

## Psychiatry Power Hour

Presentation for the Mental Health Coalition of the Greater LaCrosse Area

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### Objectives:

#### I. What is Mental Illness?

#### II. What does it mean to be a supportive community contact?

#### III. Overview of common mental illnesses

#### I. What is Mental Illness?

- A. DSM-IV Definition: Mental Illness is a Substantial disorder of THOUGHT, MOOD, PERCEPTION, or MEMORY that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.
- Associated with marked functional, social, or occupational impairment.
  - May include disorders due to medical causes and substance abuse.
- B. Stress-diathesis model for mental illnesses:  
Biologic (genetic) Vulnerability + Psychosocial (environmental) Stress → Mental Illness
- C. Mental Illness Results in:
- Premature death
  - Decreased quality of life
  - Increased medical illness and use of medical care
  - Increased arrests and incarcerations
  - Increased risk of suicide
    - Suicide is the 11<sup>th</sup> cause of death in U.S. adults
    - Prevalence of suicidal ideation in U.S. is ~3%; prevalence of attempts is 0.5%.
    - There is one completed suicide in the U.S. every 17-18 minutes.
- D. What does “getting better” mean for a person with a mental illness, particularly a major mental illness like schizophrenia?
- Can the person live outside the hospital?
  - Can the person be stable outside of the hospital?
  - Can the person live independently?
  - Can the person function better?
  - Can the person recover, or have a life that is more than just being ill?
- E. *We all have a risk of developing mental illness. No individual or community is exempt from the effects of mental illness. We need to care for ourselves and support each other.*

## **II. What does it mean to be a supportive community contact? How can you contribute to the best possible outcome for persons with mental health issues?**

- Be a good listener.
- Be respectful, nonjudgmental, and unassuming to the person with mental illness.
- Be informed, as knowledge is empowering for you as a helper and for the person experiencing the symptoms, but...
- Be humble in knowing when you don't know the answer. Be cautious to not provide advice beyond your scope of practice or expertise, and...
- Expand the field and involve others who can also help (i.e. professional mental health providers, Crisis team, support groups).
- When you are able, tend to family and loved ones of the person with mental illness with the same respect, non-judgment, and openness.
- Find sources of support for yourself in your role as a support giver. This will prevent burn-out and replenish your energy and source of giving.
- It is appropriate to convey hope, but do not provide unfounded or premature reassurance.
- Focus also on the healthy aspects and capabilities of the person and build upon those.
- Be a stigma-buster!

## **III. Overview of common mental illnesses and helpful tips for assisting an individual with specific symptoms:**

### **A. Mood Disorders**

1. Up to 25% of the population is at risk for a mood disorder. The most serious consequence of mood disorders is attempted or completed suicide.

#### **2. DEPRESSION:**

- a. **Symptoms:** Sad mood, loss of interest/pleasure, appetite and sleep disturbance, fatigue or loss of energy, guilt, low self esteem, psychomotor retardation, poor concentration, hopelessness, and thoughts of death.
- b. **Typically a recurrent illness:** risk for relapse after 1st episode is about 50%, after 2nd relapse is about 80%. After 3rd relapse is about 95%. Average lifetime episodes=4.

#### **3. MANIA (the "other" pole of BIPOLAR DISORDER):**

- a. A medical condition in which people experience mood swings out of proportion or totally unrelated to things going on in their lives.
- b. **Symptoms:** grand or extravagant style, or expanded self-esteem; reduced need of sleep (e.g. three hours may be sufficient); talks more often and feels the urge to talk longer; ideas flit through the mind in quick succession, or thoughts race and preoccupy the person; over indulgence in enjoyable behaviors with high risk of a negative outcome (e.g., extravagant shopping, driving too fast, sexual adventures or improbable commercial schemes). Effusive and elated or irritable mood, where the mood is not caused by drugs or a medical illness.
- c. May have psychosis: break from reality.

### **B. Anxiety Disorders**

**1. PANIC DISORDER:** Core symptoms of a panic attack include cardiac symptoms (heart racing, palpitations, chest pain), pulmonary symptoms (shortness of breath, rapid and shallow breathing), gastrointestinal symptoms (nausea, vomiting, stomach upset), neurologic symptoms (numbness, tingling, tremor), sweating/chills, and psychological symptoms (fear of impending doom, a need to “escape,” severe worry). These attacks typically peak within 10 minutes and are usually over within 30 minutes. May have a complication of agoraphobia.

**2. GENERALIZED ANXIETY DISORDER:** Excessive worry out of proportion to situational factors and difficult to control, more days than not for at least 6 months. Common symptoms include muscle tension, restlessness, insomnia, fatigue, irritability and concentration difficulties.

**3. OBSESSIVE-COMPULSIVE DISORDER:** People have intrusive, unwanted thoughts that cause distress and anxiety. They are not real-life worries, but one cannot just ignore or neutralize them or realize the worries are a product of own mind. Compulsions take place in response to obsessions or rigid rules and typically help to decrease stress. Symptoms of OCD often seen in autistic spectrum and schizophrenia.

**4. POST-TRAUMATIC STRESS DISORDER:** Person experienced first-hand or witnessed an event with the threat of death, injury, or severe harm to personal integrity. No escape. Often consequence of child physical, sexual abuse, or witnessing abuse. Core symptoms intrusive recollections/reliving (flashbacks) or nightmares, “numbing,” depression, problems concentrating, hypervigilance (scanning for danger, afraid to rest), hyperstartle (jumpy, easily startled or provoked). Prevalence is 3.5-15 % civilians and up to 20-25% for combat veterans (Vietnam). PTSD is the “great mimicker” of other psychiatric disorders.

**5. PHOBIAS:** Social and Specific Phobias both have core symptoms of avoidance, anticipation of feared stimulus and are present for greater than 6 months.

**a. Social Phobia (Social Anxiety Disorder):** Fear of being scrutinized in public, fear of humiliation or embarrassment.

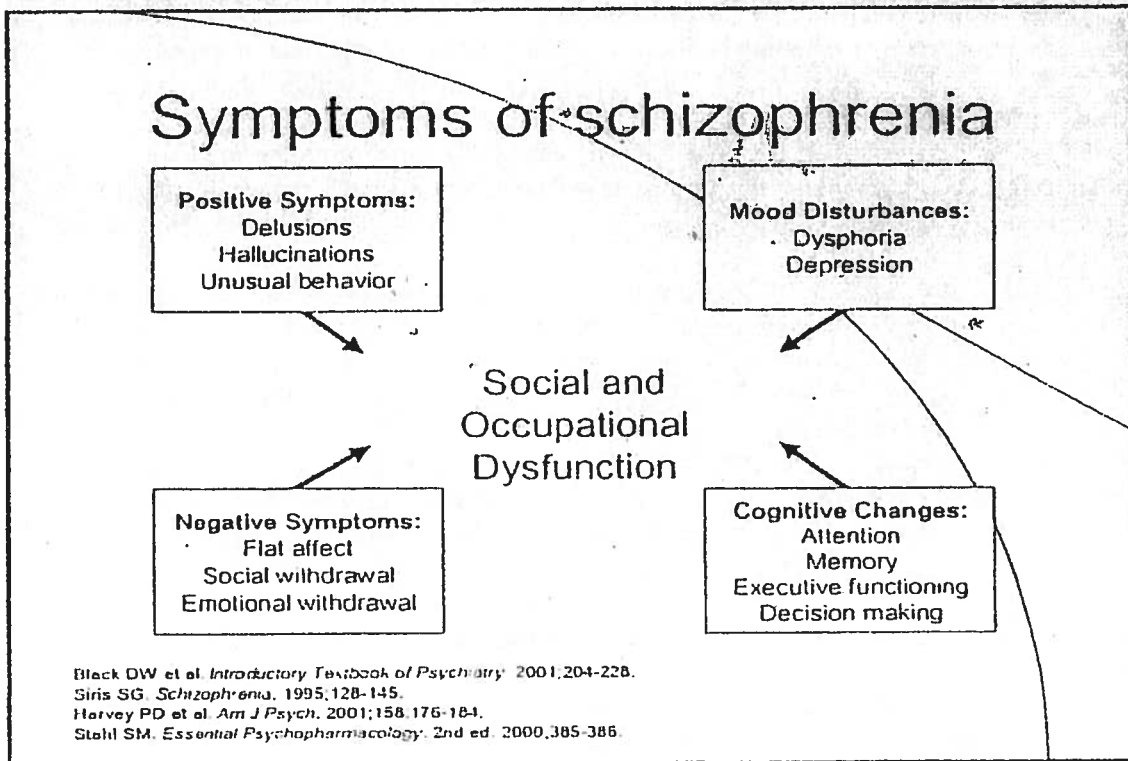
**b. Specific Phobia:** Marked and persistent fear of circumscribed situations or objects.

### **C. Psychotic or Thought Disorders:**

#### **1. *What is Psychosis?***

- Psychosis and Schizophrenia are not the same. Psychosis is the general term for a symptom of schizophrenia.
  - Psychosis is a disturbance in thought and reality.
- It may include disorganized thinking, ideas of reference, thought broadcasting, thought insertion, delusions or hallucinations.
- Psychosis is often subtle in presentation for evolving illness.
- Psychosis is found in other disorders including mood, substance, anxiety, and personality disorders in addition to thought disorders.

## 2. SCHIZOPHRENIA:



**3. SCHIZOAFFECTIVE DISORDER:** Patients meet criteria for schizophrenia and a major mood disorder simultaneously. Between mood episodes, they continue to have symptoms of schizophrenia. Can have depressive or bipolar subtypes with schizoaffective disorder.

### D. Personality Disorders:

#### 1. General Characteristics of Personality Disorders:

- Enduring pattern of behavior & experience affecting cognition, affectivity, impulse control and interpersonal function.
- Socially, pattern is inflexible and pervasive.
- Ego-syntonic, early adult onset, externalizing.
- Caution with PD diagnosis in context of exacerbation of Axis I symptoms.

**2. Cluster A:** Paranoid, Schizoid, Schizotypal PD; odd, eccentric. Typically do not appear for treatment, loners, reclusive.

**3. Cluster B:** Antisocial, Borderline, Histrionic, Narcissistic PD; dramatic, emotional and erratic. Dramatic, unpredictable, interpersonal problems, externalizing, difficulties tolerating frustration or regulating emotions.

**4. Cluster C:** Avoidant, Dependent, Obsessive-Compulsive PD; anxious & avoidant. Anxious overlay, may be in a continuum with other anxiety disorders. Very common in clinical populations often complicating treatment response.

## **E. Substance-Related and Addictive Disorders**

1. Common Substances leading to social/functional difficulties:
  - a. Alcohol and/or Benzodiazepines: Can be dangerous to abruptly stop; medically-assisted detoxification might be necessary to avoid serious complications of withdrawal such as seizures, delirium, or death.
  - b. Marijuana: 50x more potent than marijuana of 30-40 years ago. K-2 is a new synthetic marijuana-type substance that is 10x more potent than marijuana of today. It is not detectable on most drug tests, and can cause psychosis and agitation.
  - c. Opioids: Including heroin as well as prescription pain killers. An increasing trend in La Crosse, especially in adolescents.
  - d. "Uppers": Methamphetamine, cocaine, crack, prescriptions for ADHD
  - e. Hallucinogens: LSD, mushrooms; other drugs of abuse can cause hallucinations as well.
2. Gambling is also an addictive disorder that can be catastrophic in a person's life.
3. Comorbidity of mental illness with substance abuse is very high. People are often "self-medicating" symptoms with substances.
4. Risk of Suicide increases during substance intoxication.

## **F. Delirium and Dementia**

1. Delirium can be a medical emergency! A sudden change in someone's mental presentation might mean delirium—especially if they are elderly or have a new medical condition.
2. Both delirium and dementia can include confusion and memory impairment. The difference is that in delirium, there is a waxing and waning of mental status and level of consciousness.
3. Delirium can be caused by many medical issues and the risk is increased with age and psychiatric illness. Diagnosis and treatment of the underlying issue resolves the delirium. In contrast, dementia does not improve over time, and often progressively worsens over time.

## **G. Disorders Diagnosed in Infancy, Childhood, or Adolescence:**

- Intellectual Disability (formerly referred to as Mental Retardation)
  - Learning Disorders
  - Autistic Spectrum Disorders
  - Attention-Deficit and Disruptive Behavioral Disorders
  - Tic Disorders
  - Motor Skills Disorder
  - Communication Disorders
  - Elimination Disorders
  - Feeding/Eating Disorders of Infancy or Early Childhood
1. **General Criteria for Autistic Spectrum Disorders**
    - a. Social: Qualitative impairment in social interaction including impairment of nonverbal communication, spontaneous play, peer relationships, seeking out others, lack of emotional reciprocity.
    - b. Communication: Abnormalities in verbal process such as initiation, sustain/initiate speech, stereotypic speech, lack of make-believe play, (delay or no speech)
    - c. Restricted/repetitive/stereotypic patterns of behavior, interests and activities.

## **2. ADHD:**

- a. Definition: Persistent pattern of inattention and/or hyperactivity/impulsivity that is more frequent and severe than that observed in kids with comparable development.
- b. Present before age of 12 years.
- c. Interferes with developmentally appropriate social, academic, or occupational functioning.

## **H. Adjustment Disorders**

- Basically refer to situational depression or anxiety.
- Reflective of major stressors such as abuse/neglect, death of a loved one, early chaotic family of origin, conflicted relationships.
- Typically of short duration.
- Likely on a continuum whereby stressors can precipitate biological underpinnings of anxiety, depressive or psychotic illness.