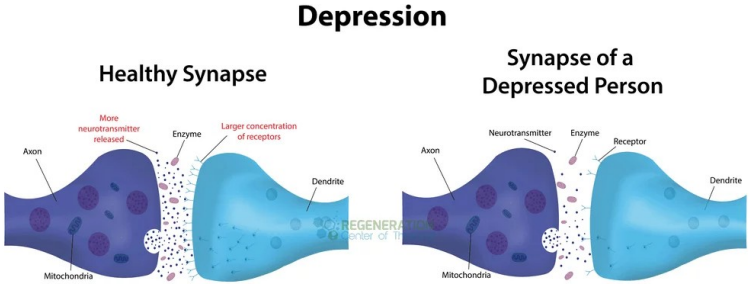
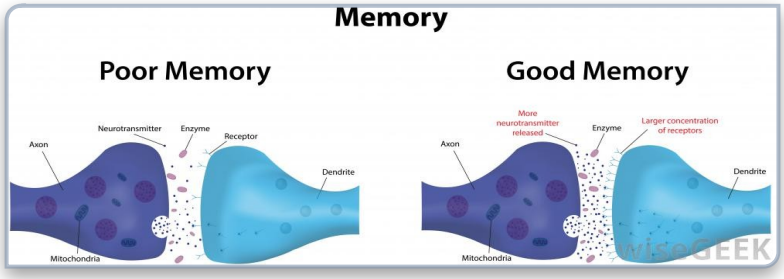
Biological Basis for Understanding Psychopharmacology

- Psychotropic Drugs
  - Psychiatric illness is related to several factors
  - Psychiatric illness results in alteration in neurotransmitters
  - These alterations are the targets of psychotropic drugs
- Visualizing the brain
  - Structured imaging techniques: CT, MRI
  - Functional imaging techniques: PET-positron emission tomography, SPECT- single emission computed tomography
- Neurotransmitters
  - Major components in the brain's chemical makeup
  - Monoamine neurotransmitters
    - Norepinephrine, dopamine, serotonin
  - Amino acid neurotransmitters
    - Glutamate, GABA
  - Acetylcholine
- Activities of Neurons
  - Once an electrical impulse reaches the end of a neuron, a ***neurotransmitter*** is released, crossing the synapse to attach to receptors on the postsynaptic cell to inhibit or excite it.
- Insufficient Transmission
  - An insufficient degree of transmission may be caused by a deficient release of neurotransmitters from the presynaptic cell or by a decrease in receptors.
- Excessive Transmission
  - Excessive transmission may be due to excessive release of a transmitter or to increased receptor responsiveness, as occurs in schizophrenia.
- Functions of Monoamine Neurotransmitters
  - Dopamine- Fine muscle movement, integration of emotions and thoughts, decision making, stimulates hypothalamus to release hormones
  - Norepinephrine- Mood, attention and arousal, fight or flight in response to stress
  - Histamine- Alertness, inflammatory response, stimulates gastric secretion
  - Serotonin- Mood, sleep regulation, hunger, pain perception, aggression and libido
- Monoamine Neurotransmitters
  - Dopamine
    - Decrease: Parkinson Disease, Depression
    - Increase: Schizophrenia, Mania
  - Norepinephrine
    - Decrease: Depression
    - Increase: Anxiety, Mania, Schizophrenia
  - Histamine
    - Decrease: Sedation, Weight gain
  - Serotonin
    - Decrease: Depression
    - Increase: Anxiety



- Function of Amino Acid Neurotransmitters
  - GABA- reduces anxiety, aggression, pain perception, anticonvulsant and muscle- relaxing properties
  - Glutamate- learning & memory
- Amino Acids Neurotransmitters
  - **GAMMA-AMINO BUTYRIC ACID (GABA)**
    - Decrease: Anxiety disorders, schizophrenia, mania
    - Increase: Reduction of anxiety
  - **Glutamate**
    - Decreased: Psychosis
    - Increased: Neurotoxicity & Neurodegeneration
- Functions of Acetylcholine Neurotransmitters
  - Acetylcholine- Plays a role in learning and memory, regulates mood, mania, sexual aggression, stimulates the parasympathetic nervous system



- Acetylcholine Neurotransmitters
  - Acetylcholine
    - Increase: Depression
    - Decrease: Alzheimer disease, Dementia, Parkinson disease, Huntington's Chorea

<u>Psychotropic Drugs</u>

- Antidepressant Drugs
  - **Monoamine Oxidase Inhibitors**
    - ↑ **serotonin & Norepinephrine**
  - **Hypertensive crisis:**
    - Tyramine: fermented foods, aged foods, and some beverages
    - Pseudoephedrine
  - Dietary restriction
  - 2 weeks after stopping MAOIs.
  - **Tricyclic antidepressants (TCAs): amitriptylene (Elavil), nortriptyline (Pamelor)**
    - Increase norepinephrine.
    - Side effects include anticholinergic effects.
  - **Selective serotonin reuptake inhibitors (SSRIs): fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil)**
    - Increase serotonin.
    - Side effects: Insomnia, sexual dysfunction, GI disturbances
  - **Serotonin-norepinephrine reuptake inhibitors (SNRIs): venlafaxine (Effexor), duloxetine (Cymbalta)**
    - Increase serotonin and norepinephrine.
- Antianxiety of Anxiolytic Drugs: Benzodiazepines
  - **Anxiety:** diazepam (Valium), clonazepam (Klonopin), alprazolam (Xanax)
    - Lorazepam (Ativan) and alprazolam (Xanax) reduce anxiety without being as sedating, at lower therapeutic doses.

        - Used to be one of the most prescribed medications for anxiety
        - Also used to treat seizures & alcohol withdrawal
        - Side effect: Ataxia
- Mood Stabilizers
    - **Lithium**
        - Stabilizes depression and mania (bipolar disorder).
        - Low therapeutic index.
        - Has a potential for toxicity.
        - Side effects: fine hand tremor, weight gain, polyuria, nausea
        - Toxicity: Ataxia, large output of dilute urine, seizures, coarse hand tremors, hypotension
- Antipsychotic Drugs/ First Gen Agents
    - Chlorpromazine (Thorazine)
    - Fluphenazine (Prolixin)
    - Haloperidol (Haldol)
        - Extrapyramidal side effects
            - Dystonia (muscle stiffness); Akathisia (restlessness); Tardive dyskinesia (TD); parkinsonism; neuroleptic malignant syndrome
        - Benztropine (Cogentin)
- Second-Gen Atypical Antipsychotic Drugs
    - Produce fewer extrapyramidal side effects (EPS)
    - Target negative and positive symptoms of schizophrenia
        - clozapine (Clozaril)
        - risperadone (Risperdal)
        - quetiapine (Seroquel)
        - olanzapine (Zyprexa)
        - iloperidone (Fanapt)
        - lurasidone HCl (Latuda)
        - ziprasidone HCl (Geodon)
        - aripiprazole (Abilify)
        - paliperidone (Invega)
- Side Effects
    - Conventional
        - EPS
            - Dystonic reaction
            - Akathisia
            - Parkinsonism
            - Tardive dyskinesia
    - Atypical
        - Risk of metabolic syndrome
            - Increased weight
            - Increased blood glucose
            - Increased triglyceride levels
            - Insulin resistance
        - Lower risk of EPS
- Identify the main neurotransmitters affected by the following psychotropic drugs and their subgroups
    - Antidepressant
    - Antianxiety
    - Sedative Hypnotic
    - Mood Stabilizer
    - Antipsychotic
    - Anticolinesterase

<u>Caring for Patients Psychobiological Disorders: Anxiety and Anxiety Related Disorders</u>

- What is anxiety?
  - A feeling of discomfort, apprehension, or dread related to anticipation of danger, the source may be unknown
  - Normal anxiety = health reaction for survival
    - Is a normal response to threatening situation either real or perceived
  - When does it become abnormal?
- Good Stress vs Distress
  - "Good" stress or eustress motivated people to develop the skills needed to solve problems
  - "Distress" is a negative experience
  - Stressor- something that triggers stress can be real or perceived
- Levels of anxiety
  - Mild anxiety
    - Everyday problem-solving leverage
    - Grasps more information effectively
  - Moderate anxiety
    - Selective inattention
    - Clear thinking hampered
    - Problem solving not optimal
    - Sympathetic nervous system symptoms begin
  - Severe anxiety
    - Perceptual field greatly reduced
    - Difficulty concentrating on environment
    - Confused and automatic behavior
    - Somatic symptoms increase
  - Panic level
    - Markedly disturbed behavior- running, shouting, screaming, pacing
    - Unable to process reality; impulsively
- Prevalence
  - Anxiety is the most common form of psychiatric disorder in the US
  - Affects 18.1% of Americans
  - Women are affected more than man
- Defense Mechanisms
  - Automatic coping styles
  - Protect people from anxiety
  - Maintain self-image by blocking
    - Feelings, conflicts, memories
  - Can be healthy or unhealthy
  - Pathological
    - Denial
  - Immature
    - Projection
    - Passive aggression
  - Neurotic
    - Intellectualization
    - Rationalization
    - Regression
    - Repression
    - Displacement
  - Mature
    - Humor
    - Sublimation
    - Suppression

        - Altruism
    - Reaction Formation
- Anxiety and nursing students
    - Did you know..
        - Nursing students have a higher risk of developing depression, anxiety, and stress compared with other college students (Karaca & Sisman, 2019).
        - Students with high levels of anxiety are more likely to have poor academic outcomes (Bamber & Schneider, 2015).
        - A national survey found that >62% of students who withdrew from college did so for mental health problems; anxiety has surpassed depression as the most common problem among college students (Stinson et al., 2020).
        - 41.6% - anxiety
        - 36.4% - depression
- Generalized Anxiety Disorder (GAD)
    - Chronic, unrealistic and excessive anxiety and worry
    - Occurring more days than not for at least 6 months
    - Individual worries about a number of events or activities
    - Anxiety/ physical symptoms cause significant impairments in social, occupational, or other areas of important functioning
    - Defense mechanisms are used by individuals for anxiety reduction
- GAD DSM-5 Criteria
    - The anxiety and worry are associated with 3 or more of the following 6 symptoms for the past 6 months:
        - Restlessness
        - Fatigue
        - Irritability
        - Decreased ability to concentrate
        - Muscle tension
        - Irritability
        - Disturbed sleep
- Panic Disorder
    - Characterized by recurrent panic attacks
    - Unpredictable onset
    - Manifested by intense apprehension, fear, or terror
    - Associated with feelings of impending doom
    - Accompanied by intense physical discomfort
- Panic Disorder DSM-5 Criteria
    - Sudden unexpected panic attacks
    - Sudden onset of extreme apprehension or fear, usually with a feeling of doom
    - Terror is so severe that normal function is suspended
        - Palpitations
        - Sweating
        - Trembling
        - Shortness of Breath
        - Feeling of choking
        - Chest pain
        - Nausea
        - Chills or Dizziness
        - heat sensations
        - Paresthesia (numbness)
        - Derealization (feeling of unreality)
        - Depersonalization (feeling detached from self)
        - Fear of losing control or “going crazy”

        - Fear of dying
- Panic Attack with Agoraphobia
    - Feared places are avoided to control anxiety, such as
        - Being alone outside
        - Being alone at home
        - Traveling by car, bus, or airplane
        - Being on a bridge
        - Riding in an elevator
    - Can be debilitating and life constricting
- Phobic Disorders
    - A persistence, intense irrational fear of a specific object, activity, or situation
    - Leads to a desire for avoidance, or actual avoidance
    - Becomes a problem when daily functioning is impaired
- Phobias: Social Anxiety Disorders
    - Is severe anxiety provoked by exposure to a social or performance situation.
        - Fear of saying something foolish, not being able to answer questions in a classroom, eating in the presence of others, and performing on a stage, among others
    - Fear of public speaking is the most common.
- Assessment
    - Determine primary vs. secondary cause
    - Determine level of anxiety
    - Assess for potential self-harm
    - Complete psychosocial assessment
        - Ask patient about causes they can identify
- Nursing Diagnoses
    - Ineffective Coping
    - Anxiety
    - Powerlessness
    - Chronic low self esteem
- Generalized Anxiety Disorder
    - Short term goals
        - Patient will be able to recognize signs and symptoms of intensifying anxiety
        - Patient will be able to perform self care activities independently
        - Patient will be alert and oriented
        - Patient will be able to identify precipitants of anxiety
        - Patient will identify strengths and coping skills
- Phobic Disorders
    - Goal: The patient will function adaptively in the presence of the phobic object or situation without experiencing panic anxiety
- Interventions
    - #1 Provide a safe environment
    - Establish trust & rapport
    - Stay with the patient
    - Speak slowly and remain calm
    - Use short simple sentences
    - Give brief directions
    - Decrease excessive stimuli
    - Administer anxiolytics
    - Provide safe outlets for excess energy
    - Goal = to decrease their anxiety level
    - Determine types of situations that increase anxiety
    - Help the client to identify thoughts or feelings before the onset of anxiety

        - "What were you thinking right before you started to feel anxious"
    - Develop healthy coping mechanisms
    - Explore past behaviors used to decrease anxiety
- Teaching
    - Teach signs and symptoms of anxiety disorders
    - Identify risk factors- substance abuse
    - Relaxation techniques
    - Medication side effects
    - Benefits of psychotherapy
    - Teach to limit caffeine, Nicotine, and other CNS stimulants
- Obsessive-compulsive disorder
    - Obsessions
        - Recurrent thoughts, impulses, or images experienced as intrusive and stressful, and unable to be expunged by logic or reasoning
    - Compulsions
        - Repetitive ritualistic behavior or thoughts, the purpose of which is to prevent or reduce distress or to prevent some dreaded event or situation
    - Individual knows their behavior is excessive and unreasonable
    - Common compulsions: hand washing, ordering, checking, repeating words silently
    - Interventions
        - Help the client identify types of situations that increase anxiety and result in ritualistic behaviors.
        - Do not try to change the client overnight.
        - Non- judgmental
        - Provide a structured schedule of activities
        - Gradually reduce time allotted for ritualistic behaviors
        - Provide positive reinforcement for non ritualistic behaviors
        - Teach thought stopping, relaxation, and physical exercise techniques
    - Short term goals
        - The patient is able to maintain anxiety at a manageable level without resorting to the use of ritualistic behavior
        - The patient uses more adaptive coping strategies for dealing with anxiety instead of ritualistic behaviors
- Posttraumatic Stress Disorder
    - A reaction to an extreme trauma, which is likely to cause pervasive distress to almost anyone
    - **Most people who experience a traumatic event do not develop PTSD**
    - **Those who do, the symptoms develop 3 months after the event to years later**
    - **Also in those who have witnessed the event**
    - Characteristic Symptoms Include
        - Reexperiencing the traumatic event: Flashbacks
        - A sustained high level of anxiety or arousal
        - A general numbing of responsiveness
        - Intrusive recollections or nightmares
        - Amnesia to certain aspects of the trauma
        - Depression; survivor's guilt
        - Substance abuse
        - Anger and aggression
        - Relationship problems
    - Interventions
        - Assign the same staff
        - Use a nonthreatening manner
        - Be consistent, keep all promises, convey acceptance, spend time with the client

        - Stay with the client during periods of flashbacks
        - Encourage the client to talk about the trauma at their own pace
        - Discuss coping strategies
- Milieu Management
    - Routine
    - Activities
    - Therapeutic Techniques
    - Include patient in decisions

Pharmacological Interventions: Medications for Effective Treatment

- Antidepressants
    - SSRI
        - First-line of treatment
        - Fluoxetine (Prozac)
        - Paroxetine (Paxil)
        - Sertraline (Zoloft)
        - Monitor for suicidal thinking
    - SNRI
        - Venlafaxine (Effexor)
        - Duloxetine (Cymbalta)
- Anxiolytics
    - Potentiate the effects of GABA
    - Produces a calmative effect
    - All levels of CNS depression can be affected, from mild sedation to hypnosis to coma
    - Benzodiazepines: Taken PRN
        - Alprazolam (Xanax)
        - Clonazepam (Klonopin)
        - Lorazepam (Ativan)
        - Diazepam (Valium)
- Benzodiazepines
    - Side Effects: sedation, ataxia, decreased cognitive functioning
    - Withdrawal: anxiety, insomnia, diaphoresis, tremors, delirium, seizures
    - Teaching:
        - Dose should be tapered over several weeks
        - Avoid alcohol & grapefruit juice
        - Should avoid during pregnancy
    - Oral toxicity- drowsiness, lethargy, confusion
    - Treatment for an overdose: gastric lavage, activated charcoal, administer flumazenil, monitor VS, maintain airway, administer fluids to maintain BP
- Beta Blockers
    - Propranolol
        - For GAD and Panic disorder
        - Blocks beta-adrenergic receptors in the sympathetic nervous system causing a relaxation response
- Buspirone (BuSpar)
    - Binds to serotonin and dopamine receptors
    - Does not cause dependence
    - Need 2 to 4 weeks to reach full effect
    - May be used long-term
    - Should be taken regularly not PRN
    - S/E: dizziness, blurred vision, palpitations
    - Adverse Reactions: excessive sweating, restlessness, fever

    - Teaching: take with food, increase fiber and fluids, report thoughts of suicide, do not take with a MAOI
- Integrative Therapies
    - Herbs: Kava, Valerian, Chamomile, Lavender
    - Massage
    - Therapeutic Touch
    - Yoga
    - Meditation

Somatic Symptom Disorders: Physical Symptoms in Absence of Known Medical Illness

- Introduction
    - Physical symptoms without organic pathology
    - Somatization: psychological distress is expressed as physical symptoms
        - Somatic Symptom Disorder
        - Illness Anxiety Disorder
        - Conversion Disorder
        - Factitious Disorder
- Prevalence
    - 10x higher in women
    - Children who experienced a traumatic event
- Theory
    - Genetic Factors
    - Psychological Theory
        - Lack of Verbal Expression → Physical Symptoms
        - Precursors → history of divorce, maltreatment, trauma
    - Interpersonal Model
        - Adverse childhood experiences (ACEs)
        - Loneliness
- Somatic Symptom Disorder
    - A syndrome of multiple somatic symptoms
    - Cannot be explained medically
    - Excessive thoughts, anxiety and behaviors around symptoms
    - Causes psychosocial distress
    - Suffering is authentic
    - Anxiety, depression, and suicidal ideation are common
- Illness Anxiety Disorder
    - Unrealistic or inaccurate interpretation of physical symptoms or sensations, leading to preoccupation and fear of having a serious disease
    - Somatic symptoms are not present
    - High level of anxiety about health
    - The behavioral response to even the slightest changes in feeling or sensation is unrealistic and exaggerated.
- Conversion Disorder
    - A loss of or change in body function that cannot be explained medically
    - The most obvious and “classic” conversion symptoms are those that suggest neurological disease.
    - May be precipitated by psychological stress.
    - Symptoms:
        - Paralysis
        - Coordination disturbances
        - Difficulty swallowing
        - Blindness
- Factitious Disorder Imposed on Self

    - Intentionally faking symptoms
    - Assumes the role of the patient
    - Motivation → comfort, attention, nurture
    - Exaggerate or induce symptoms
- Factitious Disorder Imposed on Another
    - Same criteria as factitious disorder except the fabrication of symptoms is imposed by another person, usually to a child.
- Somatic Symptom Disorders: Assessment
    - Thorough physical exam & medical tests
    - Assess nature, location, & onset of symptoms
    - Thought process
    - Medications
    - Trauma
    - Previous evaluations/ treatments
    - Ability to communicate feelings and emotional needs
- Somatic Symptom Disorders: Short Term Goals
    - The patient will articulate feelings such as anger, shame, guilt, and remorse.
    - The patient will verbalize relief from pain
    - The patient will identify levels of anxiety
    - The patient will seek support from staff when anxiety level is heightens
    - The patient will utilize the therapeutic milieu to increase ability to express feelings
    - The patient will participate and be active in unit activities
    - The patient will replace negative thoughts with positive thoughts
- Somatic Symptom Disorders: Long Term Goals
    - The patient will identify and express emotions without resorting to physical symptoms
- Somatic Symptom Disorders: Interventions
    - #1- Establish Rapport
    - Encourage patient to verbalize fears and anxieties
    - Shift focus from somatic complaints to feelings
    - Identify secondary gains
    - Reinforce patient's strengths & problem-solving abilities
    - Initially, fulfill client's physical needs, but gradually withdrawal attention to the physical complaints
    - Monitor lab reports, assessments, VS, etc.
    - Recognize and accept the physical complaints are real to the client
    - Assist client with developing more appropriate ways to verbalize feelings and needs
- Treatments
    - Cognitive Behavioral Therapy
    - Tricyclic Antidepressants
    - Selective Serotonin Reuptake Inhibitors
    - Serotonin Norepinephrine Reuptake Inhibitors
        - Venlafaxine & Duloxetine
    - Benzodiazepines (short-term use)

<u>Dissociative Disorders: Response to extreme external or internal events or stressors</u>

- Overview
    - Disturbances in a normally well-integrated continuum of consciousness, memory, identity, and perception.
    - Dissociation—is the unconscious defense mechanism to protect an individual against overwhelming anxiety.
    - The onset may be sudden or occur gradually, and the course may be long term or transient
- Prevalence and Comorbidity

- 2% of the population
- Higher in women
- ½ of adults' experience symptoms
- SUD, depression, anxiety, r/f suicide

- Theory
  - Trauma
  - Children → long term abuse
  - Genetic Factors
- Dissociative Disorders
  - Depersonalization / Derealization Disorder
    - The feeling of being detached from one's mental processes
  - Dissociative Amnesia
    - Not Normal forgetting
  - Dissociative Identity Disorder (DID)
    - Two or more personalities
- Depersonalization / Derealization Disorder
  - Characterized by a temporary change in the quality of self-awareness, which often takes the form of:
    - Feelings of unreality
    - Changes in body image
    - Feelings of detachment from the environment
    - A sense of observing oneself from outside the body
  - Depersonalization: disturbances in the perception of oneself
    - Feeling detached from oneself as if an observer
    - Feeling as if in a dream
    - Feeling a sense of unreality of self or body or of time
  - Derealization: an alteration in the perception of the external environment
    - Experiencing an unreality of surroundings
    - The world is experienced as unusual, dreamlike, distant, or distorted
- Dissociative Amnesia
  - Dissociative Amnesia
    - Inability to recall information
    - Usually related to a traumatic events
    - Not ordinary forgetfulness
    - Not because of substance use or a medical condition
    - Onset usually follows severe psychosocial stress.
  - Dissociative Fugue
    - A sudden, unexpected travel away from home with the inability to recall some or all of one's past
- Dissociative Identity Disorder
  - Characterized by the existence of two or more personalities within a single individual
  - Alternate Personality (alter)
  - Transition from one personality to another usually sudden, often dramatic, and usually precipitated by stress
  - Only one of these identities is evident at any given moment
    - Each personality has their own pattern of perceiving, affect, cognition, behavior, and memories
  - One of these is dominant (in control) most of the time
  - The sub personalities have different names, may be of a different gender, race, or age
  - Primary personality is usually not aware of the alters; however, alters may be aware of each other
- Assessment
  - Gather information:
    - Life events
    - Memory

        - Suicide Risk
        - Evaluate level of anxiety and signs of dissociation
        - Identify support systems
- Assessment: Questions to Ask
    - Have you ever found yourself wearing clothes you can't remember buying?
    - Have you ever had strangers talk to you as if they were old friends?
    - Do you have differing sets of childhood memories?
    - Can you remember recent and past events?
    - Do you have gaps in memory?
    - Do you ever find yourself in a place with no idea of how you got there?
- Goals
    - Will verbalize clear sense of personal identity & perceive the environment accurately
    - Will maintain a sense of reality during stressful situations
    - Will monitor anxiety, identify triggers, and use effective coping strategies
- Interventions
    - Provide undemanding, simple routines
    - Ensure patient safety
    - Confirm identity to patient; orient to time and place
    - Support patient during exploration of feelings surrounding stressful events
    - Allow patient to progress at their own pace until memory is recovered
    - Teach grounding techniques
    - Reorient to the present using the 5 senses
        - Encourage patients to look around and name objects they see
        - Have them taste a flavored drink and ask them to describe what they taste
        - Point out the date on a newspaper or the time on the clock
    - Promote emotional regulation
        - DDs disrupt the mind-body connection
        - Interventions: Deep breathing, therapeutic journaling, progressive muscle relaxation, mindfulness, yoga
- Treatment Modalities
    - Cognitive Behavioral therapy
    - Psychopharmacology
        - Antidepressants
        - Antianxiety
        - Antipsychotics
    - Milieu Therapy

Personality Disorders

- Introduction
    - Personality, defined
        - The totality of emotional and behavioral characteristics that are particular to a specific person and that remain somewhat stable and predictable over time.
        - How we perceive and interact with the world.
    - Personality disorders (PDs)
        - An enduring pattern of inner experience and behavior that deviates from the individual's culture
    - Personality disorder traits
        - Personality traits tend to be inflexible and unpredictable
        - Coping strategies tend to be more primitive and immature
- Prevalence and Comorbidity
    - 6% of the global population
    - 10% in the U.S.

    - No variation in sex or race
    - 84.5% have ≥1 mental disorder(s)
    - Substance Use & Depression
- Types of Personality Disorders
    - Cluster A: Behaviors described as odd or eccentric
    - Cluster B: Behaviors described as dramatic, emotional, or erratic
    - Cluster C: Behaviors described as anxious or fearful
- Characteristics
    - Are mild to severe.
    - Patients do not see behavior as a problem.
    - They blame others.
    - Patients believe they are *normal*; it is the others who have the problem.
    - Difficult to treat
    - Become apparent during adolescence
    - Often have comorbid substance use disorders
- 3 Clusters
    - The 3 W's
        - Weird (cluster A): Oddness/ eccentricity- paranoid, schizoid, schizotypal
        - Wild (cluster B): Emotional/ erratic- antisocial, borderline, histrionic, narcissistic
        - Worried (cluster B): Anxiety/ fear- avoidant, dependent, obsessive-compulsives

<u>Cluster A: Paranoid Personality Disorder, Schizoid Personality Disorder, Schizotypal Personality Disorder</u>

- Paranoid Personality Disorder
    - Characterized by a pervasive, persistent, and inappropriate mistrust of others
    - Individuals with this disorder are suspicious of others' motives and assume that others intend to exploit, harm, or deceive them.
    - Ready for any real or imagined threat
    - Trusts no one
    - Constantly tests the honesty of others
    - Clinical Picture
        - Insensitive to the feelings of others
        - Tends to misinterpret minute cues
        - Magnifies and distorts cues in the environment
        - Does not accept responsibility for his or her own behavior
        - Attributes shortcomings to others
- Schizoid Personality Disorder
    - Characterized primarily by a profound defect in the ability to form personal relationships
    - Failure to respond to others in a meaningful emotional way
    - Clinical Picture
        - Aloof and indifferent to others
        - Emotionally cold
        - No close friends; prefers to be alone
        - Appears shy, anxious, or uneasy in the presence of others
        - Inappropriately serious about everything and difficulty acting in a light-hearted manner
- Schizotypal Personality Disorder
    - Resembles schizophrenia
    - May develop into schizophrenia
    - Up to 10% suicide
    - Clinical Picture
        - Aloof and isolated
        - Behave in a bland and apathetic manner
        - Magical thinking

        - Ideas of reference
        - Illusions
        - Depersonalization
        - Superstitious
        - Withdrawal into self
        - Lacks close friends
        - Exhibits bizarre speech pattern
        - When under stress, may decompensate and demonstrate psychotic symptoms
        - Demonstrates bland, inappropriate affect
- Guidelines for Nursing Care: Cluster A
    - Attempt to establish trust
    - Professional demeanor
    - Be Honest
    - Clear, simple explanations
    - Set limits

<u>Cluster B: Antisocial personality disorder, Borderline Personality Disorder, Histrionic Personality Disorder, Narcissistic Personality</u>

- Antisocial Personality Disorder
    - Clinical picture
        - Fails to sustain consistent employment
        - Fails to conform to the law
        - Exploits and manipulates others for personal gain
        - Fails to develop stable relationships
        - Persistent disregard for others
        - Persistent violation of others' rights
        - Absence of remorse for hurting others
- Borderline Personality Disorder
    - Characterized by a pattern of intense and chaotic relationships with affective instability
    - Fluctuating and extreme attitudes regarding other people
    - Highly impulsive
    - Chronic depression
    - Abandonment issues
    - Chronic feelings of emptiness
- Borderline Personality
    - Emotionally unstable
    - May dissociate under stress
    - Difficulty controlling anger
    - Self-destructive
    - Splitting defense
    - High suicide rate
- Narcissistic Personality Disorder
    - Sense of entitlement
    - Believe they should receive special consideration
    - Lack of empathy; exploiting others to meet own needs
    - Envious of others
    - Use of splitting, tantrums
    - Clinical Picture
        - Because of fragile self-esteem, mood can easily change if clients do not:
            - Meet self-expectations
            - Receive the positive feedback that they expect

        - Criticism from others may cause them to respond with rage, shame, and humiliation
- Historic Personality Disorder
    - Behavior is:
        - Excitable & Emotional
        - Colorful & Dramatic
        - Extroverted
    - Clinical picture
        - Self-dramatizing
        - Attention-seeking
    - Overly gregarious
        - Seductive & Manipulative
- Guidelines for Nursing Care: Cluster B
    - Give positive reinforcement for unselfish or other-center behaviors
    - Keep communications & interactions professional
    - Provide support
    - Help clarify true feelings
    - Assess for suicidal ideation

<u>Cluster C: Avoidant personality disorder, Dependent personality disorder, Obsessive-compulsive personality disorder</u>

- Dependent Personality Disorder
    - Characterized by a pattern of relying on others for emotional support
    - Relatively common within the population
    - More common in women than in men
    - Intense fear of separation and being alone
    - Lack of self-confidence
    - Low self-worth and easily hurt by criticism and disapproval
    - Tolerant of poor, even abusive relationships
        - If relationship does end, the individual has an urgent need to get into another
    - Inability to make decisions without excessive reassurance
    - Needs support from others
    - High levels of anxiety
- Avoidant Personality Disorder
    - Characterized by:
        - Extreme sensitivity to rejection
        - Social withdrawal
    - Clinical picture
        - Awkward and uncomfortable in social situations
        - Desire close relationships but avoid them because of fear of being rejected
        - Perceived as timid, withdrawn, or cold and strange
        - Often lonely and feel unwanted
        - View others as critical and betraying
- Obsessive- compulsive disorder
    - Characterized by inflexibility about the way in which things must be done
    - Devotion to productivity at the exclusion of personal pleasure
    - Clinical Picture
        - Especially concerned with matters of organization and efficiency
        - Tend to be rigid and unbending
        - Socially polite and formal

        - High achievers
- Guidelines for Nursing Care: Cluster C
        - Teach and role model assertiveness
        - Friendly, gentle reassuring approach
        - Guard against power struggles
        - Provide structure
        - Assist in developing effective coping techniques
- Personality Disorders: Assessment Guidelines
    - Assess suicidal and homicidal thoughts.
    - Determine whether the patient has a medical disorder or another psychiatric disorder.
    - Evaluate for changes in personality in middle adulthood or later:
    - May signal an unrecognized substance use disorder.
        - Be aware of strong negative emotions that patients evoke.
- Personality Disorders: Interventions
    - Safety is always the priority
    - Set limits on patient behavior.
    - All staff should consistently enforce limits.
    - Assess your own reactions toward the patient.
    - Have discussions with staff members
    - Observe client's behavior frequently
    - Do not give positive reinforcement for manipulating behavior
    - Encourage client to talk about their feelings
    - Identify triggers
    - Discuss alternative behaviors
    - Teach coping skills
    - Create a therapeutic relationship
    - Encourage verbalization of feelings, perceptions, & fears
- Personality Disorders: Managing Behaviors
    - Behaviors should be objectively documented (e.g., time, date, circumstances).
    - Provide clear boundaries and consequences.
    - Acknowledge manipulative behaviors
    - Enforce consequences.
    - **Avoid:**
        - Discussing yourself or other staff members with patient
        - Promising to keep a secret
        - Accepting gifts from patient
        - Doing special favors for patient
- Personality Disorder': Goals
    - Patient will have a decreased level of stress
    - Patient will refrain from self harm
- Treatment Modalities for Personality Disorders
    - Milieu/ group therapy
    - Cognitive/behavioral therapy
    - Psychopharmacology
        - Antipsychotics
        - SSRIs
        - Mood Stabilizers

<u>Suicide: The Act of Taking One's Own Life</u>

- Introduction

- Suicide is not a diagnosis or a disorder; it is a behavior.
- DSM-5: Suicidal behavior disorder
- The CDC (2018) estimates that for those who committed suicide
  - 22% had a physical health problem
  - 28% had problematic substance use
  - ~46% had a known mental health issue

- Suicide: Definitions and Concepts
  - **Suicide** or **completed suicide**
    - The intentional ending of one's own life.
  - **Suicide attempts**
    - Willful, self-inflicted, life-threatening attempts that have not led to death.
  - **Suicidal ideation**—Is a person thinking about personal death
    - They wish to be dead
    - Consider methods of accomplishing death
    - Formulate plans to carry out the act
- Epidemiological Factors
  - Every year approximately 800,000 people around the world die by suicide.
  - 48,344 Americans died by suicide in 2018
  - On average, 113 Americans died by suicide each day.
  - 1 death every 13 minutes
  - 1.4 million Americans attempted suicide.
  - Active-Duty service members surpass civilians for suicide rates
- Suicide Facts
  - Gender
    - Women attempt suicide 2-3x more than men
    - Men commit suicide 4x the rate of females, 78% of all suicides are male
  - Race & Ethnic Statistics
    - American Indian/ Alaskan Natives
      - Aged 10-34; suicide is the 2nd leading cause of death
    - Hispanic high school students
      - 11.3% higher suicide rate then black or white students
  - Caucasians have the highest completed suicide rate : 85-90%
  - Age Statistics
    - 17% of US high school students have seriously considered suicide
      - 8% attempted
    - 3rd leading cause of death among 10-14yr olds
    - 2nd leading cause of death among 15-34 yr olds
    - 12th leading cause of death overall
  - LGBT Youth are 4x more likely to attempt suicide than straight youth
  - Transgender adults are 9x more likely to attempt suicide
- Risk Factors
  - Biological Factors: Genetic?
    - SKA2 Gene
    - Low Serotonin levels
  - Environmental Factors
    - Loss of job, imminent incarceration, guilt
    - Copycat suicide
      - Adolescents at highest risk
  - Cultural Factors

        - Religious beliefs, family values, sexual orientation, gender identity, bullying behavior, and attitude toward death
    - Marriage
        - Divorced men have higher rates than women
    - Profession
        - Physicians, dentists, veterinarians, chiropractors
    - Physical health
        - Chronic illnesses, loss of mobility, chronic pain
    - A previous suicide attempt
    - History of suicide in the family
    - Substance use
    - Mood disorders
    - Access to lethal means
    - History of trauma
- Protective Factors
    - Access to mental healthcare
    - Strong connections with family, friends, & community
    - Problem solving & conflict resolution
    - Frequent contact with providers
- Warning Factors
    - Frequently talking about death or suicide
    - Making comments about being hopeless, helpless, worthless
    - Verbalizing "It would be better if I wasn't here"
    - Increased alcohol or drug use
    - Withdrawal from friends, family, or community
    - Dramatic mood changes
    - Giving away prized possessions
    - Exhibiting sudden or unexpected improvement in mood after being depressed and withdrawn
- Assessment: Verbal Clues
    - **Overt Statements**
        - "I can't take it anymore."
        - "Life isn't worth living anymore."
        - "I wish I were dead."
        - "Everyone would be better off if I died."
        - "Living is useless"
    - **Covert Statements**
        - "It's okay now. Everything will be fine."
        - "I won't be a problem much longer."
        - "Nothing feels good and never will again."
- Assessment: Lethality of Suicide Plan
    - Is there a specific plan?
    - How lethal is the proposed method?
    - Is there access to the method?
    - Hard Methods
        - Gun, jumping off a bridge, carbon monoxide poisoning, car crash
    - Soft Methods
        - Cutting one's wrists, inhaling natural gas, taking pills
- Assessment Guidelines
    - If you, as a nurse, feel concern, **always ask**: **"Are you thinking of harming or killing yourself?"**

        - Assess the precipitating event. “Is there something difficult you are facing?”
        - Assess risk factors, *as well as* protective factors.
        - Assess the history of suicide in family, friends, and others; the degree of hopelessness and helplessness; and the lethality of the plan.
- Assessment Tools
    - SAD PERSONS scale
        - Ten categories
        - Total points correlate to an action plan
        - One point is assigned to each applicable characteristic
- Assessment Modified SAD Persons Scale
    - S: Male sex → 1
    - A: Age If <19 or >45 years → 1
    - D: Depression or hopelessness → 2
    - P: Previous suicidal attempts or psychiatric care → 1
    - E: Excessive ethanol or drug use → 1
    - R: Rational thinking loss (psychotic or organic illness) → 2
    - S: Separated, widowed, or divorced → 1
    - O: Organized plan or serious attempt → 2
    - N: No social support → 1
    - S: Stated future intent (determined to repeat or ambivalent) → 1
- **Guidelines for Clinical Action**
    - 0-5: May be safe to discharge (depending upon circumstances)
    - 6-8: Probably requires psychiatric consultation
    - > 8: Probably requires hospital admission (voluntary or involuntary)
- SAFE-T Pocket Card
    - The Suicide Assessment Five-step Evaluation and Triage (SAFE-T) pocket card
        - Protocols for developing treatment plans and interventions responsive to the risk level of patients
        - Includes triage and documentation guidelines
        - Intended for use by trained professions
    - Nursing Diagnosis
        - *Risk for suicide* is immediately important.
            - Self-restraint from suicide is the hoped-for outcome.
        - Other diagnoses include:
            - Ineffective coping
            - Hopelessness
            - Social isolation
            - Spiritual distress
            - Chronic low self-esteem
            - Disturbed thought processes
            - Post trauma syndrome
    - Interventions During the Crisis Period
        - Safety
        - Document the patient’s activity
        - Implement Suicide Precautions
        - Construct a *verbal or written no-suicide contract*.
        - Encourage the patient to talk about his or her feelings
        - Establish rapport
    - Suicide Precautions
        - One-to-one sitter

        - Chart behaviors Q15 minutes
        - Safe meal trays
        - Stay within arms length of the patient
        - Be sure patient swallows all medication
        - Remove telephone cord, oxygen tubing, etc.
        - Remove all harmful objects
        - Search visitors for harmful objects
- Interventions
    - Be direct and talk matter-of-factly about suicide.
    - Discuss the current crisis in the client's life.
    - Identify areas of self-control.
    - Help is available
    - You are not alone
    - Patient Safety Plan
        - Six-step plan
            - Identification of:
                - Warning Signs
                - Internal coping strategies
                - Social settings
                - People who provide distractions
                - People who the patient can ask for help
                - Crisis resources
                - Making the environment safe
                - Identify the most important thing worth living for
- Pharmacological Interventions
    - Depressive Disorder/ Anxiety Disorder
        - Antidepressants
            - SSRIs
            - Tricyclic & MAOIs
    - Bipolar Disorder & Major Depression
        - Lithium
    - Schizophrenia
        - 2nd Generation Antipsychotics
            - Clozapine
- Information for family and friends
    - Take any hint of suicide seriously.
    - Do not keep secrets.
    - Be a good listener.
    - Know about suicide intervention resources.
    - Restrict access to firearms or other means of self-harm.
    - Do not judge or show anger toward the person or provoke guilt in him or her.
    - Show love and encouragement.
- Short Term Goals
    - Refrains from self injury
    - Seeks assistance as needed
    - Attends support groups
    - Takes medications as prescribed
    - Utilizes effective coping strategies
- Long Term Goals
    - Develop and maintain a more positive self-concept.

- Learn more effective ways to express feelings to others.
- Achieve successful interpersonal relationships.
- Feel accepted by others and achieve a sense of belonging.