Chapter 16 Suicide Prevention

Suicide is the voluntary act of killing oneself. It is fatal, self-inflicted destructive act with explicit or inferred intent to die.

Interventions would include, reconnecting the patients with other people and reinforcing hope, restoring emotional stability, helping the pt make safer choices, helping create a safe place, removing dangerous items, supervision, therapeutic interactions (group participation) avoid engaging in No-suicide contract. Medication management would include Clozapine which decreases depression and decreases suicide drive

Chapter 16 Suicide Prevention (cont)

Suicidality is all suicide-related behaviors and thoughts of completing suicide and suicide ideations

Intervention for social domain would include to assess their social capabilities, and help with social skills, participation in social networks, and how to manage and anticipate stigmatizing concepts from others

Chapter 16 Suicide Prevention (cont)

Suicidal ideation is thinking about and planning one's death Homosexual men are 40-55% higher than heterosexual men at 18-30%

increasing the patients social support will be a important long term outcome and never promise to keep the interview 100% confidential due to the need to documentation

Chapter 16 Suicide Prevention (cont)

adoles-cents are the age group who has the highest suicide rate

Can be highly stressful for nurses and may experience secondary trauma so it is always best to share feelings and experiences.

Chapter 16 Suicide Prevention (cont)

parasuicide is a voluntary apparent attempt at suicide, in which the aim is not death (i.e. taking a sublethal drug instead of a lethal drug)

Chapter 16 Suicide Prevention (cont)

How may the individual feel when conducting suicidal gestures/ parasuicide? The individual attempts to feel nothing, may truly want to die or want to send a message about their emotional state.

Chapter 16 Suicide Prevention (cont)

Most people who die from suicide have depression the first priority will be to initiate the least restrictive care possible, promting mental health, determine the imminent threat, changing social behaviors, implementations of effective interventions to prevent future episodes

Chapter 16 Suicide Prevention (cont)

lethality is the probability that a person will successfully complete suicide, determined by the seriousness of the person's intent and likelihood that the method will succeed. Take into consideration the seriousness of ideation, degree of emotions such as hopelessness, amount of pervious attempts, planning, availability of lethal methods, resources, episodes of self-harm, final acts, alcohol use, anxiety, impulsivity

Chapter 16 Suicide Prevention (cont)

Factors that enhance risk for suicide would be vulnerability, risk, intent, disinhibition(thrill-seeking) mental illness, medical illness

Chapter 16 Suicide Prevention (cont)

Suicide risk factors: Psycho-social such as internal distress, low self esteem, interpersonal distress, childhood physical and sexual abuse, cognitive factors, Social: isolation, social distress, economic problems, poverty, knowing someone who had a successful suicide attempt. Males v. females, completion, methods, ages, type of community

Chapter 16 Suicide Prevention (cont)

Females are more likely to attempt and males tend to be more successful with their attempts four times more than women

Chapter 16 Suicide Prevention (cont)

Older victims consider suicide due to alienation, loss, sense of disconnection, physical illness, financial difficulties the races most prone are White, American Indian, and Alaskan Native

Chapter 16 Suicide Prevention (cont)

In women that are in the military, military sexual trauma is what causes most victims to attempt suicide

Chapter 16 Suicide Prevention (cont)

Some cognitive risk factors would include problem solving deficits, impulsivity, rumination (Deep thinking) and hopelessness

Chapter 16 Suicide Prevention (cont)

During the assessment process keep in mind IS PATH WARM: Ideation, Substance abuse, Purposelessness, Anxiety, Trapped, Hopelessness, Withdrawal, Anger, Recklessness, Mood change

Chapter 24 Bipolar disorder

What is Bipolar Disorder? A disorder of mood consisting of episodes of depression and mania (or hypomania) a.k.a. Manic-Depression

What is a Manic Episode? A period of elevated, euphoric or irritable mood lasting at least one week 3 (or 4, if mood is irritable) symptoms characterized by accelerated cognitive and behavioral activity which occur simultaneously with the mood change.(D-IGFAST) Must cause severe impairment

Chapter 24 Bipolar disorder (cont)

D.I.G.F.A.S.T. way to remember characteristics of manic episodes D-distractibility I-insomnia (decreased NEED for sleep) G-grandiosity F-fast (racing) thoughts/flight of ideas A-activities (increased/goal directed) S-speech (overtalkative) T-thoughtlessness/recklessness/impulsive

What is a Hypomanic Episode? A period of elevated, euphoric or irritable mood lasting at least four days 3 (or 4, if mood is irritable) symptoms characterized by accelerated cognitive and behavioral activity which occur simultaneously with the mood change. (DIGFAST) Must NOT cause severe impairment

Chapter 24 Bipolar disorder (cont)

What is a Depressive Episode? A period of sad mood or loss of interest in most things all day long, nearly every day for at least two weeks. 4 symptoms characterized by decelerated cognitive and behavioral activity. Must cause impairment

S.I.G.E.C.A.P.S. way to remember characteristics of depressive episodes S-Sleep changes (usually increased) I- loss of interest G-guilty feelings/-worthlessness E-Energy low C-difficulty concentrating A-Appetite changes (usually increased, or could be Reduced appetite but with carb craving) P-Psychomotor changes (usually retardation) S-Suicidal ideation or recurrent thoughts of death

Chapter 24 Bipolar disorder (cont)

What is a Mixed Episode? A mood episode including symptoms of both depression and mania occurring simultaneously Depressive Mixed Episode - mostly depressive with a couple of manic symptoms Mixed Manic Episode- mostly manic with a couple of depressed symptoms DSM V reflects the above more closely than just saying 'mixed'

Making the Bipolar Diagnosis if patient presents with depressive symptoms If the patient presents with a depressive episode, must rule out medical causes and other psychiatric illnesses that present with depression AND search for a history of manic or hypomanic episodes

Chapter 24 Bipolar disorder (cont)

making bipolar diagnosis if patient presents with manic/hypomanic symptoms If the patient presents in a manic or hypomanic episode, must rule out medical causes and other psychiatric illnesses that present with mania or hypomania

Medical Causes of Mania and Depression Substance abuse: Stimulant (cocaine, meth, caffeine, pseudoephedrine) intoxication/withdrawal, Alcohol, Opiate Medications: Steroids Neurological conditions: MS, Frontal lobe syndromes, Temporal Lobe Epilepsy, Stroke Endocrine conditions: Hyper-hypothyroidism, Cushing's syndrome Infections: HIV (- can alter mood/cognition- can cause symptoms like depression/manic) Autoimmune disease: SLE (same as HIV) Metabolic states: Hypoxia

Chapter 24 Bipolar disorder (cont)

Psychiatric Differential Diagnosis Unipolar Depression Schizophrenia Schizoaffective Disorder Attention Deficit Hyperactivity Disorder Borderline Personality Disorder Narcissistic Personality Disorder Antisocial Personality Disorder Primary Substance Abuse Post Traumatic Stress Disorder

how many individuals that are bipolar have had depressive symptoms? how many have had only manic symptoms? 90% have had depressive symptoms that have bipolar, This means 10% have only had manic episodes (unipolar mania, predominant polar mania)

Chapter 24 Bipolar disorder (cont)

how many individuals with bipolar have dealt with pscyhosis? 60% lifetime prevalence only 15% point prevalence

how many patients who are bipolar deal with anxiety? 50% of bipolar patients might have comorbid anxiety disorder, generalized anxiety that comes up with the episodes.

Chapter 24 Bipolar disorder (cont)

Type I bipolar One manic episode = type 1 (don't need any other symptoms)

type II bipolar hypomanic episode + major depression = type 2 (NO mania in type 2)

Chapter 24 Bipolar disorder (cont)

Cyclothymia rapid fluctuation between hypomania and subthreshold depressions (don't last more than 2 weeks). Happens over 2 years to be diagnosed.

Reasons for Misdiagnosis patient's Lack of Insight patient's Poor Memory Unreliability of Hypomania Involve families

Chapter 24 Bipolar disorder (cont)

unipolar disorder major depressive disorder No history of manic or hypomanic episodes Different treatments, illness course, personality variables and family history as compared to Bipolar patients

things that would point you toward bipolar diagnosis rather than unipolar Atypical depression features= (increased sleeping, increased appetite, etc) - might hint you toward bipolar Psychotic symptoms during depression (poverty, nihilism)- might hint you toward bipolar Postpartum depression (especially w/ psychotic symptoms)- might hint you toward bipolar Early age of onset might hint you toward bipolar Poor response to antidepressnats- bipolar patients don't get helped by antiepressants. Antidepressants- can actually cause mania BP 3-6 months UP 6-12 months

Chapter 24 Bipolar disorder (cont)

Epidemiology of Bipolar Disorder Males = females Age of onset 19 New onset rare after 50 # Depressive episodes > # Manic episodes 10-25% are rapid cycling

Phenomenology of Bipolar Disorder in childhood Preadolescence (age < 12) 80% continuous rapid-cycling 1 week of hypomania/mania identifiable Adolescence (age > 13) 60% mixed, chronic

Chapter 24 Bipolar disorder (cont)

ADHD/bipolar The ADHD problem In children, 90% of BP diagnosable with ADHD In adults, 1/3 diagnosable with childhood ADHD Different developmental presentations of the same underlying disease

Suicide in Bipolar Patients 19% suicide rate, lower if never hospitalized 50% suicide attempt rate Women attempt more often and their attempts are evenly distributed over time Men have bimodal distribution of attempts (within 2 yrs of illness onset and after 23 yrs)

Chapter 24 Bipolar disorder (cont)

Risk Factors for Suicide in Bipolar Patients
Prior history of attempt
ETOH/Substance abuse
Recent onset of illness
Type II Rapid Cycling
Mixed and depressive states
Increased aggressiveness/-impulsivity
Anxiety (panic attacks, psychic anxiety)

Etiology of bipolar
Interaction of Genetics and Environment 8-10 fold increased risk (odds ratio) compared to general population of having BD if a family member has it 7% risk of having BD if a first degree family member has it MZ concordance rate of 40-75%/DZ rate of 6-11%
Genetics Additive genetics (nonmendelian), multiple small genes
Environment: Specific environment (not shared family experiences) Random events Genotype environment interaction Intrauterine/perinatal

Chapter 24 Bipolar disorder (cont)

strlly a collection of stressors comibned with underlying susceptibility that leads to illnesss.ess-diathesis model
Genera

The Kindling Process The kindling process- no wellness period, you don't necessarily need stressor eventually to set off the chain reaction. You're changing your brain chemistry. You lose the well time. Much harder to treat at that point. We want to treat earlier to prevent patients from getting to this stage

Chapter 24 Bipolar disorder (cont)

predictors of poor outcome for bipolar
Predictors of poor outcome
Substance Abuse, Psychosis, Early age of onset, Predominant depression, Mixed states, Many episodes

predictors of good outcome for bipolar
Predictors of good outcome
Euphoric mania, unipolar mania, late age of onset, few episodes

Chapter 24 Bipolar disorder (cont)

medication options for bipolar Mood stabilizers
Antipsychotics
Antidepressants

Mood Stabilizers Lithium
Valproate
Carbamazepine
Lamotrigine

Chapter 24 Bipolar disorder (cont)

lithium treatment- watch out for: reduced GFR over time, but if used correctly this is minor. Lithium toxicity- is the biggest issue. When patients dehydrated lithium levels rise= too high (greater than 1.5) very serious consequences - seizures, coma, cardiac problems, kidney failure).

valproate treatment- watch out for: (depacot) - these symptoms are quite rare. If hx of liver/pancreatic issues, maybe be cautious with this drug. BAD with preganncy so don't give first line to women of child-bearing age.

Chapter 24 Bipolar disorder (cont)

carbamazepine treatment- watch out for: drug interaction is the serious issue here. It induces CYT450 3A4 it induces more of this enzyme so that the drugs aren't nearly as affective as they used to be.

lamotrigine treatment- watch out for: (anticonvulsant)- not good at treating mania/depression, but good at PREVENTION of these states. Not many side effects except for steven's johnson and it's rare and to prevent you can titrate very slowly. Good In combo with other drugs.

Chapter 24 Bipolar disorder (cont)

Antipsychotics (2nd generation) list
Quetiapine
Olanzapine
Aripiprazole
Risperidone
Ziprasidone
Lurasidone
Clozapine
Iloperidone
Asenapine

Metabolic side effects of second generation antipsychotics Insulin resistance, increased cholesterol, increased weight gain

Chapter 24 Bipolar disorder (cont)

neuromuscular side effects of second generation antipsychotics Akathisia, dystonic reactions, parkinsonism, tardive dyskinesia

why would you want to review blood work for someone being treated for bipolar? CBC Liver function tests Thyroid studies (lithium) Glucose (2 gen antipsychotic) Electrolytes Lipids PREGNANCY STATUS (depacot)

Chapter 24 Bipolar disorder (cont)

first line treatment/management of bipolar Start with mood stabilizer monotherapy Optimize dose of mood stabilizer Li (0.8), valproate (80-100), carbamazapine (8) Assess target symptoms Assess side effects and treat appropriately Adjust dose Additional medications to treat side effects (propanolol for lithium-tremor, Zinc/selenium for valproate-alopecia, etc.)

If patient with psychotic symptoms or presentation particularly severe (e.g. mania) how do you treat? Add atypical antipsychotic (olanzapine/quetiapine/aripiprazole,- etc.)

Chapter 24 Bipolar disorder (cont)

If depressed or manic and only partially responsive to initial treatment how do you treat? Add second mood stabilizer or atypical antipsychotic Eventually, may consider antidepressant for depression

beware of what medication when treating bipolar patients? Avoid use of antidepressants except when patient is severely depressed and suicidal. Use with mood stabilizer Taper off quickly after recovery. Avoid antidepressants when treating anxiety/anxiety disorders. Benzos for those without hx of sub abuse Gabapentin (Neurontin), Pregablain (Lyrica), propanolol (Inderal), D-cycloserine Psychotherapy "Tincture of time"

Chapter 24 Bipolar disorder (cont)

If bipolar symptoms are refractory, consider: Reassessing diagnosis Drug-drug interactions reducing drug efficacy Drug not at therapeutic level/dose Lack of medication adherence Concomitant substance use Adding another mood stabilizer not previously used Adding Electroconvulsive Therapy

little tips to help manage bipolar Advise patient to keep regular hours of sleep, and to avoid substance use RISKS for recurrence! Recommend concurrent Psychotherapy/Psychosocial Treatments Develop a working relationship with expert therapists to whom you can refer ..... Be Available!!!!!

Chapter 24 Bipolar disorder (cont)

primary care PA role in bipolar diagnosis/care Identify the illness Don't start an antidepressant Educate the patient/de-stigmatize illness Refer to a psychiatrist Monitor and treat the cardiovascular risk factors associated with treatment Accurately diagnose bipolar disorder early Treat effectively Monitor for suicidality Identify and treat comorbid illnesses Collaborate with family and patient Attend to psychological issues Shame, embarrassment, loss of mania, medication side effects, perceived loss of creativity, etc.

Chapter 21 Depression

Depression is a common mental state characterized by sadness loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, poor concentration

Risk factors for MDD would be weak social networks, prior history of depression, family history of depression, environmental and life stressors, lack of knowing how to cope with problems, addiction, medical or mental comorbities

Chapter 21 Depression (cont)

Mood: pervasive and sustained emotion that influences one's perception of the world and how one functions.

Need to assess any culturally distinctive experiences to ascertain any presence of depressive disorder from a "normal" cultural emotional response.

Chapter 21 Depression (cont)

Affect: outward emotional expression; provides clues to person's mood
Blunted
Bright Flat
Inappropriate
Labile
Restricted or constricted

Keeping in mind the root cause of the pts. MDD: Psychological theories: Psychodynamic factors Behavioral factors Cognitive factors Developmental factors. Social: Family factors, environmental factors. Biological: genetics

Chapter 21 Depression (cont)

When feeling depressed those feelings interfere with daily activities impair judgement and contribute to negative views in the world the best cognitive intervention to teach patients is thought stopping

Women ages 18-35 experience MDD the most, incidence is higher in children who were born to mothers who experience depression Premenstrual dysphoric disorder Recurring mood swings, feelings of sadness, or sensitivity to rejection in the final week before the onset of menses The mood begins to improve a few days after menses begins Stress, history of interpersonal trauma, and seasonal changes are associated with this disorder.

Chapter 21 Depression (cont)

Overview of depressive disorders include Disruptive diagnostic categor mood dysregulation, Major depressive disorder, Persistent depressive (dysthymic) Premenstrual dysphoric Substance/medication induced Other specified depressive Unspecified depressive disorders.

Goals of treatment Reduce or control symptoms and, if possible, eliminate signs and symptoms of the depressive syndrome Improve occupational and psychosocial function as much as possible Reduce the likelihood of relapse and recurrence through recovery-oriented strategies

Chapter 21 Depression (cont)

In the Biopsychosocial aspect Patients experience lower quality of life Greater risk for development of physical health problems Generally diagnosed in primary care setting Characterized by severe and debilitating depressive episodes Associated with high levels of impairment in occupational, social, and physical functioning High risk of suicide..

Cognitive and Interpersonal Therapies Short-term cognitive-behavioral therapy (CBT) Interpersonal therapy

Chapter 21 Depression (cont)

With depressive disorder in children, they present themselves as Anxiety and somatic symptoms Decreased interaction with peers Avoidance of play and recreational activities Irritable rather than sad mood High risk of suicide.

Combination therapies With severe or recurrent major depressive disorder combination of psychotherapy (interpersonal, CBT, behavior, brief dynamic, or dialectical behavioral therapies) and pharmacotherapy has been found to be superior to single modality. If not successful, other options are available: ECT, light therapy, repetitive transcranial magnetic stimulation.

Chapter 21 Depression (cont)

With depressive disorders in older adults they present as Often undetected and under treated Commonly associated with chronic illness Symptoms possibly confused with those of dementia or stroke Highest suicide rates in those older than 75 years Treatment is successful in 60% to 80%, but response to treatment is slower than in younger adults

In regard to the nurse's role, be aware of the risk factors of MDD, interview close friends or family members of the pts. assess the family's level of support.

Chapter 21 Depression (cont)

Major depressive disorder tends to recur more often as the illness progress, usually the onset has a higher chance of starting during early 20 or when puberty begins. Recurrence related to age of onset, increased intensity and severity of symptoms, presence of psychosis, anxiety, and/or personality features Risk for relapse higher if initial onset at younger age & additional mental disorders.

When conducting a physical assess-ment, look at the pts. weight and weight changes, appetite habits. sleep patterns, and level of energy.

Chapter 21 Depression (cont)

To be able to be diagnosed for MDD 4 out of 7 symptoms have to be present in pt disruption in sleep, appetite, weight, concen-tration, energy, Psychomotor agitation or retardation Excessive guilt or feelings of worthlessness Suicidal ideation.

When conducting a medication reconcili-ation assess anything they take or drugs they do such as supple-ments, alcohol, street drugs, St. Johns wart, or any other mood-altering substances.

Chapter 21 Depression (cont)

The prevalence of MDD is more common in women than men, episodes last longer than 6 months and most diagnosis occur around the ages of 18-29 More prevalent in younger adults, white adults, Native American adults than African American, Asian American, Hispanic adults.

When conducting a psychosocial assessment make sure to ask questions about addiction because most pts who have MDD are addicted to some substance as well as Mental status Coping skills Developmental history Psychi-atric family history Patterns of relationships Mood and affect: anhedonia Quality of support system.

Chapter 21 Depression (cont)

Major depressive disorders often co-occur with other psychiatric disorders, including those that are substance related - Depression often is associated with a variety of chronic medical conditions, particularly endocrine disorders, cardiovas-cular disease, and neurologic disorders.

Suicidal ideations Passive or active Seriousness depends on frequency, intensity, and lethality Initially assessed as well as reassessed throughout the course of treatment Require immediate mental health assessment regarding the depth of their thoughts and intentions. This is the nurse's priority when assessing the pts. SAFETY IS ALWAYS ON THE TOP OF THE LIST!!

Chapter 21 Depression (cont)

When suicidal ideation is noticed within the pt.
Counseling and supportive services need to be provided to family and friends of persons who attempt or commit suicide because family and friends may experience feelings of grief, guilt, anger, and confusion.

Availability in the time of crisis is very important to pts going through MDD. Being vigilant when the pts is thinking about suicide.
Education about illness and treatment goals
Encouragement and feedback concerning progress
Guidance regarding patient's interactions with personal and work environment
Realistic goal setting and monitoring
Support of individual strengths in treatment choices
Must win patient's trust Avoid cheerleading

Chapter 21 Depression (cont)

When thinking of interventions think of Mass dulow's hierarchy, sleep (Start making a sleep schedule for the pt and eliminate all distractionring those hours) Food (Help plan better eating habits with good food groups) Deep breathing exercises and increasing participation in activities. Encourage the pt to be as independent as possible. Help them achieve stability.

Talk to the pts and educate them about the side effects of the medication and reinforce a schedule of what and what not to take them with.
Antidepressants:
SSRIs
SNRIs
NDRIs
TCAs
MAOIs

Chapter 21 Depression (cont)

Other Somatic Therapies
Electroconvulsive therapy
Light therapy (phototherapy)
Repetitive transcranial magnetic stimulation

Psychosocial Interventions
Cognitive interventions
Behavioral interventions Group interventions
Psychoeducation
Milieu therapy
Safety Family interventions
Support groups

Chapter 21 Depression (cont)

Continuum of care beyond these settings:
Partial hospitalization or day treatment programs
Individual, family, or group psychotherapy Home visits

Persistent depressive disorder (dysthymia)
Major depressive disorder symptoms last for 2 years for an adult and 1 year for children and adolescents

Chapter 21 Depression (cont)

Disruptive mood dysregulation disorder Severe irritability and outbursts of temper Onset before the age of 10 when children have verbal rages and/or are physically aggressive toward others or property The behavior disrupts family functioning as well as the ability to succeed in school and social activities; this disorder can co-occur with attention-deficit/hyperactivity disorder.

Chapter 23 Schizophrenia and related disorders

What conditions fall under schizophrenia & related disorders? Schizophrenia Delusional Disorder Schizoaffective Disorder Schizophreniform Disorder Brief Psychotic Disorder Substance /medication induced Psychosis Psychosis due to another medical condition Shared Psychosis Brief Psychotic Disorder Other Schizophrenia Spectrum and Psychotic Disorders

How does schizophreniform differ from schizophrenia? symptoms of schizophreniform disorder last ≥ 1 mo but < 6 mo.

Chapter 23 Schizophrenia and related disorders (cont)

What is Brief psychotic disorder? consists of delusions, hallucinations, or other psychotic symptoms for at least 1 day but < 1 m

What causes Brief Psychotic Disorder? severe stress in susceptible people; rare

Chapter 23 Schizophrenia and related disorders (cont)

What is Substance/medication--induced psychotic disorder? characterized by hallucinations or delusions due to the direct effects of a substance or withdrawal from a substance in the absence of delirium.

What is Psychotic disorder due to another medical condition? hallucinations or delusions that are caused by another medical disorder.

Chapter 23 Schizophrenia and related disorders (cont)

What happens in Shared Psychosis?	What characterizes schizophrenia? Psychosis Delusions (False Beliefs) Hallucinations (False Perceptions) Disorganized speech and behavior Cognitive Deficits Other symptoms that cause social or occupational dysfunction
people acquire a delusion from someone with whom they have a close personal relationship	

Chapter 23 Schizophrenia and related disorders (cont)

What do people with schizophrenia have difficulties with? real vs not real Think and speak clearly Have normal emotional responses Act normally in social situations Functioning	What is the incidence of schizophrenia? 1% of population; men and women equally

Chapter 23 Schizophrenia and related disorders (cont)

What population has a higher prevalence of schizophrenia? lower socioeconomic classes in urban areas single people	What population has a higher prevalence of schizophrenia? lower socioeconomic classes in urban areas single people

Chapter 23 Schizophrenia and related disorders (cont)

What factors can predict schizophrenia in youth (prodromal period)? isolation, withdrawal, increase in unusual thoughts and suspicions, family history of psychosis.	What is the etiology of schizophrenia? unknown; biologic basis; neurodevelopmental vulnerability interacts with environmental stressors and result in onset, remission or reccurrence

Chapter 23 Schizophrenia and related disorders (cont)

What are brain differences seen in schizophrenia? alterations in brain activity and structure (enlarged cerebral ventricles, thinning of the cortex, decreased size of the anterior hippocampus), changes in neurotransmitters (dopamine and glutamate), Changes in distribution /characteristics of brain cells that likely occurred before birth	What are the neurodevelopmental vulnerabilities seen in schizophrenia? Genetic predispositions (10% 1st degree relatives, 50% monozygotic twins), birth complications, viral or CNS infections, maternal exposure to famine & flu, rh incompatibility, hypoxia, low birth weight

Chapter 23 Schizophrenia and related disorders (cont)

What are social issues that may trigger schizophrenia? Unemployed Poverty Leaving home Ending romance Joining armed forces	What are mitigating factors in schizophrenia? social support, coping skills, antipsychotics

Chapter 23 Schizophrenia and related disorders (cont)

What are the DSM 5 criteria for schizophrenia? at least 2 of 5: 1. Delusions 2. Hallucinations 3. Disorganized speech 4. Grossly disorganized or catatonic behavior 5. Negative symptoms	What are additional requirements of DSM 5 for diagnosis of schizophrenia? 1 symptom must be delusions, hallucinations or disorganized speech; at least 6 mo

Chapter 23 Schizophrenia and related disorders (cont)

What happens in the premorbid phase of schizophrenia? no symptoms or may have impaired social competence, mild cognitive disorganization or perceptual distortion, a diminished capacity to experience pleasure (anhedonia), and other general coping deficiencies	What happens in the prodromal phase of schizophrenia? subclinical symptoms may emerge; they include withdrawal or isolation, irritability, suspiciousness, unusual thoughts, perceptual distortions, and disorganization

Chapter 23 Schizophrenia and related disorders (cont)

What happens in the middle phase of schizophrenia? symptomatic periods may be episodic (with identifiable exacerbations and remissions) or continuous; functional deficits tend to worsen	What happens in the late illness phase of schizophrenia? the illness pattern may be established, and disability may stabilize or even diminish.

Chapter 23 Schizophrenia and related disorders (cont)

How does schizophrenia begin? may be sudden (over days or weeks) or slow and insidious (over years)	What are positive symptoms in schizophrenia? psychotic symptoms, loss of contact with reality, hallucinations, delusions, disorganized thoughts & behavior

Chapter 23 Schizophrenia and related disorders (cont)

What are hallucinations? Sensory perceptions that are not perceived by anyone else. Auditory, visual, olfactory, gustatory, or tactile Auditory by far most common. "Hearing Voices"	What are the types of thought disorders in schizophrenia? Thinking disorganized and speech reflects this. Thought blocking - stops speaking abruptly (someone removed thought) Neologisms - made up meaningless words Loose associations jump between different topics

Chapter 23 Schizophrenia and related disorders (cont)

What are the types of thought disorders in schizophrenia? Thinking disorganized and speech reflects this. Thought blocking - stops speaking abruptly (someone removed thought) Neologisms - made up meaningless words Loose associations jump between different topics	What are examples of disorganized behavior in schizophrenia? Childlike silliness Agitation Inappropriate appearance, hygiene, or conduct. Catatonia is an extreme behavior that can include maintaining a rigid posture and resisting efforts to be moved or engaging in purposeless and unstimulated motor activity.

Chapter 23 Schizophrenia and related disorders (cont)

What are negative symptoms in schizophrenia?	Are positive or negative symptoms of schizo-phrenia harder to treat?
blunted affect alogia anhedonia associality avolution	negative

Chapter 23 Schizophrenia and related disorders (cont)

What is a major determ-inant of overall disability in schizophr-enia?	What are the cognitive deficits in schizophrenia?
cognitive impairment	Attention processing speed working memory abstract thinking problem solving understanding of social interactions Problem solving Empathy Learning from experience inflexible thinking

Chapter 23 Schizophrenia and related disorders (cont)

What are the impacts of schizophrenia on occupations?	What is the treatment for schizophr-enia?
sleep issues; play/leisure impacted by negative symptoms; hallucinations may impact what they eat/drink; voices coming out of shower	Antips-ychotic medications are most effective; control positive symptoms; may need hospitali-zation for safety

Chapter 23 Schizophrenia and related disorders (cont)

What are some side effects of antipsychotic medications?	What are serious side effects of antipsychotic medications?
Dizziness Akathesia - Feelings of restlessness or "jitters Sedation Slowed movements Tremor Weight gain	Extrapyramidal Syndrome (like PD) & Tardive Dyskinesthia (uncontrolled, repetitive movements esp around mouth)

Chapter 23 Schizophrenia and related disorders (cont)

What are treatments for schizophrenia other than medication? Rehabilitation (prevocational,social, adls,etc), Supportive Services (emotional), Psychotherapy, Psychodeuction, Relapse Prevention

What are complications/co-morbidities of schizophrenia? substance abuse, cigarette smoking, weight gain, diabetes, suicide, spontaneous movement disorders, major depression

Chapter 23 Schizophrenia and related disorders (cont)

What is the prognosis for Schizophrenia? early Tx, BPD, adherence to medication, later onset = better outcome OCD = worse outcome

What factors are related to a good prognosis in schizophrenia? Good premorbid functioning Late and/or sudden onset of illness Family history of mood disorders other than schizophrenia Minimal cognitive impairment Few negative symptoms Shorter duration of untreated psychosis

Chapter 23 Schizophrenia and related disorders (cont)

What factors are related to a poor prognosis in schizophrenia? early onset Poor premorbid functioning Family history of schizophrenia Many negative symptoms Longer duration of untreated psychosis Men have poorer outcomes than women Comorbid substance abuse is a significant predictor of poor outcome

What substances are highly disruptive to schizophrenia patients? marijuana and other hallucinogens

Chapter 23 Schizophrenia and related disorders (cont)

What characterizes schizoaffective disorder? significant mood symptoms psychosis other symptoms of schizophrenia. occurrence of ≥ 1 episodes of depressive or manic symptoms

What does the diagnosis of schizoaffective disorder require wrt mood? significant mood symptoms (depressive or manic) be present for a majority of the total duration of illness concurrent with ≥ 2 symptoms of schizophrenia

Chapter 23 Schizophrenia and related disorders (cont)

What is the prognosis for schizoaffective disorder?	What is Delusional Disorder? Characterized by delusions (false beliefs) that persist for at least 1 month, without other symptoms of schizophrenia Uncommon Onset middle or later adult life Psychosocial functioning is not as impaired Impairment related to delusion
somewhat better than that for schizophrenia but worse than that for mood disorders.	

Chapter 23 Schizophrenia and related disorders (cont)

What are some subtypes of delusion?	Are delusions always bizarre in Delusional Disorder? No, they can involve situations that could occurAre delusions always bizarre in Delusional Disorder? No, they can involve situations that could occur
Erotomanic Grandiose Jealous Persecutory Somatic	

Chapter 23 Schizophrenia and related disorders (cont)

What does Delusional Disorder arise from?	What are early symptoms of Delusional Disorder?
may arise from a preexisting paranoid personality disorder. In such people, a pervasive distrust and suspiciousness of others and their motives begins in early adulthood and extends throughout life.	feeling of being exploited, preoccupation with the loyalty or trustworthiness of friends, a tendency to read threatening meanings into benign remarks or events, persistent bearing of grudges, and a readiness to respond to perceived slights.

Chapter 23 Schizophrenia and related disorders (cont)

What characterizes Erotomanic delusions?	What characterizes Grandiose delusions?
Patients believe that another person is in love with them. Efforts to contact the object of the delusion through telephone calls, letters, surveillance, or stalking are common. People with this subtype may have conflicts with the law related to this behavior.	Patients believe they have a great talent or have made an important discovery.

Chapter 23 Schizophrenia and related disorders (cont)

What characterizes Jealous delusions? Patients believe that their spouse or lover is unfaithful. This belief is based on incorrect inferences supported by dubious evidence. They may resort to physical assault.

What characterizes Jealous delusions? Patients believe that their spouse or lover is unfaithful. This belief is based on incorrect inferences supported by dubious evidence. They may resort to physical assault.

Chapter 23 Schizophrenia and related disorders (cont)

What characterizes Somatic delusions? The delusion relates to a bodily function; eg, physical deformity, odor, or parasite.

What, in general, helps all psycho-social disorders? structure

Chapter 18 Trauma and stress disorders

Anxiety - Part of many emotional problems and mental disorders - Anxiety disorders are now redefined - Some previous disorders considered anxiety disorders are now categorized as separate disorders o Trauma-stressor-related disorder o Obsessive-compulsive disorder - Uncomfortable feeling of apprehension or dread in response to internal or external stimuli - Physical, emotional, cognitive, and behavioral symptoms.

Normal Versus Abnormal Anxiety Response - Unavoidable, takes many forms, serves different purposes - Normal anxiety: realistic intensity and duration for the situation, followed by relief behaviors intended to reduce or prevent more anxiety - Normal anxiety response: appropriate for situation, can be used to help identify which underlying problem has caused the anxiety.

Chapter 18 Trauma and stress disorders (cont)

Factors that determine whether anxiety is a symptom of mental disorder: - Intensity of anxiety relative to the situation - Trigger for anxiety - Four degrees of anxiety Mild, Moderate, Severe, Panic

Phobias - Irrational fear of an object, person, or situation that leads to a compelling avoidance - Development of phobia may be outcome of extreme anxiety - Often present in anxiety disorders - May also develop into a specific phobia disorder.

Chapter 18 Trauma and stress disorders (cont)

Defense Mechanisms and Anxiety Used to reduce anxiety by: - Preventing or diminishing unwanted thoughts and feeling May be helpful but problematic if overused - Identify use of defense mechanism - Determine whether use is healthy or detrimental - What is healthy for one may be unhealthy for another.

Overview of Anxiety Disorders - Primary symptoms are fear and anxiety - Most common of the psychiatric illnesses; chronic and persistent - Women experience anxiety disorders more often than men - Association with other mental or physical comorbidities such as depression, heart disease, and respiratory disease - Most common condition of adolescents - Prevalence decreasing with age.

Chapter 18 Trauma and stress disorders (cont)

Anxiety Disorders Across the Life-Span - Prompt identification, diagnosis, and treatment may be difficult for special populations - In the older adult population, rates of anxiety disorders are as high as mood disorders - This combination of depressive and anxiety symptoms leads to decrease in social functioning, increase in somatic (physical) symptoms, and increase in depressive symptoms - Because the older adult population is at risk for suicide, special assessment of anxiety symptoms is essential - Detecting and treating anxiety important component of pain management

If left untreated in children and adolescents, symptoms persist and gradually worsen and sometimes lead to: - Separation anxiety disorder and/or mutism - Suicidal ideation and suicide attempts - Early parenthood - Drug and alcohol dependence - educational underachievement later in life.

Chapter 18 Trauma and stress disorders (cont)

Panic Disorder - Extreme, overwhelming form of anxiety often experienced when an individual is placed in a real or perceived life-threatening situation - Panic normal during periods of threat; abnormal when continuously experienced in situations of no real physical or psychological threat - Panic attacks: sudden, discrete periods of intense fear or discomfort accompanied by significant physical and cognitive symptoms - Panic attacks

Panic: Clinical Course - Onset between 20 to 24 years of age - The physical symptoms include palpitations, chest discomfort, rapid pulse, nausea, dizziness, sweating, paresthesia's (burning, tickling, pricking of skin with no apparent reason), trembling or shaking, and a feeling of suffocation or shortness of breath - Cognitive symptoms include disorganized thinking, irrational fears, depersonalization, and poor communication - Feelings of impending doom or death, fear of going crazy or losing control, and desperation ensue - Physical symptoms similar to cardiac emergencies - Individuals may seek medical assistance, remain unconvinced it is only a panic attack after negative cardiac workup - Symptoms are physically taxing and psychologically frightening to patient

Chapter 18 Trauma and stress disorders (cont)

Diagnostic Criteria - Chronic condition with several exacerbations and remissions during course of disease - Often lead to other symptoms, such as phobias - Other diagnostic symptoms: palpitations, sweating, shaking, shortness of breath or smothering, sensations of choking, chest pain, nausea or abdominal distress, dizziness, derealization or depersonalization, fear of going crazy, fear of dying, paresthesia, chills or hot flashes - Key Diagnostic Characteristics

Epidemiology and Risk Factors - Risks: female; middle aged; low socioeconomic status, and widowed, separated, or divorced - Experienced differently across racial/ethnic groups - Other risk factors: family history, substance and stimulant use or abuse, smoking tobacco, severe stressors - Several anxiety symptoms + experience of separation anxiety during childhood à panic disorder later in life - Comorbidity: anxiety disorder(s), depression, eating disorder, substance abuse, schizophrenia.

usually peak in about 10 minutes but can last as long as 30 minutes before returning to normal functioning

Chapter 18 Trauma and stress disorders (cont)

Etiology - Biologic theories - Genetic factors - Neuroanatomic theories o Abnormalities in fear network Changes in volume of different brain areas - axis Biochemical theories Serotonin and norepinephrine o GABA o Hypothalamus-pituitary-adrenal (HPA)

Etiology - Psychosocial theories - Psychoanalytic and psychodynamic theories: Inadequate empirical evidence - Cognitive behavioral theories: Interoceptive conditioning

Chapter 18 Trauma and stress disorders (cont)

family Response to Disorder - Persons with panic disorder may inadvertently cause reactions from other family members - May limit social functions to prevent panic attack - Need tremendous amount of support and encouragement from significant others

Teamwork and Collaboration - Safe and therapeutic environment - Medication and monitoring of effects - Individual psychotherapy - Psychological testing - Priority care issues: safety because of a high risk for suicide

Chapter 18 Trauma and stress disorders (cont)

Panic Control Treatment - Systematic desensitization - Implosive therapy - Exposure therapy - Cognitive behavioral therapy - Pharmacologic interventions: SSRIs

Integration with Primary Care - Coordination of care with primary care providers and mental health providers - PCP treat physical consequences - Anxiety can be caused by physical health issues - Side effects of some prescription and nonprescription drugs - Can prevent misdiagnosis and/or wrong treatment

Chapter 18 Trauma and stress disorders (cont)

Mental Health Nursing Assessment - Overall physical and mental status, suicidal tendencies and thoughts, cognitive thought patterns, avoidance behavior patterns, family and cultural factors - Encourage keeping log, will become basic tool

Panic Attack Assessment - Identify characteristics of attack - Individual's strengths and problems

Chapter 18 Trauma and stress disorders (cont)

Physical Health Assessment - Substance use - Sleep patterns - Physical activity - Medications - Other physical assessments

Psychosocial Assessment - Self-report scales (Table 18.2, Box 18.4) - Mental status examination - Cognitive thought patterns (Table 18.3) - Family factors - Cultural factors - Identifying strengths.

Chapter 18 Trauma and stress disorders (cont)

riority of Nursing Care - First priority: suicide prevention: Adolescents with pain disorder may be at higher risk - Assess for depression, loneliness, social isolation - Physical symptoms: dizziness, hyperventilation - Family needs - Outcomes depend on particular health care issue and intervention agreed upon

Therapeutic Relationship - Critical aspect - Patient may appear very nervous or anxious - Help patient relax and be comfortable discussing fears and anxiety - Provide therapeutic environment/ relationship

Chapter 18 Trauma and stress disorders (cont)

Establishing Mental Health and Wellness Goals - Drastically changing lifestyle to avoid situations does not aid recovery - Goals: Develop healthy lifestyle, Support sense of accomplishment and control, Reduce anxiety and panic - Wellness challenges (Box 18.5) - Teaching breathing control - Teaching nutritional planning - Teaching relaxation techniques - Promoting increased physical activity - Pharmacologic interventions: SSRIs, SNRIs, Benzodiazepine

Evaluation and Treatment Outcomes - Panic control treatment - CBT therapy - Exposure therapy - Medication

Chapter 18 Trauma and stress disorders (cont)

Continuum of Care - Care across multiple settings is crucial - Treated in least restrictive environment, meeting safety needs - Emergency → inpatient → outpatient clinic → individual therapy

Integration With Primary Care - Patients may seek care from primary care instead of psychiatric provider - Panic attacks often mimic cardiac difficulties, important for patient to continue seeking health care from providers who can monitor the situation: Family intervention, Inpatient focused care, Community care

Chapter 18 Trauma and stress disorders (cont)

Integration With Primary Care - Patients may seek care from primary care instead of psychiatric provider - Panic attacks often mimic cardiac difficulties, important for patient to continue seeking health care from providers who can monitor the situation: Family intervention, Inpatient focused care, Community care

Generalized Anxiety Disorder - Feelings of frustration, disgust with life, demoralization, and hopelessness - Sense of ill-being and uneasiness and fear of imminent disaster

Chapter 18 Trauma and stress disorders (cont)

GAD: Clinical Course - Insidious onset - Many complain of being chronic worriers - Individuals of all ages affected - Typical onset (more than half) in childhood and adolescence; onset after age 20 years also common - May exhibit mild depressive symptoms - Highly somatic - Experience poor sleep habits, irritability, trembling, twitching, poor concentration, exaggerated startle response

Diagnostic Criteria GAD - Excessive worry and anxiety for at least 6 months - Anxiety related to a number of real-life activities or events - Patient with little or no control over the worry - Significant impairment in daily personal or social life

Chapter 18 Trauma and stress disorders (cont)

GAD: Nursing Care - Similar to panic disorder - Medication: Antidepressants, Antianxiety agent - Nursing interventions focus on helping person target specific areas of anxiety and reducing the impact of anxiety

Agoraphobia - Fear or anxiety triggered by two or more situations. - Individual believes something terrible might happen and escape will be difficult - Leads to avoidance behaviors - May occur with panic disorder but considered a separate disorder

Chapter 18 Trauma and stress disorders (cont)

Specific phobia - Persistent fear of clearly discernible, circumscribed objects or situations leading to avoidance behavior (Box 18.11) o Animals, natural environment, blood injection injury, situational - Anxiolytics for short-term relief of anxiety - Exposure therapy (treatment of choice)

Social anxiety disorder (social phobia) - Persistent fear of social or performance situation in which embarrassment may occur - Go to great lengths to avoid situations - Generalized social anxiety disorder: experiences fear related to most social situations, including public performances and social interactions - SSRIs to reduce social anxiety and phobic avoidance - Benzodiazepines to reduce anxiety caused by phobias

Chapter 27 Somatic symptom disorder study guide

Somatic symptom disorder Excessive thoughts, feelings, and behaviors related to somatic symptoms (Symptoms do not have to be medically unexplained) Specifier: Pain

Illness anxiety disorder Unwarranted fears about a serious illness despite absence of any significant somatic symptoms

Chapter 27 Somatic symptom disorder study guide (cont)

Conversion disorder Neurological symptom(s) that cannot be explained by medical disease or culturally sanctioned behavior (emphasizes the importance of neurological testing)

Malingering Intentionally faking psychological or somatic symptoms to gain from those symptoms

chapter 24 Personality and impulse control

Personality disorders Overly rigid and maladaptive patterns of behavior and ways of relating to others that reflect extreme variations on underlying personality traits, such as undue suspiciousness, excessive emotionality, and impulsivity. Ego Syntonic

Ego Syntonic - Behaviors or feelings that are perceived as natural parts of the self

chapter 24 Personality and impulse control (cont)

Ego Dystonic - Behaviors of feelings that are perceived not to be part of one's self identity

Cluster A - People who are perceived as odd or eccentric. -Includes paranoid, schizoid, and schizotypal disorders

chapter 24 Personality and impulse control (cont)

Cluster B -People whose behavior is overly dramatic, emotional, or erratic -Antisocial, borderline, histrionic, and narcissistic

Cluster C - Appear anxious or fearful - Avoidant, dependent, and obsessive-compulsive

chapter 24 Personality and impulse control (cont)

Paranoid Personality Disorder - Pervasive suspiciousness- the tendency to interpret other people's behavior as deliberately threatening or demeaning -Sensitive to criticism, whether real or imagined - Clinicians need to weigh cultural and sociopolitical factors when arriving at a diagnosis

Symptoms of Paranoid Personality Disorder - Suspects that others are exploiting, harming, or deceiving him/her -Doubts about friends' loyalty - Reluctant to confide in others because of fear that this information will be used maliciously - Reads hidden meaning into benign events - Persistently bears grudges -Frequently perceives attacks on his/her character and reacts swiftly with anger -Excessively suspicious about partner's fidelity

chapter 24 Personality and impulse control (cont)

Schizoid Personality Disorder - Reserved displaying one's feelings, especially when among strangers - Rarely express emotions and are distant and aloof -Emotions are not as shallow or as blunt as people with schizophrenia -Lack of interest in social relationships, flattened affect, and social withdrawal - Described as a loner or an eccentric, lacks interest in social relationships

Schizotypal Personality Disorder - Characterized by eccentricities of thought or behavior - Similar to schizophrenia but it is milder and neurological dysfunction is less pronounced. Also doesn't follow an episodic course - Slightly more common in males than females - Higher rates of disorder among african americans than whites or hispanic

chapter 24 Personality and impulse control (cont)

Symptoms of Schizotypal Personality Disorder - Delusions of reference - Strange or "magical" thinking - Abnormal perceptual experiences -Paranoia - Inappropriate or flat affect - Inappropriate appearance -Lack of close friends

Antisocial Personality Disorder -Characterized by antisocial and irresponsible behavior and lack of remorse for misdeeds - Violate the rights of others, disregard social norms and conventions, and break the law - Tend to be impulsive and fail to live up to their commitments to others

chapter 24 Personality and impulse control (cont)

Antisocial behavior and criminality - Tend to think of antisocial behavior as synonymous with criminal behavior -Not all criminals have antisocial behavior though -Many people with antisocial personality disorders are law abiding and successful in their careers, even though they may treat others in a callous and insensitive manner

Profile of the antisocial personality - Failure to conform to social norms - Irresponsibility -Aimlessness and lack of long term goals or plans -Impulsive behavior - Outright lawlessness - Violence - Chronic unemployment - Martial problems - Lack of remorse - Substance abuse or alcoholism - Disregard for others

chapter 24 Personality and impulse control (cont)

Psychopaths - 1% of population - "born that way" -Brain differences -Controlled -Manipulative -No attachment - Calculated risks

Sociopaths - 4% of population - Environmental -Unsteady lifestyle - Erratic, angry -Impulsive - May be attached - Sloppy work

chapter 24 Personality and impulse control (cont)

Borderline Personality Disorder - Characterized by a deep sense of emptiness, an unstable self-image, a history of turbulent and unstable relationships, dramatic mood changes, impulsivity, difficulty regulating negative emotions, self-injurious behavior, and recurrent suicidal behavior - At the core is a pervasive pattern of instability in relationships, self-image, and mood, along with a lack of control over impulses -Tend to be uncertain about their personal identities- their values, goals, careers, and even their sexual orientations -Very troubles relationships with their families

Symptoms of Borderline Personality Disorder - Frantic attempts to avoid abandonment - Pattern of intense, unstable relationships - Identity disturbance - Impulsivity in self-damaging areas - Recurrent suicidal or self-harming behavior - Marked mood reactivity - Chronic feelings of emptiness -Difficulty controlling anger - Paranoia or dissociation may be present

chapter 24 Personality and impulse control (cont)

Borderline personality and cutting - May engage in impulsive acts of self-mutilation, such as cutting themselves, perhaps as a mean of temporarily blocking or escaping from deep, emotional pain -Self-mutilation is sometimes an expression of anger or a mean of manipulating others -Acts may be intended to counteract self-reported feelings of "numbness" particularly in times of stress

Borderline personality disorder and splitting - An inability to reconcile the positive and negative aspects of the self and others, resulting in sudden shifts between positive and negative feelings

chapter 24 Personality and impulse control (cont)

Histrionic Personality Disorder - Characterized by excessive emotionality and an overwhelming need to be the center of attention - Latin histrio means "actor" -People tend to be dramatic and emotional, but their emotions seem shallow, exaggerated, and volatile - Formerly called hysterical personality

Symptoms of Histrionic Personality Disorder - Uncomfortable when not center of attention - Displays inappropriately provocative behavior - Shifting, shallow emotional expression - Sense of self is focused on physical appearance - Shallow, impressionistic manner of speaking - Theatrical and exaggerated behavior -Easily suggestible - Thinks relationships are unrealistically intimate

chapter 24 Personality and impulse control (cont)

Narcissistic Personality Disorder -Characterized by inflated or grandiose sense of themselves and an extreme need for admiration - Expect others to notice their special qualities, even when their accomplishments are ordinary and they enjoy basking in the light of adulation -Self--absorbed and lack empathy for others -Tend to be preoccupied with fantasies of success and power, ideal love, or recognition for brilliance or beauty -Interpersonal relationships are inveriably strained by the demands that people with narcissistic personality impose on others and by their lack of empathy with, and concern for, other people -Seek the company of flatterers -Interest in people is one-sided: they seek people who will serve their interests and nourish their sense of self-importance

Symptoms of Narcissistic Personality Disorder - Grandiose sense of self-importance - Preoccupied with fantasies of success, love - Believes he or she is "special" and should only associate with other "high status" people - Requires excessive admiration -Sense of entitlement - Interpersonally exploitative - Lacks empathy - Envious of others or believes self to be envied - Arrogant or haughty attitude or behaviors

chapter 24 Personality and impulse control (cont)

Avoidant Personality Disorder - Characterized by avoidance of social relationships due to fears of rejection - Few close relationships outside of immediate families - Tend to avoid group occupational or recreational activities for fear of rejection - Lunch alone at their desks - Equally common in men and women - 2.4% of general population

Dependent Personality Disorder - Characterized by an excessive need to be taken care of by others -Linked to other psychological disorders, including mood disorders and social phobia, as well as to physical problems such as hypertension, cardiovascular disorder, and gastrointestinal disorders -Link between dependent personality and "oral" behavior problems, such as smoking, eating disorders, and alcoholism

chapter 24 Personality and impulse control (cont)

Obsessive-Compulsive Personality Disorder - Characterized by excessive orderliness, perfectionism, rigidity, difficulty coping with ambiguity, difficulty expressing feelings, and meticulousness in work habits - Persons are so preoccupied with the need for perfection that they cannot complete work on time -Their efforts fall short of their expectations, so they redo their work - 2.1-7.9% of the population

Symptoms of Obsessive-compulsive personality disorder - Overly preoccupied with details, order, etc. -Perfectionism interferes with task completion - Devoted to work to the exclusion of leisure -Inflexible about matters of ethics or morality - Unable to throw away useless objects - Reluctant to delegate tasks to others - Hoards money for anticipated catastrophes - Generally shows rigidity and stubbornness

chapter 24 Personality and impulse control (cont)

Psycho-dynamic Perspectives - Traditional Freudian theory focused on problems arising from the oedipus complex as the foundation for abnormal behaviors. - Freud believed that children normally resolve the Oedipus complex by forsaking incestuous wishes for the parent of the opposite gender and identifying with the parent of the same gender -As a result, they incorporate the parent's moral principles in the form of a personality structure called the superego

Genetic Factors -Plays a role in the development of antisocial, narcissistic, paranoid, and borderline disorders - Parents and siblings of people with personality disorders, such as antisocial, schizotypal, and borderline types are more likely to be diagnosed with these disorders themselves than are members of the general population - Play a role in the develo-pment of certain psychopathic personality traits such as callousness, impulsivity, and irrespons-ibility

chapter 24 Personality and impulse control (cont)

Lack of emotional responsiveness - When people get anxious, their palms tend to sweat. This is a skin response called the galvanic skin response (GSR), is a sign of activation of the sympathetic branch of the autonomic nervous system - An early study showed that people with antisocial personalities had low GRS levels when they were expecting painful stimuli than normal controls - They experience little anxiety when expecting pain

The craving-for-stimul-ation model -People with antisocial person-alities appear to have exaggerated cravings for stimulation - Perhaps they require a higher-th-an-normal threshold of stimulation to maintain an optimum state of arousal - They may need more stimulation than other people to maintain interest and function normally

chapter 24 Personality and impulse control (cont)

Areas of the brain most directly implicated are the prefrontal cortex and deeper brain structures in the limbic system - These abnorm-alities may help explain difficulties with impulse control problems that we see in many people with BPD and antisocial

Sociocultural Perspectives -Bc antisocial disorder is reported most frequently among people from lower socioeconomic classes, the kinds of stressors encountered by disadvantaged families may contribute to antisocial behavior patterns -Many inner-city neighb-orhoods are beset by social problems such as alcohol and drug abuse, teenage pregnancy, and disorganized and disintegrating families

chapter 24 Personality and impulse control (cont)

Treatment of person-ality disorders - People with these disorders see their behaviors as natural parts of themselves -Even when unhappy and distre-ssed, they are unlikely to perceive their own behavior as causative - Despite these obstacles, evidence supports the effect-iveness of therapy in treating personality disorders

Psychodynamic Approaches - Used to help people become aware of the roots of their self-defeating behavior patterns and learn more ways of relating to others - However, people with personality disorders especially BPD and narcissistic often present challenges to the therapist -Ex. people with BPD tend to have turbulent relati-onships with therapists, sometimes idealizing them, sometimes denouncing them as uncaring

chapter 24 Personality and impulse control (cont)

Cognitive-Behavioral approaches - Focus on changing clients' maladaptive behaviors and dysfunctional thought patterns rather than their personality structures - Use techniques such as modeling and reinforcement to help clients develop more adaptive behaviors - Beck's approach focuses on helping the individual identify and correct distorted thinking - Linehan's technique, dialectical behavior therapy (DBT) combines cognitive-behavioral and buddhist mindfulness mediation

Biological approaches - Drug therapy does not directly treat personality disorders. Antidepressants or anti anxiety are sometimes used to treat associated depression/anxiety -Antidepressants of the selective serotonin reuptake inhibitor increase the availability of serotonin in synaptic connections between neurons and can help temper feelings of anger and rage. -Atypical antipsychotics may have benefits in controlling aggressive self-destructive behavior in people with BPD, but the effects are modest and the drugs carry potential side effects

chapter 24 Personality and impulse control (cont)

Impulse control disorders - Category of psychological disorders characterized by failure to control impulses, temptations, or drives, resulting in harm to one or others - Grouped in a broader category of disruptive, impulse-control, and conduct disorders that also includes conduct disorder and oppositional defiant disorder

Kleptomania -Type of impulse control disorder characterized by repeated acts of stealing - Stolen objects are of little value - Person may give them away, return them secretly, discard them, or just keep them hidden at home -In most cases they can easily afford what they steal

chapter 24 Personality and impulse control (cont)

Intermittent Explosive Disorder -Type of impulse-control characterized by repeated episodes of impulsive, uncontrollable aggression in which people strike out at others and destroy property - They have episode of violent rage in which they suddenly lose control and hit or try to hit other people -Experience a state of tension before their violent outbursts and a sense of relief after

Pyromania -Impulse--control disorder - Repeated acts of compulsive fire setting in response to irresistible urges - Rare disorder, which may help explain why it is poorly understood -Sense of release when setting fires and perhaps feelings of empowerment

chapter 24 Personality and impulse control (cont)

Impulse control disorder Tx - IED: Antidepressants, anger management training -Covert sensitization -Aversion therapy - Relaxation training -Cognitive restructuring