TCHP Education Consortium

Introduction to Psychiatry

Part of the Foundations of Psychiatry Independent Learning Program

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Introduction/Purpose Statement

Staff who are entering into the psychiatric care setting need to have all kinds of information so that they can deliver optimal care without falling into the pitfalls that may loom before them. The Foundations of Psychiatric Care home study series was developed by expert staff from Hennepin County Medical Center, the Minneapolis VA Medical Center, and Regions Hospital to get this information out in an easy-to-read, practical, and relevant manner. This program is divided into four sections: I) Introduction; II) Patient Care; III) Safety; and IV) Interventions. The purpose of the *Introduction to Psychiatric Care* module (this home study) is to give you an overview of the major theories/frameworks of psychiatric care, psychopathology, and legal aspects of care.

Target Audience

We developed this program to provide the information necessary to care for the psychiatric client. The sections were written for the person who has not worked in psychiatry before; however, more experienced psychiatry staff may find the information useful and interesting.

The sections in this module are applicable to all health care workers.

Content Objectives

1. Review prominent theories and models related to mental health.
2. Differentiate between the models related to assessment, diagnosis, and interventional approach to the psychiatric patient.
3. Describe the current theories about the etiologies of mental illness.
4. Review the multi-axis diagnostic system of the DSM IV TR.
5. Review the characteristics of the major psychiatric disorders.
6. Describe the procedures for voluntary admission and treatment for the mentally ill person.
7. Describe the indications, procedure, and duration of involuntary holds.
8. Identify the role of each member of the multi-disciplinary team in regard to involuntary holds and the commitment process.
9. Review the civil commitment process.
10. Review patient rights in regards to psychiatry.

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Thinking About the Mind and Emotion

Introduction

Juanita Johnson is a 54 year old woman with obsessive-compulsive disorder. She enters the mental health care system at the insistence of her family. Mrs. Johnson has reportedly been washing her hands for 45 minutes out of each hour. Her hands are swollen, chapped, and bleeding.

There are many theories that attempt to explain why some people's behavior is different than the norm. In this section, we will look at some of the different models of psychiatry and the prominent nursing theorist's approaches and investigate how these theories might be used in the clinical setting.

Theoretical Models of Psychiatry

Psychoanalytical Model

If Dr. Sigmund Freud were to meet with Mrs. Johnson, he would probably investigate what her childhood was like and what her relationship with her parents was. Best known for his radical view of sexuality during the puritan Victorian era, Freud believed that all disrupted behavior in adults could be traced back to problems in their earlier developmental stages. He said that neurotic behavior arises when so much energy is used to deal with anxiety related to a certain developmental stage that there is no energy left to deal with functioning.

Dr. Freud may have traced Mrs. Johnson's current behavior to early childhood, when she was told that she was "dirty" after soiling a diaper. Her constant hand-washing was a symbol of her attempts to become "clean," thereby decreasing her anxiety about being "dirty."

The therapist becomes a "shadow" figure, listening and prompting gently to allow the patient to reconstruct his/her personality through free association and dream analysis. The therapist assists the patient in recognizing conflict by analyzing what is said and what is not said in verbal and non-verbal communication and dreams. The psychoanalyst may see a patient five times a week for several years. The practice of this model is rare in the inpatient setting; however, patients who see a psychoanalytical therapist may enter the hospital when an exacerbation of their illness occurs.

Interpersonal Model

According to Harry Stack Sullivan, all behavior revolves around interpersonal (social) relationships and is associated by two complex drives:

- The need for satisfaction of basic human drives (sleep, hunger, lust, and loneliness).
- The need for security as derived from culturally defined needs and norms.

In this model, Mrs. Johnson might be viewed as being stressed from trying to keep the house clean in the manner to which her family has become accustomed. This stress led to anxiety, resulting in the symptom of the compulsive hand-washing.

The interpersonal therapist would work with Mrs. Johnson on establishing trust and security. The patient would be encouraged to share her stresses and anxieties with the therapist, who would be empathetic and involved. The therapist would use the trusting relationship to build corrective interpersonal experiences.

Social Model

In this model, Mrs. Johnson's social environment and history would be looked at. Thomas Szasz and Gerald Caplan believed that social and environmental factors caused stress, resulting in anxiety and symptom formation.

For social therapists, finding that Mrs. Johnson lived in poverty and was routinely abused by her husband and grown sons would be of paramount importance. Mrs. Johnson had a decreased ability

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to deal with stress and had few environmental supports. Her only means of coping, compulsive hand-washing, was pathological.

Szasz and Caplan differed greatly in their philosophical approach to diagnosis and treatment. Caplan believed that primary prevention in the social setting was the key to limiting the initiation or severity of the mental illness. Szasz believed that "mental illness" was a term given to individuals who did not conform to societal standards. He believed that a person has control over whether to conform or not to conform to social expectations, and that treatment of any form not initiated by the person was coercion.

Many "social" programs are aimed at reducing poverty, increasing family stability, increasing education, and decreasing other environmental problems which lead to a decreased coping ability.

Existentialist Model

There are many different processes that sprout off of the existentialist model; however, the main theory is that behavioral deviations occur when the person is not in touch with himself or his environment. The person is not able to choose freely among alternatives because of restrictions or inhibitions which he has placed on himself.

Rationale-emotive therapy: The patient is encouraged to become more responsible for his behavior by the use of confrontation. This therapy encourages risk and trying out new behavior. (Albert Ellis)

Logotherapy: The patient works toward understanding the meaning (logos) of his life, in order to take control of his life and responsibility for his actions. (Viktor Frankl)

Reality therapy: Focusing on behavior, rather than on feelings, the patient is helped to recognize his own goals and how he has put roadblocks in the way of meeting his goals. The need for identity is reached by loving, feeling worthwhile and acting responsibly (William Glasser).

Gestalt therapy: The present is emphasized by helping the patient to identify feelings and increase self-awareness. Self-acceptance is the goal in increasing self-awareness. (Frederick Perls)

Encounter Group: William Schutz and Carl Rogers began a series of group interactions in which group members discussed feelings, rather than actions, and emphasized responsibility. The members were encouraged to share their thoughts honestly and openly, increasing self-awareness.

In a melding of some of the existential therapies, Mrs. Johnson might be encouraged to reflect on her life to achieve self-awareness, to set reasonable goals, and to develop a greater sense of responsibility for her own actions.

Communication Model

Behavioral deviations are caused by failure to communicate, unclear communication, or incongruence between verbal and non-verbal messages, according to communication theorists.

Therapists working with the communication model may observe Mrs. Johnson in various interactions, such as with her husband, son, or mother, to analyze communication patterns.

Family therapy often uses this model. The therapist acts as an interpreter with the patient and others and as a stimulus to improve communication with others. The term "game playing" was developed in this model. Game playing refers to a mode of communication in which there was a "payoff" for the individuals involved in the "game."

In direct observation of the communication between Mrs. Johnson and her husband, the therapist noted that Mr. Johnson was "game-playing." The therapist played back the videotape with their conversation.

Him: "Sometimes I just need some time to be by myself, and you never let me be alone." (the bait)

Her: "I know that you need some free time sometimes; but every time I encourage you to go off and do something by yourself, you get mad."

Him: "Well, why shouldn't I get mad? You're supposed to be my wife; you're supposed to want to be around me." (the switch)

Her: "I don't know what I'm supposed to do; am I supposed to be around all of the time, or am I supposed to let you have some free time?"

Behavioral Model

Based on the idea that behavioral deviations are actions that are learned, the behavioral model focuses on changing the behavior to a more socially acceptable form. Pavlov began the investigation into this model when he studied the learned behavior of dogs in response to the ringing of a bell. He found that if he rang a bell at the same time that the dog would be fed, the dog would salivate. When he began to ring the bell **without** giving the dog food, the dog would salivate anyway.

The behaviorist, as described by Wolpe, B.F. Skinner, and H.J. Eysenck, would use negative reinforcement to discourage the "bad" behavior and positive reinforcement to encourage the "good" behavior. This type of therapy may include systematic desensitization or the relaxation technique, assertiveness training, and behavior therapy with a token system.

According to the behavioral model, Mrs. Johnson may be put on a behavior modification program, in which she would accrue tokens for a desired goal (such as a walk outside, visits from family, or special food) when she did not wash her hands for a certain length of time; she would lose tokens for failing to go that length of time.

Medical Model

The medical model is used as a basis for assessment and intervention in modern psychiatry. Although often used in conjunction with therapeutic interactions from the other models, the medical model places its emphasis on diagnosis of the illness and treatment based on that diagnosis. Treatment with somatic interventions, such as medications, electroconvulsive therapy, and psychosurgery, is based on the concept that the etiology and symptoms of mental illness have (at least in part) a biological base.

Mrs. Johnson was diagnosed with obsessive compulsive disorder. She may be placed on medications which would boost her level of serotonin (a neurochemical implicated in OCD). She may also be placed in therapy based on the behavioral model to try to change her behavior to one that is more healthy.

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Theoretical Approach

While the theoretical models of psychiatry are important for understanding the goals and methods of therapy, some time should be spent on the role of the clinical practitioner in the day to day interaction with the client. Prominent nursing theorists have developed practice oriented approaches to the relationship with the nurse and the client.

Interpersonal Theory

This framework is similar to the Interpersonal Model developed by Sullivan. According to Peplau, the nurse communicates with the client during the four phases of the therapeutic relationship:

1. **Orientation:** in this phase, the nurse works with the client in establishing a working relationship. The nurse assesses the client for themes that emerge related to problem areas and for the possible need for referrals. This is the "ground rule" setting phase.

   Fran S., a mental health nurse, meets Mrs. Johnson on a one-to-one basis. Ms. S. assesses the physical, emotional, intellectual, and social dimensions of Mrs. Johnson. Ms. S. tells Mrs. Johnson that all conversations between them will be confidential, unless Mrs. Johnson shows Mrs. S. that she may harm herself. Ms. S. shows Mrs. Johnson that she can be trusted to listen openly and without judgments.

   Ms. S. finds that Mrs. Johnson is very hesitant to bring up any potentially hurtful thoughts, especially in relation to her family. Mrs. Johnson says that she has always been the "one to give in" and will not "get into a fight with anyone."

2. **Identification:** during this phase, the nurse works with the client to clarify the client's perceptions of her surroundings/environment; her problems; and her relationships with the staff. Both the nurse and the client work toward a more clear understanding of the client's problems, and discuss possible solutions to the problems.

   Mrs. Johnson has developed a clearer understanding of why she is in the hospital and what her problems are. Ms. S. and Mrs. Johnson continue to talk about Mrs. Johnson's relationships, both in and out of the hospital. Ms. S. tells Mrs. Johnson that she is worried that Mrs. Johnson is becoming dependent on her; the two discuss the matter in depth. Together, they develop a preliminary plan in which Mrs. Johnson can become more independent and more assertive.

3. **Exploitation**: the nurse continues to work on developing a non-threatening environment for the client, in which the nurse listens, accepts, clarifies, and interprets what the client is saying or demonstrating. During this phase, the nurse and the client must look for and work out conscious or unconscious conflicts between them. The client is encouraged to become involved in problem solving.

   Mrs. Johnson feels comfortable with Ms S. to the point that Mrs. Johnson comes to talk about her last visit with her family voluntarily. She expresses anger at their impatience with her progress; she feels that they are not being supportive of her efforts. When Ms. S. explores her anger, Mrs. Johnson becomes angry at Ms. S. With further discussion, they determine that Ms. S. reminds Mrs. Johnson of an older sister, who seemed to listen in the same way, but would then go to their mother and tell her what Mrs. Johnson had said. Mrs. Johnson is encouraged to continue to be assertive in voicing her feelings to Ms. S.; they agree to work on sharing Mrs. Johnson's feelings with her family.

4. **Resolution**: in this last stage, the nurse works with the client in assessing whether the goals of the client have been met through the work that was done. The relationship is terminated, with an eye toward using the bond that was developed between the nurse and the client to move onto other fulfilling relationships.

   Through multi-disciplinary therapies, Mrs. Johnson is exhibiting much less compulsive hand-washing behaviors. She has demonstrated assertiveness and sharing of feelings with staff, and to a lesser extent, with her family, on a fairly consistent basis. The decision to move Mrs. Johnson into an outpatient setting is made. Ms. S. discusses the changes in therapy with Mrs. Johnson, expressing her own feelings about terminating the relationship, as well as listening to Mrs. Johnson's fears and hopes for moving on to better mental health.

The roles that the nurse may assume include those of: counselor; resource; leader; surrogate; teacher; technical expert. This model is most frequently used as a basis for nursing practice in in-patient psychiatry settings.

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Orem's Self Care Model

Dorothea Orem developed her theory in 1959 with the main concepts of "self-care" and "nursing systems." To Dr. Orem, all people have certain needs:

- **Universal needs:** breathing, eating, activity, rest, socialization, and safety from harm.
- **Developmental needs:** various stages of growth and development.
- **Health deviation needs:** diagnosis and treatment of defects and aberrations, such as seeking health care, following through with the plan of care, and dealing with the long-term effects of the aberrations.

With growth and development, most people are able to take care of their own needs, leading to "self-care." For example, a suicidal patient is not meeting her elemental need for safety from harm. Another example is the severely depressed patient who fails to eat or socialize with others.

A self-care deficit comes about when the compensatory process that the client uses is ineffective. Self-care deficits are influenced by the client's orientation, skills in coping, knowledge of the problem, and motivation to take responsibility for their deficits.

The "nursing system" is the practical approach that the nurse takes to help the patient develop mechanisms for self-care. Although the nurse may care for those elemental needs of the patient for a time, the emphasis in this model is to assist the person in taking responsibility for her own care.

According to this theory, Mrs. Johnson was experiencing a self-care deficit on several levels: universal and health deviation. She was neglecting key components of the universal needs, such as eating and protecting herself from harm. She was also not meeting her health deviation needs: she did not seek health care until forced to by her family.

The staff caring for Mrs. Johnson would encourage her to look at her behavior and accept responsibility for her behavior. Measures would be taken to enhance her motivation (possibly through behavioral management), and she would receive education appropriate to her mental status and education level that would help her to deal with her self-care deficit.

Goal Attainment Theory

This theory, first introduced by Imogene King in the early 1960's, describes a dynamic, interpersonal relationship in which a person grows and develops to attain certain life goals. Interaction with other people, the perceptions which the person holds and understands, and communication with other people are the primary ways in which the person can grow to meet his or her goals. Factors which influence the attainment of goals are the **ROLES** of the person and the people with whom he interacts, the amount and quality of **STRESS** placed on the individual, and the **SPACE** and **TIME** in which the growth takes place.

In practice, the psychiatric nurse would assist the client in recognizing what his long-term and short-term goals are. The nurse would assess the client in the client's interactions with others, perceptions held by the client in terms of himself, others, and the environment, and the client's method of communication.

Communication is encouraged between the nurse and client in a "give-and-take" way; the relationship is based on open, honest, and mutual communication.

The compulsive hand-washing that Mrs. Johnson exhibits may be related to her perception of herself, influenced by her role and the stress in her life. This behavior prevents her from reaching her goals. The staff working with Mrs. Johnson would have open discussions with Mrs. Johnson to work on goal development and attainment.

Behavioral Systems Theory

The notion that all people respond to the environment in behaviors that are based on their goals, choices, and predisposition to act (set) is the basis of Dorothy Johnson's 1968 framework.

There are seven subsets in the environmental system, each with specific goals:

Affiliative:	security
Dependence:	independence and inter-dependence with others
Achievement:	goals related to self and others accomplished in an internally mandated way
Ingestive:	adequate consumption of nutrition in socially acceptable ways
Eliminative:	adequate elimination of wastes in socially acceptable ways
Sexual:	gratification and procreation
Aggressive-protective:	survival

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The health care professional would assess the client's environmental subsystems to find what need(s) are not being met. Behavior is based on met and unmet needs as determined by the person's goals and choices.

The nurse assessing Mrs. Johnson finds that Mrs. Johnson's affiliative and achievement needs have not been met. Mrs. Johnson had always wanted to go to college and become a teacher; she felt insecure knowing that if something happened to her husband, she would have no way to make a living. The nurse would help Mrs. Johnson develop new, realistic goals to meet her needs, and would work with her on acting to achieve those goals.

Adaptation Theory

Sister Callista Roy believed that people are under constant bombardment from the environment in the form of focal, contextual, and residual stimuli. **Focal stimuli** are those things that the person perceives and needs to deal with immediately. For example, touching a hot stove with a finger will normally cause a person to quickly withdraw her finger. **Contextual stimuli** achieve importance in the prioritization of behavior with the context in which that information can be placed. An example of contextual stimuli is hearing the voice of a family member in the midst of a crowd -- that voice "sticks" out in importance against all other stimuli. **Residual stimuli** come from a person's belief system, values, attitudes, and past experiences.

Everyone needs to deal with environmental stimuli on a constant basis through adaptation. There are two main adaptive mechanisms: the regulator system, which controls neural and endocrine body responses; and the cognator, which handles information processing, learning, and decision making.

The person has problems if she is not able to use her normal adaptive mechanisms to counter the environmental stimuli. Additional modes are needed to help the person cope. The modes that can be used are: physiological, self-concept, role function, and interdependence. Adaptation through these modes is said to be either positive or negative.

Mrs. Johnson experienced environmental stimuli in all three forms and was unable to cope using normal adaptive mechanisms. She began utilizing a physiological adaptive mode (compulsive hand-washing) to deal with her stress. This would be called a negative adaptation.

Conclusion

Over the years, many theories have been developed to explain the causes, effects, assessment, and treatment of the mentally ill patient. These theoretical models can assist the practitioner in developing a treatment plan that will assist the client in becoming as independent and mentally healthy as possible. The enormous contributions of the nursing theorists give clinical practitioners a practical and sound foundation on which to base care within and outside of the hospital setting.

Applying What You've Learned...

In order to apply the information from this section, you are encouraged discuss the model that is used in your clinical setting; for example, does your unit use the format of Peplau's interactional model?

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Psychopathology

Causes of Mental Illness

What causes mental illness? Unlike many physical illnesses, the causes of mental illness are probably multi-dimensional. Current research suggests it is a combination of biological, psychological and environmental factors.

Biological

Some mental illnesses are believed to be the result of faulty neurological connections or neurotransmitters which are out of balance. The symptoms of mental illness that results are a consequence of the messages not being transmitted properly.

Genetics may also play a role in which neurological and psychological traits from one generation are transferred to the next generation through genetic DNA transmission.

Other causes may include infections, brain injury or defects and prenatal damage.

Psychological

Some mental illnesses may be caused by psychological trauma suffered as a child, such as severe emotional, physical or sexual abuse. An important early loss, such as the loss of a parent or neglect may also be a contributing factor.

Environmental

Certain stressors including a death or divorce, a dysfunctional family life, changing jobs or schools and substance abuse may trigger a development of progression of mental illness.

Assessing & Diagnosing Mental Illness: The DSM-IV TR

The Diagnostic and Statistical Manual of Mental Disorders (DSM) was developed in 1952 to describe the clinical features of the mental illnesses using a five-axis, medical model approach. In 2000, the DSM-IV TR (Text Revision) was first published.

The DSM-IV TR is a manual commonly found on psychiatry units. Physicians use the five-axis approach to document a thorough assessment and diagnosis of the psychiatry client.

The purpose of the DSM is to provide clear descriptions of diagnostic categories so mental health professionals can diagnose, communicate about, study, and treat people with various mental disorders.

A DSM diagnosis usually describes the current presentation and typically is not used to describe past diagnoses from which the person has recovered.

Which Psychiatric Disorder is it?

Each "axis" represents a separate diagnostic section.

Axis I includes the major psychiatric disorders:

- Delirium, dementia, amnestic and other cognitive disorders
- Substance related disorder
- Schizophrenia and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Sexual and gender identity disorders
- Eating disorders
- Sleeping disorders
- Impulse-control disorders
- Adjustment disorders

The cause of some of these disorders is not currently known.

Axis II lists disorders that are either related to personality or **mental retardation**. The personality disorders include:

Cluster A (odd or eccentric)
- Paranoid
- Schizoid
- Schizotypal

Cluster B (dramatic, emotional, erratic)
- Borderline
- Narcissistic
- Histrionic
- Antisocial

Cluster C (anxious or fearful)
- Avoidant
- Dependent
- Obsessive-compulsive

Axis III assesses for general medical problems that the client may have that either directly or indirectly influence

their mental illness. The general medical problems are separated into different categories

Axis IV assessment relates to the social aspects of a client's life, and specifies problems related to the client's social, environmental, and economic status.

Finally, ***Axis V*** is a global assessment tool that assigns a "score" to the patient. The "score" is based on the Global Assessment of Functioning (GAF) scale. The scale is 1 to 100 and describes functioning at a certain time (i.e. current, past year, etc...). This does not include functional impairment due to physical or environmental factors.

The number and intensity of signs and symptoms are used when specifying if the condition is mild, moderate, severe, in partial remission, in full remission, and prior history.

How serious is the Psychiatric Disorder?

For most disorders, these definitions may be used:

- Mild: few, (if any) excessive symptoms, other than those needed to make the diagnosis are present. Symptoms result in minor social or occupational impairment.
- Moderate: Symptoms or functional impairment are between mild and severe.
- Severe: Many symptoms in excess of those required tomake a diagnosis, or severe symptoms are present, or the symptoms cause marked social or occupational impairment.
- In Partial Remission: Previously, the full criteria for the disorder were met. Currently, only some of the symptoms remain.
- In Full Remission: There are no symptoms of the disorder present, but it is still clinically relevant to the disorder. "In Full Remission" differs from "recovered' by factors such as course of the disorder, length of time since that first symptoms were present, the total duration of the symptoms and the need for continued evaluation and treatment.
- Prior History: It may be useful to note certain criteria for a disorder were met in the past even when the person has recovered.
- Principle Diagnosis: This is the diagnosis that is mainly responsible for the patient's admission. This diagnosis will be listed first on the Axis I diagnoses.
- Not Otherwise Specified (NOS): There are four situations where this diagnosis may be appropriate.
    - The presentation conforms to the general guidelines for the disorder, but the symptoms do not meet specific disorder criteria.
    - The presentation conforms to a pattern not included in the DSM, but it causes clinically significant distress or impairment.
    - There is uncertainty about the etiology.
    - While data collection is incomplete, inconsistent, or contradictory, there is enough information to put it in a diagnostic class.

Anxiety Disorders

Anxiety disorders can keep you from coping and can disrupt your daily life. They aren't just a case of "nerves." They are illnesses, often related to the biological makeup and life experiences of the individual, and they frequently run in families. It may be there is a genetic susceptibility to an anxiety and it becomes an actual anxiety disorder in the proper environment.

Anxiety disorder doesn't appear suddenly. It is not a sign of flawed character. Typically most adults do not seek help. If help is sought, it is usually for a medical reason. Many anxiety patients view themselves as having physical and psychological problems, and may believe they have a disability.

Anxiety disorders are among the most common psychiatric conditions in the United States. They cause morbidity, use of health care resources, and functional impairment. Chronic anxiety may increase physical problems. This makes rapid diagnosis and treatment essential.

Generalized Anxiety Disorder

> *"I always thought I was just a worrier. I'd feel keyed up and unable to relax. At times it would come and go, and at times it would be constant. It could go on for days. I'd worry about what I was going to fix for a dinner party, or what would be a great present for somebody. I just couldn't let something go."*

Generalized anxiety disorder (GAD) is much more than the normal anxiety people experience day to day. It's chronic and exaggerated worry and tension, even though nothing seems to provoke it. Having this disorder means always anticipating disaster, often worrying excessively about health, money, family, or work.

Sometimes, though, the source of the worry is hard to pinpoint. Simply the thought of getting through the day provokes anxiety.

People with GAD can't seem to control their concerns, even though they usually realize that their anxiety is more intense than the situation warrants. People with GAD also seem unable to relax. They often have trouble falling or staying asleep. Their worries are accompanied by physical symptoms, especially trembling, twitching, muscle tension, headaches, irritability, sweating, or hot flashes. They may feel lightheaded or out of breath. They may feel nauseated or have to go to the bathroom frequently. Or they might feel as though they have a lump in the throat. GAD causes significant distress or functional impairment.

According to the DSM-IV TR, in GAD the intensity, frequency and duration of anxiety are significantly out of proportion with the possible damage of the event. This excessive worry about all areas of life, lasting for more than six months contributes to the diagnosis of generalized anxiety disorder.

People with relatives who have GAD are more likely to have GAD. A sleep disorder may cause anxiety and anxiety may lead to a sleep disorder. It is common for a person with GAD to also have bipolar disorder. GAD is not due to the direct effects of a medication or illegal substance, or a medical condition.

It is unusual to see a person with GAD as the primary diagnosis in the inpatient setting. It may accompany other mental illnesses, however, which would bring them into the hospital. People with more severe GAD may be seen in the outpatient setting.

Panic Disorder

> *"For me, a panic attack is almost a violent experience. I feel like I'm going insane. It makes me feel like I'm losing control in a very extreme way. My heart pounds really hard, things seem unreal and there's this very strong feeling of impending doom."*

> *"In between attacks there is this dread and anxiety that it's going to happen again. It can be very debilitating, trying to escape those feelings of panic."*

When a panic attack strikes, your heart pounds and you may feel sweaty, weak, faint, or dizzy. Your hands may tingle or feel numb, and you might feel flushed or chilled. You may have chest pain or smothering sensations, a sense of unreality, or fear of impending doom or loss of control. You may genuinely believe you're having a heart attack or stroke, losing your mind, or on the verge of death. Attacks can occur any time, even during non-dream sleep. While most attacks average a couple of minutes, occasionally they can last for up to 10 minutes. In rare cases, they may last an hour or more.

A panic attack is a single event that is unexpected. The diagnosis of panic disorder requires that the patient have at least two panic attacks. Many sufferers of panic attacks fear that an undiagnosed, life-threatening illness is causing the symptoms.

People with panic disorder have feelings of terror that strike suddenly and repeatedly with no warning. They can't predict when an attack will occur, and many develop intense anxiety between episodes, worrying when and where the next one will strike. Between attacks, there is a persistent, lingering worry that another attack could come any minute.

Most people with panic disorder experience attacks before the age of 25. Panic disorder rarely develops after the age of 45. Panic attacks may be absent for periods of time.

Panic disorder is often accompanied by other conditions such as depression or alcoholism, and may generate phobias, which can develop in places or situations where panic attacks have occurred. For example, if a panic attack strikes while you're riding an elevator, you may develop a fear of elevators and perhaps start avoiding them.

Some people's lives become greatly restricted--they avoid normal, everyday activities such as grocery shopping, driving, or in some cases even leaving the house. They may be able to confront a feared situation only if accompanied by a spouse or other trusted person. When people's lives become so restricted by the disorder, as happens in about one-third of all people with panic disorder, the condition is called *agoraphobia.* It affects women twice as often as men. A tendency toward panic disorder and agoraphobia runs in families.

Post-Traumatic Stress Disorder

> *"I was raped when I was 25 years old. For a long time, I spoke about the rape on an intellectual level as though it was something that happened to someone else. I was very aware that it had*

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happened to me, but there just was no feeling. I kind of skidded along for a while.

"I started having flashbacks. They kind of came over me like a splash of water. I would be terrified. Suddenly I was reliving the rape. Every instant was startling. I felt like my entire head was moving a bit, shaking, but that wasn't so at all. I would get very flushed or a very dry mouth and my breathing changed. I was held in suspension. I wasn't aware of the cushion on the chair that I was sitting in or that my arm was touching a piece of furniture. I was in a bubble, just kind suffocating. And it was scary. Having a flashback can wring you out. You're really shaken."

Post-Traumatic Stress Disorder (PTSD) is a debilitating condition that follows a traumatic event. People with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to.

PTSD, once referred to as shell shock or battle fatigue, was first brought to public attention by war veterans, but it can result from any number of traumatic incidents. These include kidnapping, serious accidents such as car or train wrecks, natural disasters such as floods or earthquakes, violent attacks such as a mugging, rape, or torture, or being held captive. The event that triggers it may be something that threatened the person's life or the life of someone close to him or her. Or it could be something witnessed, such as mass destruction after a plane crash.

Whatever the source of the problem, some people with PTSD repeatedly relive the trauma in the form of nightmares and disturbing recollections during the day. They may also experience sleep problems, depression, feeling detached or numb, or being easily startled. They may lose interest in things they used to enjoy and have trouble feeling affectionate. They may feel irritable, more aggressive than before, or even violent. Seeing things that remind them of the incident may be very distressing, which could lead them to avoid certain places or situations that bring back those memories. Anniversaries of the event are often very difficult.

PTSD can occur at any age, including childhood. The disorder can be accompanied by depression, substance abuse, or anxiety.
Symptoms may be mild or severe and include:

- Difficulty falling or staying asleep
- Irritability or angry outbursts
- Difficulty concentrating
- Hyper-vigilance
- Exaggerated startle response

In general, the symptoms seem to be worse if the event that triggered them was initiated by a person--such as a rape, as opposed to a flood. PTSD can cause a clinically significant distress or impairment. In severe cases they may have trouble working or socializing.

Ordinary events can serve as reminders of the trauma and trigger flashbacks or intrusive images. A flashback may make the person lose touch with reality and re-enact the event for a period of seconds or hours or, very rarely, days. A person having a flashback, which can come in the form of images, sounds, smells, or feelings, usually believes that the traumatic event is happening all over again.

Not every traumatized person gets full-blown PTSD, or experiences PTSD at all.

PTSD is classified as follows:

- Acute: symptoms last less than 3 months
- Chronic: Symptoms last 3 or more months
- Delayed Onset: symptoms start at least 3 months after the stressor

Some people recover within 6 months, others have symptoms that last much longer. In some cases, the condition may be chronic. PTSD can cause memory loss due to the effect on the growth of neurons in the brain.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is a potentially disabling condition that can persist throughout a person's life. OCD tends to occur more frequently in men. It usually manifests in adolescence and early adulthood. The individual who suffers from OCD becomes trapped in a pattern of repetitive thoughts and behaviors that are senseless and distressing but extremely difficult to overcome. OCD occurs in a spectrum from mild to severe. The obsessions or compulsions are time consuming, and may interfere with functioning.

During his last year at college, John became aware that he was spending more and more time preparing for classes, but he worked hard and graduated in the top ten percent of his class with a major in accounting. He accepted a position at a prestigious accounting firm in his hometown and began work with high hopes for the future. Within weeks, the firm was having second thoughts about John. Given work that should have taken two or three hours, he was going over and over the figures, checking and rechecking, spending a week

or more on a task. He knew it was taking too long to get each job done, but he felt compelled to continue checking. When his probation period was over, the company let him go.

Key Features of OCD

Obsessions
These are persistent and recurrent ideas or impulses that repeatedly well up in the mind of the person with OCD. Persistent fears that harm may come to self or a loved one, an unreasonable belief that one has a terrible illness, or an excessive need to do things correctly or perfectly, are common. Again and again, the individual experiences a disturbing thought, such as, "My hands may be contaminated--I must wash them"; "I may have left the gas on"; or "I am going to injure my child." These thoughts are intrusive, unpleasant, and produce a high degree of anxiety. Often the obsessions are of a violent or a sexual nature, or concern illness.

Compulsions
In response to their obsessions, most people with OCD resort to repetitive behaviors called compulsions. The most common of these are washing and checking. Other compulsive behaviors include counting (often while performing another compulsive action such as hand washing), repeating, hoarding, and endlessly rearranging objects in an effort to keep them in precise alignment with each other.

Insight
People with OCD usually have considerable insight into their own problems. Most of the time, they know that their obsessive thoughts are senseless or exaggerated, and that their compulsive behaviors are not really necessary. However, this knowledge is not sufficient to enable them to stop obsessing or the carrying out of rituals. The obsessions or compulsions can cause marked distress, are time consuming, and can significantly interfere with normal routines, job, social activities, or relationships.

Resistance
Most people with OCD struggle to banish their unwanted, obsessive thoughts and to prevent themselves from engaging in compulsive behaviors. Many are able to keep their obsessive-compulsive symptoms under control during the hours when they are at work or attending school. But over the months or years, resistance may weaken, and when this happens, OCD may become so severe that time-consuming rituals take over the sufferers' lives, making it impossible for them to continue activities outside the home.

Shame and Secrecy
OCD sufferers often attempt to hide their disorder rather than seek help. Often they are successful in concealing their obsessive-compulsive symptoms from friends and coworkers.

What Causes OCD?

OCD is believed to be both a learned and biological disorder. OCD is no longer attributed to attitudes a patient learned in childhood--for example, an inordinate emphasis on cleanliness, or a belief that certain thoughts are dangerous or unacceptable.

Research suggests that a person will not develop OCD without having a biological predisposition to it. Biology precedes learning in OCD. The biological component of OCD is not always active. At times, the symptoms lessen, or are absent even without treatment.

Learned emotions can be very resistant to change and are not affected by medication. When anxiety occurs, the usual response is to decrease the anxiety. This may lead to avoidant behaviors. The response that previously helped may be repeated. OCD usually occurs so gradually that it can be difficult to notice.

OCD is sometimes accompanied by depression, eating disorders, substance abuse disorder, a personality disorder, attention deficit disorder, or another of the anxiety disorders. Co-existing disorders can make OCD more difficult both to diagnose and to treat.

Mood Disorders

Mood disorders are a large group of psychiatric disorders with features of pathological moods and related vegetative psychomotor disturbances.

Depression

Approximately 17% of American will have depression during their lifetime.

Types of Depression

Major depression is a combination of symptoms that interfere with the ability to work, sleep, eat, and enjoyment of once pleasurable activities. These disabling episodes of depression can occur once or many times in a lifetime.

A less severe type of depression, *dysthymia,* involves long-term (at least 2 years), chronic symptoms that do not disable but are low-grade and intermittent. Depressive symptoms are absent for at least 2 months at a time in

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dysthymia. Sometimes people with dysthymia also experience major depressive episodes.

Symptoms of Depression

Not everyone who is depressed experiences every symptom. Some people experience a few symptoms, some many.

Five or more of the following symptoms must be present daily for at least two weeks and represent a change in functioning. One of these symptoms must be a depressed mood or loss of interest or pleasure. Severity of symptoms varies with individuals.

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of excessive or inappropriate guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Insomnia, early-morning awakening, or hypersomnia
- Significant loss of appetite and/or weight loss without dieting or overeating and weight gain (change of > 5% in a month)
- Loss of energy, fatigue, being "slowed down"
- Restlessness, irritability
- Diminished ability to think, concentrate and make decisions
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain
- Recurrent thoughts of death (not just fear of dying)
- Recurrent suicidal ideation without a specific plan, a suicide attempt or a specific suicide plan

Symptoms are not due to the direct physiological effects of a substance (abused chemicals or medication) or a general medical condition such as hypothyroidism. Symptoms are not due to bereavement and last for longer than two months. There may be psychotic symptoms present.

Causes of Depression

Some types of depression run in families, indicating that a biological vulnerability can be inherited. Whether inherited or not, major depressive disorder is often associated with having too little or too much of certain neurochemicals.

A serious loss, chronic illness, difficult relationship, financial problem, or any unwelcome change in life patterns can also trigger a depressive episode.

Depression is not a weakness or a character flaw. The depressed person cannot snap out of it or pull themselves together. People with depression may be embarrassed by their condition and may be reluctant to seek help. The majority of people with depression can be helped. Alcohol and illegal substances may be used by the depressed person to self-medicate. Women are more likely to suffer from depression than men.

Seasonal Affective Disorder (SAD)

Some people experience depression only during the winter. The symptoms begin in the fall when sunlight hours decrease, and they feel better when daylight hours increase in the spring. The presence of wintertime SAD is higher in northern latitudes. People with SAD usually feel lethargic and tend to sleep more than usual. Appetite increases and there may be carbohydrate cravings and weight gain. Sex drive also decreases. SAD causes distress and difficulties functioning at work and at home. SAD may be caused by the disruption of circadian rhythms.

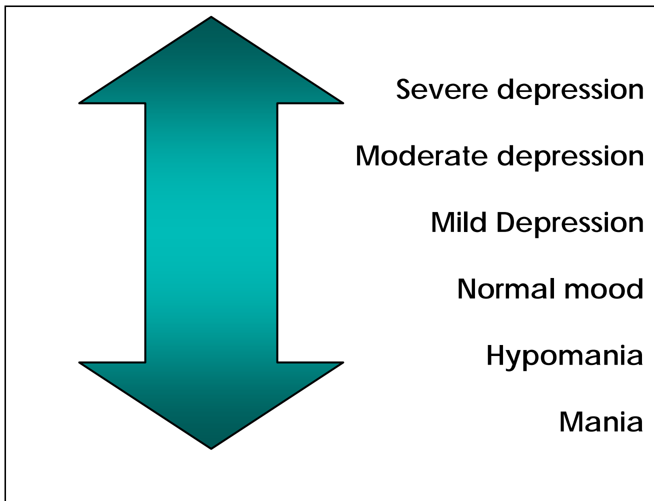
Light therapy may be used for winter SAD. If light therapy isn't effective, antidepressants may be used. It is thought that the disorder is four times more common in women. SAD occurs in all age groups, although it is more common in people in their twenties through forties.

Bipolar Disorder

What is Bipolar Disorder?

This disorder was previously called manic-depression, and some still use this term. A person with bipolar disorder has episodes of mania and depression. The person's mood usually swings from overly "high" and irritable to sad and hopeless and then back again, with periods of normal mood in between. Bipolar disorder typically begins in adolescence or early adulthood and continues throughout life.

Think of the moods in bipolar disorder as a continuum. People can go back and forth along the continuum slowly or very rapidly. It has been described as an "emotional rollercoaster".



The number of mood cycles in a year varies from person to person. The cycles don't always alternate between mania and depression. There could be several depressive episodes, followed by a manic episode. The mood changes are usually sudden and unexpected. "Rapid cycling" is having four or more cycles in one year.

Some people with untreated bipolar disorder have repeated depressions and only an occasional episode of hypomania (bipolar II). In the other extreme, mania may be the main problem and depression may occur only infrequently. In fact, symptoms of mania and depression may be mixed together in a single "mixed" bipolar state.

In a "mixed" episode the symptoms of mania and depression occur simultaneously or alternate through out the day. A "mixed" episode lasts for at least one week.

Depression:

> *I doubt completely my ability to do anything well. It seems as though my mind has slowed down and burned out to the point of being virtually useless.... [I am] haunted with the total, the desperate hopelessness of it all... Others say, "It's only temporary, it will pass; you will get over it," but of course they haven't any idea of how I feel although they are certain they do. I feel if I can't feel, move, think, or care, then what on earth is the point?*

Hypomania:

> *At first when I'm high, it's tremendous... ideas are fast... like shooting stars you follow until brighter ones appear... all shyness disappears; the right words and gestures are suddenly there... uninteresting people, things; become intensely interesting. Sensuality is pervasive, the desire to seduce and be seduced is irresistible. Your marrow is infused with unbelievable feelings of ease, power, well-being, omnipotence, euphoria....you can do anything. But somewhere this changes.*

Mania:

> *The fast ideas become too fast and there are far too many..........overwhelming confusion replaces clarity. you stop keeping up with it--memory goes. Infectious humor ceases to amuse. Your friends become frightened... everything is now against the grain.. you are irritable, angry, frightened, uncontrollable, and trapped.*

Signs and Symptoms of Mania

- Increased energy, activity, restlessness, racing thoughts, and rapid talking
- Excessive "high" or euphoric feelings
- Extreme irritability and distractibility
- Decreased need for sleep or insomnia
- Unrealistic beliefs in one's abilities and powers
- Uncharacteristically poor judgment, reckless behavior
- A sustained period of behavior that is different from usual
- Increased sexual drive
- Change in appetite
- Difficulty concentrating
- Delusions or hallucinations
- Abuse of drugs, particularly cocaine, alcohol, and sleeping medications
- Provocative, intrusive, or aggressive behavior
- Denial that anything is wrong

Bipolar disorder is often not recognized by the patient, relatives, friends, or even physicians. In its early stages, bipolar disorder may masquerade as a problem other than mental illness. For example, it may first appear as alcohol or drug abuse, or poor school or work performance.

Psychotic Disorders

Psychosis

Psychosis is a mental disorder where thoughts, affective response, ability to recognize reality and ability to communicate and relate to others is greatly impaired and interferes with the ability to deal with reality. The characteristics are impaired reality, hallucinations, delusions and illusions. [1]

Schizophrenia

Schizophrenia is a term used to describe a complex, condition. It is the most chronic and disabling of the major mental illnesses. Because of the disorder's complexity, few generalizations hold true for all people who are diagnosed as schizophrenic. Schizophrenia affects less than 1% of the world's population.

With the sudden onset of severe psychotic symptoms, the individual is said to be experiencing acute schizophrenia. "Psychotic" means "out of touch with reality", or unable to separate real from unreal experiences. Some people have only one such psychotic episode; others have many episodes during a lifetime but lead relatively normal lives during the interim periods. The individual with chronic (continuous or recurring) schizophrenia often does not fully recover normal functioning and typically requires long-term treatment to control the symptoms. Some chronic schizophrenic patients may never be able to function without assistance of some type. Hospitalization occurs because of a psychotic break, usually due to non-adherence to medication. However, the break may be due to stress.

The World of People with Schizophrenia

Schizophrenia is generally characterized by two or more of the following symptoms that have occurred for a significant portion of time during a one month period of time and there must be continuous signs of the disorder for at least six months.

Unusual Realities
Schizophrenic people have their own perceptions of reality. They live in a world that can appear distorted, changeable, and lacking the reliable landmarks. This person may seem distant, detached, or preoccupied, and may even sit as rigidly as a stone, not moving for hours and not uttering a sound. Or he or she may move about constantly, always occupied, wide awake, vigilant, and alert. A schizophrenic person may exhibit very different kinds of behavior at different times.

Hallucinations
Hallucinations are false sensory perceptions that occur in the absence of any relevant, external stimulation.[2]A schizophrenic person senses things that do not exist, such as hearing voices telling the person to do certain things, seeing people or objects that are not really there, or feeling invisible fingers or insects touching his or her body. Hearing voices that other people don't hear is the most common type of hallucination in schizophrenia. Such voices may describe the patient's activities, carry on a conversation, warn of impending dangers, or tell the person what to do. The voice may be a family member, a friend, an acquaintance or a stranger.

Delusions
A delusion is a fixed false belief that is resistant to reason despite objective, contradictory evidence and despite the fact that others do not share this belief. The person may believe that a neighbor is controlling him with magnetic waves, or that people on television are directing special messages specifically at him or her, or are broadcasting the individual's thoughts aloud to other people.

Disordered Thinking and Speech
The person may endure many hours of not being able to "think straight." Thoughts may come and go so rapidly that it is not possible to "catch them." The person may not be able to concentrate on one thought for very long and may be easily distracted, unable to focus attention.

The person with schizophrenia may not be able to sort out what is relevant and what is not relevant to a situation. The person may be unable to connect thoughts into logical sequences, as thoughts may become disorganized and fragmented. Jumping from topic to topic in a way that is totally confusing to others may result. This lack of logical continuity of thought, termed "thought disorder," can make conversation very difficult and contribute to social isolation.

Emotional Expression
People with schizophrenia sometimes exhibit an "inappropriate affect." This means showing emotion that is inconsistent with the person's speech or thoughts. For example, a schizophrenic person may say that he or she is being persecuted by demons and then laugh.

1 Sadock B. & Sadock V. (2000). Comprehensive textbook of psychiatry. Philadelphia: Lippincott Williams and Wilkins.

2 Sadock B. & Sadock V. (2000). Comprehensive textbook of psychiatry. Philadelphia: Lippincott Williams and Wilkins.

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Often people with schizophrenia show "blunted" or "flat" affect. This refers to a severe reduction in emotional expressiveness. A schizophrenic person may not show the signs of normal emotion, perhaps using a monotonous tone of voice and diminished facial expression.

Grooming

Grooming is usually poor, and there is a disheveled appearance.

Suicide Risk

Suicide is the leading cause of death for people suffering from schizophrenia. The risk of suicide is greater in people with schizophrenia than in the general population. People who have awareness of the deteriorative nature of the illness and of their future are at increased risk for suicide.

Schizophrenia Subtypes

Schizophrenia subtypes are defined by the most obvious symptoms present at the time of evaluation. Because sub-typing is tied to the most recent evaluation, they may change over time. There are 5 subtypes of schizophrenia.

- Paranoid
- Disorganized
- Catatonic
- Undifferentiated
- Residual

What Causes Schizophrenia?

Genetics

The close relatives of schizophrenic patients are more likely to develop schizophrenia than those who are not related to someone with schizophrenia. The children of a schizophrenic parent, for example, each have about a 10 percent chance of developing schizophrenia.

Parenting

Schizophrenia researchers now agree that parents do *not* cause schizophrenia.

Chemical Defect

No neurochemical cause has yet been firmly established for schizophrenia, but is thought to contribute to the development of the disease.

Physical Abnormality in the Brain

Some studies using CT scans suggest that schizophrenic patients are more likely to have abnormal brain structures (for example, enlargement of the cavities in the interior of the brain) than are normal persons of the same age.

Schizophreniform Disorder

- Schizophreniform disorder is essentially identical to schizophrenia.
- The symptoms have lasted at least one month, but less than the six months required for a diagnosis of schizophrenia and
- The social and/or occupational impairment required for a diagnosis of schizophrenia may not be present

Schizoaffective Disorder

In schizoaffective disorder, the person exhibits both symptoms of active–phase schizophrenia and an affective disorder, (Major Depressive Episode, Manic Episode or Mixed Episode). During this time, there is at least a two-week period of delusions or hallucinations in the absence of prominent mood symptoms. The symptoms that meet criteria for a mood disorder must be present for a substantial portion of the disturbance.

Delusional Disorder

The hallmark of this disorder is the presence of a persistent, non-bizarre delusion without symptoms of any other mental disorder. Delusions are firmly held beliefs that are untrue, not shared by others in the culture, and not easily modifiable.

> *Ruth is a clerk typist who is efficient and helpful. Her employers and co-workers value her contribution to the office. Ruth spends her evenings writing letters to State and Federal officials. She feels that God has opened her mind and given her the cure for cancer. She wants some leading treatment center to use her cure on all its patients so that the world can see she is right. Many of her letters go unanswered, or she receives noncommittal replies that only make her feel that no one understands that she can save all cancer patients if only given the chance. When one of her letters is answered by an employee of the official to whom she wrote, she is sure that the official is being deliberately kept unaware of her knowledge and power. Sometimes she despairs that the world will ever know how wonderful she is, but she doesn't give up. She just keeps writing. Ruth suffers from one of the delusional disorders, grandiose delusion.*

Persecution is the most common delusion in this disorder. The person believes that they themselves or someone close to them are being mistreated. While persons with paranoid personality might suspect their colleagues of joking at their expense, persons with

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delusional disorder suspect others of participating in elaborate master plots to persecute them. They believe that they are being poisoned, drugged, spied upon, or are the targets of conspiracies to ruin their reputations or even to kill them. They sometimes engage in litigation in an attempt to redress imagined injustices.

Another theme seen frequently is that of delusional **jealousy**. Any sign -- even a meaningless spot on clothing, or a short delay in arriving home -- is summoned up as evidence that their significant other is being unfaithful.

Erotic delusions are based on the belief that one is romantically loved by another, usually someone of higher status or a well-known public figure. Individuals with erotic delusions often harass famous persons through numerous letters, telephone calls, visits, and stealthy surveillance.

Persons with **grandiose** delusions often feel that they have been endowed with special powers and that, if allowed to exercise these powers, they could cure diseases, banish poverty, ensure world peace, or perform other extraordinary feats.

Individuals with **somatic** delusions are convinced that there is something very wrong with their bodies -- that they emit foul odors, have bugs crawling in or on their bodies, or are misshapen and ugly. Because of these delusions, they tend to avoid the society of other people and spend much time consulting physicians for their imagined condition.

Causes of Delusional Disorder

Genetic Contribution

Scientists have found that the families of paranoid patients do not have higher than normal rates of either schizophrenia or depression. However, there is some evidence that paranoid symptoms in schizophrenia may be genetically influenced.

Biochemistry

Like the other mental illnesses, there is the possibility that paranoia is caused by a disturbance in neurochemistry. Abuse of drugs such as amphetamines, cocaine, marijuana, PCP, LSD, or other stimulants or "psychedelic" compounds may lead to symptoms of paranoid thinking or behavior.

Stress

Paranoia may be a reaction to high levels of life stress. Paranoia is more prevalent among immigrants, prisoners of war, and others undergoing severe stress.

Personality Disorders

A personality disorder is a long term pattern of behavior which usually involves established, maladaptive behavioral patterns that significantly distress the patient. They are chronic and lifelong and should not be diagnosed based on behavior exhibited during an acute episode of an Axis 1 disorder (i.e. schizophrenia, mood and anxiety disorders).

Often a personality disorder co-exists with and complicates the treatment of an Axis 1 disorder. For patients in their twenties and thirties, the most common personality disorder is borderline. For older patients, dependent and narcissistic personality disorders are most common.

Paranoid Personality Disorder

People with this type of personality disorder have a suspiciousness and distrust of others beginning in early adulthood. They have low self-esteem and feelings of inferiority and weakness. This person, without cause or justification, may:

- suspect that others are harming, exploiting or deceiving him or her
- be preoccupied with doubts of the loyalty of friends
- fear that confided information will be used maliciously against him or her
- perceive that benign remarks or events have demeaning or threatening messages
- react to perceived attacks on character or reputation
- suspect that spouse or sexual partner is being unfaithful

Schizoid Personality Disorder

This disorder may be a pre-cursor to schizophrenia (a pre-morbid condition), and has many of the social aspects of schizophrenia. People with schizoid personality disorders start to have detachment from social relationships in their early adulthood, with a restricted range of emotions. They prefer mechanical or abstract tasks and may be unaware of the normal subtleties of social interaction. The patient does not respond appropriately to social cues. Additionally, they may acknowledge having painful feelings related to social interaction. The person with a schizoid personality:

- attempts to be self sufficient to avoid the recurring rejection and disappointment in others
- does not want or enjoy any close relationships (including family)
- almost always chooses solitary activities

- is not interested in other people in relation to sexual experiences
- does not enjoy activities
- does not have any close friends, except possibly close relatives
- does not seem to care about the praise or criticism of others
- has a flattened affect, or appears emotionally cold or detached
- may have experienced frustration as a child regarding getting their emotional needs met by others

Schizotypal Personality Disorder

People with this type of personality disorder are one step away from a diagnosis of schizophrenia. They may have bizarre speech, strained relationships with others, poor social skills, but **do not** have psychosis. Symptoms may include:

- paranoid or suspicious behavior
- absence of close friends or relationships
- "different" behavior or appearance
- odd speech, beliefs, fantasies, or preoccupations
- discomfort in any type of social situation
- inappropriate display of feelings

Antisocial Personality Disorder (APD)

From the age of 15, the people who are diagnosed with antisocial personality disorder have a persistent problem with the rights of others -- they either disregard them or violate them. Prior to the age of 15, they have evidence of a conduct disorder. Frequently people with APD report a history of abuse or neglect by parental figures. There is a grandiose sense of self. Behavior that is associated with antisocial personality disorder includes:

- repeatedly performs acts that are grounds for arrest (has no regard for the law)
- repeatedly lies, uses alliances, or cons others (deceitfulness)
- either does not plan ahead or acts impulsively
- repeatedly engages in fights or assaults because of irritability and aggressiveness
- does not care about their own safety or the safety of others
- cannot sustain consistent work or honor financial obligation (consistent irresponsibility)
- has no remorse for acts done to others, such as hurting, mistreating, or stealing from others

The antisocial person believes the victim is weak or deserves to be taken advantage of. They are only concerned about meeting their own needs. The incidence of Antisocial Personality Disorder is twice as high for inner city dwellers than in small towns or rural areas.

This disorder affects 4% of the general population. The incidence is five times higher inmates. Over half of all convicted criminals have Antisocial Personality Disorder. They seldom show emotion or don't feel guilt. A common misperception is that this group has poor social skills. Two subgroups are psychopaths and sociopaths.

Borderline Personality Disorder (BPD)

According to the National Alliance on Mental Illness (NAMI):

- BPD affects between 1 - 2 percent of the population. The highest estimation, 2 percent, approximates the number of persons diagnosed with schizophrenia and bipolar disorder.
- Estimates are 10 percent of outpatients and 20 percent of inpatients who present for treatment have BPD.
- More females are diagnosed with BPD than males by a ratio of about 3-to-1, though some clinicians suspect that males are underdiagnosed.

http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=44780 (accessed on July 30, 2010)

There is a much higher incidence of sexual abuse in this group as compared to the general population. The suicide rate is higher than in the general population, and higher in men with borderline personality disorder.

Individuals with BPD are very sensitive to any real or perceived rejection. Self-esteem is fragile. Self-hate may be projected onto others and there may be feelings of rage. In this lifelong disorder, much of the impulsivity and self-injurious behavior lessens as midlife approaches.

The underlying problem with borderline personality disorder is a severe pattern of relationship instability, accompanied by alterations in self-image, affect (mood) and very impulsive behavior. People with borderline disorder have a terror of real or imagined abandonment, and tend to have unstable and intense relationships. They have dramatic shifts in their self-image, which may cause them to change goals, values, vocations, sexual identity, and types of friends rapidly. Criteria for a borderline personality disorder diagnosis may include:

- frantic efforts to avoid real or imagined abandonment
- unstable and intense relationships with others, alternating between idealizing and devaluing
- marked and unstable self-image
- impulsive, self-damaging behaviors, such as spending, sex, substance abuse, driving, eating

- suicidal ideation, threats, or behavior; self-mutilation on a recurring basis
- severe reactivity of mood
- chronically feels empty
- disturbed self-identity
- has a difficult time controlling feelings of anger
- may have dissociative symptoms or stress-related paranoid ideation
- poor anxiety tolerance and poor impulse control
- chronic anxiety

Even though people with BPD use mental health resources, they have high rates of treatment failure. Dialectical Behavioral Therapy (DBT) is specifically designed for chronically para-suicidal people diagnosed with borderline personality disorder. Para-suicidal behavior is "any intentional, acute, self-injurious behavior with or without suicidal intent, including both suicide attempts and self-mutilative behaviors." (Linehan, et al 1991) It is commonly believed that some type of psychological treatment is necessary, even when pharmacotherapy is present.

Narcissistic Personality Disorder

In early adulthood, people who develop narcissistic personality disorder begin to exhibit patterns of grandiosity and an excessive need for admiration, accompanied by a lack of empathy. Everything the narcissistic person does is expected to be "raved" over; this person feels that he or she should only associate with other people who are unique, "top in their field," or other "important" people. At the same time, the person with narcissistic personality disorder has a very fragile ego -- making them very sensitive to any type of criticism or insult. Some of the criteria that people with narcissistic personality disorder must meet are:

- exaggerates achievements and talents; has an exaggerated sense of self-importance
- believes that unlimited success, power, money, beauty, or ideal love are due him or her
- sees him or herself as being special, understood only by other people or institutions who are unique or the best
- needs enormous amounts of admiration
- grandiose sense of self
- has unreasonable expectations of treatment that should be especially tailored or modified for him or her; a sense of entitlement
- takes advantage of others to meet his or her own needs
- is not able to identify with the needs of others; lacks empathy
- believes that others are envious of him or her and does not understand that they may not be
- may be arrogant, haughty, or condescending

Histrionic Personality Disorder

A person with this type of disorder is excessively emotional, seeking enormous amounts of attention. The histrionic person may have learned that dramatic displays are required to get the attention of others. These patterns begin in early adulthood, and may be characterized by:

- needs to be the center of attention
- may be inappropriately sexually seductive or provocative in interactions with others
- emotions shift rapidly and appear to be shallow
- uses physical appearance to draw attention to him or herself
- speech is very impressionistic and lacks detail
- very dramatic, theatrical, and exaggerated in emotional expression
- is easily influenced by others or by circumstances
- believes that relationships are more intimate than they really are

Avoidant Personality Disorder

Fears of criticism and hypersensitivity to negative feedback have led this person to become socially inhibited. They feel they can never measure up to their own expectations. Some of the characteristics of the person with avoidant personality disorder include:

- fears disapproval, criticism, or rejection, so avoids occupational activities which involve interpersonal contact
- does not get involved with any activity unless sure that he/she is liked
- fears being shamed or ridiculed, so is restrained in intimate relationships
- is preoccupied with the chance of being rejected in social situations
- feels inadequate in new interpersonal relationships
- feels that he/she is socially inept, unappealing, or inferior to others
- is very reluctant to take on any new activities because they may become embarrassing
- is extremely shy and fears social interactions where they may experience embarrassment or humiliation

Dependent Personality Disorder

Beginning in early adulthood, these people have an excessive need to be taken care of. This need leads to submissive behavior and clinging, including fears of separation. Often there is a background of overly involved parents. Individuals with dependent personality disorder may:

- need incredible amounts of advice and reassurance from another on making every day decisions
- need other people to make major decisions for them
- cannot disagree with others because they fear others may withdraw support or approval
- lacks self-confidence to initiate projects or do things on his/her own
- overwhelming in need to obtain nurturance and support from others
- feels that he/she cannot care for him or herself; feels uncomfortable when alone
- when one relationship ends, urgently seeks another to replace it
- is preoccupied with fears related to being able to care for him or herself
- dependency may mask hostility and aggression

Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder is different from obsessive-compulsive disorder (OCD), which is classified as an Axis I disorder. In OCD, a person is compelled to do certain behaviors again and again to relieve anxiety. In obsessive-compulsive personality disorder, the person has a pattern of preoccupation with control, cleanliness, orderliness, and perfection. This disorder begins in early adulthood and may have the following characteristics:

- is very preoccupied with details, rules, lists, order, organization, and schedules
- has such strict standards of perfectionism that tasks cannot easily be completed
- neglects leisure and friendships to focus entirely on work and productivity
- is inflexible and overconscientious about morals, ethics, and values
- cannot discard objects that are worn out, worthless, or have no sentimental value
- cannot delegate tasks or work with others unless others can conform exactly to his/her standards
- miserly; money needs to be hoarded for future problems
- rigid and stubborn
- perfectionistic traits to transcend unacceptable feelings such as rage

Self-Mutilation

In many cultures, for many reasons and in many different disorders, people self-injure. Examples of self-mutilation are body piercing, cutting and burning. A person with borderline personality disorder may repeatedly cut themselves or burn themselves with a lighted cigarette or oven cleaner. A psychotic person may cut off a body part or enucleate their eye.

These acts generally do not indicate suicidality although they can cause accidental death. Usually self mutilation offers a release of tension allowing pain to be felt physically to mirror the emotional pain, or counteracts feelings of numbness. While there may be superficial injury at times, the risk of severe injury requiring medical attention is possible.

Summary

Working with mentally ill patients can be very challenging. There are many different theories on the causes of mental illness. Diagnosis can be difficult. The causes, DSM-IV TR classifications, and characteristics of the major mental illnesses have been reviewed in this section. Knowing the characteristics of each disorder can help you assess and manage the psychiatric client.

Applying What You've Learned...

We recommend that you do one or both of the following activities to apply what you have learned in this section:

1. Review a few patient charts to correlate patient symptoms with DSM-IV-TR criteria.
2. Identify resources to keep current on etiologies and diagnosis of mental illness.

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Legal Aspects of Psychiatric Care

Introduction

Respecting the rights of the mentally ill person is vital. As long as there have been people with mental illness, there have been treatments that we would consider to be interfering with patient rights. There is evidence that some people had holes drilled in their skulls (trepanning), possibly for the release of evil spirits, four to five thousand years ago. Historically, people with mental illness have been beaten, starved, restrained, hanged, and locked away in institutions. Slowly, scientists and health care professionals have become more aware of the causes, symptoms, and efficient treatments of mental illness. The legal processes have changed to reflect the need for compassionate, least-restrictive care. This section will describe some of the legal aspects of psychiatric care, including voluntary admissions and involuntary legal holds, early intervention, civil commitment, patient rights, and various laws that apply to the mentally ill patient.

In understanding different aspects of the legal process, team members are better equipped to support and advocate for their patients and their significant others.

Who is a "Mentally Ill Person?"

According to Minnesota State Statute, a "mentally ill person" is "*any person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, which is manifested by instances of grossly disturbed behavior or faulty perceptions and poses a substantial likelihood of physical harm to self or others as demonstrated by:*

1. *Failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment, or…*
2. *Recent attempt or threat to physically harm self or others*[3]

The law describes a section of mentally ill people that are seen in the clinical setting – those that are the most impaired. There may be patients in the mental health units that do not meet these criteria. The statute was designed to protect people from being involuntarily held or committed without clear evidence of the danger they pose to themselves or others.

Voluntary Admission and Treatment

Janice H. is a 36 year-old woman who comes to the Emergency Department at 1:00 a.m. She is accompanied by a friend. Janice states that she has been having problems with depression – she can't seem to get out of bed anymore, she cries all of the time, and she hasn't had the energy to eat. She had called her friend tonight to say "goodbye." Janice had been thinking of committing suicide. Janice agrees to be admitted to the psychiatry unit at the hospital.

According to the Minnesota statute, "*Any person 16 years of age or older may request to be admitted to a treatment facility as a voluntary patient for observation, evaluation, diagnosis, care and treatment without making a formal written application.*"[4] The person who is admitted under a voluntary status may or may not be competent to make decisions regarding his/her care.

Janice would be considered "competent" if she:

- Had an awareness of her illness, the reasons, risks, and benefits of the treatment, and alternatives and consequences of refusing treatment; and
- Could communicate a reasoned choice concerning treatment (not based on delusions).

Janice has the right to refuse treatment at any time, and also has the right to leave treatment within 12 hours of making the request to do so. If Janice had been involuntarily admitted for chemical dependency, she would have to wait for a maximum of 72 hours after requesting to leave.

Legal (Involuntary) Holds

While in the inpatient psychiatry unit, Janice is withdrawn, uncommunicative, and seclusive. She indicates that she is continuing to think about suicide. She has developed a plan to kill herself as soon as she gets home. She has indicated that she plans to leave as soon as possible.

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3 Minnesota Statute (2004). Definitions, Chapter 253B.02. http://www.psychlaws.org/legalresources/StateLaws/Minnesotastatute.htm

4 Minnesota Statute (2004). Definitions, Chapter 253B.04. http://www.psychlaws.org/legalresources/StateLaws/Minnesotastatute.htm

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What is a 72-Hour-Hold?

If Janice meets the following three criteria, she can be held on an **Emergency Hold** (otherwise known as a **72-hour-hold**):

1. She has been examined by a licensed physician or licensed psychologist with a doctoral degree in psychology within the last 15 days;
2. The examiner believes that the person is mentally ill, mentally retarded, or chemically dependent **and** is in danger of causing injury to self or others if not immediately detained;
3. A court order cannot be obtained in time to prevent the injury.[5]

Another emergency hold is known as a **Police Hold or Peace[6] or Health Officer[7] Authority Hold.** In this situation, a person can be taken into custody and transported to a treatment facility if the officer believes that the person is mentally ill, mentally retarded, or chemically dependent **and** is at risk for harming himself or others if not immediately restrained. An officer should make every reasonable attempt to be out of uniform to transport the patient in an unmarked car. This hold is only for transporting the person to the hospital. Once hospitalized, a 72-hour hold is required for an involuntary hospitalization.

What happens in the 72 hours?

The treatment team needs to decide whether or not the person's condition warrants the filing of a petition for civil commitment. If they do, the petition must be filed, the pre-petition screening completed, a decision made by the County Attorney to accept the petition, and a court order issued to hold the person. All of these things must happen before the 72-hour time period expires.

What are my responsibilities while the patient is on an Emergency Hold?

Everyone in the psychiatry settings needs to be aware that involuntary patients may be angry, hostile, and even violent. You need to be constantly on alert for any signs that the person may try to harm herself or someone else.

5 Minnesota Statute (2004). Chapter 253B.05.
http://www.psychlaws.org/legalresources/StateLaws/Minnesotastatute.htm
6 A Peace Officer can be sheriff, or municipal or other local police officer, or a State Patrol officer when engaged in the authorized duties of office.
http://www.psychlaws.org/legalresources/StateLaws/Minnesotastatute.htm
7 A Health Officer is a licensed physician, licensed psychologist, licensed social worker, registered nurse working in an emergency room of a hospital, or psychiatric or public health nurse. http://www.psychlaws.org/legalresources/StateLaws/Minnesotastatute.htm

Careful documentation of the persons behavior and statements is also very important during this time period. Registered nurses, physicians, social workers, and other professionals are responsible for observing and documenting not only the patient's behavior, but response to medications, side effects, and any unusual occurrences. Nursing assistants and other non-licensed personnel can be of invaluable assistance in communicating the attitudes, interactions, and behaviors of the patient.

**All patients who are hospitalized need to be seen and examined by the physician within 24 hours of admission. The physician, by law, is required to be knowledgeable and trained in the diagnosis and need for admission related to the problems the patient is exhibiting.*[8]

How long can an Emergency Hold last?

People can be held for 72 hours on an emergency hold. This 72-hour period does not include weekends or holidays – for example, a person who is held on a 72-hour hold starting at 8:00 a.m. on **Monday** would need to be released by 8:00 a.m. on Thursday. A person who was started at 8:00 p.m. on **Friday** would need to be released by 8:00 p.m. on Wednesday. The physician can cancel the 72-hour-hold at any time if the patient has improved or has consented to voluntary treatment.

What happens when the time is up?

At any time prior to the end of the 72-hour time period, the physician may lift the hold if the person has an improved condition, or if the patient is willing to sign in voluntarily. If a civil commitment is not pursued, the person is released from the hospital. The patient can also be encouraged to stay for voluntary psychiatric treatment. A physician may place another 72-hour hold, but there must be an adequate reason why the original hold was not filed with a pre-petition.

> *Janice starts with group therapy and an anti-depressant medication. She begins to feel less depressed and much less suicidal by the end of the 72-hour period. Janice agrees to continue treatment on an outpatient basis.*

Emergency Forced Medications

In an emergency, a physician may administer neuroleptic medication to a patient who does not have the capacity to make a decision regarding medications. An emergency is defined as needing to prevent serious or immediate harm to the patient or others.

8 Joint Commission Standards, page 166, 2006.

When medication is no longer necessary, the physician discontinues the order for emergency forced medications. At the time of the first court hearing, the physician informs the court of the continued emergency, the need to continue treatment with neuroleptic medication and request authorization to continue treatment until the court makes a decision about the petition.[9]

The Civil Commitment Process[10]

Jason L. is a 44-year-old male with a long history of schizophrenia. Jason has auditory and visual hallucinations that urge him to kill his wife and children. He has become increasingly paranoid and is refusing to take his anti-psychotic medications. He is brought involuntarily to the hospital under a Police Hold after threatening his family with a gun. Jason continues to be paranoid, violent, and hallucinating while in the inpatient setting. He refuses to take any neuroleptic medications.

Pre-Petition Screening

The decision is made by the multi-disciplinary team to seek civil commitment. The social worker begins the process by applying for pre-petition screening. The designated agency for the County appoints a screening team to interview Jason and his family, investigate the events, symptoms, and behaviors that have triggered the request for the petition, and identify information about his neuroleptic medication.

The screening team:

1. personally interviews the person and any other individuals who appear to have knowledge of the situation.
2. identifies and investigates specific alleged conduct which is the basis for the request for screening.
3. identifies, explores, and lists reasons for rejecting or recommending an alternative to involuntary placement.
4. in cases of the mentally ill, finds information relevant to the administration of neuroleptic medications and whether the person is likely to consent or refuse medications.
5. decides if they can support a petition filing or not.
6. files a report with the County Attorney.

If the screening team recommends commitment, a report is sent to the County Attorney. If the screening team finds insufficient evidence to recommend a commitment, the petitioner will be notified. The physician has the option to appeal directly to the county attorney when the pre-petition screening team denies a case. ***Please see Appendix A for a sample Pre-Petition Screening Report.***

The Petition

The pre-petition screening team finds sufficient evidence to recommend proceeding with the process and forwards the report to the county attorney's office. The County Attorney accepts the petition by drafting and filing it in the district court.
The petition includes:

- the name and address of patient } *Petition*
- the name(s) and address(es) of patient's family members } *Petition*
- a factual description of behavior, location of behavior, and time period during which behavior took place} *Exhibit A*
- a written statement verifying that the patient has been examined within the past 15 days accompanies the petition, diagnosis and reason for petition} *Examination Statement*

After reviewing the petition, the court issues a Hold order to prevent Jason from leaving the hospital while the petition is under consideration. The court also appoints an attorney for Jason.

The Social Worker is responsible for completing the petition and Exhibit A if the family is not going to be the petitioner. The physician is responsible for the examiners' statements, which need to be completed before the pre-petition screening team is contacted.

Although the Minnesota Statute reads that the pre-hearing examination precedes the preliminary hearing, legal practice in Dakota, Ramsey, and Hennepin Counties typically do the preliminary hearing first, then the examination if sufficient cause is found to proceed.

A petition for commitment is sufficient reason to hold a person against their will after the petition has been officially filed **and** the Notice of Petition for Commitment has been given to the patient **or** the unit has been notified

9 Minnesota Statute (2004). Judicial Commitment; preliminary procedures, Chapter 253B.092.
http://www.psychlaws.org/legalresources/StateLaws/Minnesotastatute.htm
10 Minnesota Statute (2004). Judicial Commitment; preliminary procedures, Chapter 253B.07.
http://www.psychlaws.org/legalresources/StateLaws/Minnesotastatute.htm

of the filing by the Civil Commitment Court Office and there isn't time to deliver the papers to the patient.

Preliminary Hearing

Jason, his wife, the hospital psychiatrist, and social worker are given 24 hours written notice of the date and location of the hearing. When they arrive at the hearing, Jason is represented by a court appointed attorney. Jason is quiet at the beginning of the hearing, but becomes agitated, starts to yell and throw chairs. Jason is removed by the police.[11]

The purpose of the preliminary hearing is to determine whether there is enough evidence to hold the patient until the commitment hearing is set. If the patient admits that the information in the pre-petition report is true and that he/she is mentally ill, the patient can be directly committed without further court action.

A Special Note About Neuroleptic Medication Administration

The court may appoint a *substitute decision maker* at this time if the patient lacks the capacity to make decisions regarding neuroleptic medications. The patient can be given neuroleptic medications if the substitute decision maker consents and the patient does not refuse. If either the patient or the substitute refuses, the medication cannot be given without a court order except during a behavioral emergency. It is at this point that the court may order the patient to take neuroleptic medications. (See the section on *Jarvis v. Levine* at the end of this section.)

11 People who are disruptive or who are clearly incapable of participating in the court proceeding may be excluded or excused by the court

Pre-Hearing Examination

The court appoints an independent examiner to review Jason's chart, pre-petition screening report, and petition. The examiner then interviews Jason, Jason's wife, parents, and outpatient therapist. After a thorough examination, the examiner prepares and files a report 48 hours before the scheduled commitment hearing.

An examiner is a licensed physician or psychologist with a doctorate in psychology. The examiner must be **currently** practicing in the diagnosis and treatment of the alleged impairment. Copies of the examination report are given to the patient and attorneys.

Commitment Hearing

Jason is scheduled for the commitment hearing 10 days after the preliminary hearing.[12] *He continues to refuse to take any medications and has been violent on the inpatient unit. He has been given medications to control his violent outbursts and his attempts to injure himself and staff.*[13]

Everyone involved with the case needs to be notified at least five days before the hearing. The hearing takes place in the District Court, but it may take place in a treatment facility if it meets the court's standards.

Testimony is given by Jason's wife, therapist, and the social worker handling the petition. Jason is not attentive during the hearing. The court is presented with documentation as to why Jason has been given neuroleptic medications, the effect they have had, and the ramifications of removing him from the medications.[14]

12 The actual commitment hearing is held within 14 days of the petition being filed.

13 The court allows for neuroleptic medications to be given on an emergency basis for up to 14 days if the physician determines that the medication is necessary to prevent harm to the patient or others. A request for authorization to use the medications are made to the court before the commitment hearing.

14 Minnesota Statute (2004). Standards and Criteria for Administration of Neuroleptic Medications; Emergency Administration, Chapter 253B.092, subd. 3.
http://www.psychlaws.org/legalresources/StateLaws/Minnesotastatute.htm

COMMITMENT PROCESS UNDER MINNESOTA COMMITMENT and TREATMENT ACT

Decision

The court decides, based on witness testimony and the evidence, that Jason should be committed to a treatment center for a maximum of six months.[15]

The court may elect to issue a continuance for dismissal, order a stay of commitment, commit the person or dismiss the petition.

A **continuance for dismissal**, with or without findings, can last up to 90 days. This is used if the court believes that the person is likely not a danger to him/herself or others, but needs a short period to observe this due to the extent of the concern expressed by family or the community.

A court can "**stay**" an order for commitment. The person who is willing to cooperate and participate in a written plan of services may be eligible for a stay. Resources must be available and accessible to the person. The conditions of the stay that must be met by the person to avoid revocation of the stayed commitment and are clearly stated in the order.

The court may elect to **commit** the person. The court is required to commit patients to the least restrictive environment possible that will meet the patient's treatment needs. The alternatives include:

1. Community-based nonresidential treatment
2. Community residential treatment
3. Partial hospitalization
4. Acute care hospitalization
5. Community Behavioral Health Hospitals/ Regional Treatment Centers

Finally, the court can find that the requirements for commitment are not met and the person should be **released**.

What happens after the court's decision is made?

If the patient is found to need commitment, the health officer, case manager, or peace officer will escort the patient to the treatment environment. After 60-90 days, the treatment facility is required to send a report with very specific information to the court. The court will decide whether the patient continues to require treatment or not.

If the patient completes treatment at the hospital, the patient will be provisionally discharged. A provisional discharge is one in which conditions are set for the patient by the court and the treatment team. The conditions, such as taking medications and keeping appointments with the psychiatrist and case manager, need to be followed for the duration of the commitment.

What are my responsibilities with a civil commitment?

Although you may not be involved with the legal process of civil commitment, you will be working with the patient. For the petition to succeed (in the patient's best interests), it is vital that you carefully observe the patient's behaviors, attitudes, and communications. It is as important to document these observations – if you don't write it down, no one will know what you observed. Certain people may be called as witnesses in the civil commitment hearing to give testimony about the patient.

You also should watch for angry, hostile, and aggressive behavior. Some patients who are in the process of a civil commitment may try to strike out at you, other staff, other patients, or themselves.

Please see the following flowchart for the Civil Commitment Process for the Mentally Ill Person (does not include Mental Retardation, Chemical Dependency, or Criminal Procedures) from the Minnesota Department of Human Services. http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_137968.pdf

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15 Minnesota Statute (2004). Decision; Standard of Proof; Duration, Chapter 253B.09. *The initial commitment period shall not exceed six months.*
http://www.psychlaws.org/legalresources/StateLaws/Minnesotastatute.htm

APPLICATION FOR PRE-PETITION SCREENING:
By interested person to designated agency in county of proposed patient's residence or presence.

Pre-Petition screening team investigates. Provides notice to proposed patient of process, purpose and legal efforts of commitment.

If meets criteria, sends report to county attorney.

Team must oppose if insufficient evidence.

Nevertheless, petitioner may apply to county attorney.

County Attorney may decide whether to proceed with petition.

May proceed with petition.

If not, notifies interested party.

Any interested person, except a member of the prepetition screening team, may file petition
Petition includes:
- Written examiner's statement:
  - o Obtained within 15 days of filing petition
  - o Designates disability and person requires commitment
  - o Reasons for opinion
  - o If no statement by examiner, documentation that a reasonable effort was made.
- Name/address of proposed patient and
- Nearest relatives, reasons for petition.
- Factual description of recent behavior, where occurred, and time period over which it occurred.
- Examiner's statement in support of commitment.
- If petition for MI, need statement regarding neuroleptic medication, patient's capacity to make decisions regarding neuroleptic medication and reasons for opinion.
- Request, as applicable, for proceedings under 253B.092.

COURT:
1. Appoints attorney for proposed patient
2. Appoints examiner
3. Appoints second examiner chosen by patient, if requested.
4. Issues summons to appear for pre-hearing exam and commitment hearing, or
5. Issues apprehend and hold order only if person fails to appear after summons, or harm to patient or others, or if the person is on an emergency hold order and a commitment petition has been filed.
6. Sets preliminary hearing.

PRELIMINARY HEARING:
o If patient has been held under a judicial hold order, and to determine whether continued holding is necessary after 72 hours.
o Issue: Is there serious physical harm to person or others if released?
o Court may appoint a substitute decision maker.

COURT APPOINTED EXAMINATION:
At suitable place.
County Attorney and patient's attorney may be present.
Examiner files report with court 48 hours before commitment hearing.

COMMITMENT HEARING:
Held within 14 days of petition filing (unless extended up to 30 days more for good cause 90 days for SPP/SDP petitions).
Proposed patient must be given 5 days notice of hearing; 2 days notice of time and place..
Proposed patient or head of facility may demand immediate hearing, which must be within 5 days (unless extended for 10 days more for good cause.)
Patient may attend and testify, present and cross-examine witnesses.
Patient may not be so influenced by medication or other treatment as to be hampered in participating. (*If discontinuance of treatment is not in patient's best interest, court must be given a record of all treatments in preceding 48 hours.)
Must be held in courtroom meeting standards prescribed by local court rules. (May be at a treatment facility if it meets standards.)

FOR COMPLETE INFORMATION REGARDING THE COMMITMENT PROCESS, SEE MINNESOTA STATUTES, CHAPTER 253B; SPECIAL RULES OF PROCEDURE GOVERNING PROCEEDINGS UNDER THE COMMITMENT ACT; AND APPLICABLE COURT DECISIONS.

RELEASE BEFORE COMMITMENT:
o Court may issue stay of commitment for MI, DD, CD petitions. If stay is more than 14 days, there must be a written service plan, available funds, conditions for revocation of the stay and case manager appointed. Case manager files reports with court every 90 days.
o Court may issue continuance for dismissal up to 90 days with or without findings.

COMMITMENT DECISION: INITIAL COMMITMENT Standard of proof: Clear and convincing evidence. Court must find that person has the alleged disability. For MI, DD, and CD: There are no suitable alternatives to commitment; court commits to least restrictive alternative meeting the patient's treatment needs. Court may commit to community based alternative. For MI&D, SPP, SDP: Committed to secure treatment facility. Initial commitment may be up to 6 months for MI, DD, and CD.

MI, DD, CD: 60-90 DAYS AFTER BEGINNING OF INITIAL COMMITMENT
When patient remains hospitalized, facility sends court a report with specified information. If patient is on PD, designated agency does report.

If report describes patient as no longer needing treatment, or if report is not filed in the prescribed time, patient must be discharged.

(If report describes patient as needing treatment, initial commitment remains in effect).

BEFORE END OF INITIAL COMMITMENT:
When patient remains hospitalized, facility sends court a report with specified information. If patient is on PD, designated agency does report. Patient may be changed to voluntary status if head of facility consents to patient's written request, in which case, proceedings are ended.

If report describes patient as no longer needing treatment or supervision or if report is not filed in the required time, commitment is terminated.

MI, DD, CD:
If recommitment report describes patient as needing further treatment or supervision:
o Patient may request examiner;
o Holds hearing within 14 days of receipt of report and before commitment expires unless extended for good cause or waived by patient and his counsel.

MI&D, SPP, SDP
At end of 60 days: Court reviews commitment.

A hearing must be held within 14 days of receipt of report or within 90 days of the initial commitment or admission, unless otherwise agreed by the parties.

Court may waive review hearing & order indeterminate commitment.

Court may continue the review hearing for up to one (1) year.

CONTINUED COMMITMENT DECISION BY COURT
Standard of Proof: Clear and convincing evidence.

MI or CD:
If court's review of treatment report shows patient meets continued commitment criteria, may commit up to a maximum of 12 months.

DD:
If court's review of treatment report shows patient meets continued commitment criteria, may commit for an indeterminate period, subject to 3 year judicial review.

MI&D, SPP, SDP:
After the hearing, may commit for an indeterminate period.

If court finds patient is MI but not D, may commit as MI only.

No extension of commitment is permitted unless a new petition is filed, with a court hearing and determination. Under a new petition, the initial commitment period must be the "probable length of commitment necessary or 12 months, whichever is less". Continued commitment criteria must be used.

FOR COMPLETE INFORMATION REGARDING THE COMMITMENT PROCESS, SEE MINNESOTA STATUTES, CHAPTER 253B; SPECIAL RULES OF PROCEDURE GOVERNING PROCEEDINGS UNDER THE COMMITMENT ACT; AND APPLICABLE COURT DECISIONS.

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Court-Ordered Early Intervention

A newer standard that allows for less intrusive, mandated treatment than civil commitment is called "Early Intervention."[16] This may or may not be inuse at your facility.

Who is eligible?

Patients who have documented mental illness and will not consent to treatment or hospitalization for a mental health exacerbation may be eligible for early intervention. The patient must have grossly disturbed thoughts and/or behavior that either:

1. interferes with the ability of the patient to care for him/herself in way that the patient would normally choose, or…

2. has caused the patient to receive court-ordered inpatient treatment twice in three years; have symptoms like those that have preceded other commitments, or deteriorate to the point of civil commitment.

What is the process of early intervention?

The process is very much the same as the process of civil commitment, including application, pre-petition screening, pre-hearing, and petition. An early intervention hearing is held within 14 days of filing the petition.

How is this different than civil commitment?

The court has different options for treatment than a civil commitment. The court may order the patient to:

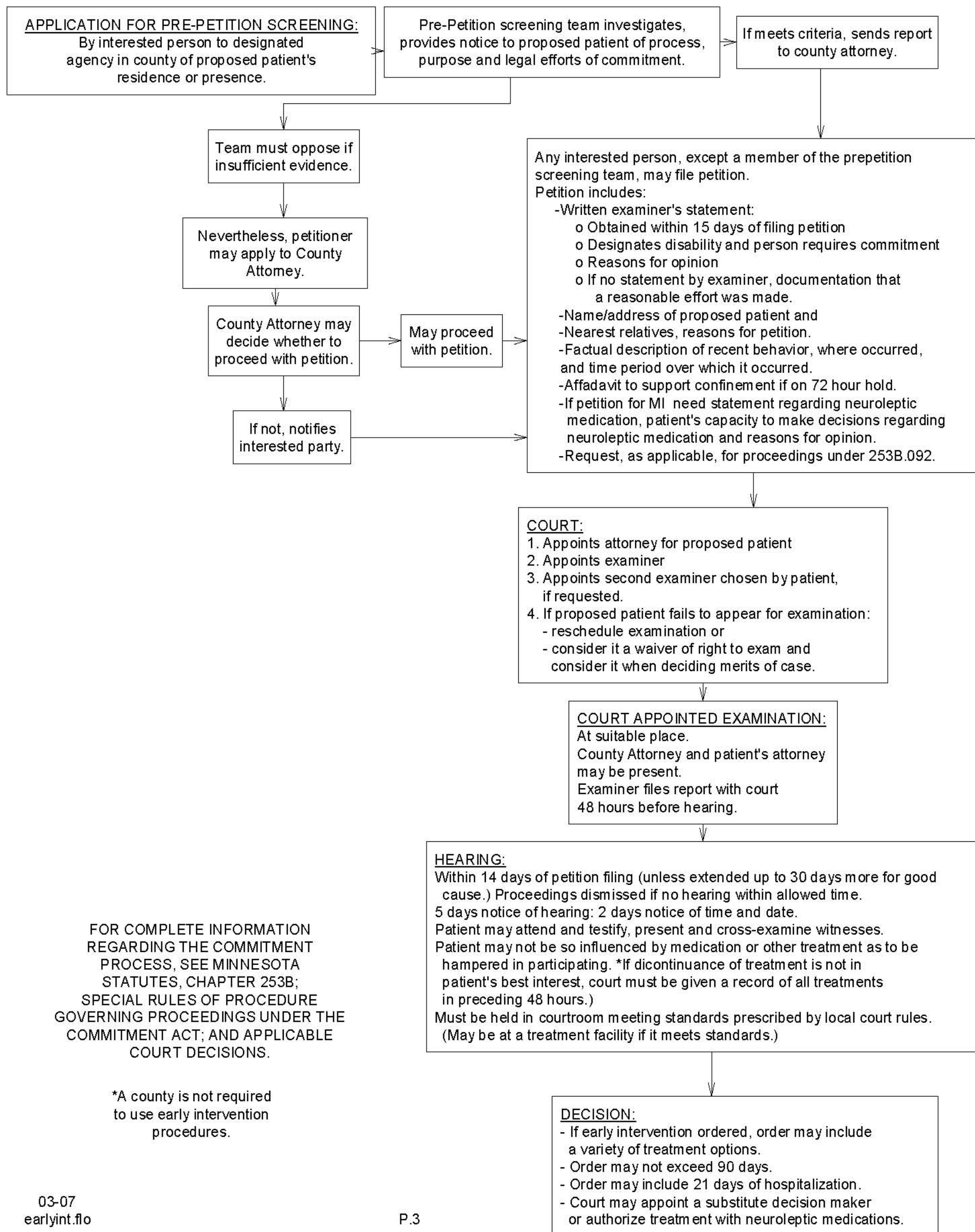
1. attend day treatment
2. participate in medication compliance monitoring
3. be hospitalized for less than 10 days

The patient may be taken to the hospital by a health officer, peace officer, or other person. Early intervention cannot last longer than 90 days. The court may also order neuroleptic medications if the patient refuses to take them.

Please see the following flowchart from the Minnesota Department of Human Services for the Early Intervention process.
http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_137968.pdf

16 Minnesota Statute (2004). Court-ordered Early Intervention, Chapter 253B.064

EARLY INTERVENTION*
UNDER MINNESOTA COMMITMENT AND TREATMENT ACT



Rights of the Psychiatric Patient

Psychiatric patients have many of the same rights as any other patient in the clinical setting. There are special rights that have been set down in law for psychiatric patients.

What are the rules regarding restraints?

A restraint is any method used to limit the person's ability to move, be physically active, or have normal access to his/her own body. According to Minnesota Statute, patients have the right to be free from restraints. If the patient requires restraints to prevent injury to himself or to others, the use of restraints and the reasons for it should be documented in the patient record. Accurate and complete documentation is essential.

The Joint Commission goes further in defining the use of physical restraints. The Joint Commission states that the reason for the use of restraint and seclusion is primarily to protect the patient against injury to self or others, because of an emotional or behavioral disorder.

Standard PC.12.130 states that patients in restraints or seclusions are assessed and assisted at initiation and every 15 minutes thereafter by in-person observation.[17] Remember – if it's not documented, it's NOT DONE!

Standard PC.12.100 states that time-limited orders do not mean that restraint or seclusions must be applied for the entire length of time that the order was written. A restraint or seclusion should be discontinued when the patient meets the behavior criteria for their discontinuation.[18] Staff can use specific criteria (documented, of course!) to release a patient early. See the TCHP Safety in Psychiatry for more on behavioral management.

Can a psychiatric patient send and receive mail?

The physician can limit correspondence only if the patient's medical condition would deteriorate because of it. The reasons for any limitation of correspondence must be clearly documented in the chart. For example, if a patient was continuously writing to the object of her delusion, threatening to kill that person, the physician may elect to limit her correspondence.

17 Joint Commission on Accreditation of Healthcare Organizations (2006). 2006 Hospital Accreditation Standards. Page 197.
18 Joint Commission on Accreditation of Healthcare Organizations (2006). 2006 Hospital Accreditation Standards. Page 198.

Can psychiatric patients have visitors and make phone calls?

The physician can restrict visitors and phone calls with cause, but in general, patients have the right to receive visitors and make phone calls according to unit and hospital policy.

Can my patient see his spiritual advisor?

Yes – the psychiatric patient has the right to call or see his/her spiritual advisor, attorney, or personal physician at any time. Your patient should be able to continue his practice of religion.

My patient's employer called to see if my patient was here – what do I tell him?

The law prohibits you from giving **any** information out about your patient without your patient's approval. Your response to your patient's employer? *"I'm sorry, I cannot give out any information."*

How often should my patient be assessed by a physician?

The Minnesota Statute on Patient Rights declares that the patient has the right to be assessed by a physician on a "periodic" basis, not less often than annually. The Joint Commissions requirements are much stricter:

Standard PC2.12 states that "*The patient's history and physical examination, nursing assessment, and other screening assessments are completed within 24 hours of admission as an inpatient."*[19]

Standard PC3.130 states that "*The special needs of patients who are receiving treatment for emotional or behavioral disorders are addressed by the assessment process."*[20] This assessment includes the past history and current functioning of the patient, clinical needs, social history, history of abuse, ethnic, cultural, and other health factors, and a psychiatric evaluation as necessary.

19 Joint Commission on Accreditation of Healthcare Organizations (2006). 2006 Hospital Accreditation Standards. Page 166.

20 Joint Commission on Accreditation of Healthcare Organizations (2006). 2006 Hospital Accreditation Standards. Page 169.

Can a psychiatric patient refuse treatment?

Any patient has the right to refuse medical or surgical treatment other than treatment for chemical dependency or nonintrusive treatment for mental illness.[21] If the patient consents to a treatment, a signed informed consent must be entered into the chart. If the patient is not deemed competent, the nearest relative can sign for treatment. Relatives who can sign for a patient are (in order):

1. Spouse
2. Parent
3. Adult child
4. Adult sibling

Refusal of any treatment against medical advise is not proof of incompetence!

Intrusive mental health treatment must also have a written, informed consent. "Intrusive" treatment includes electroshock therapy and neuroleptic medication administration. Administration of any intrusive therapy against the patient's will requires a court order. Neuroleptic medications can be given in an emergency situation (see "Emergency Forced Medications" section).

Do we still have to write care plans?

Every person receiving mental health care has the right to a written plan of care in which the problems, goals, and timeline are specified. This plan must be reviewed with the patient.

My patient wanted to see her chart… what do I do?

Check your facility's policy regarding a patient reviewing the chart. Many institutions have a policy in which the physician is notified in the event that a patient wants to view their chart.

How do patients know about all of these rights?

Everyone admitted to the hospital or treatment facility needs to be notified in writing of all of the rights. Many units and hospitals have pre-printed forms which outline patient's rights. Patient's rights may also be posted on the unit.

21 Minnesota Statute (2004). Rights of Patients, Chapter 253B.03.

Special Laws Pertaining to Psychiatric Patients

Jarvis v. Levine (418 N.W.2d; MN 1988)

This court ruling allowed the administration of neuroleptics without the patient's consent. The court found that civilly committed patients may not be administered neuroleptic medications over their objections without a finding that they lack the legal capacity to make the decision for themselves or if they do, without consent of someone other than their physician.

A "Jarvis", or Intrusive Treatment Plan (ITP), hearing is one in which the court is petitioned to approve the administration of neuroleptic medication to an incompetent mentally ill person.[22]

Price v. Shepard (239 NW2d 905) (Minnesota, 1976)

Price v. Shepard was a case in which the court ruled about the administration of electroconvulsive therapy (ECT). Much the same as a Jarvis ruling, the court in Price v. Shepard ruled that there must be a court hearing when a provider wants to administer ECT to a patient who is refusing the treatment.

Vitaly Tarasoff v. Regents of University of California, et. a. (1974)

The parents of Tatiana Tarasoff sued the student health service at the University of California in this case for failing to warn Tatiana about a threat that had been made against her. Prosenjit Poddar told the psychologist at the health service that he wanted to kill Tatiana. The psychologist informed the supervising psychiatrist, who then notified campus police. Poddar did kill Tatiana. The California Supreme Court heard the case in 1974 and in 1976. In 1974, the court ruled that "Privilege ends where public peril begins," meaning that the rules that govern confidentiality need to be broken when another **identifiable** individual is in imminent danger. The second ruling in 1976 ruled that the therapist has an obligation to use reasonable care to protect potential victims. This is also known as a *duty to warn*.

The Tennessen Warning

The patient needs to be made aware of the rights that he/she has regarding release of private or confidential information. The patient has the following rights:

22 Minnesota Statute (2004). Rights of Patients, 253B.03, subd. 6c.

- To know the purpose and intended use of the information;
- To know that he has the right to refuse to provide the information;
- To know what the possible consequences of not supplying the information are;
- To know who is authorized by law to receive information without their consent.

Summary

Understanding the complexities of the law surrounding psychiatric patients can be a challenge. Knowing some of the basic information about legal holds, early intervention, civil commitment, and patient rights can help you safeguard the patient, yourself, and others.

Resources

Internet

1. American Psychiatric Association: www.psych.org
2. Obsessive Compulsive Foundation: www.ocfoundation.org
3. Anxiety Disorders Association of America: www.adaa.org
4. National Foundation for Depressive Illness: www.depression.org
5. National Institute of Mental Health: www.nlmh.nih.org
6. National Alliance for the Mentally Ill: www.nami.org
7. American Foundation for Suicide Prevention: www.afsp.org
8. National Mental Health Association: www.nmha.org
9. Depression and Bipolar Support Alliance: www.dbsalliance.org
10. Seasonal Affective Disorder Association: www.sada.org.uk
11. Suicide Awareness/Voices of Education: www.save.org
12. Joint Commission: www.jcaho.org

Other

1. DSM-IV-TR. (2000). Washington DC: APA.
2. Grayson, J. (2003). Freedom from obsessive-compulsive disorder. New York: Penguin.
3. Hospital Accreditation Standards. (2006). Oakbrook Terrace: Joint Commission Resources.
4. Hunt, D. (2005). What your doctor may not tell you about anxiety, phobias and panic attacks. New York: Warner Books.
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6. Lieb, K., et al. (2004). Borderline Personality Disorder. The Lancet (364) 453-461.
7. Linehan, M., et al. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. Archives of General Psychiatry, 48, 1060-1064.
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10. Rosenthal N. (2006). Winter blues: Everything you need to know to beat seasonal affective disorder. New York: Guilford Press.
11. Sadock B. & Sadock V. (2000). Comprehensive textbook of psychiatry. Philadelphia: Lippincott Williams and Wilkins.
12. Kessler RC, Berglund P, Demler O, *et al.* (2003). "The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R)". *JAMA* **289** (203): 3095–105. doi:10.1001/jama.289.23.3095. PMID 12813115.

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Appendix A: Pre-Petition Screening Report

The following screening report was adapted and used with permission from the Minnesota Attorney Generals Office at the Office of the Ombudsman for Mental Health and Retardation. From the Minnesota Civil Commitment and Treatment Act Training Materials handbook (1998).

PRE-PETITION SCREENING REPORT

NOTICE: THIS REPORT IS NOT ADMISSABLE IN ANY COURT PROCEEDING UNRELATED TO COMMITMENT PROCEEDINGS. MINN. STAT. § 253b.07, SUBD.1(b).

A. PROPOSED PATIENT'S BACKGROUND:

1. NAME:
2. DATE AND PLACE OF BIRTH:
3. ADDRESS:
4. CURRENT LOCATION FOR SERVICE:
5. VETERAN?
6. ALLEGED:
7. PETITIONER'S NAME:
8. PETITIONER'S PHONE:
9. PETITIONER'S ADDRESS:
10. PETITIONER'S RELATIONSHIP TO RESPONDENT:
11. SPOUSE AND NEAREST RELATIVES:
12. LIST ANY OFFENSES PATIENT IS CURRENTLY CHARGED WITH: Trespassing and Possession of Marijuana
13. PATIENT'S PROPERTY AND APPROXIMATE VALUE: Unknown
14. ABLE TO GIVE TESTIMONY: County Adult Correctional Facility staff, Dr. M., County Corrections, pre-petition screener

SCREENING TEAM: A.B., RN, MS
C.D., SW
E.F., LSW

SUBMITTED BY: F.F.

B. SCREENING TEAM ASSESSMENT

In the Examiner's Statement in Support of Petition for Commitment, Dr. M., Licensed Psychologist, indicates that the proposed patient is "a chemically dependent and paranoid schizophrenic man who makes credible threats to kill a certain person. He has a weapon and plan and does not care if he goes to prison. He likes aggression, says killing will be fun. It is my opinion that the proposed patient presents a legitimate threat to this person."

Dr. M. continues, "For the last six months client has not worked and has lived off girlfriend. If released, he'll be homeless. Admits to hallucinations, including voice that tells him to kill an acquaintance and anyone who gets in his way. He has a knife and a plan. He says he has talked to friends about helping him. When 17, he broke his brother's nose and was kicked out of family. Client believes he is chemically dependent, uses acid, alcohol, and marijuana. Does not want to quit."

HOLD: Is presently in jail and not on a medical hold.

C. PATIENT'S TREATMENT HISTORY

1. 11/21/97 to present: County adult Correctional Facility
2. 1992: Private Hospital. Hospitalized one month after attempting suicide.

D. BEHAVIORAL HISTORY

On 12/30/97 Judge, upon motion by the Public Defender in this matter, ordered a medical examination to be conducted pursuant to Rule 20.01, subd. 2(3), Minn. R. Crim. P., to determine whether the proposed patient is mentally ill or mentally deficient so as to be incapable of understanding the proceedings or participating in this defense. The proposed patient will be seen in court again on January 27, 1998, for a Rule 20 hearing. The proposed patient has been charged with two counts of Trespassing and one count of Possession of a Small Amount of Marijuana.

Dr. M. met with the proposed patient in the County Adult Correctional Facility on 1/22/98. She reports "…He appeared very preoccupied and tended to pause and then respond slowly to questions. The proposed patient gave the impression he was having many thoughts he was not sharing…He appeared delusional about an acquaintance of his named M.B. and stated repeatedly that he was going to kill him. He stated he 'wouldn't mind killing my family either' but appeared less preoccupied with that thought. The proposed patient's affect was flat except for

occasional anger when he talked about various people in his life. At times, he laughed inappropriately. He appeared to give no thought to the possible consequences to him for sharing his unusual thoughts…When asked why he thought the Court might question his competency, the proposed patient said he thought it was because he told the police he was 'going to kill a kid when I got out of jail.'"

Offense and Criminal History: "In May of 1997, the proposed patient was charged with Trespassing when he was found in the home of Mr. and Mrs. D.B., the grandparents of the person who the proposed patient wanted to kill… He said the house was unlocked and he had entered through a downstairs front door. He said he had been in the house many times because his acquaintance, M.B., lived there…The proposed patient did concede that he knew he was not supposed to be in the house, but wanted to find his things… In November of 1997, the proposed patient was charged with Trespassing and Possession of a Small Amount of Marijuana when he was reported for having locked himself in a laundry room in an apartment complex…The proposed patient indicated he had been in jail several other times. He said he spent a month in jail for Check Forgery after he stole a $20.00 check from a man's car…. He denied ever having any charges as a juvenile."

The report continues, "Psychiatric History and Symptoms: The proposed patient indicated he is not currently on any medication and is not being seen by a psychiatrist. He indicated he was hospitalized on one occasion at Fairview Medical Center for about a month when he was 17 or 18 years old. At that time, he said he was hearing voices and seeing things. He said his hospitalization occurred because he had attempted to strangle himself with a belt in front of his brother… The proposed patient indicated he was treated with anti-depressants, including Zoloft and Paxil, and said he stayed on the medication for about a year before discontinuing them on his own… The proposed patient indicated he does continue to hear voices now… When he was younger, he said the voices would tell him to kill himself. Now, he said the voices tell him how he can kill M.B. and get away with it. He said the voices also tell him he should kill anyone that gets in his way… The proposed patient described his plan to kill M.B. He said he and a buddy would put M.B. in the trunk of a car, take him out of the country, and would 'beat the shit out of him.' After that, the proposed patient said he would 'cut him real nice and set him afire.' The proposed patient indicated he has a hunting knife which he bought because he sometimes goes deer hunting. He said he thought 'it would be fun to cut up a person' and he indicated he has, in the past, cut up deer. The proposed patient indicated he did think, however, that M.B. would be afraid if the proposed patient set him on fire. The proposed patient indicates he likes fire and is fascinated by it. He said that, several times a week, he burns paper, cigarettes, or cups just to watch them burn and to think about M.B. The proposed patient also indicated he knows 'M's every move.' He said he has followed M. and has also had his friends follow M. When asked directly whether he might kill somebody in the future, the proposed patient responded 'Oh, sure.' The proposed patient indicated he had talked with various friends about killing M.B. and has a friend who would be willing to help him…..The proposed patient indicated he did not care if he was caught himself, as long as M. was dead. He said he would be quite willing to do the time for murder…"

Dr. M reports the proposed patient's chemical use history, "The proposed patient indicated he began using chemicals when he was 18 years old. He said he used marijuana on an almost daily basis and sometimes used hash. He indicated he has used acid well over a hundred times and has also used alcohol excessively. He indicated he drinks vodka or Jack Daniels and has had blackouts and loss of consciousness. He indicated he has never been in chemical dependency treatment and does not plan to be. He said he does think he is chemically dependent, but wishes to continue using… The proposed patient indicated he grew up in Spring Lake with a brother and sister who are twins and are 16 years old. He said he left home when he was 17 years-old and then added, 'I wouldn't mind killing my family either…' The proposed patient indicated that the past six months, he has not had a job… He said his girlfriend had an income from her work at Denny's Restaurant and he maintained that she was not upset that he was not working as long as he stayed home and kept the place clean… He said his relationship with his girlfriend has now ended because he returned to jail…"

In her summary and recommendations, Dr. M states, "…The proposed patient has a mental condition of Paranoid Schizophrenia and chemical abuse… While the proposed patient is not in need of commitment to obtain competency, he is in need of commitment as a person who is mentally ill and dangerous. The proposed patient has indicated his desire and plan to kill an acquaintance of his. He has also given some consideration to killing his own family. The proposed patient is preoccupied with violence, in particular his desire to kill his acquaintance. Over the last six months, the proposed patient's ability to function has declined. He has lost his job and has been relying on his girlfriend to pay rent. He has indicated his relationship with his girlfriend has now ended and he is, apparently, homeless. He reports he

has had no contact with his family since he was 17 years old… The proposed patient indicated repeatedly that he knew his behaviors were wrong and illegal, but did not care… The proposed patient does not appear to meet criteria for being criminally responsible for his actions that resulted in these charges….”

E. CONVERSATION WITH PATIENT

On 1/26/98 at 1:00 p.m. I met with the proposed patient at the County Adult Correctional Facility. I identified myself and clearly explain the purpose of my visit. I told the proposed patient that Dr. M was recommending commitment and treatment. He questioned whether it was inpatient and then replied, “Shit.” The proposed patient agreed to talk with me and reported that he was in jail on two counts of Trespassing and Possession of Marijuana. I asked the proposed patient if he indeed stated that he wanted to kill M.B. The proposed patient replied, ‘Yeh, the way I see it I’ll be doing the world a favor. He owes me $2,000 and threatened to rape my whole family. He also threatened to put my sister in the hospital.” The proposed patient reported that M.B. had been threatening his family for the past year. The proposed patient stated, “I called my buddy, Kevin, and said enough is enough, we need to end his life.” The proposed patient reported that his friends have kept track of M.B. and “know where he is at all times.” I asked the proposed patient if he was close to his family and he replied, “No, not really.” When the proposed patient was asked if he was really that concerned about M.B. threatening his family, the proposed patient admitted, “I don’t like the kid to begin with (M.B.).” I asked the proposed patient if he would care if anyone else threatened his family and he replied, “I’d say go for it.” The proposed patient was asked if he has a mental illness and he replied, “Damn, I don’t know. I asked the doctor, what is insane? In this day and age what is normal? I don’t know. It’s just a word.” The proposed patient was asked if he is chemically dependent and he replied, “I know I am.” When asked if he wanted help, the proposed patient stated, “I don’t know. The way I’m going I’d rather keep getting high and drunk.” The proposed patient acknowledged that he is not employed and at this time has no place to live. He could not identify what it is that he needs at this time. When asked if he needed treatment, the proposed patient replied, “I guess.” I asked the proposed patient if he would take medication if it was recommended and he answered, “Probably not. I don’t believe in it.” The proposed patient acknowledged that he had been on Paxil and Zoloft in the past but took himself off because “It wasn’t working, it was only making me more pissed off.” The proposed patient admitted that he broke his brother’s nose and had been involved in a few fights. He denied hurting animals except insects, “I tear the wings off of flies when I can catch them.” The proposed patient briefly discussed attempting suicide after his good friend committed suicide. The proposed patient appeared to express remorse stating, “I knew she was going to do it and I didn’t do anything. I have to live the rest of my life with that.” The proposed patient reported that he was closest to his friend. He had been close to a “couple of friends on the street, but not really, not no more.” The proposed patient did not have any questions for me. I gave him my card and a commitment brochure.

F. LIKELIHOOD OF NEED FOR NEUROLEPTIC MEDICATIONS AND CAPACITY TO COMMENT

Dr. M has indicated that treatment with neuroleptic medication is recommended. She believes that the proposed patient lacks the capacity to make decisions regarding such treatment. Dr. M stated, “He is delusional. He does not recognize that he is ill.” The proposed patient has indicated that because he does not believe he is ill, he does not need medication.

G. RECOMMENDED DISPOSITION

It is recommended that the proposed patient be committed as mentally ill and chemically dependent. There are facts which indicate that he suffers from a substantial psychiatric disorder of thought, mood, perception, orientation or memory which is grossly impairing his judgment, behavior, reason, understanding or sense of reality. The proposed patient is being held in the County Adult Correctional Facility pending a Rule 20 hearing. He has been charged with two counts of Trespassing and one count of Possession of a Small Amount of Marijuana. Dr. M is recommending “commitment, medications, chemical dependency treatment.”

H. APPREHEND & HOLD

It is recommended that the Court order that the proposed patient be held at Mercy Hospital or the County Adult Correctional Facility pending the Commitment Hearing. Other than for transportation to and from the court hearings, transportation orders will not be necessary unless the Court orders that the proposed patient be held at a facility other than Mercy Hospital or County Adult Correctional Facility.

Directions for Submitting Your Post Test for Contact Hours

To obtain a certificate of completion for this home study program, please complete the post-test and evaluation on the next few pages. The date on your certificate of completion will be the date that your home study is received. **Any materials received with a postmark after the expiration will be discarded.**

HealthEast, HCMC, & MVAMC Employees
If you are an employee of HealthEast, HCMC, or MVAMC, you may send the post-test and evaluation to TCHP for processing. Your post-test will be returned to you through your hospital. It cannot be mailed to your home.

Paid Participants
If you are not an employee of one of the TCHP hospitals, please send the post-test and evaluation to TCHP with a check for $12.00. Please make check payable to **TCHP Education Consortium** and mail to:

TCHP Education Consortium
Capitol Office Building
525 Park Street, Suite 120
St. Paul, MN 55103

Your post-test will be returned to you with the certificate of completion.

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Introduction to Psychiatry Post Test

Please print all information clearly and sign the verification statement:

Name______________________________________
(please print legal name above)

Birth date (required)
Format: 01/03/1999

M	M	D	D	Y	Y	Y	Y

For HealthEast, HCMC, or MVAMC, employees only:
Hospital ______________________ Unit___________

Personal verification of successful completion of this educational activity (required):
I verify that I have read this home study and have completed the post-test and evaluation.

____
Signature

1) Is psychoanalysis commonly practiced in the inpatient setting?
   a) Yes
   b) No

2) Which model is used as a basis for assessment and intervention in modern psychiatry?
   a) Behavioral model
   b) Psychoanalytical model
   c) Existential model
   d) Medical model

3) Affiliative, dependence, achievement, ingestive, eliminative, sexual, and aggressive-protective needs are outlined in whose theory?
   a) Hildegard Peplau
   b) Sister Callista Roy
   c) Dorothy Johnson
   d) none of the above

4) What DSM-IV TR axis would the following conditions fall into?
   a) _____ Histrionic personality disorder
   b) _____ Schizophrenia
   c) _____ Poverty
   d) _____ Heart failure
   e) _____ Bulimia
   f) _____ Major depression

5) The anxiety in generalized anxiety disorder may be accompanied by:
   a) headaches
   b) nausea
   c) hot flashes
   d) all of the above

6) Panic attacks usually average _______ in length.
   a) 1-2 hours
   b) 2-3 minutes
   c) 20 minutes
   d) 24 hours

7) Dysthymia is:
   a) a less severe type of depression
   b) long-term
   c) not disabling, but keeps individual from operating “at full steam”
   d) all of the above

8) Another name for bipolar disorder is:
   a) manic-depressive illness
   b) dysthymia
   c) kindling
   d) none of the above

9) What does “psychotic” mean?
   a) out of touch with reality
   b) unable to separate real from unreal experiences
   c) both of the above

10) An example of inappropriate affect would be:
   a) giggling after a minor accident
   b) crying when extremely angry
   c) talking about being persecuted by demons, then laughing
   d) none of the above

11) According to Minnesota Statute, which of the following people is a “mentally ill person”?
   a) an 18-year-old with severe depression, admitted after suicide attempt with gun.
   b) a 64-year-old paranoid schizophrenic with hallucinations that command him to kill his neighbor.
   c) a 45-year-old street person who has auditory hallucinations and chemical dependency, and is unable to find food to eat.
   d) all of the above

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12) How much time does a patient who has admitted himself voluntarily for mental health treatment need to give as notice to leave?

   a) none
   b) 12 hours
   c) 24 hours
   d) 72 hours

13) What time can a patient leave if he is admitted on Thursday at 5 p.m. under a 72-hour-hold?

   a) Tuesday at 5 p.m.
   b) Monday at 5 p.m.
   c) Sunday at 5 p.m.
   d) Saturday at 5 p.m.

14) Can a patient be forced to take a neuroleptic medication?

   a) Yes, if it is in an emergency situation or the court orders neuroleptic medication administration
   b) No, never

15) How often does an order for restraints on an adult need to be renewed?

   a) every hour
   b) every four hours
   c) every twelve hours
   d) every twenty-four hours

16) What is a "Jarvis" hearing?

   a) when an application to declare the patient incompetent is made
   b) a hearing in which the legal guardian is declared
   c) a hearing where the psychologist/ psychiatrist is reprimanded
   d) a hearing in which the court can order neuroleptic medications to be administered to an incompetent person

Expiration date: The last day that post tests will be accepted for this edition is **December 31, 2019**—your envelope must be postmarked on or before that day.

Evaluation: Introduction to Psychiatry

Please complete the evaluation form below by placing an "X" in the box that best fits your evaluation of this educational activity. Completion of this form is required to successfully complete the activity and be awarded contact hours.

At the end of this home study program, I am able to:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Review prominent theories and models related to mental health.					
2. Differentiate between the models related to assessment, diagnosis, and interventional approach to the psychiatric patient.					
3. Describe the current theories about the etiologies of mental illness.					
4. Review the multi-axis diagnostic system of the DSM IV TR.					
5. Review the characteristics of the major psychiatric disorders.					
6. Describe the procedures for voluntary admission and treatment for the mentally ill person.					
7. Describe the indications, procedure, and duration of involuntary holds.					
8. Identify the role of each member of the multi-disciplinary team in regard to involuntary holds and the commitment process.					
9. Review the civil commitment process.					
10. Review patient rights in regards to psychiatry.					
11. The teaching / learning resources were effective. *If not, please comment:*					

The following were disclosed in writing prior to, or at the start of, this educational activity (please refer to the first 2 pages of the booklet).		
	Yes	**No**
12. Notice of requirements for successful completion, including purpose and objectives		
13. Conflict of interest		
14. Disclosure of relevant financial relationships and mechanism to identify and resolve conflicts of interest		
15. Sponsorship or commercial support		
16. Non-endorsement of products		
17. Off-label use		
18. Expiration Date for Awarding Contact Hours		
19. Did you, as a participant, notice any bias in this educational activity that was not previously disclosed? *If yes, please describe the nature of the bias:*		

20. How long did it take you to read this home study and complete the post test and evaluation:
______hours and ______minutes.

21. Did you feel that the number of contact hours offered for this educational activity was appropriate for the amount of time you spent on it?
____Yes
____No, more contact hours should have been offered
____No, fewer contact hours should have been offered.

Expiration date: December 31, 2019

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