Date: 26th of October 2017

Title: Psychopharmacology: What's Old and What's New?

Abstract:

A review of changes from the DSM IV-TR to the DSM-5 will include associated features, predisposing factors, characteristics or symptoms, and treatment modalities for the following mental illnesses:
a. Bi-Polar I
b. Bi-Polar II
c. Cyclothymia
d. Seasonal Affective Disorder
e. Major Depressive Disorder
f. Dysthymia
g. Schizophrenia
h. Personality Disorders:
    i. Borderline
    ii. Narcissistic
    iii. Obsessive-Compulsive

Learning Objectives:

1. Identify the major categories of mental illness based on the DSM-5 criteria
2. How mental illness impacts all facets of an individual's life
3. Identify treatment options and modalities
4. The role of the community health nurse concerning mental health issues

Bio:

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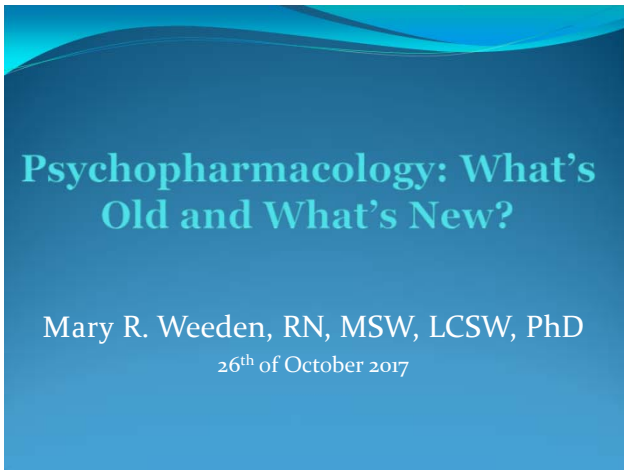


Changes in the DSM - 5

- First published in 1952, the newest version was released in 2013.
- Extensively revised diagnoses
- Deletion of subtypes of schizophrenia and autism
- Inclusion of neuroimaging, biogenetic, and neuroscience research studies
- Elimination of multi-axial system

Common Diagnoses Seen in the Community

- Bi-Polar I Disorder
- Bi-Polar II Disorder
- Cyclothymia
- Seasonal Affective Disorder (SAD)
- Major Depressive Disorder
- Dysthymia
- Schizophrenia
- Personality Disorders
  - Borderline Personality Disorder
  - Narcissistic Personality Disorder
  - Obsessive Compulsive Personality Disorder

Bi-Polar I Disorder (296.xx)

- Referenced as the classic "manic-depressive" disorder first described in the 19th century
- Vast majority will have manic and major depressive episodes throughout the lifespan
- Prevalence between males v females – almost even
- Mean age of onset is around age 18
- >90% of individual who have a single manic episode go on to have recurrent mood episodes
- Approximately 60% of manic episodes occur before a major depressive episode
- Multiple mood episodes (>4 or more per year) are considered rapid cycling

Bi-Polar I – Risk / Prognostic Factors

- Environmental
- Genetic
- Culture
- Gender
- Suicide
- Functional Issues

Bi-Polar I: Co-Morbidity Factors

- ¾ of co-occurring mental disorders are related to anxiety disorder (panic attack, social phobia)
- ADHD and other disruptive behaviors
- Substance abuse
- Adults with bipolar I have high rates of untreated and/or serious co-occurring medical disorders including metabolic issues and migraine headaches

Bi-Polar I: Symptoms

- Manic Episode
  - Abnormal increase in mood and behavior lasting at least one week and occurring nearly or every day
  - 3 or more of the following symptoms
    - Inflated self-esteem or grandiosity
    - Decreased need for sleep (<3 hours)
    - More talkative or pressured to keep talking more than usual
    - Flight of ideas or subjective racing thoughts
    - Distractibility reported or observed
    - Increase in goal-directed activity
    - Excessive involvement in activity that has a high potential for painful consequences

Bi-Polar I: Symptoms

- Mood disturbances sufficient to cause marked impairment in social or occupational functioning or to the degree that requires hospitalization to prevent harm to self or others
- The episode is not contributed to a medical condition or physiological effects of a substance

Bi-Polar I: Symptoms

- Hypomanic Episode
  - Distinct period of abnormally and persistent elevated, expansive or irritable mood and increase in activity or energy, lasting 4 consecutive days
  - During this time period of increased energy or activity, 3 or more of the symptoms of mania are present and represent a significant change in behavior, but not the same intensity

Bi-Polar I: Symptoms

- Hypomania (continued)
  - Episode is associated with unequivocal change in function that is uncharacteristic of the individual when not symptomatic
  - Disturbance in mood and functioning are observable in others
  - The episode not severe enough to cause marked impairment in social or occupational functioning or necessitate hospitalization. *If psychotic features are present, this is considered mania.*
  - The episode is not contributed to a medical condition or physiological effects of a substance

Bi-Polar I: Symptoms

- Major Depressive Episode
  - Criteria common in bipolar I but not required for a diagnosis
  - Need to differentiate between depressive disorder and significant loss
  - 5 or more of the following symptoms have been present during the same 2 week period and represent a change from previous functioning: at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure

Bi-Polar I: Symptoms

- Major Depressive Episode
  - Symptoms (5 or more required and cause distress)
    - Significant weight gain or loss when not dieting
    - Insomnia or hypersomnia
    - Psychomotor agitation or retardation observed and not just reported
    - Fatigue or loss of energy
    - Feelings of worthlessness or excessive or inappropriate guilt (can be delusional)
    - Diminished ability to concentrate, think, or make decisions (either objective or subjective)
    - Recurrent thoughts of death, suicidal ideation without a specific plan or a suicide attempt and/or plan

Bi-Polar I: Treatment

- Medication Intervention
  - Most people do not appear for treatment unless they are in a depressed state
  - Good assessment is essential – too many treated for depression, but not mania/hypomania
  - Mood stabilizers
    - Lithium
    - Anticonvulsants
    - Antipsychotics
    - Benzodiazepines (addictive)

Bi-Polar I: Treatment

- Therapy
  - Cognitive Behavioral Therapy (related to identifying thoughts and behavior patterns)
  - Interpersonal therapy (related to relationships)
  - Social Rhythm therapy (related to developing routines)
- Education
  - S/S of the illness and relapse
  - Patient and family education is key

Bi-Polar II Disorder (296.89)

- Prevalence lower than Bipolar I
- Difficult to establish with pediatric population
- Usually begins in late adolescence through mid-20s for first episode
- Usually initiates with a depressive episode but cannot be diagnosed until a hypomanic episode occurs – often diagnosed as a depressive episode prior to hypomanic episode
- Lifetime episodes slightly higher for bipolar II when compared to depressive disorder or bipolar I
- Depressive episodes are usually longer and more disabling
- Approximately 5-15% have multiple episodes within the 12 previous months
- 5-15% will develop mania, resulting in a bipolar I diagnosis

Bi-Polar II: Risk/Co-Morbid Factors

- Genetic
  - No difference in gender related diagnosis
- Co-morbidity
  - Different – females more likely to report hypomania with mixed depressive and rapid cycling course
  - Childbirth can trigger a hypomanic episode
- Suicide
  - High risk – about 1/3 will report a suicide attempt over a lifetime

Bi-Polar II: Risk/Co-Morbidity

- Comorbidity Factors
  - 75% of co-occurring mental disorders are related to anxiety disorder
  - 37% have substance abuse issues
  - 14% have ED issues at least once throughout the life span, BED more common
- Co-morbidity disorders associated with depressive episode include anxiety and ED, while hypomania associated with substance abuse

Bi-Polar II: Symptoms

- Hypomanic episode
  - Must have experience at least one present or past episode to qualify for bipolar II
    - Distinct period of abnormally and persistent elevated, expansive or irritable mood and increase in activity or energy, lasting 4 consecutive days
    - Intensity episodes are not as severe or intense as mania
    - 3 or more symptoms are present and represent a significant change in behavior (see mania symptoms)

Bi-Polar II: Symptoms

- Major Depressive Episode
  - Must have at least one current or past episode for criteria with bipolar II
  - Need to differentiate between depressive disorder and significant loss
  - 5 or more of the following symptoms have been present during the same 2 week period and represent a change from previous functioning: at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (See Major Depressive Episode)

Bi-Polar II: Symptoms

- Mixed Depressive States
  - Experience depression and non-euphoric hypomania simultaneously
  - Difficult to diagnose when in this state
  - In a mixed state, the individual's mood is depressed, but they also report symptoms of:
    - Irritability
    - Mental overactivity (racing thoughts)
    - Behavioral overactivity (bursts of energy)
  - Mixed states associated with higher levels of suicidality compared to non-mixed states of depression
- Antidepressants can exacerbate suicidal risk

Bi-Polar II: Symptoms

- Criteria have been met for at least 1 hypomanic episode and at least one depressive episode
- No manic episode
- The symptoms of depression or unpredictability cause by frequent alternation between periods of depression and hypomania cause clinical significant distress or impairment in social, occupational, or other areas of functioning.
- Chronic relapsing nature

Bi-Polar II: Treatment

- Mood stabilizers
  - Lithium
  - Anticonvulsants
  - Antipsychotics
  - Benzodiazepines (addictive)
- Antidepressants
  - May be given first if presenting in a depressed state
  - May increase suicidal risk
  - Outcomes not certain – caution
- Therapy and education same as Bi-Polar I

Cyclothymic Disorder (301.13)

- Milder symptoms compared with bi-polar disorders - cyclic as with bi-polar
- Symptoms present for a period of 2 years
- Moods swing between short periods of mild depression and hypomania, an elevated mood
- The low and high mood swings never reach the severity or duration of major depressive or full mania episodes
- Not as disruptive to occupational/social functioning

Cyclothymic Disorder

- Risk/Prevalence
  - Early adolescence/adulthood
  - Persistent course
  - 15-50% individuals will develop bi-polar I or II
- Treatment
  - Medication
    - Lithium
    - Anticonvulsants
    - Atypical antipsychotics
    - Anti-anxiety
    - Antidepressants – CAUTIOUS use only

Seasonal Affective Disorder (SAD)

- Considered part of Bi-polar disorders
- Regular pattern of a mood episode (mania/depressive) during a particular time of year
- Must occur consecutively for a period of 2 years
- Most often begins in the fall/winter and end in the spring (time change with daylight savings) disruption of circadian rhythms

Seasonal Affective Disorder

- Risk/Prognostic Factors
  - Women.
  - People who live far from the equator, where winter daylight hours are very short.
  - People between the ages of 15 and 60
  - People who have a close relative with SAD
- Treatment
  - Light therapy – special types of lights/light boxes
  - Dawn stimulation with lighting
  - Medication (short-term antidepressant therapy or SSRI's)

Major Depressive Disorder (296.2x)

- The essential feature of a major depressive episode is the presence of symptoms for a minimum of 2 weeks and characterized by at least 5 of the previous symptoms described
- The mood often described as "down", this condition can manifest itself both emotionally, but also physically with facial/body expressions and/or somatic complaints
- Social withdrawal is very common
- Distinguishable from grief related to symptom presentation

Major Depressive Disorder

- Risk factors
  - Temperament
  - Historically, negative affectivity
- Environment
  - Adverse, often multiple childhood events
- Genetic predisposition
  - 2-4 x higher in 1st degree relatives
  - Hereditability upwards of 40%
  - Can be refractory in nature, especially if diagnosed in conjunction with other mental health conditions or chronic illness

Major Depressive Disorder: Risk/Co-Morbidity

- Risk factors
  - Gender
    - Higher in females (based on studies),
      - Higher incidence of suicide attempts
      - Lower rates of completion
    - Higher rates of completion with males – usually by violent means
    - Elderly, divorced, widowed, or single males most at risk, especially those with feelings of hopelessness
  - Cultural considerations
    - Under diagnosed, different presentation

Major Depressive Disorder

- Prevalence/Development/Course
  - Approximately 7% overall
  - Highest in ages 18-29 (3 x that of individuals >60)
  - Females 1.5-3x higher compared to males
  - Vastly *underdiagnosed* in the elderly population with first episode
  - Increased incidence beginning in adolescence and peaks in 20s
  - Length of episode variable, with recovery of symptoms starting between 3-12 months

Major Depressive Disorder: Treatment

- Medication
  - Selective SSRI's
  - Other antidepressants
  - Anxiolytics
  - Antipsychotics
- Therapy
  - Cognitive-behavioral (CBT)
  - Behavioral (BT)
  - Interpersonal (IPT)

Major Depressive Disorder

- Combination of both therapy and medication intervention the best
- Long-term use of medication may require a change due to loss of effectiveness
- Electroconvulsive Therapy (shock therapy)
  - Often used in refractory depression
  - Changes brain wave patterns
- Family education is very helpful

Dysthymia (300.4)

- Otherwise known as Persistent Depressive Disorder
- Depressed mood that occurs most days, consistently for a 2 year period
- Can be preceded by a major depressive episode or can occur during a major depressive episode
- Essentially replaced chronic major depressive disorder or episode
- Often co-morbid with substance abuse or personality disorders, especially with early onset
- Functionality of individual varies greatly, but can be worse than MDD
- Neuroscience indicates changes in multiple areas of the brain

Dysthymia

- Treatment
  - Selective SSRIs
  - Antidepressants
  - Therapy
  - Physical exercise (increases production of serotonin)
- Symptoms much less likely to resolve over a period of time

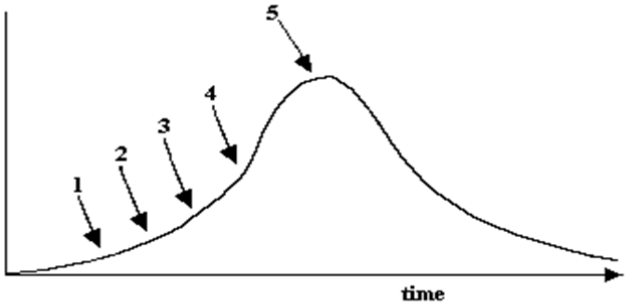
Psychotic Disorders

- Key features
  - Delusions
    - Fixed beliefs not subject to change despite evidence to the contrary
  - Hallucinations
    - Perception-like experiences that occur without external forces
  - Disorganized thinking
    - Speech and thought process incoherent, not organized (word salad), tangential (unrelated), or loose association (switching from one topic to another)

Phases of Psychosis

Taken from Gray, 2016)

Figure 1. Development of psychosis over time, with arrows indicating points of change noted by the patient or informants



Arrow points: 1 = patient first notices some change in self, 2 = family or friends first notice some change in patient, 3 = patient first notices psychotic symptoms in self, 4 = family or friends first notice psychotic symptoms in in patient, 5 = first psychotic intervention. See text for amplification.

Schizophrenia (295.90)

- No specific tests/x-rays, etc. to determine if present
- Neuroimaging indicates reduced overall brain volume
- Differences in cellular activity, and matter connectivity compared to healthy individuals
- Impairments in motor coordination, sensory integration, and motor sequencing of complex movements, left-right confusion, minor facial, limb anomalies may be noted

Schizophrenia: Risk/Incidence

- 1% of the population
- Affects both sexes equally
- Overt symptoms usually begin between ages 16 to mid-30s
- Peak age of onset early to mid-20s (male), late 20s (female)
- Recent increase in youth noted
- Rarely occurs past middle adulthood

Schizophrenia

- Genetic
  - Increased incidence in both 1st and 2nd degree relatives
  - Highest incidence (50%) in identical twins
  - Higher rates of gene mutation, but no specific gene isolated as of now
  - Females demonstrate greater issues with psychotic symptoms
- Environmental factors
  - Prenatal nutrition?
  - Season of birth (late winter/early spring)
  - Higher incidence in urban, some minority groups
- Genetics may load the gun and the environment can pull the trigger

Schizophrenia: Culture/Co-Morbidity

- Cultural / SES Considerations
  - What are described as delusions can be common in some cultures
  - Witchcraft or other religious content need to be considered
- Co-Morbidity Factors
  - Increase in suicidal ideation/attempts (10% suicide rate)
  - Violent behavior – delusions of persecution
  - Substance abuse higher in this population
  - Poor health hygiene/follow-up

Schizophrenia: Symptoms

- Must display 2 or more of the following that have been present for a one month period (active phase), with at least one of the first 3 symptoms present:
  - **Delusions**
  - **Hallucinations**
  - **Disorganized speech**
  - Grossly disorganized or catatonic behavior
  - Negative symptoms that include diminished emotional expression or avolition (lack of interest in any goal-directed activity)

Schizophrenia: Symptoms cont.

- Significant impairment in work, school, interpersonal relationships, and ADLs
- Continuous symptoms for a period of 6 months
  - One month of symptoms (less if treated) in the active phase
  - May include prodromal or residual symptoms
  - During prodromal or residual phase, may exhibit negative symptoms or an attenuated form of active symptoms (i.e. not as intense)

Schizophrenia: Treatment

- Medication a must (neuroleptics)
  - Antipsychotics
  - Atypical antipsychotics
  - Anti-tremor (specifically Cogentin)
  - Antidepressants (conjunctively)
  - Benzodiazepines (addicting)
- Compliance an issue

Schizophrenia: Treatment

- Psych/Social Interventions
  - Co-occurring substance abuse treatment (if appropriate)
  - Social skills and self-care/hygiene
  - Vocational rehab
  - Family education – specifically psychoeducation
  - Self-help and support groups
  - CBT – these patients lack insight, so other forms of therapy are not particularly effective

Personality Disorders

- Behaviors and traits that demonstrate ongoing patterns of perceiving, relating to, and thinking that deviate from that individual's cultural expectations
- These behaviors/traits are manifested in at least 2 areas:
  - Cognition
  - Affectivity
  - Interpersonal functioning
  - Impulse control
- Personality disorders not "curable"
- Affects approximately 9.1% of the US population (NIH, 2007)

Personality Disorders: Characteristics

- Individuals with personality disorders demonstrate a lack of flexibility and pervasive behaviors across a broad range of personal and social situations
- These behaviors/reactions lead to significant problems in social, occupational, or personal functioning
- Behaviors usually become apparent in adolescence or early adulthood
- Medication not helpful and only used to manage symptoms

Personality Disorders: Clusters

- Cluster A
  - Odd, bizarre, eccentric, or "weird"
    - Paranoid Personality Disorder
    - Schizoid Personality Disorder
    - Schizotypal Personality Disorder

Personality Disorders: Clusters

- Cluster B
  - Drama, drama, and more drama, emotional and erratic behaviors
    - Antisocial Personality Disorder
    - Borderline Personality Disorder
    - Histrionic Personality Disorder
    - Narcissistic Personality Disorder

Personality Disorders: Clusters

- Cluster C
  - Anxious and fearful behaviors
    - Avoidant Personality Disorder
    - Dependent Personality Disorder
    - Obsessive Compulsive Personality Disorder

Borderline Personality Disorder

- Characterized by:
  - Feelings of emptiness and abandonment
  - Impulsive behaviors
  - Self-destructive behaviors
  - Creating chaos and splitting wherever they go

Borderline Personality Disorder

- Behaviors demonstrated:
  - Self-mutilation
  - Pattern of extreme intensity and instability in relationships
  - Emotionally labile
  - Sexual promiscuity
  - Outbursts of anger and sometimes violence if criticized
  - Spending sprees
  - Frequent threats of suicide
  - Highly manipulative
  - Always in crisis and will drag others in with them

Borderline Personality Disorder

- Predisposing factors:
  - History of sexual abuse/assault when young
  - History of neglect
  - 1st degree relative (genetics)
  - History of impulsiveness/aggression
  - More commonly diagnosed in women compared to men

Narcissistic Personality Disorder

- Characterized by:
  - Sense of self-importance and entitlement
  - Need to be admired by all
  - Envious of others and expects they are the same of him/her
  - Exploitive of relationships
  - Believes they are "special" while others are just ordinary

Narcissistic Personality Disorder

- Behaviors demonstrated:
  - Grandiosity
  - Lacks empathy
  - Easily lies and exploits others to achieve his/her aims
  - Self absorbed
  - Controlling
  - Intolerant (especially of criticism)
  - Insensitive
  - Can fly into a rage if they feel slighted or ridiculed – will seek revenge
  - Unable to genuinely apologize

Narcissistic Personality Disorder

- Predisposing factors:
  - Excessive praise, admiration, or overindulgence by parent
  - Learning manipulation from caregivers early in life
  - Emotional abuse in childhood
  - Unpredictable parental care

Obsessive Compulsive Personality Disorder

- Characterized by:
  - Perfectionist
  - Extremely detail-oriented
  - Wants to control
  - Will neglect relationships and activities over excessive commitment to work/project

Obsessive Compulsive Personality Disorder

- Demonstrated by:
  - Preoccupation with rules, details, and order -rigid
  - Extremely punctual and expects the same of others
  - Stiff, formal mannerisms
  - Wants to control virtually everything and everyone – people, tasks, situations
  - Unable to delegate to others
  - Overly conscientious, scrupulous, and inflexible concerning morality, ethics, or values – and demands others comply as well to their standards
  - Inability to throw out/discard worthless or broken objects
  - Tight, miserly with money/budget both with self and others
  - Significant distress and dysfunction when perfectionism is not achieved

Obsessive Compulsive Personality Disorder

- Predisposing factors:
  - Combination of genetic and environmental factors
  - Harsh discipline as a child
  - Being the oldest child in a family

Personality Disorders

- Co-morbidities (42%-83%)
  - Substance abuse
  - Eating disorders
  - Mood disorders
  - Anxiety disorders
    - Panic disorder
  - Physical medical issues
  - Higher risk of suicide attempts/completion
  - Results in poorer outcomes

Personality Disorders: Treatment

- Therapy
  - Limited in scope – address symptoms and impact
    - CBT
    - Dialectical behavior therapy (DBT)
    - Psychodynamic (not as much)
    - Group support/social skills
    - Psychoeducation
- Do not usually seek treatment voluntarily
- Lack insight

Personality Disorders: Treatment

- Medication
  - Antidepressants
  - Anti-anxiety medication
  - Mood stabilizers
  - Antipsychotics (neuroleptics) – used only if psychosis present

- Thank you for your time, attention, patience, and commitment to nursing
- Questions?
- Comments?

Role of Community Nursing and Mental Health

- Frequently serve the most vulnerable and oppressed populations
- Often the vital link between PCCs, hospitals, other medical personnel – interprofessional approach
- Requires strong assessment skills and broad knowledge base
- Knowledge of available resources
- Educator – of clients, families, and greater community
- Support system to others – clients/families