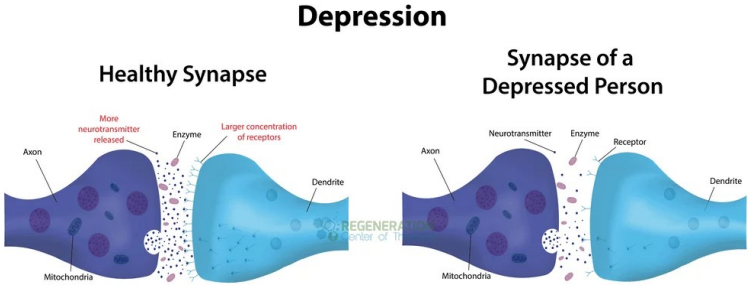
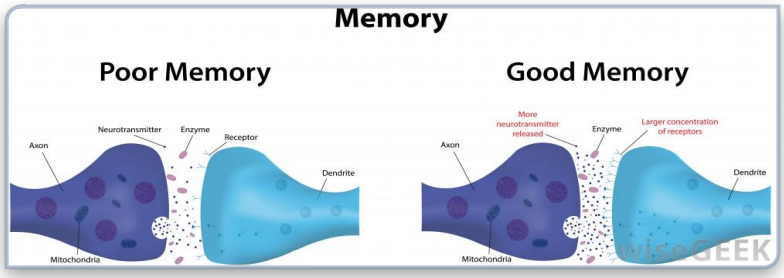
Mental Health Unit II Part I
Biological Basis for Understanding Psychopharmacology

- 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
- Atypical Anxiolytic
    - Buspirone (BuSpar)
        - Dependency is unlikely
        - May take 1 week to notice effects
        - Must take on a scheduled basis
        - Do not take with a MAOI
        - Side Effects: dizziness, lightheadedness, nausea

- 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

Caring for Patients Psychobiological Disorders: Anxiety and Anxiety Related Disorders

- 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

<u>Pharmacological Interventions: Medications for Effective Treatment</u>

- 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)

Dissociative Disorders: Response to extreme external or internal events or stressors

- 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

Paranoid personality disorder
SUSPECT[9]
Spousal infidelity suspected
Unforgiving (bears grudges)
Suspicious
Perceives attacks (and reacts quickly)
Enemy or friend? (suspects associates and friends)
Confiding in others is feared
Threats perceived in benign events

Schizoid personality disorder
DISTANT[9]
Detached or flattened affect
Indifferent to criticism or praise
Sexual experiences of little interest
Tasks done solitarily
Absence of close friends
Neither desires nor enjoys close relationships
Takes pleasure in few activities

Schizotypal personality disorder
ME PECULIAR[9]
Magical thinking
Experiences unusual perceptions
Paranoid ideation
Eccentric behavior or appearance
Constricted or inappropriate affect
Unusual thinking or speech
Lacks close friends
Ideas of reference
Anxiety in social situations
Rule out psychotic or pervasive developmental disorders

- 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

Antisocial personality disorder
CORRUPT[9]
Cannot conform to law
Obligations ignored
Reckless disregard for safety
Remorseless
Underhanded (deceitful)
Planning insufficient (impulsive)
Temper (irritable and aggressive)

Borderline personality disorder
IMPULSIVE[10]
Impulsive
Moodiness
Paranoia or dissociation under stress
Unstable self-image
Labile intense relationships
Suicidal gestures
Inappropriate anger
Vulnerability to abandonment
Emptiness (feelings of)

Histrionic personality disorder
ACTRESSS*
Appearance focused
Center of attention
Theatrical
Relationships (believed to be more intimate than they are)
Easily influenced
Seductive behavior
Shallow emotions
Speech (impressionistic and vague)

Narcissistic personality disorder
GRANDIOSE[11]
Grandiose
Requires attention
Arrogant
Need to be special
Dreams of success and power
Interpersonally exploitative
Others (unable to recognize feelings/needs of)
Sense of entitlement
Envious

- 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

Cluster C: Avoidant personality disorder, Dependent personality disorder, Obsessive-compulsive personality disorder

- 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

Dependent personality disorder
RELIANCE[9]
Reassurance required
Expressing disagreement difficult
Life responsibilities assumed by others
Initiating projects difficult
Alone (feels helpless and uncomfortable when alone)
Nurturance (goes to excessive lengths to obtain)
Companionship sought urgently when a relationship ends
Exaggerated fears of being left to care for self

Avoidant personality disorder
CRINGES[9]
Criticism or rejection preoccupies thoughts in social situations
Restraint in relationships due to fear of shame
Inhibited in new relationships
Needs to be sure of being liked before engaging socially
Gets around occupational activities with need for interpersonal contact
Embarrassment prevents new activity or taking risks
Self viewed as unappealing or inferior

Obsessive-compulsive personality disorder
SCRIMPER*
Stubborn
Cannot discard worthless objects
Rule obsessed
Inflexible
Miserly
Perfectionistic
Excludes leisure due to devotion to work
Reluctant to delegate to others

- 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.