A NATIONAL EPIDEMIC

WE ALL KNOW . . .
. . . that U.S. Copyright Law grants to the copyright owner the exclusive right to duplicate copyrighted, printed and recorded materials. Piracy involves the illegal duplication of copyrighted materials.

YOU MAY NOT KNOW . . .
. . . that every time you use or make an illegal copy of cassettes or printed material in any form or by any method you may be subject to litigation.

. . . that your institution’s duplication or processing equipment may also be confiscated and destroyed if involved in illegal duplication.

. . . that the penalty for criminal violation is up to five years in prison and/or a $250,000 fine under a tough new law. (Title 17, U.S. Code, Section 506, and Title 18, U.S. Code Section 2319).

. . . that civil or criminal litigation may be costly and embarrassing to any organization or individual. We request you contact us immediately regarding illegal duplication of these copyrighted, printed materials. The National Center of Continuing Education will pay a substantial reward for information leading to the conviction of any individual or institution making any unauthorized duplication of material copyrighted by W.S. Keefer or The National Center of Continuing Education.
# Table of Contents

- About the Authors ........................................3
- Purpose & Goals ..........................................3
- Instructional Objectives ................................3
- What is Mental Illness? ..................................3
- Epidemiology of Mental Illness ......................3
- History of Mental Illness ...............................4
- Classification, Etiology & Diagnosis .................4
- Etiology of Mental Disorders .........................6
  - Genetics ..................................................6
  - Brain Chemistry and Neurotransmitter Activity .6
  - Prenatal Damage .......................................7
  - Infection and Inflammation .........................7
  - Environmental and Social Factors ...............7
- Diagnosis of Mental Disorders ......................8
- Bipolar Disorder ........................................8
  - Classification of Bipolar Disorder .............8
  - Clinical Presentation of Bipolar Disorder ....8
  - Risk Factors ............................................9
  - Screening for Bipolar Disorder .................9
- Management of Bipolar Disorder ....................10
  - Pharmacological Treatment ......................10
- Depression ................................................12
  - Symptoms of Depression ........................12
  - Classification of Depression ......................12
- Diagnosis and Assessment of Depression ........13
  - Management of Depression ......................13
- Schizophrenia ..........................................14
  - Symptoms of Schizophrenia ....................14
  - Classification of Schizophrenia .................14
  - Assessment of Schizophrenia .................14
- Management of Schizophrenia .....................15
- Hallucinations ..........................................15
- Delusions ................................................15
- Anxiety Disorders ......................................15
  - Social Anxiety Disorder ..........................16
  - Separation Anxiety Disorder ..................16
  - Selective Mutism .....................................16
  - Generalized Anxiety Disorder ................16
  - Phobias ................................................16
  - Panic Disorder .......................................16
  - Obsessive-Compulsive Disorder (OCD) ........16
  - Post-Traumatic Stress Disorder (PTSD) .......16
- Assessment of Anxiety Disorders .................16
- Management of Anxiety Disorders ...............17
- Personality Disorders ................................18
  - Paranoid Personality Disorder .................18
  - Schizoid Personality Disorder ................18
  - Schizotypal Personality Disorder ...........18
  - Antisocial Personality Disorder ...............18
  - Borderline Personality Disorder ...............18
  - Histrionic Personality Disorder ...............18
  - Narcissistic Personality Disorder .............18
  - Avoidant Personality Disorder .................19
  - Dependent Personality Disorder ...............19
  - Obsessive – Compulsive Personality Disorder .19
- Assessment & Management of Personality Disorders .................19
- Nursing Interventions ...............................19
- References .............................................20

---

**Extraordinary efforts have been made by the authors, the editor and the publisher of the National Center of Continuing Education, Inc. courses to ensure dosage recommendations and treatments are precise and agree with the highest standards of practice. However, as a result of accumulating clinical experience and continuing laboratory studies, dosage schedules and/or treatment recommendations are often altered or discontinued. In all cases the advice of a physician should be sought and followed concerning initiating or discontinuing all medications or treatments. The planner(s), author(s) and/or editor(s) of each course have attested to no conflict of interest nor bias on the subject. The National Center of Continuing Education, Inc. does not accept commercial support on any course nor do they endorse any products that may be mentioned in the course. Any off-label use for medications mentioned in a course is identified as such.**

No part of this publication may be reproduced stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the prior written permission of the publisher.
About the Authors

Denise Warren, RN, BSN has been a nurse educator in a hospital setting. In this capacity, she has authored continuing education materials for nursing staff as well as training and competency manuals for various hospital units. She has worked closely and counseled patients on a variety of medical conditions in both an inpatient and outpatient setting. She continues to write health-related articles and continuing education courses.

Sheida L. Hudson, RN, BSN, PHN Director of Healthcare Information, completed her baccalaureate degree in Nursing and public health certificate at Azusa Pacific University. Ms. Hudson has over 21 years of extensive experience in publishing courses in continuing education for healthcare professionals with the National Center.

Content Review Expert Meredith Patterson, RN, BSN, CRRN is a neurology nurse with clinical background in acute care neurology, head injury rehabilitation and dementia care management. She is owner of Brainstorm Mind Fitness, an educational company focusing on brain health and neuro-fitness. She has authored numerous presentations and lectures conferences, professional and community groups.

Purpose & Goals

The goal of this course is to provide nurses and other health care professionals with a comprehensive overview of mental illness, including schizophrenia, bipolar, anxiety, depression, and personality disorders. The course will examine the impact, etiology, assessment and management of these mental disorders.

Instructional Objectives

1. Account for the epidemiology of mental health disorders
2. Briefly review the history concerning the treatment of mental disorders
3. Outline the diagnostic criteria for mental disorders
4. Differentiate the classification factors of the mental disorders covered in this course
5. Identify the cause of mental disorders.
6. Identify ways mental disorders are diagnosed.
7. Differentiate various subtypes of bipolar disorders.
8. List the classification of medications used to treat mental disorders.
9. Recall the clinical presentation and management of depression.
10. Explain effective management strategies for patients with schizophrenia.
11. Interpret the six different types of anxiety disorders
12. Compare the ten types of personality disorders
13. Describe effective nursing interventions for mental health patients

What is Mental Illness?

At one time, the medical community poorly understood mental illness. People with mental disorders were considered possessed and were concealed away from the general public in locked institutions, known as asylums. The scientific community no longer considers mental disorders as rare “demonic infictions.” They now understand that mental disorders can affect people of any age, sex, race, income and religion. Psychiatrists have also realized that mental illness is not caused by “character flaws” or personal weakness. In fact, research indicates a large scope of mental disorders and their etiologies.

The updated 2013 version of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Health Disorders, 5th Edition (DSM-5) classifies a mental disorder as “a clinically significant behavior or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability, or an important loss of freedom.” According to DSM-5, this behavioral pattern reflects an “underlying psychobiological dysfunction,” which is not the result of a common stressor or conflict with society.

Understanding the definition of mental health can help shine some light on the characteristics of mental disorders. According to the World Health Organization (WHO), mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” The understanding of mental disorders has evolved throughout the years, as has the variations in classification and assessment methods. Without dispute current evidence reveals that mental disorders are very common in the United States. By understanding and identifying the etiology and classification, medical health professionals will be armed with the knowledge to manage the wide variety of mental disorders.

Epidemiology of Mental Illness

The U.S. Centers for Disease Control and Prevention (CDC) recently reported the staggering statistic that approximately 25% of adults in America currently have a mental illness, and almost 50% of adults in America will develop some type of mental illness during their lifetime. Examples of these illnesses include depression, bipolar disorder, schizophrenia, as well as other anxiety and personality disorders. The National Institute of Health (NIH) has also published the following statistics concerning the percentage of adults in the U.S.A. that are affected by the following mental disorders during any given year:

- Depression – 6.7%
- Bipolar disorder – 2.6%
- Schizophrenia – 1.1%
- Anxiety disorders – 18.1%
- Personality disorders – 9.1%

According to the National Institute of Mental Health (NIMH), nearly 50% of individuals with mental disorders meet the criteria for at least two or more disorders. A study by WHO states that these disorders result in more cases of disability than heart disease or cancer.

It is evident that mental illness is an important health concern in the United States. According to studies conducted by the Substance Abuse and Mental Health Services Administration (SAMSHA), only 13.4% of adults in the United States received treatment for mental health problems. Although mental disorders are prevalent, debilitating or severe mental illness only impacts about 6% of the population. Approximately 25% of the homeless population along with 11% to 19% of male prison inmates and 22% to 42% of women inmates have serious mental disorders. The National Mental Health Association (NMHA) has also reported that over 12 million children under the age of 18 have mental disorders.

The economic burden of mental illness in the United States is substantial. The
Centers for Disease Control and Prevention recently reported an approximated annual cost of $300 billion related to mental health care. These expenses include direct healthcare costs as well as indirect costs, such as premature death and loss of workplace productivity. Almost 50% of money spent on mental health care comes from public funding, such as Medicare and Medicaid.

**History of Mental Illness**

The history of mental health treatment can be traced back to ancient civilizations. The Greeks were the first people to use the term for hysteria, melancholy and phobias, but, they did not believe there was a difference between physical ailments and mental conditions. Physicians of the time believed that mental illness was inflicted upon people as a curse from the gods. The standard belief was that people afflicted with mental illness deserved to die.

Mentally ill people who were able to work were often forced into slave labor. Those who were not able to function in society were frequently tortured or left to die. Some treatments documented by historians of the time include exorcisms in attempts to “cast out the demons”, and the use of balms and oils.

During the Middle Ages, people still believed that divine or demonic intervention was the cause of mental illness. Before the Age of Reason, treatment consisted of ridding what was believed to be a diabolical ailment by any means possible. These typical treatments consisted of lashings and torture.

By the 18th century, known as the Age of Enlightenment, mental illness was seen as organic in nature rather than a curse from above or other magical means. Institutions, known as asylums, were created to house mentally ill patients. Treatment was not much better than it had been in earlier times. In many cases, these asylums housed both mentally ill patients as well as those with other physical health conditions. People with physical disabilities, including children, were placed into these institutions, and the conditions were harsh. People inside these asylums were subjected to beatings, starvation, and ice cold baths for treatment. Many patients succumbed to infection due to the lack of proper infection control. Treatments also consisted of bloodletting, which was the ritual practice of withdrawing blood from the patients to “release the illness.” Physical constraint and solitary confinement were also common forms of treatment.

During the 19th century, asylums sprung up across the United States. Conditions remained callous, however, gradual movements to improve conditions started to take place. In the 1840’s the superintendent of nurses during the Civil War, Dorthea Dix (1802-1887) led the cause to increase conditions for the mentally-ill after she witnessed dangerous and appalling conditions inside the asylums.

Due to the involvement of people like Dorothy Dix, the government started to fund state psychiatric hospitals. During the latter part of the 19th century, Jean-Martin Charcot presented the idea of a psychological view of mental illness. His theory focused on how the role of childhood development plays on mental illness. His pupil, Sigmund Freud, later expounded on this theory, leading the field of psychiatry develop into a whole new level.

By the 19th century, early psychiatrists wrote the first Diagnostic and Statistical Manual of Mental Disorders (DSM), which is now published by the American Psychological Association, and regarded as the gold standard concerning the identification and classification of mental disorders. Around the time of WWII, psychiatrists were relying on psychotherapy to help treat patients. Despite psychotherapy’s benefits on patients with mild forms of mental disorders, psychiatrists realized its flaws on treating more severe forms of mental disorders. Physicians of the time attempted to treat major psychosis by inducing high fevers through vaccination. During the 19th century, chemists also started to experiment with sedatives and hypnotics to help treat mental illness. Benzodiazepines were in their infancy, however, experimentation with agitated patients revealed promising results. By 1959, doctors regarded electroconvulsive therapy (ECT) as the treatment of choice for major depression and manic-depressive illness.

By the early 1960’s, a push for deinstitutionalization gradually swept across America in an attempt to reform psychiatric hospitals. Many hospitals were closed in favor of community mental health facilities. This trend continued throughout the latter part of the century. By the 1980’s, there were only about 130,000 people institutionalized for mental health disorders, compared to approximately 560,000 in the 1950’s. Debates concerning the effectiveness of deinstitutionalization still exist today. Mental health specialists today agree that more funding should be provided for support, advocacy and research concerning the growing mental health population in America. Many unwarranted stigmas about mentally ill patients are still erroneously molded by society. History has shown the complexities and unfortunate circumstances presented to patients with mental health issues.

Today, one of the primary goals of mental health professionals is to successfully diagnose factors that may predispose people to mental illness and to help treat associated symptoms before they affect the patient’s quality of life.

Gone are the days of bloodletting and other archaic treatments. Researchers of the 21st century rely on well-studied clinical trials, which provide proof of a certain medication efficacy prior to release. Current research and brain imaging studies help to show patterns of activity that can identify certain conditions. For example, areas near the hippocampus and amygdala are known to play a role in anxiety conditions, while limbic and prefrontal irregularities are commonly dysfunctional in patients with schizophrenia. Evidence-based treatments have revealed how new medications can effect these areas of the brain. Along with advances in medication, mental health professionals also rely on cognitive behavioral therapy and other forms of psychotherapy tailored to the patient’s specific disorder.

**Classification, Etiology & Diagnosis**

The defining symptoms of mental illness are classified by the American Psychiatric Association (APA) and the WHO in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) and the International Classification of Diseases (ICD). In May of 2013, the APA released DSM-5, which is the most recent edition of their diagnostic tool for classifying a wide array of mental disorders. The WHO’s ICD-10 outlines specific mental disorders in chapter five of the guide. Both the DSM-5 and ICD-10 remain essential for treatment recommendations by
Classifications to the Diagnostic and Statistical Manual of Mental Health Disorders, 5th Edition (DSM - 5)

**Bipolar and Related Disorders:**
DSM-4’s diagnosis of “mixed episode,” which required the coexistence of mania and major depressive episode was replaced with the new specifier “with mixed features.” This can now be applied to episodes of mania when depressive features are present and to episodes of depression when mania and/or hypomania are present. DSM-5 also allows for specification of certain related disorders including categorization for individuals with a past history of major depressive disorder, who meet most of the criteria for hypomania.

**Depressive Disorders:**
DSM-5 contains several new depressive disorders, which include premenstrual dysphoric disorder and mood dysregulation disorder. To address concerns about overdiagnosing, disruptive mood dysregulation disorder was included for children under 18 years of age who have frequent episodes or extreme behavioral problems and persistent irritability. The previously categorized term of dysthymia (less severe form of depression) is now called persistent depressive disorder. There is also no longer a bereavement exclusion for depressive disorders in DSM-5.

**Anxiety Disorders:**
Panic disorder and agoraphobia (fear of having a panic attack in a public place) are now categorized as two separate disorders. Also for the various forms of anxiety disorders, DSM-5 removes the previous requirement that the individual be over the age of 18. Additionally, the duration of six months, previously designated to people under the age of 18, now applies to everyone. Under DSM-5, panic attacks are specifiers for anxiety disorders. The requirement of symptoms for at least six months for the disorder, known as social phobia, now applies to people of all ages. The term “generalized” social phobia was replaced with “performance only.” This delineates those who have excessive worry about public speaking or performing in front of an audience. Separation anxiety and selective mutism (unable to speak in certain situations) are now classified as an anxiety disorders rather than a disorder of early onset.

**Schizophrenia and Other Psychotic Disorders:**
All subtypes of schizophrenia, such as paranoid, catatonic, disorganized, residual, and undifferentiated, were omitted. Schizoaffective disorder now requires the presence of a major mood disorder for the majority of the disorder’s total duration.

**Personality Disorders:**
The criteria for the 10 types of personality disorders remain unchanged, however, they no longer are listed on a separate axis; they are now classified together with the other disorders. DSM-5 also places greater emphasis on trait-based criteria to increase the empirical basis of the conditions.

*Figure 1*
mental health professionals as well as for payment classifications by medical insurance companies. A 2013 study published in the International Journal of Psychology revealed that clinicians relied on both the DSM-5 and the ICD-10 as universal reference guidelines for diagnosing patients with certain mental disorders.

The 5th edition of the DSM replaced the five-axis classification system of mental disorders, which was previously published in DSM-4. This Axis system, published in 1995 and revised in 2000, consisted of clinical disorders (axis I); personality disorders and mental retardation (axis II); somatic conditions (axis III); severity of psychosocial stressors (axis IV); psychosocial, and environmental problems (axis V). DSM-5 discarded this axis system and made other notable changes affecting future diagnostic criteria. The new classifications and diagnosis include some noteworthy changes listed in Figure 1.

Figure 2 lists the current classification categories for ICD-10.

Etiology of Mental Disorders

A variety of factors are thought to cause mental disorders. Mental health professionals believe that most mental health disorders are influenced by a wide assortment of causes rather than just a single reason. These etiological factors include inherited traits, chemical imbalances, prenatal damage, infection, along with other psychological and environmental experiences.

Genetics

Research has shown that mental illness is more common in people whose biological relatives have a mental health disorder. For most of the 20th century, many mental health professionals believed that mental illness was caused by relationship problems between parents and children. In the last decades of the 20th century, research concerning quantitative genetics has helped shine a light on the role of genetics on mental illness. This launched the widely publicized nature versus nurture debate. Recent literature corroborating genetic causes has had significant impact on the public and professional understanding of mental disorders. According to a 2013 report published by the National Institute of Health, scientists uncovered common genetic factors found in five mental disorders – bipolar disorder, major depression, schizophrenia, autism, and hyperactivity disorder (ADHD). During this study, researchers screened over 33,000 patients who had been diagnosed with one of these disorders. The results showed inherited variations in two genes that regulate the flow of calcium into the neurons. These genes, called CACNA1C and CACNB2 have been linked to schizophrenia, major depression, and bipolar disorder. CACNA1C affects thinking, emotion, memory, and attention. Abnormal levels of certain brain chemicals, such as dopamine and serotonin are also thought to play a role in mood as well as the development of mental disorders.

Brain Chemistry and Neurotransmitter Activity

A recent study published by the Cognitive Science Society asked clinicians to identify the extent to which the mental disorder categories were biologically, psychological, or environmentally based. The participants included 20 licensed psychiatrists, 20 licensed psychologists, 19 licensed clinical social workers, 10 psychiatry residents, 10 psychology interns, and 10 social worker fellows. Based on their respective experiences, the surveys revealed the clinician’s theories concerning a mixed blend of biological, psychological, and environmental factors contributing to mental illness. However, certain disorders, such as schizophrenia, major depressive disorder, and bipolar disorder, were thought to be biological rather than psychological or environmental. Conversely, several personality and anxiety disorders scored higher in both psychological and environmental influences.

The biological factors thought to cause mental disorders stem from abnormalities in the brain’s neurotransmitters, which are the chemicals that transmit signals across the synapse through neurons. A perfect blend of neurotransmitters is needed to relay messages across synapses. The major neurotransmitters have either an excitatory or inhibitory action, which have a variety of different effects on the brain. Figure 3 illustrates the different neurotransmitters and their affects on a variety of psychobiological responses.

Recent studies have helped to corroborate the clinicians’ hypothesis regarding biological considerations for mental disorders. According to a recent study published in the Journal of Clinical Investigation, patient-based research using functional neuroimaging have identified abnormalities in the brains of individuals with bipolar disorder. For example, studies have shown reduced activity in the right prefrontal cortex during episodes of mania. Irregularities in this area of the brain are thought to contribute toward poor attention, delusions, poor impulse
Disorders, such as generalized anxiety and serotonin have been implicated in mental disorders, such as multiple sclerosis. Other research, published in the *Journal of Molecular Psychiatry*, revealed that abnormalities in dopamine, norepinephrine, and serotonin have been implicated in mental disorders, such as generalized anxiety disorder and major depression.

**Prenatal Damage**

Prenatal damage is caused by any trauma that occurs while the fetus is still in the mother’s womb. Prenatal stress has been the subject of many studies, that have linked environmental events surrounding pregnancy to mental disorders such as autism and schizophrenia. These conditions include gestational exposure to psychological stress, alcohol, drugs, trauma, and famine. Recent research published by the Association for Psychological Science has revealed several factors during pregnancy that can increase the risk of schizophrenia later in life. These factors include:

- Maternal stress
- Low birth weight
- Gestational diabetes
- Older paternal age
- Maternal infections

Meta-analysis has also shown that loss of oxygen during delivery were associated with a higher risk for schizophrenia. The complications of delivery most clearly linked to schizophrenia are a severe lack of oxygen, known as asphyxia. Uterine atony (weakening of the uterine muscles) and emergency caesarean section have also been linked to schizophrenia according to research published by The Association for Psychological Science.

**Infection and Inflammation**

Research has linked infection and inflammation to several mental disorders. This growing body of evidence suggests that the body’s defensive response to infection may trigger some types of mental illness, particularly schizophrenia and depression. A study published in the *Journal of Neuroinflammation* revealed that patients who had an autoimmune disease or a previous hospitalization for serious infection had an increased risk of developing schizophrenia by 29% to 60% respectively.

Researchers have also established links to medical conditions with chronic inflammation and mental disorders. A recent investigation reported in the *Journal of Affective Disorders* revealed strong associations between conditions, such as diabetes, obesity, metabolic syndrome and bipolar disorder. Previous studies have also shown ties between other chronic inflammatory abnormalities, such as multiple sclerosis and rheumatoid arthritis with bipolar disorder and depression.

The association between inflammation and mental disorders has sparked further research. One interesting meta-analysis found in the *Journal of Clinical Psychiatry* revealed positive effects of omega-3 fatty acids on mental disorders. During this recent meta-analysis, researchers examined five randomized-controlled trials. The results showed that omega-3 supplementation on 291 participants with bipolar disorder significantly improved depressive symptoms, however, they had no effect on the symptoms of mania. Another recent study published in the *Archives of General Psychiatry* showed that omega-3 supplementation helped to prevent progression of schizophrenia as well as relapses.

**Environmental and Social Factors**

Unlike biological factors, environmental and social causes are life events and stressors that have been associated with certain mental disorders. These factors include:

- Social expectations
- Relationships
- Socioeconomic status
- Childhood adversities
- Substance abuse
- Loss of a loved one
- Divorce

These environmental and social influences often merge with biological factors, contributing toward mental disorders. For example, an individual may have a predisposed biological condition increasing the likelihood of mental illness that is triggered by a specific environmental or social situation. This is particularly evident with adversity in early childhood. Research published in the *Archives of General Psychiatry* suggested that maltreatment stressors occurring in early life resulted in dysregulation of the hypothalamic-adrenal-pituitary-axis. The researchers in this investigation concluded that this early trauma and associated biological response mechanism culminated in benign outcomes.
in later mental disorders, such as depression and anxiety. Examples of trauma include sexual abuse, emotional abuse, physical abuse, and bullying. Given the recent explosion of school violence and associated tragedies in the United States, additional studies are warranted concerning the effect bullying has on children.

Diagnosis of Mental Disorders

Along with the widely used classification systems, mental health providers rely on physical exams to rule out other conditions. Laboratory tests may be performed to screen for other factors that may be causing issues, such as alcohol or drug use. In recent years, blood tests have been developed to help psychiatrists diagnose schizophrenia. This blood test uses a single serum sample to identify protein biomarkers. Researchers have currently identified 51 biomarkers that may be linked to schizophrenia. By targeting these biomarkers, researchers have taken a step toward distinguishing persons with schizophrenia from those whom are not affected with the disorder. Further research is needed to ascertain if the presence of the 51 biomarkers is causative or secondary to the disease process.

Brain imaging scans are also being used to help detect mental disorders. In some cases, physicians use brain scans to rule out other conditions, such as tumors. Neuroscientists believe that assessing brain abnormalities through imaging studies can show evidence of mental illness. There are two types of neuroimaging tests being used today. Structural imaging creates a quick snapshot of the brain’s structure. This picture identifies tissue, blood vessels, bone, as well as any damage, infection, or tumors. Functional imaging shows the brain’s chemistry by assessing electrical impulses and the rate of blood flow during specific tasks. Both of these neuroimaging tests are in use in several ongoing studies.

The National Institute on Mental Health is currently conducting the Research Domain Criteria Project, which plans on categorizing mental disorders based on certain brain irregularities. This is one of several examples of the growing popularity and supporting evidence regarding the use of brain imaging to identify and categorize certain mental disorders. Researchers are also relying on imaging studies to better understand disease progression and the effects of medications on the brain.

While blood tests and imaging studies are gaining popularity as important diagnostic tools, the gold standard for diagnosing mental illness is the psychological evaluation, known universally as the mental status examination (MSE). Clinicians rely on careful screening through a thorough interview process utilizing questions that help them understand the mental status of their patients. During the mental status examination, mental health professionals gather patient medical history, complete social history, list of medications, known symptoms of mental illness, and past psychiatric history. Once the medical examination is complete, the information along with observations taken during the interview regarding the patient’s mental status, personal grooming, and level of awareness are documented in order to help make a complete and accurate diagnosis. By applying the classifications set forth in DSM-5 to what was learned during the mental status examination, clinicians can investigate for signs of mental disorders, such as bipolar disorder, schizophrenia, personality disorders, anxiety and other potential mental health conditions.

Bipolar Disorder

Bipolar disorder is a mood disorder marked by episodes of elevation and grandiosity followed by agitation and alternating periods of depression. One minute, the patient feels on top of the world, however, this feeling of euphoria soon ends and is followed by intense agitation, known as mania, and feelings of hopelessness and helplessness. These are the extremes of bipolar disorder. These mood swings may occur only a couple times a year, or as frequent as several times a day. Once a patient is diagnosed with bipolar disorder, the ultimate goal of the treatment program is to focus on stabilizing the patient’s mood through medication and psychological intervention. This may include cognitive therapy, group therapy, electroconvulsive therapy, and patient education.

Classification of Bipolar Disorder

The DSM-5 classifies bipolar disorder into several subtypes according to the pattern and severity of the symptoms. Each one of these subtypes presents their own set of symptoms, which can be identified based on identifiers from the patient’s most recent mood episode. These types of bipolar disorder include:

- Bipolar I – Manic or mixed (rapid cycling) episodes with or without psychosis and major depression. The manic episodes typically last for at least seven days and the depression episodes can last for 24 or more days. During the mania phase, negative effects include irritability or euphoria along with impulsiveness and marked excitability. Under DSM-5, the full criteria for an individual to meet mania and major depressive episodes has been removed. Instead, the new specifier, called “with mixed features,” can be applied to episodes of mania or hypomania when depression is present.
- Bipolar II – This includes a series of hypomanic and depressive episodes without the presence of complete manic or mixed rapid cycling episodes. Hypomania is similar to mania, however, the symptoms are less severe and typically do not last as long. In the case of bipolar II, hypomania must be present for at least four days. Depression is the predominate symptom of bipolar II classification. Although patients with bipolar II do not experience manic episodes, the chronic symptoms of depression increase the risk for suicide in this population. According to new research published in the Journal of Psychiatry and Neurological Sciences, between 25% to 56% of bipolar patients attempted suicide at least once in their lifetime and 50% of those people did so during the depression episode of the disorder.
- Cyclothymia – This is a mild form of bipolar disorder. During cyclothymia, hypomania and depression can affect the patient’s quality of life. The severity of the symptoms are not as severe as they are with other types of bipolar disorder. This low-grade cycling of mood lasts for at least two years, but does not meet the criteria for bipolar disorder.
- Other specified bipolar and related disorder – Symptoms are characteristic of bipolar, but fail to meet criteria for bipolar I, bipolar II, cyclothymia, and major depression. This was previously called bipolar disorder not otherwise specified (NOS).

Clinical Presentation of Bipolar Disorder

The symptoms associated with bipolar alternate depending on whether the patient is in a manic state, depressive state, or a
mixed state, in which symptoms of mania and depression are present simultaneously. As discussed in the classification section, the scope and severity of the disorder varies in patients; nevertheless, the following symptoms are hallmark characteristics that are usually present with bipolar disorder:

**Manic episodes**

Mania is one of the defining characteristics of bipolar disorder. During the manic phase, people commonly experience a rush in euphoria, which interferes with normal everyday activities. This “wired” feeling causes individuals to act out and engage in behavior that is often inappropriate. According to the APA, the following symptoms are common signs of mania:

- Racing thoughts
- Inflated self-esteem or grandiosity
- Euphoria
- Aggressive behavior
- Risky behavior
- Rapid speech
- Sexual indiscretion
- Increased physical activity
- Agitation or irritation
- Poor financial judgment
- Decreased attention span
- Delusional thoughts or disconnected from reality

During extreme episodes of mania, individuals may feel out of control and exhibit signs of psychosis. Mental health professionals should also be aware of certain signs, such as sleep disturbances and anxiety that may foreshadow an upcoming bout of mania.

**Hypomaniac Episodes**

Hypomaniac episodes are also known as hypomania and consist of less severe signs of elevated mood and episodes of increased energy. The chief difference between mania and hypomania is that during hypomania, a person’s ability to function is not impaired. Unlike mania, delusional pattern of thoughts are not associated with hypomaniac episodes. People with hypomania often exhibit different symptoms. Some may show increased creativity and productivity, while others demonstrate poor judgment and irritability. Classification of hypomania entails at least three of these symptoms lasting for more than four days.

**Depressive Episodes**

During periods of depression, the previous highs associated with mania come to a crashing halt. A major depressive episode lasts for at least two weeks and can persist for over six months if undiagnosed or untreated. Signs and symptoms of the depressive phase include:

- Hopelessness
- Sadness
- Sleep disturbances
- Irritability
- Guilt
- Suicidal thoughts
- Anxiety
- Difficulty concentrating
- Loss of interest in sexual activity
- Social anxiety
- Indifference

**Mixed Episodes**

A mixed state, also known as rapid-cycling, occurs when symptoms of mania and depression happen simultaneously. Mixed episodes can happen several times a day or as few as a couple times a year. During this confused state, individuals may have thoughts of grandeur followed by feelings of failure. This can be a vulnerable time for people who are affected by the disorder. Research has shown that the likelihood of substance abuse and other complications increases during mixed episodes.

**Risk Factors**

Bipolar disorder typically begins between the ages of 15 and 30 years, but can affect people of all ages. According to research published in *American Family Physician*, children of parents with bipolar disorders have approximately 4% to 15% risk of inheriting the disorder. Although bipolar affects both sexes equally, women have higher incidences of rapid cycling and cyclothymia. Men have higher incidences of substance abuse associated with the disorder. Recent studies reported in the *Journal of Affective Disorders* indicate other potential risk factors, such as stressful life events and disruptions in sleep cycles.

**Screening for Bipolar Disorder**

Clinicians base the diagnosis of bipolar disorder on symptoms reported by patients. *Figure 4* highlights clues to help diagnose bipolar disorder. The type of disorder is based on the duration and severity of these self-reported symptoms. As discussed in the Classification of Mental Illness section, the DSM-5 and ICD-10 remain widely used as classification guides for many mental health conditions including bipolar disorder.

Laboratory tests, physical examination and psychological screening are also typically conducted in outpatient settings.

Along with the DSM-5 and ICD-10 classification systems, mental health professionals rely on several additional rating scales. The United States Preventive Task Force recommends screening for comorbid conditions, such as depression. This screening is recommended for patients 12 to 18 years of age. One screening tool, known as the Beck Depression Inventory (BDI), is designed to identify commonly associated symptoms of depression, such as helplessness and hopelessness. Another evaluation tool, known as the *Mood Disorder Questionnaire*, located at http://www.dbssalliance.org/pdfs/MDQ.pdf, can be used by both professionals and patients.
Management of Bipolar Disorder

There are a variety of psychotherapeutic and pharmacological techniques available to treat patients with bipolar disorder (See Figure 5). The major goals are to reduce the severity and frequency of mania and depressive episodes, and to help the patient to function as well as possible between episodes. Patients often require life-long treatment in outpatient care. In severe cases of mania or depression, hospitalization may also be required. Patients also typically require a multidisciplinary team of psychiatrists, psychologists, psychiatric nurses, and social workers to manage their plan of care. The type of treatment also depends on the type of episode present (e.g., mania, depression, rapid cycling).

Acute Stage

During the acute stage of a manic or depressive episode, clinicians attempt to stabilize the patient. Focus should be placed on patient safety. In this capacity, careful screening to ascertain the presence of suicidal ideatilization is often necessary. If a patient does exhibit harmful behavior, they should be hospitalized either voluntarily or involuntarily until these thoughts diminish. Clinicians often rely on a combination of psychotherapy and antipsychotic medication during this phase. Medical staff should also assess the patient for decision-making capacity and the ability to comply with extended treatment.

Maintenance Stage

After a manic or depressive episode subsides, the maintenance phase of care begins. During this phase, clinicians should conduct routine examinations that focus on identifying any signs of an upcoming episode of mania or depression. Medications should be monitored for efficacy and potential complications. Continued treatment also focuses on other therapeutic techniques, such as cognitive behavioral or family therapy, and electroconvulsive therapy.

Therapeutic Options for Bipolar Disorder

<table>
<thead>
<tr>
<th>Cognitive-Behavioral Therapy (CBT)</th>
<th>Pharmacological Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Helps patients to recognize negative emotions and redirect their attention to focus on positive thoughts</td>
<td>Patients in acute mania or depressive episodes are not likely to respond favorably to psychotherapy or other adjunct treatments because of their objection to help and insufficient level of reasoning at this stage of the disorder. For this reason, continued pharmacologic treatment is often necessary. Several clinical trials corroborated by meta-analysis have revealed that certain medications, such as antidepressants, antipsychotics, mood stabilizers and anticonvulsant medications have produced favorable outcomes regarding the reduction of symptoms associated with bipolar disorder. Physicians also prescribe benzodiazepines to help control anxiety and improve sleep. Figure 6 lists medications and some common adverse effects.</td>
</tr>
<tr>
<td>• Goals of CBT are to identify manic or depressive episodes before they occur</td>
<td>Antidepressants&lt;br&gt;Physicians may prescribe antidepressants for depressive episodes. Because antidepressants can trigger episodes of mania, they are often combined with other mood stabilizers, such as lithium. There is evidence that antidepressants can be effective in treating short-term depression associated with bipolar disorder, but large trials have shown that they are not effective in monotherapy due to the risk of manic switching. First line choices are selective serotonin reuptake inhibitors (SSRIs); atypical and cyclic antidepressants are second-line choices.</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>Antipsychotics&lt;br&gt;Antipsychotics are standard medications for schizophrenia, and are also sometimes prescribed to treat psychotic symptoms, such as hallucinations and delusions associated with bipolar disorder. Recent research reported in <em>Psychiatric Times</em> revealed adjunctive benefits of several antipsychotic drugs for comorbid conditions, such as anxiety, in patients with bipolar disorder. Some of the newer atypical antipsychotic drugs also have similar beneficial qualities as mood stabilizers.</td>
</tr>
<tr>
<td>• Helps to engage the entire family as active participants in the patient’s management team</td>
<td>Mood Stabilizers&lt;br&gt;This class of medication controls mood swings by regulating the flow of electric current to the brain. Lithium is the most widely used mood stabilizer and remains the best established long-term medication of choice for patients with bipolar disorder. Recent meta-analysis published in <em>The Lancet</em> reported the results of five placebo-controlled maintenance trials of lithium for patients with bipolar disorder. The results showed that lithium reduced the risk of mania episodes by 38% and depressive episodes by 28%. The risk of suicide was also reduced by more than 50% in patients who were prescribed lithium.</td>
</tr>
<tr>
<td>• Assists the patient with compliance of treatment and helps with coping techniques</td>
<td>Anticonvulsants&lt;br&gt;Physicians prescribe anticonvulsants to patients with bipolar disorder for their known mood-stabilizing effects. Anticonvulsants are a viable option for patients who cannot tolerate lithium because of side effects. These anti-seizure drugs are thought to reduce mania by</td>
</tr>
</tbody>
</table>

**Therapeutic Options for Bipolar Disorder**

<table>
<thead>
<tr>
<th>Electroconvulsive Therapy (ECT)</th>
<th>Figure 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A small amount of electricity is sent to the brain causing a generalized seizure that lasts about 40 seconds. Helps patients with severe mania who cannot tolerate medications</td>
<td><strong>Figure 5</strong></td>
</tr>
</tbody>
</table>

**Pharmacological Treatment**

- Antidepressants for depressive episodes
- Antipsychotics for psychotic symptoms
- Mood stabilizers for bipolar disorder
- Anticonvulsants for mood swings

**Management of Bipolar Disorder**

- Cognitive-Behavioral Therapy (CBT)
- Family Therapy
- Electroconvulsive Therapy (ECT)

**Figure 5**

- Lithium for the treatment of bipolar disorder
- Antidepressants and antipsychotics for mood stabilization
- Mood stabilizers for long-term management
- Anticonvulsants for seizure control and mood stabilization
<table>
<thead>
<tr>
<th>Medication</th>
<th>Adverse Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selective serotonin reuptake inhibitor (SSRI) Antidepressants</strong></td>
<td>Gastrointestinal problems, insomnia, mild tremor, dry mouth, headache, sexual dysfunction, weight gain, suicidal thoughts</td>
</tr>
<tr>
<td>• Fluoxetine (Prozac)</td>
<td>• Citalopram (Celexa)</td>
</tr>
<tr>
<td>• Paroxetine (Paxil)</td>
<td>• Sertraline (Zoloft)</td>
</tr>
<tr>
<td>• Escitalopram (Lexapro)</td>
<td>Nausea, dry mouth, weight gain, sexual dysfunction, dizziness, mild tremor, suicidal thoughts</td>
</tr>
<tr>
<td><strong>Atypical Antidepressant</strong></td>
<td>Nausea, dry mouth, weight gain, insomnia, muscle aches</td>
</tr>
<tr>
<td>• Venlafaxine (Effexor)</td>
<td>• Bupropion (Wellbutrin)</td>
</tr>
<tr>
<td>• Trazodone (Oleptro)</td>
<td>• Duloxetine (Cymbalta)</td>
</tr>
<tr>
<td><strong>Monoamine oxidase inhibitor (MAOI)</strong></td>
<td><strong>Tricyclic Antidepressants</strong></td>
</tr>
<tr>
<td>• Phenelzine (Nardil)</td>
<td>• Clomipramine (Tofranil)</td>
</tr>
<tr>
<td>• Isocarboxazid (Marplan)</td>
<td>• Nortriptyline (Pamelor)</td>
</tr>
<tr>
<td><strong>Atypical Antipsychotics</strong></td>
<td>Nausea, dry mouth, constipation, urinary retention, weight gain, sexual dysfunction, suicidal thoughts</td>
</tr>
<tr>
<td>• Risperidone (Risperdal)</td>
<td>• Quetiapine (Seroquel)</td>
</tr>
<tr>
<td>• Aripiprazole (Abilify)</td>
<td>• Olanzapine (Zyprexa)</td>
</tr>
<tr>
<td>• Ziprasidone (Geodon)</td>
<td><strong>Typical Antipsychotics</strong></td>
</tr>
<tr>
<td>• Haloperidol lactate (Haldol)</td>
<td><strong>Mood Stabilizers</strong></td>
</tr>
<tr>
<td>• Lithium (Eskalith, Lithobid)</td>
<td>Nausea, diarrhea, polyuria, polydipsia, weight gain, sedation, hypothyroidism</td>
</tr>
<tr>
<td><strong>Anticonvulsants</strong></td>
<td>Sedation, nausea, dizziness, fatigue, ataxia, cognitive impairment</td>
</tr>
<tr>
<td>• Lamotrigine (Lamictal)</td>
<td>• Carbamazepine (Tegretol)</td>
</tr>
<tr>
<td>• Divalproex (Depakote)</td>
<td>• Topiramate (Topamax)</td>
</tr>
<tr>
<td>• Gabapentin (Neurontin, Horizant, Gralise)</td>
<td><strong>Benzodiazepines</strong></td>
</tr>
<tr>
<td>• Lorazepam (Ativan)</td>
<td>• Clonazepam (Klonopin)</td>
</tr>
<tr>
<td>• Alprazolam (Xanax)</td>
<td>• Diazepam (Valium)</td>
</tr>
<tr>
<td>• Triazolam (Halcyon)</td>
<td>Sedation, nausea, cognitive impairment, respiratory depression, anterograde amnesia, weight gain, skin rash</td>
</tr>
</tbody>
</table>

*Figure 6*
increasing the brain’s threshold for stimulation.

Figure 6 shows some examples of medications used in the treatment of bipolar disorder along with their respective potential side effects. Some of the medications on this list are also commonly prescribed to patients with other medical disorders, such as schizophrenia, depression, anxiety disorders, and personality disorders, which will be covered later in this course.

Depression

Clinical depression is a common disorder affecting more than 18 million Americans every year. According to WHO, depression will be surpassed only by heart disease as the leading cause of disability by 2020. Everyone experiences times when they sad or blue, however, these emotions are typically short-lived. Depression is a mood disorder characterized by a persistent low mood accompanied by a loss of interest or pleasure in normally enjoyable activities. Major depression can be disabling and may affect a person’s work or school, family, personal relationships, sleeping, eating habits, and general health. Besides loss of function, depression can be fatal if left untreated. WHO reports that in the United States approximately 60% of people who commit suicide suffered from depression or another mood disorder. This mental health condition poses serious concerns for the medical community. By understanding the symptoms and classification of the various types of depression, clinicians will be armed with the knowledge to treat this troubling disorder.

Symptoms of Depression

Depression can manifest in a variety of symptoms. The severity and frequency may also vary depending on the particular individual. The hallmark symptoms involve low mood, as well as lack of pleasure and self-worth. Depressed people also exhibit the following feelings, which may pervade all aspects of life:

- Hopelessness
- Helplessness
- Regret
- Guilt
- Self-hatred
- Withdrawal
- Agitation
- Fatigue

During episodes of depression, clinicians should also watch for changes in appetite, trouble concentrating, and recurring thoughts of death or suicide. Along with cognitive symptoms, such as trouble with concentration and memory, a depressed person may also report physical symptoms. Increased pain and dull body aches are common. According to research reported by the U.S. Department of Health and Human Services, irregularities in the neurotransmitters serotonin and norepinephrine are believed to play a role in the perception of pain.

Insomnia is also a frequent complaint associated with depression. Studies reported in Principles and Practice of Psychiatric Nursing have reported that sleep EEGs have indicated disrupted REM sleep cycles of people with depression.

Depression also frequently occurs with other psychiatric problems. According to research published by the National Institute of Mental Health, coexisting conditions include anxiety disorders, such as post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), panic disorder, obsessive-compulsive disorder (OCD), and social phobia. Similar to that of pain modulation, chemical imbalances in the neurotransmitters serotonin and norepinephrine are involved with increased levels of anxiety. To help alleviate feelings of nervousness, people with depression frequently turn to alcohol and other substances, in turn making substance abuse another comorbidity often associated with depression.

Classification of Depression

There are two different forms of depressive disorders recognized under DSM-5 and ICD-10. These types of depression include major depressive disorder (MDD), and dysthymia (now called persistent depressive disorder under DSM-5). There are also several subtypes or features, such as: seasonal depressive disorder (SAD), atypical depression (AD), catatonic depression, postpartum depression (PPD) and psychotic major depression (PMD). DSM-5 has also classified a new depressive disorder called mood dysregulation disorder. Premenstrual dysphoric disorder has been moved from the appendix to the main body of DSM-5.

Major Depressive Disorder (MDD)

The DSM-5 has published certain criteria for classifying major depression. In order for an individual to be diagnosed with depression, at least five of the following symptoms must be present for at least two weeks:

- Diminished or lack of interest in usual activities
- Sad or empty mood
- Fatigue
- Guilt or worthlessness
- Insomnia
- Agitation
- Significant weight loss
- Lack of concentration
- Thoughts of death or suicide

Major depression can further be classified on the level of severity as mild, moderate, or severe. During an episode of major depression, individuals feel a constant impending sense of darkness and despair. An individual with major depression is at an increased risk of suicide so it is crucial for members of the healthcare community to be vigilant regarding the signs and symptoms of major depression in their patients.

Persistent Depressive Disorder

Persistent depressive disorder, formally known as dysthymia, is characterized by a chronic but less severe form of depression. Under DSM-5 dysthymia now falls under the classification of persistent depressive disorder. This condition lasts for at least two years in adults and one year in children. Although symptoms are similar to that of major depression, the chief differences are the severity and duration. According to DSM-5, an individual diagnosed with persistent depressive disorder must exhibit at least two of the aforementioned clinical symptoms.

Some of the forms of depression may have their own set of unique features. There are also other conditions that are characterized as mood disorders with depression. These features and disorders include:

- Atypical depression includes symptoms of significant social impairment due to extreme hypersensitivity to perceived rejection, leaden paralysis, hypersonnia, and appetite changes.
- Catatonic depression involves motor disturbances, such as echopraxia (repetition of movements), stupor, waxy flexibility (immobile posture...
Depression assessment

Assessment of diagnosis and sedimentation rate (ESR) to rule out chronic illness, and a full blood count with erythrocyte thyroxine and TSH to rule out hypothyroidism. These may include blood tests to measure other potential causes of symptoms.

- **Psychotic depression** occurs during times of profound depression and may include delusions and hallucinations.
- **Postpartum depression** occurs during the initial four-week postpartum period and is marked by grief caused by hormonal changes coupled with the responsibility of caring for an infant.
- **Premenstrual dysphoric disorder** is characterized by depression and irritability prior to menstruation.
- **Seasonal affective disorder** is a seasonal pattern of low moods that begin in autumn or winter and resolve by spring or summer.
- **Disruptive mood dysregulation disorder** is characterized by persistent irritability, anger and outbursts by a child under the age of 18 years.

### Diagnosis and Assessment of Depression

Prior to the workup for depression, physicians may order several tests to rule out other potential causes of symptoms. These may include blood tests to measure thyroxine and TSH to rule out hypothyroidism, and a full blood count with erythrocyte sedimentation rate (ESR) to rule out chronic disease or infection. Basic electrolyte and serum calcium may also be measured to investigate for the presence of any metabolic disturbance. Brain imaging studies may also be ordered to distinguish depression from dementia in elderly patients.

Although there are no specific biological tests for depression, mental health professionals rely on several assessment tools to help formulate a clinical diagnosis. These rating scales ask a series of questions, which help identify the known clinical symptoms of depression as outlined in the DSM-V.

In addition to these assessment scales, the United States Preventive Service Task Force recommends the following two specific questions when screening patients for depression and anhedonia - the inability to experience joy/pleasure from activities usually found enjoyable:

1. During the past month, have you felt down, depressed, or hopeless?
2. During the past month, have you felt little interest in doing things?

Researchers assessed the effectiveness of these two questions in diagnosing depression during a cross-sectional study, published by the online medical journal bmj.com (formerly the British Medical Journal). The results of the study revealed that these two assessment questions indicated a 97% sensitivity for depression and a 67% specificity.

### Various diagnostic scales are listed in Figure 7.

#### Management of Depression

The treatment of depressive disorders involves the combination of psychotherapy and pharmacotherapy. Research has shown that counseling and medication together are more effective than either alone. Even after the feelings of depression subside, it is important to maintain a long-term treatment approach to help avoid relapse. Similar to treatment of bipolar disorder, the types of psychotherapy include cognitive behavioral therapy and family therapy. Electroconvulsive therapy may also be used in cases of severe depression. The pharmacological approach consists of SSRIs, SNRIs, atypical antidepressants, tricyclic antidepressants, and monoamine oxidase inhibitors.

The goals of the treatment program are to reduce the symptoms during the acute phase of depression, which lasts six to 12 weeks. The goal of the second phase, which typically lasts up to six months, is to help the patient restore function. The last phase, known as the maintenance phase, may last a year to a lifetime. The goal of this phase is to reduce relapse of depression. During these three phases, clinicians rely on various forms of psychotherapy in conjunction with medication. Patient education is also an important part of a

<table>
<thead>
<tr>
<th>Depression Assessment Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hamilton Rating Scale for Depression (HAM-D-17)</strong> - A 17-item scale that allows the clinician to assess for symptoms of depression</td>
</tr>
<tr>
<td><strong>Hamilton Rating Scale for Depression (HAM-D-7)</strong> - A 7-point shorter version of the scale allowing for a quicker method of assessment</td>
</tr>
<tr>
<td><strong>Beck Depression Inventory</strong> - A five minute, 21 question scale used to assess the intensity of depression in individuals ages 13 to 80 years</td>
</tr>
<tr>
<td><strong>Global Assessment Scale</strong> - Single-term rating scale used to evaluate the overall functioning of a patient during a period on a continuum from depression</td>
</tr>
<tr>
<td><strong>Geriatric Depression Scale</strong> - A 30-question basic screening tool used with older adults</td>
</tr>
<tr>
<td><strong>Zung Self-Assessment Scale</strong> - A 20-question self-reporting questionnaire that asks patients to identify and rate feelings on a scale of 0 to 3</td>
</tr>
<tr>
<td><strong>Patient Health Questionnaire-9</strong> - A 9-question depression assessment scale that uses a rating system of 0 to 3 for depressive feelings</td>
</tr>
</tbody>
</table>

Source: Shives L, Psychiatric-Mental Health Nursing 7th Ed.
Schizophrenia

Mental health professionals consider schizophrenia one of the most disabling psychotic disorders. Schizophrenia stems from physiological malfunction of the brain, which results in a combination of disordered thinking, delusions, and hallucinations. Brain imaging studies and genetic testing confirm neurobiological irregularities in people with schizophrenia, however, the precise cause of the disorder remains a mystery. Nevertheless, the scientific community recognizes that schizophrenia is a chronic condition and requires lifelong treatment.

This common form of psychosis typically manifests between the ages of 16 and 25 years. It usually appears in men, in their late teens or early twenties. In women, it typically appears in their twenties or early thirties. Signs of the disease may appear suddenly or develop gradually over time. For some people, the symptoms follow a stable path while others experience worsening symptoms that eventually become disabling. People with the disorder may hear voices, believe that other people are controlling their minds, or believe that people are plotting against them. Because of the complexities associated with this disorder, the National Institute of Mental Health has designated research and training for schizophrenia a national priority. Treatment goals consist of relieving symptoms and educating patients and their families in order to help them cope with the disorder.

Symptoms of Schizophrenia

The symptoms of schizophrenia are grouped into three categories:

1. Positive
2. Negative
3. Cognitive

1. Positive symptoms reflect alterations in thinking that are recognizable. These distortions of thought are caused by excessive amounts of dopamine that affect the cortical areas of the brain. They include the following symptoms:
   - **Hallucinations** – Typically auditory and involve hearing voices that do not exist.
   - **Delusions** – The most common symptom of schizophrenia and involve excessive misinterpretation of perception or experience.
   - **Disorganized thinking** – Includes the stringing together of random words which renders speech incomprehensible, known as “word salad”.

Other overt behavior associated with positive symptoms includes unpredictable, agitation and frequent loss of reality. Besides hearing voices, hallucinations may involve feeling, tasting, and seeing things that do not exist.

2. Negative symptoms are a loss of normal functions. Negative symptoms may appear with or without positive symptoms.

   They include:
   - Lack of pleasure
   - Lack of emotion “flat affect”
   - “Poverty of speech” (characterized by brief/empty replies to questions)
   - Neglect of personal hygiene
   - Loss of motivation
   - Social withdrawal
   - Lack of concentration

Negative symptoms can pose significant problems for patients who suffer from them. They often do not respond well to antipsychotic medications. In addition, they are not as easily recognized as positive symptoms and may go unnoticed and untreated. It is up to the health professional to recognize the presence of negative symptoms in patients with schizophrenia.

3. Cognitive symptoms are subtle and involve problems with thought processes. Like negative symptoms, they may also be difficult to identify. They include deficits in memory, attention, and the ability to make sense of certain information.

Classification of Schizophrenia

Under DSM-5, the diagnostic features of schizophrenia include the presence of at least two of the following symptoms for at least a one-month period:

- Hallucinations
- Delusions
- Disorganized speech
- Disorganized or catatonic behavior
- Negative symptoms

Symptoms must have caused significant disruption in work or interpersonal relations continuously for at least a six-month interval. At least one of the symptoms must include hallucinations, delusions, or disorganized speech. In the previous version of DSM-IV there were also subtypes (e.g. paranoid, catatonic, disorganized, undifferentiated, and residual). Under DSM-5, these subtypes have been eliminated due to their “limited diagnostic stability, low reliability, and poor validity.” The severity of schizophrenia is also rated on a five-point scale ranging from 0 (not present) to 4 (severe).

The DSM-5 also identifies other conditions similar to schizophrenia. These shared disorders have similar symptoms, but do not meet the criteria to be classified as schizophrenia. They include:

- **Schizoaffective disorder** – A period of illness characterized by major depressive, manic, or mixed episodes, along with the negative symptoms of schizophrenia. A major mood episode must also be present throughout the duration of the illness
- **Brief psychotic disorder** – A brief (less than one month) illness that involves at least one of the positive symptoms of schizophrenia
- **Schizophreniform disorder** – This entails the presence of schizophrenia features for more than one month but less than six months.

Assessment of Schizophrenia

Assessing patients with schizophrenia can be challenging. As a result of the symptoms, patients may refuse to communicate or may not be able to adequately express their true symptoms. Careful screening and a complete physical examination are necessary to rule out other or concomitant illnesses. The following exams are routinely performed during the initial workup:

- Liver, thyroid and renal function tests
- Complete blood cell (CBC) count
- Liver, thyroid and renal function tests
- Complete blood cell (CBC) count
• Urine for culture sensitivity (to rule out UTI)
• Urine testing for substance abuse
• Electrolyte, vitamin B-12, glucose, folate, methylmalonic acid, and calcium levels
• Brain imaging studies (to look for tumors, cerebral abscesses, or subdural hematomas)
• Chest radiography (to rule out pulmonary illness)
• Electroencephalography (EEG)
• Rapid plasma regain (RPR)

Along with the above-sited tests, neuropsychological testing may be conducted to help ascertain potential cognitive weaknesses. Typical findings in patients with schizophrenia are impaired memory, poor concentration, difficulty in recognizing social cues, and poor organization of thoughts.

During the assessment, physicians also conduct a detailed mental status examination (MSE). During the MSE, the physician documents observations concerning behavioral symptoms associated with schizophrenia. Examples may include:
• The patient may express odd beliefs or delusions
• The patient may be socially awkward
• The patient exhibits a flat affect
• The patient has little if any insight concerning the positive or negative symptoms
• The patient may exhibit thought blocking
• The patient has difficulty with abstract thinking
• The patient’s speech may be awkward or disorganized

In addition to physical examination and the MSE, physicians may also rely on assessment tools, such as the Positive and Negative Syndrome Scale (PANSS), the Brief Psychiatric Rating Scale (BPRS), and the Scale for Assessment of Negative Symptoms (SANS). These diagnostic tools help to measure symptom severity and provide useful data concerning affect, mood, insight, judgment, and intellectual function.

Management of Schizophrenia

After all the data has been collected and a positive diagnosis of schizophrenia has been made, it is time to develop an effective, long-term management program that consists of a combination of psychotherapy and pharmacotherapy for symptom management. Medication is used to treat anxiety, depression, hostility, and psychotic symptoms. Behavioral techniques, cognitive therapy, and family therapy may also be used to help patients cope with both the negative and positive symptoms of schizophrenia. Clinicians typically treat patients on an outpatient basis, however, hospitalization may be necessary during crisis periods to ensure proper nutrition, medication compliance, adequate sleep, and safety. The treatment team is multifaceted and often consists of psychiatrists, psychologists, psychiatric nurses, case managers, and social workers. This integrated approach focuses on patients as well as their family members. (For more in depth information, see our course Psychiatric Crisis, available online).

Medical intervention may vary depending on the patient’s symptoms or stage of the disorder, with medication as the cornerstone of a successful management program. Antipsychotics are commonly prescribed to help diminish the positive symptoms of schizophrenia. According to a comprehensive review carried out by the Schizophrenia Patient Outcomes Research Team (PORT) of the University of Maryland, early treatment of acute schizophrenic symptoms with antipsychotics is associated with significant symptom reduction. While studies have shown that antipsychotics help alleviate the positive symptoms of schizophrenia, research has also indicated that patient non-compliance with adherence to medication can create difficulties for clinicians, in part, due to adverse effects.

Patients with schizophrenia may also feel that it is acceptable to stop the medication once their symptoms are under control. For this reason, clinicians must be vigilant in medication management. The ultimate goal of the pharmacological approach is to focus on the stabilization of acute symptoms by maintaining therapeutic plasma levels of the medications to avoid relapse. Nurses can help with maintenance therapy by understanding the adverse effects, such as weight gain, sedation, and adverse sexual effects. It is important to listen to patients’ frustration about a particular medication complication. In this capacity, important information can be gathered concerning whether adjustments are needed. Building a trusting relationship with the patient increases their receptiveness to education and medication compliance.

In addition to medication management, physicians and nurses should educate the patient’s families on how to cope with some of the positive symptoms, such as hallucinations and delusions. Nursing techniques for handling patients exhibiting positive symptoms of schizophrenia consist of the following interventions:

Hallucinations
• Identify precipitating factors by asking the patient what happened before the hallucination began
• Monitor external stimuli, which may contribute toward hallucinations, such as flashing lights, or loud noises
• Watch for command hallucinations that may cause aggressive behavior
• Administer prescribed medication

Delusions
• Do not argue with the patient concerning delusional thoughts
• Maintain eye contact during interactions
• Try to establish open lines of communication
• Do not whisper or laugh at the patient
• Explain all procedures and medications
• Do not touch the patient without verbally warning first.

Anxiety Disorders

Everybody experiences some level of anxiety. In a healthy individual, it is a normal physiological response to alert us about a potential threat. However, many anxiety disorders involve a state of excessive worry without, or long after, the presence of a genuine threat. This state of hypervigilance and worry can become chronic affecting an individual’s long-term health. With sustained anxiety, the body’s immune system may weaken resulting in illness. According to literature published by the American Journal of Lifestyle Medicine, a state of constant stress has been widely associated with chronic low-grade inflammation and increased susceptibility to infection.

According to the National Institute of Mental Health, anxiety disorders affect over 40 million Americans. This common mental health disorder causes considerable loss of productivity and often occurs with other psychiatric conditions. Anxiety disorders remain underdiagnosed and are often undertreated. While symptoms of
anxiety vary depending on the specific condition, anxiety disorders contain three defining characteristics:
1. Feeling of dread
2. Excessive physiological response
3. Irrational thoughts.

The DSM-5 classifies several kinds of anxiety disorders into the following categories:
• Social anxiety disorder
• Separation anxiety disorder
• Selective mutism
• Generalized anxiety disorder
• Phobias
• Panic disorder

In the previous edition of the DSM, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) were listed under the anxiety disorders classification, however, under DSM-5, they are grouped into their own chapters.

**Social Anxiety Disorder**
Also called social phobia, is characterized by overwhelming worry and excessive self-consciousness in social situations. People with social anxiety disorder have intense fear of public embarrassment or humiliation, which can cause considerable inconvenience in daily life. Examples include fear of public speaking, using public transportation, or eating in public. Clinical social anxiety typically begins in early childhood and can often be hereditary. Physical symptoms include profuse sweating, trembling, blushing, and nausea.

**Separation Anxiety Disorder**
Separation anxiety disorder is characterized by distress over being separated from a loved one. Separation anxiety occurs more frequently in children than adults and in some cases, even a brief separation, can produce panic. Symptoms include extreme worry about potential harm befalling a loved one coupled with fear of separation. Physical symptoms may include nausea, headache, and even vomiting.

**Selective Mutism**
This anxiety disorder occurs when a person who is normally capable of speech does not speak in certain situations. Selective mutism occurs more frequently in children than adults and can disrupt school and social activities. It is also frequently associated with other comorbid anxiety disorders, such as social phobia and separation anxiety disorder. In addition to lack of speech, other symptoms include difficulty making eye contact, sensitivity to noise, moodiness, and sleep problems.

**Generalized Anxiety Disorder**
Generalized anxiety disorder affects approximately 5% of adults at some time during their life, and is characterized by a constant state of excessive worry. This common disorder occurs during a period of more than six months and results in persistent fear about unrealistic situations or occurrences. Symptoms include being overly concerned with routine matters, restlessness, difficulty concentrating, irritability, fatigue, muscle tension, and sleep disturbances. According to the National Institute of Health, depression is also common with generalized anxiety disorder.

**Phobias**
Phobias consist of irrational fears that are triggered by a specific situation. This state of anxiety is usually out of proportion to the specific stimulus and frequently results in complete avoidance of the situation. Some examples of common phobias include:
• **Agoraphobia** (fear of public places)
• **Acrophobia** (fear of heights)
• **Claustrophobia** (fear of enclosed places)
• **Hematophobia** (fear of blood)
• **Aviophobia** (fear of flying)

**Panic Disorder**
Panic disorders carry psychological and physical consequences. Patients with panic attacks are frequently seen in EDs due to the accompanying symptoms, such as:
• Palpitations
• Shakiness
• Sweating
• Shortness of breath
• Choking sensation
• Chest pain
• Nausea

These physical symptoms are often presented with intense fear, anxiety, and a sense of impending doom. Panic attacks typically last 15 to 30 minutes, although residual effects can last longer. A diagnosis of panic disorder requires that an individual experiences at least two recurrent panic attacks, and that these said attacks trigger chronic anxiety and fear of potential future attacks.

**Obsessive-Compulsive Disorder (OCD)**
Obsessive-compulsive disorder (OCD) is characterized by intrusive and unwanted repeated thoughts (obsessions) and behaviors (compulsions). Most people with OCD are aware of their behavior, however, their level of anxiety prevents them from stopping their thoughts or behaviors. Common obsessive thoughts involve the need for exactness, doubting one’s memory, obsession with contamination, and unwanted thoughts of violent or sexual situations. Common compulsive behavior includes frequent cleaning, hand washing, checking locks, rearranging objects, and hoarding behavior.

For more information on OCD, please see our course, #334 Imprisoned in Rituals: Unlocking the Gates of OCD.

**Post-Traumatic Stress Disorder (PTSD)**
Post-traumatic stress disorder (PTSD) results from a traumatic experience in which the individual constantly relives the trauma through intruding memories, thoughts, and nightmares. This chronic reaction to a traumatic event is common in war veterans who have been subject to threatening or terrifying situations. To be diagnosed with PTSD, a patient must have directly experienced the trauma, which ultimately presents symptoms of intense fear and hopelessness. Other symptoms include: anger, exaggerated startle response, difficulty sleeping, and lack of concentration. The duration of the symptoms must also last at least one month to be classified as PTSD. Along with combat, other antecedents of PTSD include violence, sexual abuse, acts of terrorism, natural disasters, and loss of a loved one.

**Assessment of Anxiety Disorders**
Anxiety disorders are often accompanied by other physical symptoms including nausea, chest pain, sweating, and muscle tension. Clinicians routinely screen patients for other underlying medical problems. A complete physical examination can rule out pathologies with similar symptoms, such as angina, asthma, vestibular dysfunction, and ischemic attacks. Other approach considerations include thyroid function tests, urine drug screening and complete blood count (CBC) to rule out other medical conditions.
During the assessment, clinicians focus on obtaining a thorough history regarding the patient’s emotional, physiological, behavioral, and cognitive functioning. A complete mental status examination (MSE) should be conducted to assess the patient’s mood, affect, judgment, thought process, speech, and level of activity. During the MSE, potential suicidal ideation should be assessed by asking the patient questions about thoughts of death or plans of harming themselves.

Various screening tools are also used in the clinical setting to help diagnose certain anxiety disorders. Standard examinations include the Hamilton Anxiety rating Scale, the Beck Anxiety Inventory, the Social Phobia Inventory, the Generalized Anxiety Disorder Scale, and the Yale-Brown Obsessive Compulsive Scale. These assessment scales are useful diagnostic tools that help clinicians rate the type and level of anxiety that may be present in their patients. Mnemonics, such as DREAMS (see Figure 8) assist mental health professionals recognize specific disorders, such as PTSD.

Management of Anxiety Disorders

The treatment of anxiety disorders consists of psychotherapy, such as cognitive behavioral therapy, pharmaceutical therapy, and lifestyle changes. Clinicians often rely on a combination of these treatments to help patients with anxiety disorders. The goal of the cognitive behavioral approach is to change thinking patterns that support irrational fears. Questions, such as “How do you feel about what is happening in your life?” helps the patient to get in touch with their feelings and understand the underlying emotion. Cognitive behavioral therapy uses this understanding to challenge and change anxious feelings. Cognitive behavioral therapy can be conducted individually or in a group setting.

Studies reported in the Cochrane Database have revealed that combining cognitive behavioral therapy with medications can produce favorable outcomes in resistant cases of anxiety disorders. Pharmacotherapy typically consists of antidepressants, benzodiazepines, antipsychotic agents, monoamine oxidase inhibitors (MAOIs), and beta-blockers.

Along with psychotherapy and medication, several alternative therapies have proven effective in the reduction of anxiety. Relaxation training and techniques are used to help patients focus their attention toward calming feelings, which may reduce anxiety. The following techniques are often used as complementary forms of therapy:

- **Visual imagery** involves patients imaging pleasant scenes to help reduce anxiety.
- **Breathing training** allows patients to focus on controlled methods of breathing to help with relaxation.
- **Meditation** combines breathing techniques along with focusing on a specific word or object.
- **Biofeedback** uses sensors to monitor pulse, muscle tone, and skin temperatures to help patients recognize anxiety states.

- **Acupuncture** involves the insertion of tiny needles along certain points of the body, known as meridians, to help produce relaxation.
- **Herbal supplementation** such as chamomile, valerian root, kava, St. John’s Wort, and passionflower are sometimes used to help reduce symptoms of anxiety.
- **Aromatherapy** uses natural oils to produce smells aimed at reducing stress.
- **Massage** uses massage, reflexology, and acupuncture

A surgical approach, known as deep brain stimulation, involves implanting a small device in the brain to help treat conditions, such as obsessive-compulsive disorder (OCD). This small device uses electrodes at specific locations within the brain that convey electrical charges to help block the impulses associated with OCD. According to research published in a 2013 edition of Psychiatric Annals, there are about 120 patients worldwide who are currently being treated with deep brain stimulation for OCD. Research regarding the use of deep brain stimulation in these patients showed marked improvement in relieving symptoms of anxiety associated with OCD. More data is needed to fully understand the long-term role of deep brain stimulation for treating patients with OCD and other anxiety disorders.

**Mnemonic used to diagnose PTSD D-R-E-A-M-S**

- **Detachment**: Does the patient detach from personal relationships or the specific triggering traumatic situation?
- **Re-experiencing**: Does the patient experience repeated thoughts, flashbacks, or nightmares of the traumatic event?
- **Event**: Does the patient experience significant fear or hopelessness as a result of the specific traumatic event?
- **Avoidance**: Does the patient avoid places and friends that may be associated with the event?
- **Month**: Have these symptoms been present for at least one month?
- **Sympathetic**: Does the patient experience symptoms of hyperarousal or hypervigilance?

Source: Adapted from Basic Concepts of Psychiatric-Mental Health Nursing 7th Edition

<table>
<thead>
<tr>
<th>Figure 8</th>
<th>Mnemonic used to diagnose PTSD D-R-E-A-M-S</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Detachment</strong>:</td>
<td>Does the patient detach from personal relationships or the specific triggering traumatic situation?</td>
</tr>
<tr>
<td><strong>Re-experiencing</strong>:</td>
<td>Does the patient experience repeated thoughts, flashbacks, or nightmares of the traumatic event?</td>
</tr>
<tr>
<td><strong>Event</strong>:</td>
<td>Does the patient experience significant fear or hopelessness as a result of the specific traumatic event?</td>
</tr>
<tr>
<td><strong>Avoidance</strong>:</td>
<td>Does the patient avoid places and friends that may be associated with the event?</td>
</tr>
<tr>
<td><strong>Month</strong>:</td>
<td>Have these symptoms been present for at least one month?</td>
</tr>
<tr>
<td><strong>Sympathetic</strong>:</td>
<td>Does the patient experience symptoms of hyperarousal or hypervigilance?</td>
</tr>
</tbody>
</table>

© National Center of Continuing Education, Inc. • www.nursece.com Recognizing Mental Health Disorders Page 17
Personality Disorders

Personality refers to a distinctive set of traits that determines how an individual thinks, behaves, and acts. Personality is a combination of a person’s genetic makeup and life experiences, and affects all aspects of a person’s relationships throughout their life as they interact in both personal and professional environments. Various theories have been presented in the discipline of psychology concerning personality maturation. The consistent belief concerning the etiology of personality disorders is that they are a result of genetic and biologic factors, along with early environmental experiences.

Personality disorders are defined as ways of thinking and behavior that is abnormal with respect to personal relations, mood, and the control of impulses. Personality disorders are deeply ingrained, inflexible, maladaptive, and develop early in an individual’s life. Personality disorders can lead to significant personal hardships, such as strained interpersonal and develop early in an individual’s life. Personality disorders can lead to significant personal hardships, such as strained interpersonal relationships, isolation, and in severe cases imprisonment and suicide.

The DSM-5 outline the following characteristics that are typically present in patients with personality disorders:

- Self-centered
- Inflexibility
- Lack of accountability
- Inability to tolerate minor stress
- Difficulty comprehending reality
- Vulnerable to other mental disorders

Along with general diagnostic criteria, DSM-5 lists 10 personality disorders into three clusters of descriptive categories. Figure 10 lists the American Psychiatric Association’s clusters of personality disorders.

### APA’s Clusters of Personality Disorders

- **Cluster A** – Paranoid, Schizoid, Schizotypal
- **Cluster B** - Antisocial, Borderline, Histrionic, Narcissistic
- **Cluster C** – Avoidant, Dependent, Obsessive-Compulsive

**Figure 10**

**Paranoid Personality Disorder**

Individuals with paranoid personality disorder have chronic irrational suspicion and hostility toward others. They often misinterpret actions directed at them as malevolent. Because of their mistrust of others, patients with paranoid personality disorder are plagued by feelings of anxiety and fear. They are also frequently confrontational, hypersensitive, and lack a sense of humor. Their guarded behavior makes healthy relationships very difficult.

**Schizoid Personality Disorder**

Individuals with schizoid personality disorder lack the desire to have social interaction with others. Along with social detachment, patients affected with schizoid personality disorder also have restricted emotional expression. This impaired communication can be seen in vague speech and lack of eye contact. They are often classified by others as “loners” or “introverted.” Many people with schizoid personality disorder choose professions with limited or no human contact.

**Schizotypal Personality Disorder**

The classification of schizotypal personality disorder includes symptoms similar to, but not severe enough to meet the diagnosis of schizophrenia. These symptoms include an extreme pattern of discomfort in close relationships, paranoid ideation, eccentric behavior, and extreme social anxiety. Individuals affected with schizotypal personality disorder also experience disturbances in thoughts, which result in feelings of “déjà vu” or a “sixth sense.” These thought processes ultimately contribute toward paranoid beliefs.

**Antisocial Personality Disorder**

Antisocial personality disorder is a pattern of lack of empathy or regard, as well as a violation of rights for others. Patients with antisocial personality disorder are focused on their own personal gain despite the consequences. Behaviors include manipulation, deceit, impulsiveness, aggression, reckless behavior, and a disregard for their own or others’ safety. Although they can exhibit superficial charm, individuals with antisocial personality disorder are often involved in brushes with the law, assaults and other reckless behavior. They typically have an exaggerated self-opinion and are prone to irritability and the inability to tolerate boredom.

According to the NIMH, persons with antisocial disorder have difficulty following rules and social norms; repeatedly lie; place others at risk for their own benefit and show a profound lack of remorse.

**Borderline Personality Disorder**

Individuals with borderline personality disorder often have problems with interpersonal relationships due to distorted views of identity and self-image. This pervasive view of self often results in impulsivity and self-harm. Patients with borderline personality disorder have intense fear of rejection. They often exhibit intense reactions toward what they may perceive as neglect or rejection. They typically begin a relationship with strong emotion and even idealize others in an intense manner. However, the relationship rapidly deteriorates when they feel that they are not of value to the relationship.

**Histrionic Personality Disorder**

Individuals with histrionic personality disorder are often described as having an excessive concern for their appearance; they also enjoy being the center of attention. If they think that they are not at the center of attention, they feel unwanted and unappreciated. Patients with histrionic personality disorder often use exaggerated physical appearance, provocative or seductive behavior to draw attention to self. They can also easily misinterpret relationships to be more intimate than they really are.

**Narcissistic Personality Disorder**

The chief characteristic of narcissistic personality disorder is an inflated sense of self-importance. Patients affected with this disorder are preoccupied with beauty, power, and success. Delusions of grandeur are common. Patients who exhibit clinical symptoms believe that they are superior to others and have extreme difficulty accepting disapproval. Although they seem overconfident, these individuals actually have low self-esteem, which
makes them vulnerable to any type of criticism. Reactions could vary from social withdrawal to rage. This disorder affects about 1% of the population and is more prevalent in men.

**Avoidant Personality Disorder**

Individuals with avoidant personality disorder suffer from a pattern of hypersensitivity and feelings of inadequacy concerning rejection or criticism. They feel devastated at even the slightest hint of disapproval. Feelings of anxiety, depression, and anger are common. Social situations can cause intense anxiety, due to the fear of potential criticism. Patients with avoidant personality disorder have a desire to participate in relationships, however, their fear of rejection can be unbearable.

**Dependent Personality Disorder**

The primary clinical symptom of dependent personality disorder is a lack of confidence that results in the individual’s inability to function independently in society. Patients with dependent personality disorder are thoughtful, devoted, agreeable, and considerate, but lack the ability to make decisions. They have no initiative to make even the simplest decisions, such as deciding what clothes to wear for the day. As a result of this dependency, they become obsessed with fears of being left alone.

**Obsessive – Compulsive Personality Disorder**

Obsessive-compulsive personality disorder is often confused with obsessive-compulsive disorder. The key difference is that patients with obsessive-compulsive personality disorder do not feel the need to perform ritualistic actions, which is often the case with obsessive-compulsive disorder.

Individuals with obsessive-compulsive personality disorder have an obsession with orderliness and perfectionism. Strict attention is focused on an inflexible set of rules and guidelines. Patients with this disorder often become overly concerned with minute and trivial detail to the extent that the major point of the activity is lost.

**Assessment & Management of Personality Disorders**

Mental health professionals rely on physical examinations to investigate for the presence of any underlying biologic disturbances. During the mental status examination, clinicians pay close attention to symptoms, which may indicate characteristics of specific personality disorders. Various screening tools are also frequently used for patients with potential personality disorders. These diagnostic tools help assess disturbances of cognition, affect, and interpersonal functioning, as well as lack of impulse control. Important questions regarding impulsiveness may include:

- Does the patient have a history of being easily provoked?
- Does the patient act out on aggressive impulses?
- What specific maladaptive behavior does the patient present?

Other questions used in the standardized assessment tools are tailored to specific personality disorders within one of the three clusters listed in Figure 10. After the mental health professional determines a patient’s diagnosis, a comprehensive treatment program must be initiated. This program includes a combination of psychotherapy, pharmacotherapy, and patient education.

The goals of psychotherapy are to improve the patient’s perceptions and actions to various situations. To do this, clinicians rely on cognitive-behavioral therapy, interpersonal therapy, and group therapy. Coping skills and patient counseling concerning lifestyle changes are also an important part of the mental health management program. Pharmacotherapy management includes antidepressants, mood-stabilizing medications, anti-anxiety medications, and antipsychotics medications.

**Nursing Interventions**

After the patient has been diagnosed with a certain mental disorder, a detailed plan of therapeutic guidance must be developed. This nursing care plan should identify priorities specific to the patient along with proposed effective interventions. Once the physical and psychological needs of the patient have been met, such as a well-disciplined medication regime along with psychotherapy interventions, and a carefully-structured long-term therapeutic plan must be implemented.

This plan should include patient and family education to help achieve favorable outcomes. A key element of this care plan is set forth in what is known as the therapeutic milieu, or a therapeutic community, defined as “An attempt to use a hospital not as an organization run by doctors in the interests of their own greater technical efficiency, but as a community with the immediate aim of full participation of all its members in its daily life and the eventual aim of the resocialization of the neurotic individual for life in ordinary society” (Tom Main and Maxwell Jones). The nurse’s role in milieu therapy consists of actively encouraging the patient and their families to become engaged in their mental healthcare plan. This promotes patient interaction that focuses on social relationships to help promote personal growth and self-esteem.

A therapeutic milieu can be implemented in a variety of settings to include hospitals, long-term care facilities, private practice, as well as at home and in the community. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has established criteria as a guide to help healthcare professionals develop a therapeutic milieu. Components of this guide suggest that nursing staff:

- Encourage participation in group activities
- Provide a testing ground for new patterns of behavior to allow patients to take responsibility for their actions
- Treat all patients equally with respect to rules and policies
- Make provisions for patient privacy
- Promote an attitude of acceptance and optimism
- Conduct continued evaluation of the patient’s progress

Research has consistently shown that milieu therapy is successful at providing educational and coping strategies for the patient as well as their families. It also provides a safe environment that encourages the patient to want to learn about their specific disorder.
Treatment in this controlled environment provides a predictable routine, which also fosters trust between the patient and their caregivers. The ultimate benefit of milieu therapy provides the patient with a much needed sense of being in a safe environment.

Mental health nursing requires more than traditional healthcare training, skill, and resilience. The ability to frame emotionally challenging experiences into opportunities to grow as a better equipped professional, more adept at providing support to a population that has long been misunderstood and mistreated, the greater benefit to our society as a whole.

References
Kudlow P. DSM-5 lends new urgency to brain-based evidence for mental illness. CMAJ. 2013; 185(10): 1-3

© National Center of Continuing Education, Inc. • www.nursece.com


Notes: