

Criminal Justice

Response

**To people with mental illness
arrested or incarcerated in Tennessee**

**Module 2
Mental Health and Mental Illness**

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Module Two:

Mental Health and Mental Illness

Length of Presentation: 30 minutes (brief version)
1 hour (full version)

Handouts and Materials:

- 2-1 *Mental Health and Mental Illness*
- 2-2 *Mental Illness: Facts and Figures*
- 2-3 *Myths and Facts of Mental Illness*
- 2-4 *Common Psychiatric Diagnoses*
- 2-5 *Mental Illness and Effective Communication*
- 2-6 *Response: Crisis Communication*
- 2-7 *Schizophrenia and Psychotic Disorders*
- 2-V *Optional Video: Training the M.E.T. Part IV: Community Encounters, California Alliance for the Mentally Ill (CAMI)*
- 2-V *Optional Video: Training the M.E.T. Part V: In Custody, (CAMI)*
- 2-8 *Depression*
- 2-9 *Bipolar Disorder*
- 2-10 *Panic Attack*
- 2-11 *Posttraumatic Stress Disorder, PTSD*
- 2-12 *Obsessive Compulsive Disorder*
- 2-13a *Personality Disorder/ Borderline Personality Disorder*
- 2-13b *Personality Disorder/ Antisocial Personality Disorder*
- 2-14 *Childhood Behavioral Disorders*
- 2-15 *Dementia and Alzheimer's Disease*
- 2-16 *Malingering*
- 2-17 *Crossword Quiz*

Motivational supplies:

*Candy: pieces of hard candy;
Several small candy bars; and
One large chocolate bar;
Raffle tickets, a jar or hat for tickets and 3 small prizes for winners.*

[Notes to Instructor:

There are more handouts on specific mental illnesses than you can cover in the presentation.

- *Full version: Cover two diagnoses that are of most interest to participants.*
 - *Brief version: Cover general information on handouts 2-1 through 2-6.*
- Handouts on specific diagnoses can be distributed as reference material.*

Response exercises are required if participants work directly with offenders or inmates. It is important for participants to connect information on mental illness to their work.

At the end of the session, make sure participants complete Handout 2-17: Crossword Quiz.]

Optional activity: To encourage participation and to instill a sense of fun you can award raffle tickets to those who contribute to the discussion. Show the prize(s) to participants at the beginning of the session. At the end of the session, draw for a prize. To encourage attendance, draw for prizes after breaks, after lunch and/or at the end of the day. Do not spend much time on the drawings. They should be quick and fun. Prizes should be small, but useful (e.g. a flashlight rather than a knick-knack.)]

Objectives

- Learn about mental health;
- Learn about mental illness;
- Learn to distinguish behaviors associated with types of mental illness;
- Learn to respond effectively to people displaying symptoms of mental illness;
- Learn about recovery from serious mental illness.

DISCUSSION

Mental Health and Mental Illness

Mental Health

[Refer to Handout 2-1: Mental Health and Mental Illness. Refer trainees to “Mental Health column.]

“Mental health is a relative term. It can mean many things to many people. Generally, mentally healthy people have a positive self-image and can relate successfully to others. Mental health is the ability to integrated one’s self with one’s environment. Good mental health is reflected in:

- Solid interpersonal relationships;
- Satisfaction in living;
- Success in achievements;
- Flexibility and coping skills, and
- Maturity.

“In dealing with life’s challenges, changes and traumas each person develops methods that enable him or her to function effectively despite these distractions. At times, the pressures may impair one’s ability to fulfill responsibilities effectively. The person often deals quickly with the condition, soon restoring effectiveness. It is when the person’s methods for dealing with those pressures fail that one begins to experience a disorder in functioning.” (PERF, 1997)

Law enforcement may become involved when people who are otherwise mentally healthy make bad decisions. Legal penalties alone or combined with short-term mental health counseling can be expected to restore such people to normal functioning.

Temporary impairment of judgment is different from serious mental illness.

Optional Discussion:

[5-minute limit]

- Describe a situation you have worked with where the offender, inmate or probationer appeared to be a mentally healthy person that had committed a crime.

Mental Illness

Serious mental illnesses are brain disorders that:

- Impair thinking, feeling, and behavior; and
- Disrupt ability to function in activities of daily living such as:
 - Social interaction;
 - Employment;
 - Education; and
 - Self-care.

Mental illness can be caused or triggered by:

- Genetic transmission;
- Biochemical disorder;
- Prolonged or very intense social stress;
- Recreational drugs; and
- Other environmental toxins.

[Review remainder of Handout 2-1: Mental Health and Mental Illness.]

[Review Handout 2-2: Mental Illness: Facts and Figures. Emphasize the points concerning employment, co-occurring substance abuse, homelessness, and incarceration.]

Myths and Facts of Mental Illness

[Review Handout 2-3: Myths and Facts of Mental Illness.]

People with mental illness frequently become victims of discrimination because of commonly held, but false beliefs about mental illness. Just as with the rest of society, these myths influence the actions of law enforcement, correctional staff, court staff and probation and parole officers.

Optional Discussion:

[5-minute limit]

- How have these myths influenced your work with offenders or inmates who have mental illness?

Psychiatric Diagnoses

There are no current laboratory methods or blood tests for diagnosing mental illness. Psychiatric diagnoses are made by asking the individual what he or she is thinking and feeling, and by observing behavior. Symptoms of thought, mood and behavior are grouped into common patterns called diagnoses. Initial diagnoses are usually changed as patterns are clarified over time.

The purpose of psychiatric diagnosis is to guide treatment, not to dictate what the person can or cannot do. Although some mental illnesses are considered to be more disabling than others, individuals across the psychiatric diagnosis spectrum are capable of living and working in a manner indistinguishable from the average person.

Common psychiatric diagnoses are shown in Handout 2-4 along with symptoms and recommended mental health treatments and supports.

[Review Handout 2-4: Common Psychiatric Diagnoses, emphasizing those diagnoses most common in the criminal justice system: psychotic disorders, mood disorders, PTSD and personality disorders.]

[Refer to Handout 2-4a. Only discuss it if you have time.]

Mental Illness and Effective Communication

Psychiatric symptoms often interfere with communication. When an individual is experiencing an episode of mental illness it may be necessary to change your way of communicating to increase the chances of being understood and to get an effective response.

Handout 2-5 shows a few basic techniques for communicating with individuals who are in a psychiatric crisis. The most important point is to remain calm, clear and caring. You will have a much greater chance of resolving the situation peacefully if you keep in mind that the individual is trying to cope with a confusing, overwhelming situation. Giving the individual an opportunity to be heard will often defuse potential violence. Of course it is vital to continuously assess for dangerousness and maintain safety.

[Review Handout 2-5: Mental Illness and Effective Communication.]

Response: Communicating with Individuals in Psychiatric Crisis

[Notes to Instructor:

Refer to Handout 2-6: Response: Crisis Communication.

- *Read client scenarios to the class.
(Choose those most appropriate to the audience.)*

- After each scenario is read, ask participants to suggest the best approach to effective communication.
- Then ask participant who suggested approach to role-play what s/he would say and do to facilitate effective communication:
 - a. “What symptoms is this client displaying?”
 - b. “What would you say to me, the client?”
 - c. “Show me what you would do.”
- Reward participation by giving a small piece of candy to each participant who suggests approaches, and a larger piece to those who role-play. As the exercise progresses, place a large candy bar in view of the audience. At the end of the exercise, give the candy bar to the student whose participation was most helpful.

Alternative: Distribute raffle tickets to each person who responds. See instructor notes at beginning of module.]

*[If doing the brief section, skip to the **Conclusion** on page 13. Complete quiz.]*

[If doing the full version cover two or more handouts on particular diagnoses. Choose those that are of most interest to participants. Each segment on mental disorders takes about 20 minutes with discussion.]

Optional segment: Schizophrenia and Psychotic Disorders

Schizophrenia is one of the most disabling mental disorders. In the past, it was thought that people with schizophrenia and other psychotic disorders could not function normally in their families or communities. With new, effective medications and services, many people with psychotic disorders are now living and working productively in the community. The problem is that many people who need the new medications and services don't get them because of lack of funding and other policy barriers. Some of those people end up in the criminal justice system for behaviors that could be attributed to untreated psychosis.

[Review Handout 2-7: Schizophrenia and Psychotic Disorders]

[Optional: View CAMI video:

For law enforcement, show Part IV: Community Encounters, the section on the delusional man in the park.

For corrections, show Part V: In Custody, the sections on inmates with psychotic behavior.]

Discussion:

[10-minute limit.

Optional: Award a raffle ticket to participants who talk about their experience.]

- In your work, what situations have you encountered where the individual displayed psychotic symptoms such as delusions or hallucinations?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Depression

Depression is a serious medical illness. In contrast to the normal emotional experience of sadness, loss or passing mood states, depression lasts for a period of months or years and can greatly interfere with an individual's ability to function. Depression is the most common mental illness. It is estimated that one in five Americans will suffer serious depression at some time in their lives. Many people with depression believe that symptoms of depression are "not real," that a person should be able to get through it by just trying harder. Because of these beliefs and the stigma associated with mental illness, many depressed people do not seek treatment.

Untreated depression may lead to suicide. It is estimated that 2% of Americans who have ever been treated for depression will end their lives by suicide¹ as compared to .01% of the general population. Law enforcement is frequently called when an individual has made a suicide attempt. Risk of suicide is also higher for persons who are incarcerated, estimated at nine times that of the general population². Therefore it is essential that you know how to recognize symptoms of depression as well as signs of suicide risk. More specific information on suicide will be presented later, but we will begin with a discussion of depression.

[Review Handout 2-8: Depression.]

[Optional: View CAMI video:

For law enforcement, show Part IV: Community Encounters, the section on the suicidal woman.

For corrections, show Part V: In Custody, the section on inmate with suicidal ideation.]

Discussion:

[10-minute limit.

Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of depression?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Bipolar Disorder

Also known as manic depression, bipolar disorder is a biologically-based, hereditary mental illness. Moods swing from an intense high of excitement, irritability and inflated sense of self-importance to intense lows of sadness, hopelessness and lethargy. At least two million Americans (1.6% of the population) have bipolar

¹ <http://www.nimh.nih.gov/research/suicidefaq.cfm>

² Hayes, L.; Rowan, R. (1988) National Study of Jail Suicides: Seven Years Later, Alexandria, VA: National Center on Institutions and Alternatives. National Institute of Corrections, US Department of Justice.

disorder with average onset in early adulthood. Bipolar disorder can vary from mild to severe and can involve only a few episodes of mania, alternating mania and depression, or mood swings associated with seasons.

There is an increased risk of suicide in individuals with bipolar disorder who are in the depressive cycle. Studies show that 10 – 15% of individuals with bipolar disorder complete suicide. In a manic phase, the individual is more likely to engage in violence or high-risk behavior such as truancy or occupational absenteeism, substance abuse, spending sprees or sexual promiscuity. At either of these extremes, individuals' behavior may bring them into contact with the criminal justice system.

[Review Handout 2-9: Bipolar Disorder.]

[Optional: View CAMI video:

For law enforcement, show Part IV: Community Encounters, the section on the manic woman in the marketplace.

For corrections, show Part V: In Custody, the section on inmate with delusions of grandeur (God).]

Discussion:

[10-minute limit.

Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of mania?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Panic Attack

A panic attack is a severe episode of anxiety involving intense fear and physical symptoms. Physical symptoms often mimic a heart attack or other life-threatening condition. An individual who has experienced repeated panic attacks, called “panic disorder,” often develops intense anxiety between episodes, avoiding situations where they believe another panic attack may occur or where help would not be immediately available. Panic disorder affects an estimated 1.6% of American adults ages 18 to 54 and usually develops in early adulthood.

While behaviors associated with panic attacks do not normally lead people into the criminal justice system, an individual may experience a panic attack as a *result* of an encounter with law enforcement or corrections.

[Review Handout 2-10: Panic Attack.]

Discussion:

[10-minute limit.

Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of a panic attack?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Posttraumatic Stress Disorder, PTSD

Individuals with PTSD may have experienced a single, traumatic event such as a natural disaster, fire, airline accident or rape, or may have been subject to ongoing, overwhelming suffering such as child abuse, domestic abuse, war or political oppression. The individual has intense feelings (to the point of hallucination) of reliving a traumatic event, is easily startled, may have insomnia, or inability to remember events accompanied by a feeling of numbness, disconnected from others, no future, a “loner”. PTSD can occur at any age. Symptoms usually begin within the first three months after the trauma, although there can be a delay of months or even years. An estimated 8% of Americans experience PTSD at some point in their lives.

While reliving a trauma, persons with PTSD may engage in violent or self-destructive behavior. They may be unaware of their actual surroundings and respond only to threats perceived in a flashback. Law enforcement may be contacted if the person becomes violent or out-of-control behavior occurs in a public setting. Individuals who are incarcerated may experience a flashback and behave aggressively.

[Review Handout 2-11: Posttraumatic Stress Disorder.]

Discussion:

[10-minute limit.

Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of PTSD?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Obsessive Compulsive Disorder (OCD)

Obsessive Compulsive Disorder (OCD) is thought to be the most disabling anxiety disorder. Biological and possible hereditary in nature, symptoms interfere with basic daily activities. The person with OCD becomes trapped in a cycle of obsessions and compulsions spending at least one hour per day going over and over an upsetting, unwanted thought (obsession) or doing something to prevent what is feared (compulsion). OCD affects about 2% of the population, with age of onset from early childhood to adolescence.

Despite the fact that the person recognizes that thoughts and actions are unreasonable, he or she cannot control them. A sense of desperation may lead the individual to become suicidal. In a correctional setting, an individual with OCD may become agitated when attempts at compulsive behavior are thwarted. The individual may also be at risk of mistreatment from other inmates who do not like the individual's odd, compulsive behavior.

[Review Handout 2-12: Obsessive Compulsive Disorder.]

Discussion:

[10-minute limit.

Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of OCD?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Personality Disorder

Personality disorders are groups of personality “traits” resulting in ongoing, troublesome patterns of thought, feeling and behavior. To be considered a personality disorder, these patterns must cause major problems in self-care, social relationships, work or school. Personality disorders usually become apparent in late adolescence or early adulthood and continue throughout life unless treated. Personality disorders are usually associated with a difficult childhood or early environment. Women tend more toward dependent, borderline traits while men tend more toward aggressive, antisocial traits.

Borderline Personality Disorder

Individuals with borderline personality disorder tend to look upon themselves and others as “all good” or “all bad”. Because of that they have a pattern of unstable relationships, poor self-image, emotional ups and downs, and impulsive behavior. They make frantic efforts to avoid being abandoned or rejected. Borderline personality disorder is most common among young women, affecting about 2% of the general population.

[Review Handout 2-13a: Personality Disorders, including Borderline Personality Disorder.]

Antisocial Personality Disorder

Antisocial personality disorder is common among male offenders and inmates because the characteristics of disregard for the rights of others, deceit and manipulation lay the foundation for criminal activity. In the general population, about 3% of males and 1% of females have antisocial personality disorder, compared with

25-30% of the American inmate population. Effective treatment involves extremely structured residential therapy in a controlled setting. Most mental health agencies are not equipped to treat antisocial personality disorder, but special needs prisons do offer structured, effective programs.

[Review Handout 2-13b: Antisocial Personality Disorder.]

Discussion:

[10-minute limit.

Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of antisocial or borderline personality disorder?
- How did you handle the situation?
- Based on the information you have heard today, what else could you have done?

Optional segment: Behavioral Disorders of Childhood

Oppositional Defiant Disorder

Oppositional defiant disorder is a childhood behavioral disorder involving ongoing patterns of defiant attitudes; and disobedient, hostile behavior toward authority figures. Serious marital discord, parental mood disorders, and parental substance abuse are common in families of children with this disorder. The diagnosis is not usually made before the age of eight or after the onset of adolescence. Children with oppositional defiant disorder do not usually come to the attention of law enforcement or juvenile justice authorities.

[Review Handout 2-14: Childhood Behavioral Disorders, section on Behaviors Associated with Oppositional Defiant Disorder.]

Conduct Disorder

Conduct disorder is a childhood behavioral disorder consisting of a persistent pattern of violating the basic rights of others or major age-appropriate societal norms or rules. Estimated at 1% - 10% of the population, conduct disorder has increased over the last decades. Research shows that conduct disorder has both genetic and environmental influences. Conduct disorder is often preceded by oppositional defiant disorder. Conduct disorder usually goes away by adulthood, but may develop into antisocial personality disorder if left untreated. Acts committed by children and youth with conduct disorder frequently require intervention from law enforcement and juvenile justice authorities.

[Review remainder of Handout 2-14: Childhood Behavioral Disorders.]

Discussion:

[10-minute limit.

Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In what situations have you encountered youth that appeared to have conduct disorders?
- What did you do that got the result you desired?
- What did you do that did not get the result you desired?
- What else could you have done?

Optional segment: Dementia and Alzheimer's Disease

Dementias are mental disorders that are more common later in life, and involve the loss of the ability to think and remember. Despite popular misconceptions, dementias are not inevitable, striking less than 15% of those over the age of 65. Alzheimer's disease is the best-known type of dementia but vascular disease, HIV, head trauma and Parkinson's disease can all lead to dementia.

[Review Handout 2-15: Dementia and Alzheimer's Disease.]

Alzheimer's Disease

Alzheimer's disease is a biological dementia that most typically strikes after age 65. It is possibly genetic, but may be triggered by other diseases and environmental toxins. The person gradually loses memory and the ability to think and respond to the environment, eventually becoming mute and bedridden. At some stages of the disease, individuals may develop paranoia and bizarre behaviors, and could cause enough disturbance to come to the attention of law enforcement.

Law enforcement may also be alerted to abuse of persons who have dementia. Elder abuse is common when caregivers become stressed to the point of aggression.

[Optional: *View video: Unheard Cries (TBI and Tennessee Commission on Aging and Disability.)*

Discussion:

[10-minute limit.

Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In what situations have you encountered offenders that appear to have dementia?
- What did you do that got the result you desired?
- What did you do that did not get the result you desired?
- What else could you have done?

Optional segment: Malingering

Malingering is not a mental illness. It is behavior that involves intentionally feigning physical or psychological symptoms, motivated by external incentives such as evading criminal prosecution, avoiding military duty, avoiding work, obtaining financial compensation, or obtaining drugs.

[Review Handout 2-16: Malingering]

Discussion:

[10-minute limit.

Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In what situations have you encountered offenders that appear to be malingering?
- What did you do to detect malingering?
- How well did it work?
- What else could you have done?

Conclusion

[Instructor: Ask for questions.

Distribute Crossword Quiz (see Forms section)

Tell participants that this is not a graded quiz; it is just to help them reinforce some points from the session. When they have completed the crossword, they can take a break. Review correct responses after the break.]

Recommended Reading

Police Executive Research Forum (1997) *The Police Response to People with Mental Illness*, Washington DC: PERF.

Handout 2-1 Mental Health and Mental Illness

Mental Health	Mental Illness
<p>Mental health is the ability to integrate one's self with one's environment.</p> <p>Mentally healthy people:</p> <ul style="list-style-type: none"> ○ Have a positive self-image; and ○ Can relate successfully to others. <p>Good mental health is reflected in:</p> <ul style="list-style-type: none"> ○ Solid interpersonal relationships; ○ Satisfaction in living; ○ Success in achievements; ○ Flexibility and coping skills; and ○ Maturity. <p>Mental Health and Stress</p> <ul style="list-style-type: none"> ○ Each person develops methods to continue functioning effectively when pressure impairs the ability to fulfill responsibilities effectively. ○ The person often deals with pressures quickly and effectiveness is restored. ○ When coping methods fail, one begins to experience a disorder in functioning and may make unwise decisions. ○ Temporary impaired judgment is different from serious mental illness. 	<p>Brain disorders that:</p> <ul style="list-style-type: none"> ○ Impair thinking, feeling, and behavior; and ○ Disrupt ability to function in activities of daily living: <ul style="list-style-type: none"> ▪ Social interaction; ▪ Employment; ▪ Education; and ▪ Self-care. <p>Causes or triggers:</p> <ul style="list-style-type: none"> ▪ Genetic transmission; ▪ Biochemical disorder; ▪ Prolonged/very intense social stress; ▪ Recreational drugs; and ▪ Other environmental toxins. <p>Impaired Thoughts</p> <p>Positive symptoms are unusual perceptions:</p> <ul style="list-style-type: none"> ○ Delusions: fixed false beliefs such as Paranoia, delusion of grandeur or guilt, obsession ○ Hallucinations: auditory, visual, tactile <p>Negative symptoms: Reduced ability to think:</p> <ul style="list-style-type: none"> ▪ Confusion; ▪ Lack of concentration; ▪ Indecision. <p>Feelings</p> <p>Mental illness:</p> <ul style="list-style-type: none"> ○ Damages self-concept and social relationships; and ○ Alters or numbs emotions. <p>Painful, intense emotions may be <u>normal responses</u> to the trauma of mental illness.</p> <p>Normal responses are combined with emotional reactions caused by mental illness.</p> <p>Behaviors</p> <p>Behavior changes as a result of impaired thoughts or feelings:</p> <ul style="list-style-type: none"> ○ Person responding to voices, delusions, hyper-stimuli or manic feelings may appear strange, agitated and irrational. ○ Person responding to negative symptoms, depression, apathy, withdrawal or confusion may appear lethargic, disconnected, confused.

Handout 2-2

Mental Illness: Facts and Figures

(From: National Alliance for the Mentally Ill, "NAMI Advocate", Spring, 2001)

- ❖ Mental illnesses are health conditions characterized by alterations in thought, mood and behavior (or a combination) associated with distress and impaired functioning.
- ❖ Of American adults, 5.4 percent have a serious mental illness.
- ❖ In any given year, 23 percent of American adults (age 18 or older) have a diagnosable mental disorder, but only half report impairment of their daily functioning due to the mental disorder. Six percent of adults have addictive disorders alone, and three percent have both mental and addictive disorders.
- ❖ Almost half of the adults with serious and persistent mental illnesses are between the ages of 25 and 44.
- ❖ Approximately nine percent to thirteen percent of children ages nine to seventeen have a serious emotional disturbance with substantial functional impairment, and five percent to nine percent have a serious emotional disturbance with the extreme functional impairment caused by mental illness.
- ❖ Not all mental disorders identified in childhood and adolescence persist into adulthood, even though the prevalence of mental disorders is almost the same percentage for both age groups. A substantial number of children and adolescents recover from mental illness.
- ❖ Four of ten leading causes of disability in the United States and other developed countries are mental disorders, which include major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder.
- ❖ The treatment success rate for a first episode of schizophrenia is 60 percent. It is 65 percent to 70 percent for major depression and 80 percent for bipolar disorder. The treatment success rate for a first episode of schizophrenia is 60 percent. It is 65 percent to 70 percent for major depression and 80 percent for bipolar disorder.
- ❖ Of the 1,012, 582 total hospital admissions in the U.S. in 1998, 261, 903 (25.8%) were psychiatric admissions.
- ❖ The total cost of mental health services in the U.S. was \$148 billion in 1990. The direct cost of mental health services (treatment and rehabilitation costs) totaled \$69 billion, and the indirect costs (lost productivity at work, school or home due to disability or death) were estimated at \$78.6 billion.
- ❖ Serious mental illnesses interfere with employment. An estimated 57% of adults with these illnesses were not employed in 1990. compared to 29 percent of the general population.
- ❖ Approximately one-third of the estimated 600,000 homeless people in the U.S. have a severe mental illness, however, only one in 20 persons with severe mental illness are homeless.
- ❖ Only five percent to seven percent of homeless persons with mental illness need to be institutionalized. Most can live in the community with appropriate, supportive housing.
- ❖ In 1998, 283,800 people with mental illnesses were incarcerated in American prisons and jails. This is four times the number of people in state mental hospitals throughout the country.
- ❖ Sixteen percent of state prison inmates (179,200), seven percent of federal inmates (7,900), 16 percent of jail inmates (97,600) and 16 percent of probationers (547,800) have reported a mental illness.
- ❖ Mentally ill offenders are more likely than other offenders to have a history of substance abuse/dependency and a higher rate of homelessness and unemployment prior to incarceration.

Handout 2-3 Myths and Facts of Mental Illness

Myths: People with Mental Illness...	Facts: People with Mental Illness...
- Have a rare condition.....	One in five Americans will have a mental illness at some point in their lives.
- Are not smart	People with mental illness have the same range of intelligence as the general population.
- Look different from the average person	Most mental illnesses come and go. A person whose mental illness is in remission may look like any average person. Some older psychiatric medications have side effects that may cause odd mannerisms.
- Are violent and unpredictable.....	People with mental illness are no more likely to be violent than the general population. BUT, people with mental illness who abuse alcohol or drugs ARE more likely to be violent if not receiving consistent treatment.
- Are a drain on society.....	<p>Many people with mental illness have contributed to society, including:</p> <p>Abraham Lincoln (16th US president), Ludwig Von Beethoven (composer), Isaac Newton (scientist), Virginia Wolf (author), Winston Churchill (British Prime Minister), Lionel Aldridge (football player), Patty Duke (actress).</p>

Handout 2-4 Common Psychiatric Diagnoses

Diagnosis	Symptoms & Characteristics	Treatments
Psychotic Disorders		
Schizophrenia	Distorted sense of reality: Hallucinations, Delusions, Confusion, Blunted emotional expression, Unusual speech & behavior, Social withdrawal.	Medication: anti-psychotic, Case management Therapy: cognitive-behavioral or supportive, Psychosocial rehabilitation.
Schizoaffective Disorder	Psychotic symptoms, plus Mood swings	Medication: anti-psychotic and mood stabilizer, Case management, Therapy: cognitive-behavioral or supportive, Psychosocial rehabilitation.
Substance Induced Psychotic Disorder	Psychotic symptoms associated with substance abuse	Detoxification, Addiction treatment, Assessment for underlying mental disorder.
Mood Disorders		
Depression	Persistent sadness, Loss of interest, Change in appetite/weight, Sleep problems, Physical slowing or agitation, Energy loss, Feelings of worthlessness, Concentration problems, Suicidal thoughts.	Medication, antidepressant, sedatives-hypnotics (for sleep), Case management if severely impaired, Therapy: cognitive-behavioral or interpersonal.
Bipolar Disorder	Depressive symptoms alternating with mania: Increased energy, racing thoughts, rapid speech, Denial that anything is wrong, Irritability, distractibility, Decreased need for sleep, Unrealistic belief in one's ability, Poor judgment, Impulsive behavior: sexual drive, substance abuse, spending sprees, aggression.	Medication: mood stabilizers, sedatives-hypnotics (for sleep), Case management if severely impaired, Therapy: cognitive-behavioral or interpersonal, Psychosocial rehabilitation.

Diagnosis	Symptoms & Characteristics	Treatments
Anxiety Disorders		
Generalized Anxiety Disorder	Ongoing, unrealistic sense of impending doom, Strenuous avoidance of feared situations, May involve panic attacks: Episode of intense fear, Chest pain, Rapid heartbeat, Shortness of breath, Dizziness, Abdominal distress.	Medications: anti-anxiety* and anti-depressants, sedatives-hypnotics (for sleep), Therapy: Cognitive-behavioral. * Caution: some anti-anxiety medications are habit-forming.
Posttraumatic Stress Disorder	Following a traumatic event or ongoing situation: Reliving the event through flashbacks or nightmares, Avoiding trauma reminders, Amnesia regarding trauma, Social isolation, Sense of limited future, Wary, Irritable, Insomnia, Lack of concentration.	Psychotherapy: Stress Inoculation Training, relaxation and role playing Medication: Short-term anti-depressant or anti-anxiety, Support groups, group therapy, Case management if severely impaired.
Obsessive Compulsive Disorder	Persistent, unwanted, upsetting thoughts, Repeated actions to prevent what is feared.	Medication: SSRI antidepressants, Therapy: Exposure Response Prevention. Case management if severely impaired.
Personality Disorders Most common: Women: Borderline Personality Disorder Men: Antisocial Personality Disorder	Group of personality "traits" resulting in ongoing, troublesome patterns of thought, feeling & behavior. Women more commonly have dependent, emotionally unstable traits, Men more commonly have aggressive, antisocial traits.	Borderline: Therapy: cognitive-behavioral or insight-oriented, Psychosocial rehabilitation Short term medication: antidepressant, anti-anxiety Antisocial: Therapy: Behavioral, conducted in a controlled residential setting.
Dementias		
Most Common: Alzheimer's Disease	Memory loss, Trouble speaking, Trouble moving around, Difficulty recognizing objects, Inability to plan & organize, As condition worsens: Psychosis, Depression, Agitation.	Memory training (for early stages) Medications: Anti-depressant, anti-psychotic Day treatment, Caregiver respite

Handout 2-3
Common Psychiatric Diagnoses

Handout 2-4a Signs and Symptoms of Mental Illness

<p><u>Appearance</u> Dress and hygiene: Appropriate Unkempt Smells of alcohol Body odor Unusual dress Inappropriate dress</p>	<p><u>Thought Process</u> Loose associations Disorganized Poverty of thoughts No response Incoherent Clanging/rhyming Flight of ideas</p>	<p><u>Perception</u> Hallucinations Visual illusions Auditory commenting Auditory command Visual tactile Olfactory Gustatory</p>
<p><u>Mannerisms</u> Tics Tremors Peculiar or bizarre Unusual gait Repeated acts Lack of coordination Eye movements <u>Pace of movement</u> Hyperactive Restless Agitated Lethargic Fatigue Stupor</p>	<p><u>Thought Content</u> <u>Somatic</u> Physical complaints Hypochondriasis Obsession with body <u>Guilt feelings</u> Worthlessness Feels punished Guilt Shame Suicidal thoughts Suicidal plans Past suicide attempts Homicidal thoughts</p>	<p><u>Emotions</u> <u>Mood</u> Sad Expressionless Pessimistic Tearful Helpless/hopeless Euphoric <u>Affect</u> Emotionless Blunted/flat/restricted Inappropriate Angry</p>
<p><u>Speech</u> Normal Pressured Singing Constant Poverty of content Slowed Mute Occasional</p>	<p><u>Unusual thoughts</u> Magical thinking Sexual preoccupation Bizarre thoughts Obsessions Excessive religious talk</p>	<p><u>Orientation</u> Place Time Person Situation <u>Cognitive functioning</u> Inability to concentrate Short term memory loss</p>
<p><u>Attitude</u> Withdrawn Evasive Passive eye contact Threatening Impulsive Aggressive Manipulative Demanding Distractible Overly dramatic Distrustful Accusing Entitled</p>	<p><u>Suspensions</u> Misinterpretation Delusions of persecution Delusions of reference Delusions of control Paranoid <u>Grandiose thoughts</u> Delusions of grandeur Inflated self-esteem Thought broadcasting Extraordinary abilities</p>	<p><u>Insight and Judgment</u> Poor insight Poor memory</p>

Handout 2-5 Mental Illness and Effective Communication

Psychiatric symptoms often interfere with communication. When an individual is experiencing an episode of mental illness it may be necessary to change your way of communicating.

Situation/ symptom	Do	Don't
If you suspect the person has mental illness:	Speak in a calm, patient, reassuring tone of voice. Be truthful. Maintain personal space, at least arm's length. Be helpful (what would make you feel safer/calmer, etc.?)	Don't shout or threaten. Don't stare at the person. It may be interpreted as a threat. Don't deceive the person. Don't touch the person unless taking him/her into custody. Only use your weapons as a last resort.
If the person is causing a disturbance:	Continually assess the situation for dangerousness. BUT, remember people with mental illness have rights to fair treatment just like anyone else.	Don't arrest the individual for behavioral manifestations of mental illness that are not criminal in nature.
Confusion about what is real, Belief in delusions or hallucinations.	Be simple and straight-forward. Respond to person's needs and apparent feelings.	Neither agree, nor disagree with delusional statements. Don't whisper, laugh or roll your eyes.
Difficulty in concentrating.	Be brief, repeat if needed.	Don't give long, complicated instructions.
Difficulty making decisions.	Give firm, clear directions.	Don't give open-ended or multiple choices.
Over-stimulation.	Limit input. The person may be responding to stimuli you are not aware of. Have one person talk to the individual if possible.	Don't force discussion.
Pre-occupation with internal world.	Get the person's attention before asking questions or giving instructions.	Don't assume the person is intentionally ignoring you.
Poor judgment.	Redirect person to other choices.	Don't try to reason with person. Don't expect rational discussion.
Agitation.	Recognize agitation. Try to allow person an exit, a way to save face. Continuously assess for danger.	Don't corner the person.
Fear/paranoia.	Speak and act in a calm manner. Keep communication clear and consistent. If possible, explain what you are going to do before you do it.	Don't challenge or threaten. Don't stare. It may seem threatening.
Fluctuating emotions.	Speak calmly and consistently.	Don't take words or actions personally.

Handout 2-6

Response: Crisis Communication

Instructions:

1. The instructor reads the client scenario.
2. Trainees suggest possible approaches to resolve the situation peacefully.
3. Role-play what you would say and do to get a desired response from the client.

Scenario 1: A 44-year-old male that is well known to law enforcement is causing a disturbance in a downtown shopping area by shouting obscenities at the air.

Scenario 2: A 28-year-old female is pulled over for driving 93 mile per hour on the interstate. She has been chased for 10 miles. When asked why she is going so fast she states that Oprah needs her.

Scenario 3: A 22-year-old male has barricaded himself in his parent's home (not his usual residence) and will not let anyone into the house. The parents report that he believes aliens are preparing to attack and he is responsible to defend the world. When law enforcement gains access to the residence, the young man does not make eye contact and does not respond to questions.

Scenario 4: A 35-year-old female is booked into the county jail on charges of criminal trespassing. During the intake process she responds to questions in nonsense sentence fragments.

Scenario 5: A 50-year-old male inmate is in a cell with six other inmates. In the middle of the night he springs out of his bed, apparently in a nightmare, and begins throwing things around the room. The safety of the other inmates is in jeopardy.

Scenario 6: A 20-year-old female inmate has refused meals for the past three days. The other inmates report that she says the food is poisoned.

Scenario 7: A 23-year-old male probationer on your caseload reports that he has been evicted from his apartment. When you attempt to find out why, he is unable to tell you and seems confused.

Scenario 8: A 25-year-old female probationer comes late to an appointment. She paces the office speaking very rapidly about several unrealistic projects. When asked if she has been fulfilling the terms of probation, she becomes very angry and states that you are not listening to her, that she is trying to tell you about getting back on her feet again.

Handout 2-7

Schizophrenia and Psychotic Disorders

Psychotic Disorders

Psychotic disorders are biologically-based mental disorders that cause a person to experience:

- Delusions, fixed false beliefs such as:
 - Unreasonable fears (paranoia);
 - Exaggerated sense of self-importance;
- Hallucinations, false sensations that cause the person to hear, see or feel things that are not perceived by others.

Delusions and hallucinations are symptoms of *psychosis*;

- A condition where malfunctions in the brain cause the person to be so overwhelmed by inner perceptions and thoughts that they lose contact with reality.

Schizophrenia

- Long-term, serious psychotic disorder,
- Biological origins,
- Causes impairment in self-care, social and job skills,
- Usual onset in early adulthood.

Symptoms (from the *DSM IV*³)

Positive Symptoms: Delusions;

Hallucinations;

Disorganized speech;

Grossly disorganized or catatonic behavior (odd movements);

Negative symptoms: Reduced expression of emotion;

Reduced speech and slowed thoughts; or

Difficulty with goal-directed activities.

Treatment

Medication:

Newer, atypical anti-psychotic drugs:

Much more effective, treat positive and negative symptoms,

Help the person think better, have more motivation,

Fewer troublesome side effects,

More expensive; generic only available for clozapine.

Older medications:

Treat only positive symptoms;

Side effects: non-compliance common due to discomfort;

Less expensive; generics available.

³ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Case management:

- Help getting needed treatment, rehabilitation services and resources such as income, housing, food, transportation, etc;
- Help getting to appointments;
- Help resolving social problems with family, neighbors, etc.;
- Early intervention to prevent hospitalization or incarceration.

Psychosocial rehabilitation:

- Supportive day program;
- Instruction in social and prevocational skills;
- Assistance obtaining employment, and on-the-job support;
- Assistance obtaining decent, affordable housing in the least restrictive environment.

Cognitive-behavioral therapy:

- Recognition of thought processes leading to problematic behaviors;
- Rehearsal of alternative strategies.

Supportive therapy:

- Empathy and problem-solving.

Schizoaffective Disorder

- Long-term, serious thought and mood disorder
- Symptoms of schizophrenia as well as mood swings or major depression
- Mood symptoms are present even when person is not actively psychotic
- Course and treatment are similar to schizophrenia, although prognosis is somewhat better.

Symptoms: (from the *DSM IV*⁴)

A period of illness during which there is a Major Depressive Episode, a Manic Episode, or a Mixed Episode *at the same time as:*

- (1) Delusions
- (2) Hallucinations
- (3) Disorganized speech (losing track, or not making sense)
- (4) Very disorganized or catatonic behavior
- (5) Negative symptoms (can't express emotion, less talk, low motivation)

During the same period of illness, there have also been delusions or hallucinations for at least two weeks *without* major mood symptoms. Symptoms of mood disorder are present during most of the period of illness, whether actively experiencing psychosis or not.

Substance-Induced Psychotic Disorder

Thought disorder produced by substance abuse. The person experiences psychotic symptoms of delusions (paranoia) or hallucinations that may or may not subside if substance use is stopped. Onset varies with type of substance used. It can occur in minutes if a high dose of cocaine is ingested, or it can take years. Substance induced psychosis may occur sooner and more intensely in persons prone to mental illness.

Treatment for substance-induced psychosis should integrate substance abuse treatment (detoxification, counseling and self-help group attendance) with treatment for psychotic disorders.

Handout 2-6
Schizophrenia and Psychotic Disorders

⁴ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-8

Depression

Depression involves intense sadness, lethargy and irritability or alternating moods of sadness and excitement that are out of proportion to the person's life situation. The moods must continue for more than two weeks to be considered a mental disorder,

- Not part of grief;
- Not short-term reaction to life event or situation;
- Interferes markedly with self-care, social interaction or employment.

Depression can be caused by biological factors such as heredity or physical illness, or by stress due to over-work, poverty or oppression. It is more common in women and the elderly, but recent studies show that up to 2.5 percent of children and up to 8.3 percent of adolescents in the U.S. suffer from depression.

Symptoms of Depression (*From DSM-IV⁵*)

Emotional symptoms:

- Sadness,
- Despair,
- Lack of ability to experience pleasure,
- In children depression may appear as irritability and sensitivity.

Physical symptoms:

- Slowed movements,
- Changes in eating habits,
- Changes in sleeping patterns,

Thought symptoms:

- Lack of interest,
- Lack of concentration,
- Intense and unrealistic thoughts of guilt,
- Suicidal thoughts or gestures;

Treatment

Anti-depressant medication

- There are several different types of anti-depressant medication;
- If one type does not work, another type will be prescribed.

Psychotherapy

- To resolve social stress;
- To distinguish realistic from unrealistic thoughts;
- To learn to think of self and others in a more positive light;
- To strategize life style changes.

Psychosocial rehabilitation

- To relearn job skills;
- To interact with others in a positive social environment.

⁵ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-9 Bipolar Disorder

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Formerly known as manic depression, bipolar disorder is a biologically-based, often hereditary mental illness. Moods swing from an intense high of excitement, irritability and inflated sense of self-importance, to intense lows of sadness, hopelessness and lack of energy. At least two million Americans (1.6% of the population) have bipolar disorder with average onset in early adulthood. Bipolar disorder can vary from mild to severe and can involve only a few episodes of mania, alternating mania and depression, or mood swings associated with seasons.

Symptoms of Mania (*From DSM-IV⁶*)

Abnormally excited or irritable mood lasting at least 1 week, and:

Inflated sense of self-importance;

Decreased need for sleep;

Pressure of speech;

Flight of ideas;

Distractibility;

Involvement in many goal-directed activities;

Poor judgment;

Excessive involvement in pleasurable activities with a high risk of painful consequences.

Treatment

Medication:

Mood stabilizers: lithium, a salt found naturally in the environment

Anti-convulsant medications that are also used for seizure disorders like epilepsy.

Full-spectrum light:

For Seasonal Affective Disorder. In addition to getting enough exposure to daylight, full spectrum light fixtures help the person absorb a sufficient amount of light.

Individual Counseling/therapy:

Help resolving social problems caused by mood swings. Counseling does not address the underlying biological cause of the illness, but can help the person develop healthy self-esteem and strategies for coping with problems caused by behavior during mood swings.

Case management:

Help with income, housing, basic needs, medications.

Psychosocial Rehabilitation:

Help regaining social and employment skills.

⁶ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-10

Panic Attack

A panic attack is a severe episode of anxiety involving intense fear and physical symptoms. Physical symptoms often mimic a heart attack or other life-threatening condition. An individual who has experienced repeated panic attacks, called “panic disorder,” often develops intense anxiety between episodes, avoiding situations where they believe another panic attack may occur or where help would not be immediately available. Panic disorder affects an estimated 1.6% of American adults ages 18 to 54 and usually develops in early adulthood. Panic attacks can be associated with anxiety disorders, mood disorders, psychotic disorders or substance abuse.

Symptoms of Panic Attack (*From DSM-IV⁷*)

Discrete period of intense fear or discomfort in the absence of real danger, and Physical symptoms:

- Rapid or irregular heartbeat;
- Sweating;
- Trembling or shaking;
- Shortness of breath;
- Feeling of choking;
- Chest pain;
- Nausea or abdominal discomfort;
- Dizziness;
- Chills or hot flashes.

Thoughts:

- Sense of depersonalization, being outside of oneself;
- Feeling of “going crazy”;
- Fear of dying.

Treatment

Medications (short-term):

- SSRI antidepressant medication,
- Benzodiazepine anti-anxiety medication.

Cognitive-Behavioral Therapy:

Goals:

- To identify and challenge thoughts/assumptions contributing to anxiety;
- To resolve fears; and
- To develop lifestyle changes that will reduce stress and anxiety.

⁷ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-11

Posttraumatic Stress Disorder, PTSD

Individuals with PTSD may have experienced a single, traumatic event such as a natural disaster, fire, airline accident or rape, or may have been subject to ongoing, overwhelming suffering such as child abuse, domestic abuse, war or political oppression. The individual has intense feelings (to the point of hallucination) of reliving a traumatic event, is easily startled, may have insomnia, or inability to remember event accompanied by a feeling of numbness, disconnected from others, no future, a “loner”.

Symptoms of PTSD (From DSM-IV⁸)

The traumatic event is re-lived in one or more of the following ways:

- Upsetting memories or dreams of the event that keep coming back;
- Acting or feeling as if the event were happening again;
- Feeling upset or panic reaction (sweating, pounding heart) when reminded of event.

Avoiding things that remind the person of the trauma and being less able to respond than before the trauma, shown by at least three of the following:

- Avoiding thoughts, feelings or activities that remind them of the trauma;
- Feeling separated from others, less interest in important activities;
- Sense of a limited future, not expecting to have a career, marriage, etc.

Ongoing symptoms of increased excitement such as:

- Difficulty falling or staying asleep;
- Irritability or outbursts of anger;
- Difficulty concentrating;
- Extremely wary and watchful.

Treatment

Psychotherapy:

- To bring events and dysfunctional responses to conscious thought;
- To process the fear and horror, and develop coping mechanisms.

Eye Movement Desensitization and Reprocessing (EMDR):

- A type of therapy in which the therapist helps the client produce rhythmic eye movements to help the brain reprocess information and resolve traumatic thoughts.

Medication:

- Short-term anti-depressant or anti-anxiety medication,

Support groups or group therapy:

- To reduce sense of being alone,
- To work through trauma;
- To develop strategies for recovery.

⁸ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-12

Obsessive Compulsive Disorder, OCD

Obsessive Compulsive Disorder (OCD) is thought to be the most disabling anxiety disorder. Biological and possible hereditary in nature, symptoms interfere with basic daily activities. The person with OCD becomes trapped in a cycle of obsessions and compulsions spending at least one hour per day going over and over an upsetting, unwanted thought (obsession) and/or doing something to prevent what is feared (compulsion). OCD affects about 2% of the population, with age of onset from early childhood to adolescence.

Symptoms of Obsessive Compulsive Disorders (From DSM-IV⁹)

Obsessions:

- Persistent thoughts, impulses or images that are experienced as unwanted and inappropriate, and cause distress and anxiety;
- Not simply excessive worries about real-life problems;
- The person attempts to ignore the thoughts or neutralize them with some other thought or action;
- The person recognizes that the thoughts are a product of his/her own mind, not imposed from without.

Compulsions:

- Repetitive behaviors (hand-washing, checking, counting) that the person feels driven to perform in response to an obsession and according to rigid rules,
- Behaviors are aimed at preventing distress or some dreaded event, but the acts are not connected with the goal in a realistic way, or are excessive.

Treatment for Obsessive Compulsive Disorder

Medication:

Antidepressant medication

Behavioral therapy, Exposure and Response Prevention:

The goal is to learn to explore obsessions rather than avoiding them, and To develop less disruptive array of responses.

⁹ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-13a

Personality Disorder

Personality disorders are groups of personality “traits” resulting in ongoing, troublesome patterns of thought, feeling and behavior. To be considered a personality disorder, these patterns must cause major problems in self-care, social relationships, work or school. Personality disorders usually become apparent in late adolescence or early adulthood and continue throughout life unless treated. Personality disorders are usually associated with a difficult childhood or early environment. Women tend more toward dependent, borderline traits while men tend more toward aggressive, antisocial traits.

Borderline Personality Disorder

Individuals with borderline personality disorder tend to look upon themselves and others as “all good” or “all bad”. Because of that they have a pattern of unstable relationships, poor self-image, emotional ups and downs, and impulsive behavior. They make frantic efforts to avoid being abandoned or rejected. Borderline personality disorder is most common among young women, affecting about 2% of the general population.

Behaviors Associated with Borderline Personality Disorders (*From DSM-IV¹⁰*)

- Frantic efforts to avoid abandonment;
- Unstable, intense relationships;
- Unstable self-image;
- Impulsive and self-damaging behavior;
- Recurrent suicidal behavior or self-mutilation;
- Unstable moods;
- Chronic feelings of emptiness;
- Intense, inappropriate anger;
- Paranoia when under stress.

Treatment for Borderline Personality Disorder

Counseling/Psychotherapy:

Goals: To gain insight into life situations that produced dysfunctional patterns, and
To develop healthy adult patterns of thought, feeling and behavior.

Often involves setting limits on expectations between the client and authority figures.

Medication:

Short-term only: anti-anxiety or anti-depressant medication to reduce distress during periods of change.

Psychosocial Rehabilitation:

To develop patterns of healthy social interaction in a supervised setting.

¹⁰ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-13b Personality Disorder

Antisocial Personality Disorder

Individuals with antisocial personality disorder display a consistent pattern of disregard for and violation of the rights of others. This pattern begins in childhood (see oppositional and conduct disorders) and continues into adulthood, although the diagnosis is only given to individuals who are at least 18 years of age. This pattern is also called psychopathy or sociopathy.

Behaviors Associated with Antisocial Personality Disorder (*From DSM-IV¹¹*)

There is a pervasive pattern of disregard for and violation of the rights of others:

- Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest;
- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure;
- Impulsivity or failure to plan ahead;
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults;
- Reckless disregard for safety of self or others;
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations;
- Lack of remorse, as indicated by being indifferent or rationalizing having hurt, mistreated, or stolen from another.

Treatment

Forensic residential treatment:

Usually in a prison setting, the individual must earn privileges by demonstrating motivation to change, impulse control, consideration for others, and conformity to expected conduct.

Self-help groups:

Peer influence has been effective in creating motivation for change.

Family therapy:

To help family members understand and cope with the individual's behaviors.

Medication is not helpful in treatment of antisocial personality disorder.

¹¹ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-14

Childhood Behavior Disorders

Oppositional Defiant Disorder

Oppositional defiant disorder is a childhood behavioral disorder involving ongoing patterns of defiant attitudes; and disobedient, hostile behavior toward authority figures. Serious marital discord, parental mood disorders, and parental substance abuse are common in families of children with this disorder. The diagnosis is not usually made before the age of 8 or after the onset of adolescence.

Behaviors Associated with Oppositional Defiant Disorder (From DSM-IV¹²)

- Often loses temper;
- Often argues with adults;
- Often refuses to comply with rules or adults' requests;
- Often deliberately annoys people;
- Easily annoyed by others;
- Often blames others for his or her mistakes or behavior;
- Often spiteful and vindictive.

Conduct Disorder

Conduct disorder is a childhood behavioral disorder consisting of a persistent pattern of violating the rights of others or basic age-appropriate societal norms or rules. Estimated at 1% - 10% of the population, conduct disorder has increased over the last decades perhaps due to higher populations in urban settings. Research shows that conduct disorder has both genetic and environmental influences. It is often preceded by oppositional defiant disorder. Conduct disorder usually remits by adulthood, but may develop into antisocial personality disorder.

Behaviors Associated with Conduct Disorder (From DSM-IV¹³)

- Aggression to people and animals;
- Destruction of property;
- Deceitfulness or theft; and
- Serious violations of rules.

Treatment for Childhood Behavior Disorders

Parent Training: Parents learn methods of effective parenting and discipline

Residential Programs: Treatment residence where children live and learn social skills

School Based Interventions: Mental health providers advise teachers, and provide individual or group counseling to children.

Interpersonal and Skills Training: Mental health providers teach children how get along with others.

Medication: May be prescribed for a child with underlying depression or anxiety disorder.

Wilderness Program: Highly structured, rural setting where children learn new attitudes, behaviors and skills.

¹² American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

¹³ Ibid.

Handout 2-15

Dementia and Alzheimer's Disease

Dementia

Dementias are mental disorders that are more common later in life, and involve the loss of the ability to think and remember. Despite popular misconceptions, dementias are not inevitable, and strike less than 15% of those over the age of 65. Alzheimer's disease is the best-known type of dementia but vascular disease, HIV, head trauma and Parkinson's disease can all lead to dementia.

Alzheimer's Disease

Alzheimer's disease is a biological dementia that strikes most typically after age 65. It is possibly genetic, but may be triggered by other diseases or environmental toxins. The person gradually loses memory and the ability to think and respond to the environment, eventually becoming mute and bedridden. At some stages of the disease, individuals may develop paranoia and bizarre behaviors, and could cause enough disturbance to come to the attention of law enforcement.

Symptoms and Behaviors of Alzheimer's Disease (From DSM-IV¹⁴)

Symptoms

- Memory loss;
- Trouble speaking;
- Trouble moving around;
- Difficulty recognizing objects;
- Inability to plan and organize.

As condition worsens:

- Psychosis;
- Depression;
- Agitation.

Behavioral problems:

- Wandering;
- Insomnia;
- Incontinence;
- Verbal or physical outbursts;
- Sexual disorders;
- Weight loss.

Treatment

Medications: Anti-depressants

Anti-psychotic medications

Memory training: (for early stages)

Day treatment, caregiver respite:

Offers structured activities and meals to affected person(s);

Caregivers receive respite from stress of constant care;

Helps prolong individual's ability to live at home.

¹⁴ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-16

Malingering

Malingering is not a mental illness. It is behavior that involves intentionally feigning physical or psychological symptoms, motivated by external incentives such as evading criminal prosecution, avoiding military duty, avoiding work, obtaining financial compensation, or obtaining drugs.

Malingering should be strongly suspected if:

- There is a marked discrepancy between the person's claimed distress or disability and the objective findings;
- Treatment providers report a lack of cooperation during diagnostic evaluation;
- There is lack of cooperation in complying with prescribed treatment regimen;
- The person has antisocial personality disorder.

Malingering is common among jail and prison inmates, but remains controversial.

- On one hand, malingering often goes undetected because staff do not adequately question inmates when they complain of symptoms such as "hearing voices, seeing things, or feeling suicidal".
- On the other hand, when an inmate is suspected of malingering, correctional officers are likely to dismiss threats of suicide or requests for help. All too often, the result is tragic.

Training correctional health care staff to recognize legitimate psychiatric or physical conditions can save inmate's lives while also reducing safety risks and costs due to unnecessary treatment and inappropriate use of psychiatric medication.

There are several effective approaches to detecting malingering:

- Do not automatically assume that prior psychiatric diagnoses are valid. If malingering is suspected, refer inmate for a psychiatric evaluation.
- Train correctional officers and medical staff to recognize signs and symptoms of mental illness. When an inmate complains of psychiatric symptoms, but is suspected of malingering, observe the inmate closely for 24-72 hours to see if the inmate's behaviors are consistent with alleged symptoms. Document observations. For instance, if an inmate complains of depression, but is observed talking animatedly with friends, it is likely that he is malingering.
- If uncertainty remains, submit documentation to a psychiatric professional for review.
- Malingering is often linked with drug-seeking. To determine if the inmate is attempting to obtain prescriptions for inappropriate use, inquire with the inmate's community service providers about prior substance abuse, or substance abuse treatment. The inmate will need to sign information releases to give facility staff permission to talk with his/her mental health or substance abuse providers.
- It is also helpful to corroborate details of the inmate's psychiatric history with the inmate's relatives. If the inmate's version of events leading up to psychiatric symptoms is not verified by kin, malingering should be suspected.
- To reduce misuse of psychiatric medication on a facility-wide basis, it may be cost effective to contract with a psychiatrist with expertise in addictions to conduct psychiatric examinations and substance abuse assessments.
- Behaviors associated with psychiatric symptoms differ across cultures. When malingering is suspected it is important to have observations and evaluations conducted by a professional from the inmate's culture, or one who knows the culture.

Caution: Assume psychiatric symptoms are valid unless there is convincing evidence of malingering.

Handout 2-17
Crossword Quiz: Mental Health and Mental Illness

2.						3.			4.					
		5.		2.										
									6.					
4.														
									6.					
											1.			
				1.										
			5.											
						3.								

Clues

Across:

1. A sign of mental health.
2. Mental illness disrupts thinking, feeling and _____.
3. 1999 national statistic on the percentage of jail inmates with a diagnosis of mental illness. _____%
4. A positive symptom of schizophrenia.
5. Episode of mental illness often mistaken for a heart attack.
6. If an individual displays this emotion, you should speak and act calmly.

Down:

1. A US president who had mental illness.
2. The greatest danger in depression.
3. A serious, biologically-based mental illness.
4. When communicating with an individual who appears to have difficulty concentrating, your messages should be _____.
5. Common social situation for individuals with PTSD.
6. A symptom of depression is a sense of excessive _____.

Handout 2-17

Answers to Crossword Quiz: Mental Health and Mental Illness

2. S						3. S			4. B					
U						C			R					
I		5. I		2. B	E	H	A	V	I	O	R			
C		S				I			E					
I		O				Z			6. F	E	A	R		
4. D	E	L	U	S	I	O	N							
E		A				P								
		T				H			6. G					
		I				R			U		1. L			
		O		1. F	L	E	X	I	B	I	L	I	T	Y
		N				N					L		N	
			5. P	A	N	I	C				T		C	
						A							O	
													L	
						3. S	I	X	T	E	E	N		

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5. Common social situation for individuals with PTSD.
6. A symptom of depression is a sense of excessive _____.

Raffle Tickets

<p># _____</p> <p style="text-align: center;">GOOD POINT!</p> <p style="text-align: center;">This ticket entitles the bearer to a chance at the FABULOUS PRIZES awarded for participation in the mental health/criminal justice training program.</p> <p style="text-align: center;">YOU MUST BE PRESENT TO WIN!</p>	<p># _____</p> <p style="text-align: center;">GOOD POINT!</p> <p style="text-align: center;">This ticket entitles the bearer to a chance at the FABULOUS PRIZES awarded for participation in the mental health/criminal justice training program.</p> <p style="text-align: center;">YOU MUST BE PRESENT TO WIN!</p>
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