfactory relationships and choices
- Therapy Process
  Explore wants, needs, perceptions
  Direction and doing in the present
  Evaluation
  Planning and commitment

Behavior Therapy

- psychotherapy that focuses on changing and gaining control over unwanted behaviors
- focuses on thought patterns
- Active collaborative approach
- Based on principles of learning:
  operant conditioning and classical conditioning
- Ivan Pavlov and B. F. Skinner

Cognitive Behavioral Therapy

- Thoughts first ....Then actions
- Cognitive processes such as "self-talk" mediate behavior change
- Setting goals
- Target behaviors to change=PHOBIA(irrational fears)
- Types
  Flooding=confronted by the fear object for an extended length of time without the opportunity to escape.
  Systematic desensitization=imagine the events that cause anxiety while engaging in a series of relaxation exercises.

Thought Record

1. Situation
2. Mood Rating
3. Automatic Thought
4. Evidence that supports the thought
5. Evidence that does not support the thought
6. Alternative balanced thought
7. Mood Rating

Family Therapy

- Involves a systems approach
- Active and focus on interrelationships
- Patterns of the family system
- Genograms and explore family themes and patterns
- Essential for treatment of children and adolescence

DSM-IV-TR
Diagnostic & Statistical Manual of Mental Disorders
Fourth Edition Text Revision

American Psychiatric Association=1994

will be revised in 2011

Axis I

Clinical Disorders

Other Conditions That May Be A Focus of Clinical Attention

Ex. Substance Related Disorders

Mood Disorders

Psychotic Disorders

Axis II

Personality Disorders

Mental Retardation

Axis III

General Medical Conditions

ICD-9-CM Codes

Axis IV

Psychosocial and Environmental Problems

- Primary Support Group
- Related to Social Environment
- Educational
- Occupational
- Housing
- Economic
- Access to healthcare services

Axis V

Global Assessment of Functioning

Current, Highest Level in Past Year, At Discharge

NIMH Mental Disorders in America**

All Depressive Disorders

- 18.8 million (9.5%)
- Nearly twice as many women (12%) as men (6.6%)- 12.4 million women & 6.4 million men
- Occurring earlier in life in people born in recent decades
- Co-morbidity with anxiety and substance abuse

NIMH Mental Disorders in America**

Dysthymic Disorders

- 5.4% during their lifetime (10.9 million)
- 40% also meet criteria for major depressive disorder or bipolar in a given year
- Often begins in childhood, adolescence or early adulthood

NIMH Mental Disorders in America**Con't

Bipolar Disorder

- 2.3 million (1.2%)
- Men and women – equally likely to develop
- Average age onset for the first episode - early 20's

**Annually for adults 18 yrs and older in US

Suicide in America

- 30,000 people die by suicide
- Significant majority – white males over 45
- More than 90% - diagnosable mental disorder
- Third leading cause of death in 15-24 yr olds
- Four times as many men as women die, women attempt 2-3 times more often
- Depression or alcohol – 75% of all suicides
- TCA's – most commonly used antigepressants in suicide attempts

Short-Term (6-12mo) Risk Factors for Suicide

Severe hopelessness
Panic, severe anxiety and agitation
Global insomnia
Severe cognitive difficulties and psychotic thinking
Lack of friends in adolescence
Acute overuse of alcohol
Recurrent depression

Necessary Terminology

- Manic episode
- Major depressive episode
- Mixed episode
- Hypomanic episode

Episodes do not have their own diagnostic codes and cannot be diagnosed as separate entities. They serve as building blocks for the diagnostic disorders known as Mood Disorders.

Necessary terminology cont.

- **delusions** (false, strongly held beliefs not influenced by logical reasoning or explained by a person's usual cultural concepts).
  - These erroneous beliefs usually in fall for a misinterpretation of perceptions or experiences
  - Themes include: persecution,referential, religious or grandiosity with **persecution being the most common including the belief one is being tormented, followed, tricked, spied on.**
  - Referential-certain comments, gestures, passages from books, song lyrics, are directed specifically at them

Terminology continued

- **psychosis** (or psychotic symptoms). Common psychotic symptoms are hallucinations (hearing, seeing, or otherwise sensing the presence of things not actually there)
- Usually a much longer duration (at least a month)
- Usually considered much more severe than delusions

Criteria for Manic Episode

A distinct period of abnormally and persistent elevated, expansive, or irritable mood.

Consists of at least 3 of the following symptoms and lasting at least 1 week with marked impairment of functioning:

Criteria for Manic Episode Con't

Inflated self-esteem or grandiosity
Decreased need for sleep
More talkative or pressure to keep talking
Flights of ideas or subjective experiences that thoughts are racing
Distractibility
Increase in goal directed activity or psychomotor agitation
Excessive involvement in pleasurable activities that have a high potential for painful consequences

Criteria for Hypomanic Episode

Consists of at least 3 of the following symptoms and lasting 4 days ***without*** marked impairment of functioning:

Criteria for Hypomanic Episode Con't

Inflated self-esteem or grandiosity
Decreased need for sleep
More talkative or pressure to keep talking
Flights of ideas or subjective experiences that thoughts are racing
Distractibility
Increase in goal directed activity or psychomotor agitation
Excessive involvement in pleasurable activities that have a high potential for painful consequences

Criteria for Major Depressive Episode

A period of depressed mood with a loss of interest in nearly all activities.

Consists of 5 or more of the following symptoms lasting at least 2 consecutive weeks and represent a change from previous functioning;

Must include one of the first two symptoms of either (1) depressed mood or (2) loss of interest or pleasure.

Criteria for Major Depressive Episode Con't

Depressed mood
Diminished interest
Significant weight loss
Insomnia or hypersomnia
Psychomotor agitation or retardation
Fatigue or loss of energy
Feelings of worthlessness or guilt
Diminished ability to concentrate or indecisiveness
Recurrent thoughts of death

Mixed Episode

- The criteria for both a manic episode and the major depressive episode nearly every day during at least a one week period.
- The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning, usual social activities or relationships, or hospitalization to prevent harm to self or others.
- Symptoms are ***not*** do to direct physiological effects of substance(i.e.,medication, electroconvulsive therapy, a drug of abuse) or a general medical condition.

DSM-IV-TR Mood Disorders

Mood disorder due to a general medical condition

Substance-induced mood disorder

Mood disorder not otherwise specified

DSM-IV-TR Mood Disorders

Depressive Disorders(unipolar depression)

Major Depressive Disorder

Single, Recurrent

Melancholic, psychotic, atypical, seasonal

-the primary characterization of this disorder is one or more **major depressive episode**.

Dysthymic Disorder

Early, Late Onset

Depression not otherwise specified

DSM-IV-TR Mood Disorders

Bipolar Disorders

Bipolar I

Manic, mixed, depressed

Bipolar II

Hypomanic, depressed

Cyclothymic disorder

Bipolar disorders not otherwise specified

DSM-IV-TR Mood Disorders

Mood disorder due to a general medical condition

Substance-induced mood disorder

Mood disorder not otherwise specified

Criteria for Major Depressive Episode,Con't

Depressed mood
Diminished interest
Significant weight loss
Insomnia or hypersomnia
Psychomotor agitation or retardation
Fatigue or loss of energy
Feelings of worthlessness or guilt
Diminished ability to concentrate or indecisiveness
Recurrent thoughts of death

Criteria for Dysthymic Disorder

Depressed most of the day

Consists of 2 or more of the following symptoms lasting for at least 2 years

- Poor appetite
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness

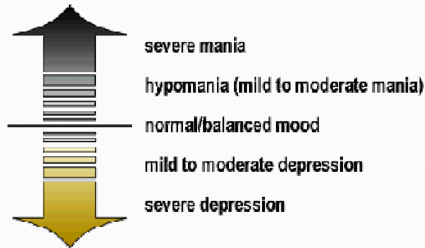
Criteria for Adjustment Disorder with Depressed Mood

Development of depressive symptoms in response to an identifiable stressor occurring within 3 months of the onset of the stressor;

Characterized by either marked distress in excess to the stressor or significant impairment in social or occupational functioning;

Does not last past 6 mos. of exposure to stressor.

Affective Continuum (emotional extremes)



Criteria for Cyclothymic Disorder

Chronic fluctuating mood disturbance involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms for at least 2 years;

During the 2 yr. Period, any symptom free intervals last no longer than 2 months;

No major depressive disorder or manic episode has been present.

Criteria for Bipolar Disorder

Bipolar I

The occurrence of 1 or more manic episodes or mixed episodes

Bipolar II

The occurrence of 1 or more major depressive episodes accompanied by 1 hypomanic episode

Medical Causes of Depression

- Autoimmune Disorders
- Cerebrovascular disease
- Endocrine disorders
- Epilepsy
- Infections

Medical Causes continued

- Metabolic Disorders
- Neurologic Disorders
- Sleep Apnea
- Structural Brain disease
- Malignancies

Substances causing Depressive Symptoms

- Alcohol
- Anabolic steroids
- Anticholinergic agents
- Anticonvulsant agents
- Barbiturates
- Benzodiazepines

Substances Causing Depression continued

- Cimetidine
- Clonidine
- Corticosteroids
- Oral contraceptives
- Sedatives
- Thiazides

Screening Tools

- Have you been feeling sad or depressed recently?"
- Hamilton Depression Rating Scale
- Beck Depression Inventory
- Geriatric Depression Scale

Antidepressants

- Tricyclics- e.g. elavil, sinequan pamelor
- SSRI's –e.g. Prozac, Paxil, Zoloft
- SNRI's e.g. Effexor,Cymbalta
- 5HT2 + SRI e.g. Desyrel, Serzone
- Others: Wellbutrin, Remeron
- MAO Inhibitors

Side Effects

- Anticholinergic-dry mouth,blurred vision, constipation
- Sedation
- Activation
- Orthostatic hypotension
- Sexual
- Cardiac Conduction Delay

Side Effects contin.

- Seizures
- Gastrointestinal
- Suicide
- Uncommon-SIADH (Syndrome of Inappropriate Antidiuretic Hormone Secretion; Extrapyramidal Side Effects (EPS); Bleeding; Cardiac Arryhthmias; Serotonin Syndrome

Alternative and New Treatment of Depression

1. Omega 3 Polyunsaturated Fatty acids and bipolar
2. Chromium
3. Inositol
4. Newer anticonvulsant and antipsychotics
5. ECT alternatives – Vagus nerve stimulation, repetitive transcranial magnetic stimulation (rTMS), magnetic seizure therapy

Alternative and New Treatment of Depression

6. Pindolol augmentation of SSRI
7. Ketoconazole for bipolar
8. Bright light therapy for SAD

DSM-IV-TR Anxiety Disorders

Panic disorders
- **without Agoraphobia**
- **with Agoraphobia**(clusters, avoided/stressful, rule out drugs,

Specific Phobia(cats, heights, bridges, etc)

Social Phobia(Social or performance situations, public scrutiny/criticism/embarrassment, situational panic attack, avoidance, interferes with normal routine or occupation and/or social life

Obsessive-Compulsive Disorder
Posttraumatic Stress Disorder
Acute Stress Disorder
Generalized Anxiety Disorder
Other Anxiety Disorders
- **Due to a general medical condition**
- **Substance-induced**

Criteria for Panic Attack

discrete period of intense fear or discomfort in which 4 or more of symptoms develop abruptly and reach peak in 10 minutes or less:

1. palpations, pounding heart, or accelerated heart rate
2. sweating
3. trembling or shaking
4. sensations of shortness of breath or smothering

Criteria for Panic Attack, Con't

5. feeling of choking
6. chest pain or discomfort
7. nausea or abdominal distress
8. feeling dizzy, unsteady, lightheaded, or faint
9. derealization (feelings of unreality) or depersonalization (being detached from oneself)
10. fear of losing control or going crazy
11. fear of dying
12. parasthesias (numbness or tingling sensations)
13. chills or hot flushes

Criteria for Cyclothymic Disorder

Chronic fluctuating mood disturbance involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms for at least 2 years;

During the 2 yr. Period, any symptom free intervals last no longer than 2 months;

No major depressive disorder or manic episode has been present.

Criteria for Panic Disorder

1. Both A and B

   A. Recurrent unexpected panic attacks

   B. At least 1 attack has been followed by 1 month or more of 1 or more of the following:

   1. persistent concern about having additional attacks
   2. worry about the implications of the attack or its consequences (e.g. losing control, having a heart attack, going crazy)

Criteria for Panic Disorder, Con't

C. Panic attacks not due to substance abuse or medical condition

D. Panic attacks not better accounted for by another medical disorder such as OCD, Social Phobia or Specific Phobia

This disorder can be with or without agoraphobia

Social Phobia

1. Marked and persistent fear of one or more social situations
2. Exposure to the feared situations invoke anxiety or panic attack
3. The person recognizes the fear is excessive
4. Feared situations are avoided or endured
5. Avoidance or distress interferes with person's normal routine

Social Phobia Con't

6. In individuals under 18 the duration lasts for at least 6 months
7. The fear or avoidance is not due to substance abuse or general medical condition or another mental disorder
8. If medical condition is present the fear is unrelated to the medical symptoms

Key Symptoms of PTSD

1. Re-experiencing the traumatic event
   - Intrusive, distressing recollections
   - Flashbacks
   - Nightmares

   Exaggerated emotional and physical reactions to triggers that remind the person of the event
2. Avoidance of activities, places, thoughts, feelings, or conversations related to the trauma

Key Symptoms of PTSD Con't

3. Emotional numbing
   - Loss of interest
   - Feeling detached from others
   - Restricted emotions
4. Increased arousal
   - Difficulty sleeping
   - Irritability
   - Difficulty concentrating
   - Hypervigilance
   - Exaggerated startle response

How to Recognize PTSD Con't

The Impact of the Stressor

Must be extreme, not just severe, e.g., actual or threatened deaths, serious injury, rape, or childhood sexual abuse

Causes powerful subjective responses – intense fear, helplessness, or horror

C0-Morbid Disorders with PTSD

Substance abuse or dependence
Major depressive disorder
Panic Disorder/agoraphobia
Generalized anxiety disorder
Obsessive-compulsive disorder
Social phobia
Bipolar disorder

Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight loss less than 85% of that expected).

Anorexia Nervosa Con't

B. Intense fear of gaining weight or becoming fat, even though underweight.

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 denial of the seriousness of the current low body weight.

Anorexia Nervosa Con't

D. In postmenarcheal females, amenorrhea ie., the absence of at least three consecutive menstrual cycles.

Restrictive Type: not engaging in binge-eating or purging behavior .

Binge-Eating/Purging Type: regularly engaged in binge-eating or purging.

NIMH Longterm AN symptoms

- thinning of the bones (osteopenia or osteoporosis)
- brittle hair and nails
- dry and yellowish skin
- growth of fine hair over body (e.g., lanugo)
- mild anemia, and muscle weakness and loss
- severe constipation
- low blood pressure, slowed breathing and pulse
- drop in internal body temperature, causing a person to feel cold all the time
- lethargy

Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g. within any 2 hr period) an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstance
   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

Bulimia Nervosa, Con't

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 mos.

Bulimia Nervosa, Con't

D. Self-evaluation is unduly influenced by body shape and weight

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa

Bulimia Nervosa, Con't

Specific Type:

Purging Type: regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Non-purging Type: used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

NIMH Other symptoms include:

- chronically inflamed and sore throat
- swollen glands in the neck and below the jaw
- worn tooth enamel and increasingly sensitive and decaying teeth as a result of exposure to stomach acids
- gastroesophageal reflux disorder
- intestinal distress and irritation from laxative abuse
- kidney problems from diuretic abuse
- severe dehydration from purging of fluids
- finger callouses

Typical Alcohol Progression

Social Drinkers – Most Americans are characterized as social drinkers. Statistics indicate, however, that one of every 16 drinkers will become alcoholic.

Warning Signs – The individual begins to drink more frequently and more than his associates. He drinks for confidence or to tolerate or escape problems. No party or other occasion is complete without a couple of drinks.

Typical Alcohol Progression, Con't

Early Alcoholism – With increasing frequency, the individual drinks too much. "Blackouts" or temporary amnesia, occur during or following drinking episodes. He drinks more rapidly than others, sneaks drinks and in other ways conceals the quantity that he drinks. He resents any interference with his drinking habits.

Typical Alcohol Progression, Con't

Chronic Alcoholism – The individual becomes a loner in his drinking. He develops alibis, excuses and rationalizations to cover up or explain his drinking. Personality and behavior changes occur that affect all relationships – family, employment, community. Extended binges, physical tremors, hallucinations and delirium, complete rejection of social reality, malnutrition with accompanying illness and disease and early death all occur as chronic alcoholism progresses.

Source: American Medical Association

Substance Dependence

A maladaptive pattern of substance use, leading to a critically significant impairment or distress as manifested by 3 or more of the following, occurring at any time in the same 12 month period:

1. Tolerance-either

   a. a need to increase amounts to achieve intoxication

   b. diminished effect with continued use of the same amount

Substance Dependence Con't

2. Withdrawal-either

   a. a characteristic withdrawal syndrome for the substance

   b. the substance (or something close) is taken to relieve withdrawal

3. The substance is often taken in larger amounts or over a longer period than was intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance

Substance Dependence Con't

5. A great deal of time is spent in activities necessary to obtain the substance
6. Important social, occupational, or recreational activities are given up or reduced because of substance
7. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

Ask yourself "Do I have a problem?"

- C -- tried but failed to "cut" down
- A -- Annoyed by criticism from others
- G -- Guilt about consequences of drinking (ie, loss of job or relationship)
- E -- Eye-opener (MVA or DUI etc)

Teenagers

- About half of U.S. teens who start drinking alcohol *before age 14* will be addicted to it at some point.

Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence

Mental retardation
Learning Disorders
Motor Skills Disorders
Communication Disorders
Pervasive Development Disorders
Attention-Deficit and Disruptive Behavior Disorders

Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence, Con't

Feeding & Eating Disorders of Infancy or Early Childhood
Tic Disorders
Elimination Disorders
Other Disorders
- Separation Anxiety Disorders
- Selective Mutism
- Reactive Attachment Disorders
- Stereotypic Movement Disorders

Pervasive Developmental Disorders

Autistic

Rett's - (female, normal prenatal/perinatal-5 months, normal psychomotor-5 months, head growth decelerates from 5-48 months, profound mental retardation)
Childhood Disintegrative- (primarily male, minimum of two years of normal development, significant loss of previously acquired skills before the age of 10.)
Asperger's – (mostly male, NO clinically significant delays in a language development, cognitive development, age-appropriate self-help skills,

Attention-Deficit Hyperactivity
Conduct
Oppositional Defiant

Autistic Disorder

A. Total of 6 (or more) items from 1,2 &3 and 1 each from 2 or 3
1. Qualitative impairment in social interaction, as manifested by at least 2 of the following:
   a. marked impairment in use of nonverbal behaviors
   b. failure to develop peer relationships
   c. a lack of spontaneous seeking to share with others
   d. lack of social or emotional reciprocity

Autistic Disorder Con't

2. Qualitative impairments in communications as manifested by at least 1 of the following:
   a. delay in or lack of spoken language development
   b. marked impairment in inability to sustain conversations
   c. stereotyped and repetitive use of language
   d. lack of social imitative play

Autistic Disorder Con't

3. Restricted, repetitive & stereotyped patterns of behavior, interest, and activities as manifested by at least 1 of the following:
   a. encompassing preoccupation with one or more stereotyped or restricted pattern of interest
   b. inflexible adherence to routines or rituals
   c. stereotyped and repetitive motor mannerisms
   d. persistent preoccupation with parts of objects

Autistic Disorder Con't

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years:

1. social interaction
2. language
3. symbolic play

Possible Indicators of Autism Spectrum Disorders

Does not:

- Babble, point or make meaningful gestures at 1 yr
- Speak one word by 16 months
- Combine 2 words by 2 yrs
- Respond to his/her name
- Smile
- Follow directions

Possible Indicators of Autism Spectrum Disorders, Con't

- Loses language, or speech is delayed
- Loses social skills or is disinterested in others
- Has poor eye contact
- Doesn't seem to know how to play with toys
- Excessively lines up toys or other objects
- Appears to be hearing impaired
- Overacts to changes
- Has violent tantrums
- Walks on toes
- Acts as if in his/her own world

Oppositional Defiant Disorder

A. Pattern of negativistic, hostile, and defiant behavior lasting at least 6 mos during which 4 of the following are present

1. often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adult requests
4. often deliberately annoys people

Oppositional Defiant Disorder, Con't

5. often blames others for his/her misbehavior
6. is often touchy and easily annoyed by others
7. is often angry and resentful
8. is often spiteful or vindictive

B. The disturbance in behavior causes clinically significant impairment in social, academic or occupational functioning

Conduct Disorder

A. Repetitive and persistent pattern of behavior in which the rights of others or societal norms are violated and manifested by 3 or more of the following criteria for 12 mos:

- Aggression to people or animals
- Destruction of property
- Deceitfulness or theft
- Serious violations of rules

B. Causes significant impairment in social, academic or occupational functioning

Coded Mild, Moderate or Severe and age of onset

Conduct Disorder, Con't

Repetitive pattern of behavior in which the basic rights of others or societal norms are violated, 3 or more of the following in the last 3 mos:

- Aggression to people and animals
  - Bullies, threatens, intimidates, uses weapons, is cruel, forced sexual activity
- Destruction of property
  - Intentional acts of fire setting or destruction
- Deceitfulness or theft
  - Broken into a house, stolen a car, forgery, shoplifting

Attention Deficit/Hyperactivity Disorder

Either 1 or 2, present before age 7 and in 2 or more settings.

1. 6 or more of the following symptoms of inattention persisting at least 6 months:

Inattention

- **Failure to attend to details or making careless mistakes**
- **Difficulty sustaining attention in tasks**
- **Does not seem to listen when spoken to**
- **Does not follow through on instructions**
- **Has difficulty organizing tasks**
- **Avoids tasks requiring sustained mental effort**
- **Often loses things**
- **Easily distracted**
- **Forgetful in daily activities**

Attention Deficit/Hyperactivity Disorder

6 or more of the following symptoms of hyperactivity-impulsiveness

Hyperactivity

- Fidgets with hands and feet
- Leaves seat assigned in class
- Runs about and climbs on things in inappropriate situations
- Difficulty engaging in quiet activities
- Talks excessively

Impulsivity

- Often blurts out answers
- Has difficulty waiting turn
- Interrupts others

Personality Disorder List

Cluster A

- Paranoid
- Schizoid
- Schizotypal

Cluster B

- Antisocial
- Borderline
- Histrionic
- Narcissistic

Cluster C

- Avoidant
- Dependent
- Obsessive - Compulsive

Criteria for Personality Disorder

Enduring pattern of inner experience and behavior that deviates markedly from expectations of the culture. It is manifested on 2 or more of the following:

1. Cognition
2. Affectivity
3. Interpersonal functioning
4. Impulse control

Criteria for Personality Disorder, Con't

5. Inflexible and pervasive pattern across social and personal situations
6. Pattern leads to clinically significant distress or impairment
7. Stable and of long duration
8. Onset in adolescence or young childhood.

Avoidant Personality Disorder

Pervasive pattern of social inhibition, feelings of inadequacy, and hyper-
sensitivity to negative evaluation

Indicated by 4 or more of the following:

APD con't

1. Avoids occupational activities that involve significant interpersonal contact, fears criticism, disapproval or rejection;
2. Unwilling to get involved with people unless certain of being liked;
3. Shows restraint of intimate relationship for fear of being shamed and ridiculed;
4. Preoccupied with being criticized or rejected in social situations;

APD con't

5. Is inhibited in new interpersonal situations because of feelings of inadequacy;
6. Views self as socially inept, personally unappealing, or inferior to others;
7. Is usually reluctant to take personal risks or to engage in any new activities.

Paranoid Personality

Pervasive distrust and suspiciousness of others: their motives are interpreted as malevolent

Indicated by four or more of the following:

1. Suspects others are exploiting, harming or deceiving
2. Preoccupied with unjustified doubts about the loyalty or trustworthiness of others
3. Reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him/her

Paranoid Personality, Con't

4. Reads hidden meanings or threatening meanings in benign remarks or events
5. Persistently bears grudges, i.e., is unforgiving to insults, injuries, or slights
6. Perceives attacks on his/her character or reputation that are not apparent to others and is quick to react angrily or counterattack
7. Recurrent suspicions, without justification, regarding fidelity of spouse or partner

Antisocial Personality Disorder

A. A pervasive pattern of disregard for and violation of the rights of others occurring since age 15, indicated by 3 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;

Antisocial Personality Disorder Con't

2.Deceitfulness, e.g., repeatedly lying, use of aliases, or conning others for personal profit or pleasure;

3. Impulsivity or failure to plan ahead;

4. Irritability and aggressiveness as in repeated physical fights or assaults;

5. Reckless disregard for safety of self or others;

Antisocial Personality Disorder Con't

6. Consistent irresponsibility, as indicted in repeated failure to sustain consistent work behavior or honor financial obligations;

7. Lack of remorse, as in being indifferent to or rationalizing having hurt, mistreated or stolen from another.

Antisocial Personality Disorder Con't

At least 18 yrs. old

C. Evidence of Conduct Disorder with onset before age 15

D. Occurrence of antisocial behavior is not exclusively during course of a Manic episode or Schizophrenia

Narcissistic Personality Disorders

Pervasive pattern of grandiosity, need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by 5 of the following:

1. A grandiose sense of self-importance
2. Preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love
3. Believes he/she is special and unique and can only be understood by or should associate with other special high-status people

Narcissistic Personality Disorders, Con't

4. Requires excessive admiration
5. A sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his/her expectations
6. Interpersonally exploitative, i.e., takes advantage of others to achieve his/her own needs
7. lacks empathy, is unwilling to recognize or identify with the feelings and needs of others
8. Often envious of others
9. Shows arrogant, haughty behaviors or attitudes

Obsessive-Compulsive

Pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency

Indicated by at least 4 of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules
2. Shows perfectionism that interferes with task completion

Obsessive-Compulsive, Con't

3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships
4. Is over conscientious, scrupulous, and inflexible about matter of morality, ethic, or values
5. Is unable to discard worn-out or worthless objects even when they have no sentimental value
6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his/her way of doing things
7. Adopts a miserly spending style toward both self and others: money is hoarded for catastrophes
8. Shows rigidity and stubbornness

Borderline Personality Disorder

Pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early childhood and present in a variety of contexts, as indicated by 5 or more of the following:

1. Frantic efforts to avoid real or imagined abandonment

Borderline Personality Disorder, Con't

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

Borderline Personality Disorder, Con't

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to marked reactivity of mood
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger
9. Transient, stress related paranoid ideation or severe

Histrionic Personality Disorder

Pervasive pattern of excessive emotionality and attention seeking, beginning by early childhood and present in a variety of contexts, as indicated by 5 or more of the following:

1. Uncomfortable in situations which he/she is not the center of attention
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior

Histrionic Personality Disorder, Con't

3. Displays rapidly shifting and shallow expression of emotion
4. Constantly uses physical appearance to draw attention to self
5. Has a style of speech that is excessively impressionistic and lacking in detail
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion
7. Is suggestible, easily influenced by others and circumstances
8. Considers relationships to be more intimate than they actually are

Dependent Personality

Pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation

Indicated by at least 5 of the following:

1. Difficulty making everyday decisions without an excessive amount of advice and reassurance
2. Need others to assume responsibility for most major areas of his/her life
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval

Dependent Personality, Con't

4. Has difficulty initiating projects or doing things on his/her own
5. Goes to excessive lengths to obtain nurturance and support from others
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
7. Urgently seeks another relationship as a source of care and support when a close relationship ends
8. Is unrealistically preoccupied with fears of being left to take care of himself or herself

Hypochrondriasis

Preoccupation with fears of having a serious disease based on misinterpretation of bodily symptoms which has a duration of at least 6 months.

Hypochrondriasis

The preoccupation:

a. Persists despite appropriate medical evaluation and reassurance

b. Is not of a delusional intensity or restricted to appearance

c. Causes clinically significant distress or impairment in functioning

d. Is not better accounted for by other anxiety disorders or major depression

Pain Disorder

1. Pain in 1 or more anatomical sites of sufficient severity to warrant clinical attention
2. Pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
3. Psychological factors are judged to have an important role in the onset severity exacerbates or maintenance of the pain
4. The symptom is not intentionally produced
5. The pain is no better accounted for by Mood, Anxiety, or Psychotic Disorder

Pain Disorder (cont.)

- Examples of impairment include:
  - Inability to work or attend school
  - Frequent use of the healthcare system
  - The pain becomes a major focus in the individual's life
  - Substantial use of medications
  - Relationship problems such as marital discord
  - Disruption of the family's normal lifestyle

Malingering

- Intentional production of false or grossly exaggerated physical or psychological symptoms
- Motivation is of external incentive
  - Avoiding work, school, or military duty
  - Obtaining financial compensation
  - Evading criminal prosecution
  - Obtaining drugs

Malingering continued

- According to the DSM-IV – TR:
- Healthcare professionals should suspect malingering in any of the following combination of circumstances;
  - Medicolegal context of presentation
  - Marked discrepancy between the persons claim to stress or disability and the objective findings
  - Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
  - The presence of antisocial personality disorder

Malingering continued

- Clinical differentiation:
  - Intentional production of symptoms
  - Prolonged recovery time
  - Unexplained exacerbation
  - Symptom relief is not obtained during the time frame suggested and discussed in the doctor-patient relationship during the report of findings.
  - Any positive tests for malingering

Professional Therapy

- Psychology
- Social work
- Psychiatry

  - All the above degrees have the option of obtaining a bachelor's, master's, and doctorate in their respective fields.

Psychology

- The American Psychological Association (APA)
- Education-
  - *Bachelors* –(BS) four years in an accredited program
    - Primarily research methods

    Masters - (MS) four years undergraduate and two or four years in a graduate program

    Ph.D. -two-year programs usually with a special emphasis on choosing a specialization, internship, and providing therapy

    Licensure: Psychologists in independent practice any type of patient care—including clinical, counseling, and school psychologists
      - Vary from state to state

Psychology continued

- Licensure-
  - Usually require a Ph.D. and one to two years of experience
  - Limit scope of practice to professional competence
  - The completion of an approved internship
  - examination

Psychiatry

- Medical doctor (MD or DO)
  - Medical school degree
  - For year residency
  - Prescribe medication
  - Some provide psychotherapy-though it may be limited to pharmaceutical management

Social Work

- bachelor's degree- usually in social work (BSW). Other majors, such as psychology or sociology.
  - Four years in an accredited program

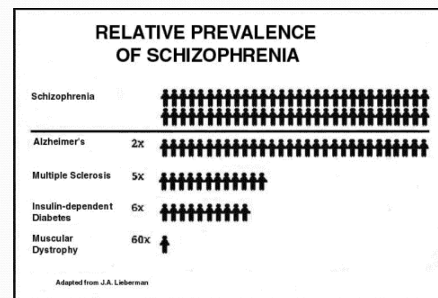
  Masters-(MSW) undergraduate degree plus two years in accredited program
  - Internship(six months or a year)

  Doctorate-(DSW) educator in university or research

Social Work continued

- Licensure-
  - All states and the District of Columbia require social workers to be either licensed, certified or registered
- **Advancement for Social Workers: MSW/DSW**
- With related work experience and an advanced degree, a social worker may move up to a position as supervisor, program manager, assistant director, or executive director of a social service agency or department.

Prevalence of Schizophrenia Compared to Other Well-Known Diseases



Schizophrenia

A. Characteristic symptoms:

2 or more of the following present during 1 month:

positive symptoms:

delusions

hallucinations

disorganized speech

grossly disorganized or catatonic behavior

Schizophrenia Con't

negative symptoms

affective flattening

alogia

avolition

Anhedonia

B. Social/occupational dysfunction

C. Duration for at least 6 months

D. R/O schizoaffective, substance abuse or medical condition

Typical (First Generation) Antipsychotic Medication

Medication	mg/day
Chlorpromazine(Thorazine)	300-100
Fluphenazine(Prolixin)	5-20
Mesoridazine(Serentil)	150-400
Perphenazine(Trilafon)	16-64
Thioridazine(Mellaril)	300-800
Trifluoperazine(Stelazine)	15-50
Haloperidol(Haldol)	5-20

Atypical (Second Generation) Antipsychotic Medication

Medication	
Aripiprazole(Abilify)	10-30
Clozapine(Clozaril)	150-600
Olanzapine (Zyprexa)	10-30
Quetiapine(Seroquel)	300-800
Risperidone(Risperdal)	2-8
Ziprasidone(Geodon)	120-200

Major Side Effects of Antipsychotic Medications

Sedation
Autonomic Effects
Endocrine Effects
Skin and Eye Complications
Neurological Effects
- Dystonia
- Pseudo parkinsonism
- Akinesia
- Akathisia

Major Side Effects of Antipsychotic Medications, Cont.

Tardive Dyskinesia
Neuroleptic Malignant Syndrome
Agranulocytosis
Seizures
Sudden Death