Working with Mental Health and Criminogenic Factors in Justice-Involved Populations

Day Two 12/16/21

Mark Lukin, Ph.D.

IN OUR GRIT, OUR GLORY.

Last updated 12.8.21

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Welcome

Thanks **to the State of Nebraska Department of Health and Human Services and the UNL Public Policy Center for this opportunity to spend time with you today.**

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Disclaimer

All opinions stated are strictly those of the author and are not intended to represent the Nebraska Department of Health and Human Services, the Public Policy Center or the University of Nebraska.

I have no conflicts of interest to report.

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Review of Day 1

Overview of mental health/criminal justice approaches

Cluster A and Cluster B Personality Disorders

Discussed Provider Self Care

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Part 2: Working with Mental Health and Criminogenic Factors in Justice-Involved Populations will build on the content of Part 1. Special attention will be paid to the integration of Mental Health and Criminal Justice approaches, balancing individual and community rights, and the use of risk assessment and risk management in directing services. Strategies for professional self-care, managing morale, and coping with "career critical incidents" will also be discussed. Objectives:

1) Identify DSM V Indicators of Severe Mental Illness (Psychotic Spectrum and Bipolar Disorders)
2) Identify how to work with allied health and criminal justice professionals to serve criminal justice-involved consumers.
3) Demonstrate how to manage provider morale and avoid burnout that can delimit provider effectiveness.

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Science is a social enterprise

One of the goals of science education in the United States is to produce citizens who are scientifically literate -- that is, able to understand and contribute to discussions of the uses of scientific knowledge, so that they can help make science socially responsible. However, science education today reflects the biases of science itself with regard to race, class, and gender… Scientists can no longer afford to ignore the fact that science is a social activity, with norms, attitudes, and practices shaped by history, institutions, beliefs, and values.

http://chronicle.com Section: The Chronicle Review Volume 50, Issue 36,

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Racial disparity: Schizophrenia

Findings reveal a clear and pervasive pattern wherein African American/Black consumers show a higher diagnosis rate of schizophrenia on average three to four higher than Euro-American/White consumers. Latino American/Hispanic consumers were also disproportionately diagnosed with psychotic disorders on average approximately three times higher compared to Euro-American/White consumers.

(Schwartz, R. C. & Blankenship, D. M. 2014)

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APA Statement on Racism

The American Psychological Association failed in its role leading the discipline of psychology, was complicit in contributing to systemic inequities, and hurt many through racism, racial discrimination, and denigration of people of color, thereby falling short on its mission to benefit society and improve lives. APA is profoundly sorry, accepts responsibility for, and owns the actions and inactions of APA itself, the discipline of psychology, and individual psychologists who stood as leaders for the organization and field.

https://www.apa.org/about/policy/racism-apology

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UNL Land Acknowledgement

The University of Nebraska is a public, land-grant institution with campuses and programs across the State that reside on the past, present, and future homelands of the Pawnee, Ponca, Oto-Missouria, Omaha, Dakota, Lakota, Arapaho, Cheyenne, and Kaw Peoples, as well as the relocated Ho Chunk (Winnebago), Iowa, and Sac and Fox Peoples.

https://diversity.unl.edu/recognizing-land

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Discrimination Matters

"Increased discrimination frequency was associated with higher prevalence of… psychological distress, mental health diagnosis, drug use and poor self-reported health."

"In this nationally representative longitudinal sample, current and past discrimination had pervasive adverse associations with mental health, substance abuse and well-being in young adults."

(Lei, et al, 2021 in Pediatrics)

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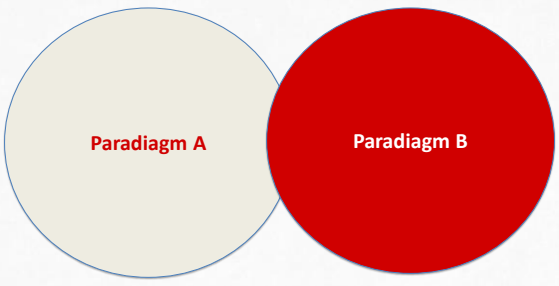
Criminal Justice: Paradigm Shifts



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DSM V Cluster "B" Personality Disorders

- Antisocial
- Borderline
- Histrionic
- Narcissistic

"Problematic or troubling"

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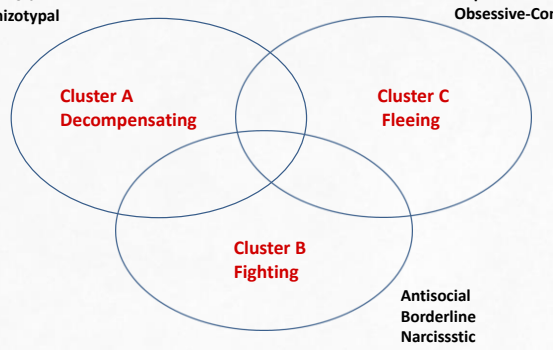
Paranoid
Schizoid
Schizotypal

Avoidant
Dependent
Obsessive-Compulsive



Antisocial
Borderline
Narcissstic
Histrionic

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Cluster B: Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following;

1. **Is uncomfortable in situations in which he or she is not the center of attention.**
2. **Interaction with others in often characterized by inappropriate sexually seductive or provocative behavior.**
3. **Displays rapidly shifting and shallow expression of emotion.**

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Histrionic Personality Disorder, continued

4. Consistently used physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.
7. Is suggestible (i.e., easily influenced by others or circumstances).
8. Considers relationships to be more intimate than they actually are.

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CBT Targets: Histrionic Personality Disorder

"No one understands how much my needs and how painful my life is"

"All is fair in love and war – I will use all resources at my disposal"

"I paint with a broad brush; don't hold me responsible for the details of my life"

"You are either with me or you are my sworn enemy"

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Histrionic Personality Disorder

Prevalence:
around 1.8%, mostly females (70%)
females may be over-diagnosed due to gender/social bias

co-morbid with somatic/conversion disorders, BPD and Depression

Differential:
manipulates to gain attention/nurturance v ASPD for profit/power
demand attention while HPD may be more passive/"one down"
More stable sense of self than BPD

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Notes: Histrionic Personality Disorder

Engages in emotional/dramatic behavior to be center of attention

Live in a high-drama world where boredom can be the enemy

May demand approval through being overly provocative/seductive

Siding with them is the only metric

They live their life making mountains out of mole hills

May demand dramatic response (or else) they feel rejected

(DSM, 2014; Fox, 2014)

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Cluster B: Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning in early and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate accomplishments).

2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love.

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Narcissistic Personality Disorder, continued

3. Believes that he or she is "special" and unique and can only be understand by, or should associate with, other special or high-status people/institutions.
4. Requires excessive admiration.
5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations).
6. Is interpersonally exploitive (i.e., takes advantage of others to achieve his or her own needs).

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Narcissistic Personality Disorder, continued

7. Lacks empathy: is unwilling to recognize and identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors or attitudes.

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CBT Targets: Narcissistic Personality Disorder

"I'm the only one that's important in the world; you're only players on my stage"

"You can't possibly begin to understand what I'm feeling"

"I deserve the best of everything or I simply can't stand it (and you'll pay)"

"What so wrong with stepping on others if I have to meet my needs?"

"I can't stand it when anyone else gets attention/praise, I hate them!"

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Management: Narcissistic Personality Disorder

Constant demands for support, admiration and fealty

May get furious if provider can't/won't meet consumer's wants and needs

At high risk to withdraw/sabotage progress when the going gets tough

There may not be any oxygen left in the room for anyone else

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Narcissistic Personality Disorder

Prevalence: varies, up to just over 6% of community samples, almost 2:1 males (caveat about gender socialization)

Differential:
Compared to other Cluster "B" PD's, the key is grandiosity
BPD have unstable self-image and self-destruction
HPD don't show exaggerated pride, disregard for others
SzPD and PPD also fear exposure but may seem odd
NPD v ASPD: no history of conduct disorder as teenage, drive for admiration/envy v profit/power

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Case Vignette: Cluster "B" Personality Disorders

Marcus is a 24 year-old inmate with NDCS; he is serving 2-4 years for assaulting his neighbor and jams next month. He has a long history of school fights, being fired from jobs and an impressive rap sheet for such a young man. He glares at his P.O. when they meet for pre-release planning, dismissing offers of help, saying, "I'll be all right." While in prison, Marcus got in trouble for "running store," CTG activity, fighting and 'talking trash' to staff, especially female staff. He is clearly bright and loves to "stir the pot." Marcus dreamed of being a chef when he was younger, but dropped out of high school and now seems to be on track for "having several more numbers in him."

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Survey Question: Cluster "B" Personality Disorder Case Vignette

What is Marcus's most likely diagnosis?

a) **Antisocial Personality Disorder**

b) **Borderline Personality Disorder**

c) **Histrionic Personality Disorder**

d) **Narcissistic Personality Disorder**

e) **All of the above**

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Case Vignette 2: Cluster "B" Personality Disorders

Paula is a 27 year-old woman who has just been paroled from the NDCS Correctional Center for Women in York (again) and is back in jail for violating release conditions – as her parole officer, you've heard that she can be "a handful". Paula enters the interview room complaining loudly about how no one understands her and that the "system is trying to screw me over again." She is overtly flirtatious with the escort officer. You heard that she filed several complaints against her last parole officer. She likes abusing pills, but the substance abuse counselor has already given her a glowing review; you get an uneasy feeling as she makes herself at home in the chair just across from your desk and glares at you. She has bright red scratches visible on both wrists.

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Survey Question 2: Cluster "B" Personality Disorder Case Vignette

What is Paula's most likely diagnosis?

a) **Antisocial Personality Disorder**

b) **Borderline Personality Disorder**

c) **Histrionic Personality Disorder**

d) **Narcissistic Personality Disorder**

e) **All of the above**

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DSM V Cluster "C" Personality Disorders

Avoidant

Dependent

Obsessive-Compulsive

"Anxious or fearful"

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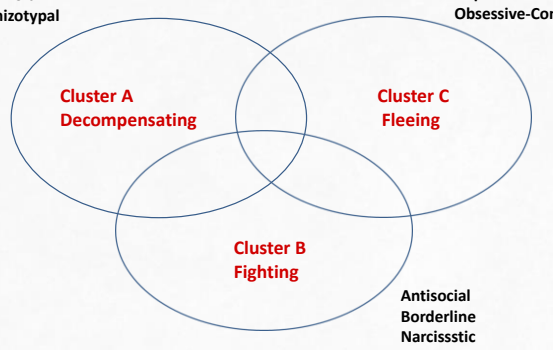
Paranoid
Schizoid
Schizotypal

Avoidant
Dependent
Obsessive-Compulsive



Antisocial
Borderline
Narcissstic
Histrionic

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Cluster C: Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning in early adulthood, and present in a variety of contexts, as indicated by four (or more) of the following:

1. **Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval or rejection.**
2. **Unwilling to get involved with people unless certain of being liked.**
3. **Shows restraint with intimate relationships because of the fear of being shamed or ridiculed**

(DSM V; 2014; Fox, 2014)

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Avoidant Personality Disorder, continued

4. Is preoccupied with being criticized or rejected in social situations
5. Is inhibited in new interpersonal situations because of feelings of inadequacy
6. View self as socially inept, personally unappealing, or inferior to others.
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

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CBT Targets: Avoidant Personality Disorder

"I can't stand the thought of any judgment or negative feedback"

"I live my life so as to avoid risk/exposure – I want to be invisible"

"I have taken my ball and gone home – nobody wants to talk to me and I don't wanna play with them"

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Avoidant Personality Disorder

Prevalence:
2.4% or higher; women and NAI (culturally) are at higher risk; risk decreases with increased level of education

Differential:
Social Phobia/Anxiety Disorder may do better without social press, those with AVD are more broadly anxious/impaired
co-morbid Paranoid PD 70%, Dependent 70%, OCD 63%, Schizoid 55%
AVD stable course of avoidance; panic/agoraphobia more reactive
AVD folks want social connection and can feel lonely without it (ego dystonic); SPD and SZPD don't want connection

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Notes: Avoidant Personality Disorder

Avoids sharing with provider in order to stay safe and not risk judgment

May only say what the therapist wants to hear to 'move to closure'

May be hypersensitive and easily injured

May not tell you if you hurt their feelings, they'll simply sabotage or drop out

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Management: Avoidant Personality Disorder

These folks want a guarantee that there won't be any trouble

Who amongst us is not afraid in life?

Life is painful and none of us is anxious to be hurt (again)

These folks can be very controlling
Illusion that we can really control anything (outside ourselves)

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Cluster C: Dependent Personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement because of fear or loss of support or approval. (X realistic retribution fears)

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Dependent Personality Disorder, continued

4. Has difficulty initiating projects or doing things on her or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone due to exaggerated fears of being unable to care for him/her self

(DSM V; 2014; Fox, 2014)

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Dependent Personality Disorder, continued

7. Urgently seeks another relationship as a source of care and support when a close relationship ends.
8. Unrealistically preoccupied with fears of being left to take care of him/her self.

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CBT Targets: Dependent Personality Disorder

"I am scared to death to make my own decisions or trust my own judgement"

"I'll probably make a mess of things so why even try to start something new"

"If _____ isn't there for me, I'll just die"

"I'll die if I don't have others to tell me what to do – I can't make it in this world."

"I'll give up anything and everything so keep _____ happy."

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Dependent Personality Disorder

Prevalence:
rate appears to hover around half-a-percent (.5-.6%)
higher concordance for MZ twins than DZ twins (around 30%)

Differential:
co-morbid anxiety disorders (panic, social anxiety, PTSD and O-C PD)
BPD will rage while DPD get passive/submissive with loss of support
AVD withdraws from others for safety, DPD actively seeks support
HPD/PBD will escalate demand for reassurance, dependent will not

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Notes: Dependent Personality Disorder

Ready compliance without the benefit of underlying commitment to change

May fear any autonomous decision making or action

May become dependent on provider

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Cluster C: Obsessive-compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning in early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. **Preoccupied with details, rules, lists order, organization, or schedules such that the major point of the activity is lost.**
2. **Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)**

(DSM V; 2014; Fox, 2014)

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Cluster C: Obsessive-compulsive Personality Disorder

3. **Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).**
4. **Is over-conscientious, scrupulous, and inflexible about matters of morality, ethics or values (not accounted by for cultural or religious identification).**
5. **Is unable to discard worn-out or worthless objects even when they have no sentimental value.**
6. **Is reluctant to delegate tasks or work with others unless they submit to exactly his or her way of doing things.**

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Obsessive-compulsive Personality Disorder, continued

7. **Adopts a miserly spending style towards both self and others; money is viewed as something to be hoarded for future catastrophes.**
8. **Shows rigidity and stubbornness.**

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"You won't get me to sit on the couch and discuss my obsession until I straighten things up, Dr. Hunter."

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CBT Targets: Obsessive-compulsive Personality Disorder

"We're good unless you try to get me to change something. Anything. I mean it!"

"My routines help me feel safe in the world – any change threatens my existence"

"I believe the maintaining order staves off impending disaster."

"I can't stand it when things are just as I need them to be – it literally makes me sick to my stomach"

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Obsessive-Compulsive Personality Disorder

Prevalence:
Prevalence in the 2-8% range
heritability accounts for 11% of the variance observed in OCPD
Co-morbid with GAD, OCD social and specific phobias

Differential:
Both OCPD & NPD seek perfection, the OCDPD will never achieve it
NPD and ASPD can be generous/extravagant, but not OCPD
SPD may not need social contact, while OCPD may fear it

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Notes: Obsessive-compulsive Personality Disorder

We have inherent conflict: we're promoting change, they're desperate to avoid it

Can defer to provider in order to avoid conflict/maintain

May balk at any change or alternative that threatens "maintenance of sameness"

Honor their fears as reasonable and prudent

What catastrophe is this anxiety protecting against?

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Case Vignette: Cluster "C" Personality Disorders

Stacey is a 31 year-old Caucasian female who works as accounting clerk. He is on probation for taking money from her employer, embezzling $11,000 over time by writing checks to a bogus account. She has a long history of being perceived as a "nerd" or a "geek" and not fitting in well with others. She is very skilled at her job but her perfectionistic nature places her in conflict with co-workers regularly. She did better while working at home (COVID), but is having more trouble now that staff are working from the office again. Stacey was very close to her co-defendant, Bruce, whom she idealized – people in the office considered Stacey to be Bruce's "pet" at work.

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Cluster C: Obsessive-compulsive Personality Disorder

What is Stacey's diagnosis?

a) Obsessive-Compulsive Personality Disorder

b) Dependent Personality Disorder

c) Histrionic Personality Disorder

d) Avoidant Personality Disorder

e) A and B

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Countertransference: Ken Pope

"Therapist's anger, hate, fear and sexual feelings…"

The denial of hate leads to "therapy that is adapted to the needs of the therapist rather than to the needs of the patient."

These feelings may be:
- **Hard to acknowledge,**
- **have devastating consequences and**
- **when acknowledged, may serve as a resource**

Pope & Tabachnick Professional Psychology Research & Practice 24(2) 142-152

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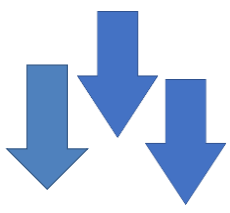
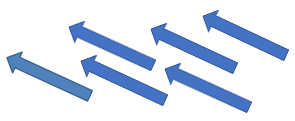
Surface level talk



Deeper level pull and push



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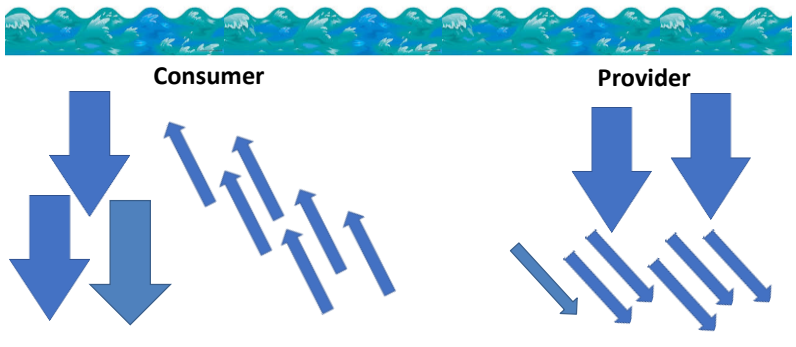

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PD Countertransference

"Patients with personality disorder often evoke negative feelings in professionals such as anxiety, condemnation, therapeutic nihilism, guilt, hopelessness, devaluation and loss of one's professional identity...

If such feelings are not acknowledged and explored, they may contribute to a negative service culture, and consciously or unconsciously influence clinicians to behavior in harmful ways – for example, instituting punitive interventions... Thus *effectively repeating the patterns of abuse relationships that the patient suffered in childhood.*"

J. Yakeley (2019) Medicine, Science and the Law

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PD Countertransference

<u>Cluster A</u> ***"Odd or bizarre" or "decompensating"***

Paranoid: criticized, unappreciated, devalued, 'walking on eggshells'

Schizoid: incompetent, inadequate, hopeless, frustrated

Schizotypal: bored, annoyed, detached, pessimistic

Colli, et. al. (2014) American Journal of Psychiatry

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PD Countertransference

<u>Cluster B</u> ***"Problematic or Troubling" or "Fighting"***

Antisocial: Mistreated, criticized, repulse, threatened, manipulated

Borderline: Overwhelemed by strong emotion, inadequate, scared, inadequate, confused

Narcissistic: bored, distracted, devalued, don't value relationship

Histrionic: engaged, engrossed, drained, seduced

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PD Countertransference

Cluster C ***"Anxious or Fearul" or "Fleeing"***

Avoidant: protectionive, sadness

Dependent: nurturant, protective, self-disclosive, needed

Obsessive-Compulsive: unengaged, bored, frustrated

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Who's a better psychologist?

Psychologist	CJ Involved Consumer
Good home life	abusive, substance-using parents
Folks met most needs	Folks met few, if any, needs
College scholarship	Survived by wits v other criminals
Misdiagnosing client	beaten up by Crips or Aryan Nation
Possible "B" on test	shot in drug deal b/c they misread
Working 50+ hours	lots of free time to get into trouble

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Substance Use Disorders

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

https://www.asam.org/resources/definition-of-addiction

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DSM IV to DSM V: Substance Use

DSM IV: Substance Abuse and Dependence
Only required one symptom

DSM V: Unified criteria
Substance Use Disorders
2-3 symptoms required out of 11
addition of craving as criteria
legal criteria remove

(Brigham Scott, CAPS Training, 9.21)

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Substance Use Disorders

1. Substance is often taken in larger amounts/ over a longer period than the patient intended.

2. Persistent attempts/one or more unsuccessful efforts to cut down/control substance use.

3. A great deal of time spent in activities necessary to obtain, use, or recover from effects.

4. Craving/strong desire/urge to use the substance

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Substance Use Disorders

5. Recurrent use resulting in failing major role obligations at work, school, or home.

6. Continued use despite persistent/recurrent social/interpersonal substance use problems.
7. Important social, occupational or recreational activities given up/reduced due to use.

8. Recurrent substance use in hazardous situations.

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Substance Use Disorders

9. Substance use is continued despite persistent or recurrent physical or psychological problem.

10. Tolerance, as defined by either of the following:
    a. Markedly increased amounts needed to achieve effect, or
    b. diminished effect with same amount used.

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Substance Use Disorders

11. Withdrawal, as manifested by either:
    a. Characteristic withdrawal syndrome
    b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

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Substance Use Disorders

Alcohol Use Disorder (ICD 10)

☐ 305.00 (F10.10)	Mild	2-3 symptoms present
☐ 303.90(F10.20)	Moderate	4-5 symptoms present
☐ 303.90(F10.20)	Severe	6+ symptoms present

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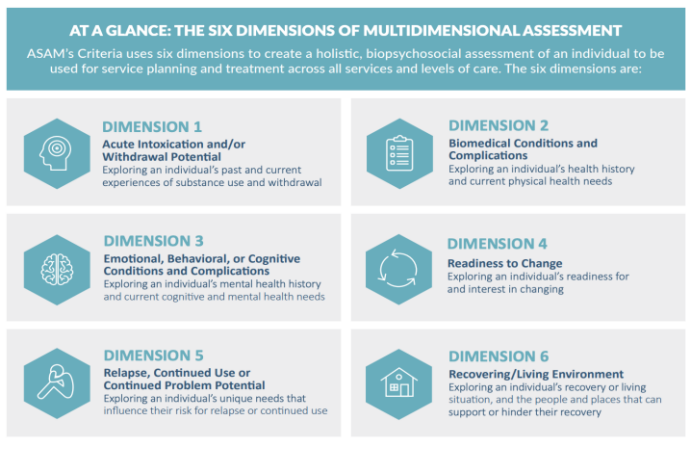

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Substance Use Disorders

"Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-5* criteria for substance use disorder) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health." (White & Kurtz, 2005)

The immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety." (McLellan, et. al., 2005)

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Substance Use Disorders

"When treating two co-occurring disorders (like substance use disorder and mental health issues), focus on interventions that impact both disorders as your priority."

- Dennis McChargue, UNL

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Substance Use Disorders

"When treating co-occurring disorders (like substance use disorder and mental illness), the key is to focus on interventions that are effective in offering treatment benefit for both conditions."

Dr. Dennis McChargue, UNL

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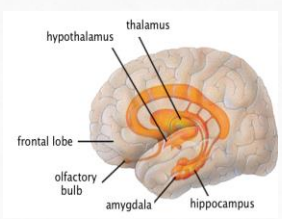
Final Common Pathway: Substance Use Disorders

Psychostimulants
Opiates
Ethanol
Cannabinoids
Nicotine



Pierce RC, Kumaresan V. The mesolimbic dopamine system: the final common pathway for the reinforcing effect of drugs of abuse? Neurosci Biobehav Rev. 2006;30(2):215-38.

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Notes: Substance Use Disorders

"Treatment for serious mental illness addiction requires interventions of high intensity and substantial duration"

William Spaulding, Ph.D.

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"*Don't drink, don't take drugs and take your medication.*

No matter what."

Roger Weiss, M.D.
Harvard/McClean Hospital

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Severe and Persistent Mental Illness: Schizophrenia

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2) or (3).

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g. frequent derailment or incoherence).
4. Grossly disorganized or catatonic behavior.
5. Negative symptoms (diminished emotional expression/avolition).

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Schizophrenia, continued

B. For a significant portion of the time since the onset of the disturbance, levels of functioning in one of more major life areas, such as: work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset

C. C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less is successfully treated) that meet Criteria A (e.g. active-phase symptoms) and may include periods of prodromal or residual periods.

(DSM, 2014)

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Schizophrenia, continued

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. Autism spectrum disorder or a communication disorder of childhood onset have been ruled out

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Schizophrenia is a chronic, progressive neurological disorder with a variable course and diverse symptom presentation, often lifetime in duration

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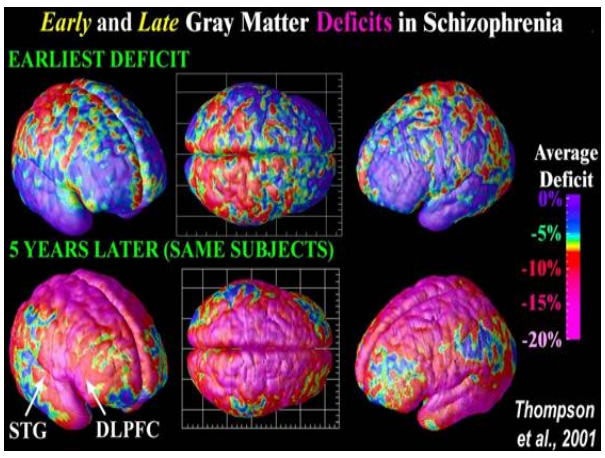


82

Continuum of Psychotic Spectrum Disorders

Schizotypal Personality Disorder

Delusional Disorder

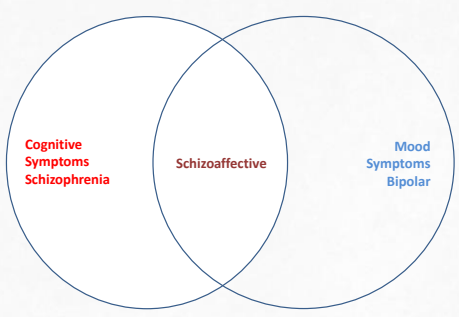
Brief Psychotic Disorder

Schizophreniform Disorder

Schizophrenia

Schizoaffective Disorder

83



84

First Episode Psychosis (FEP)

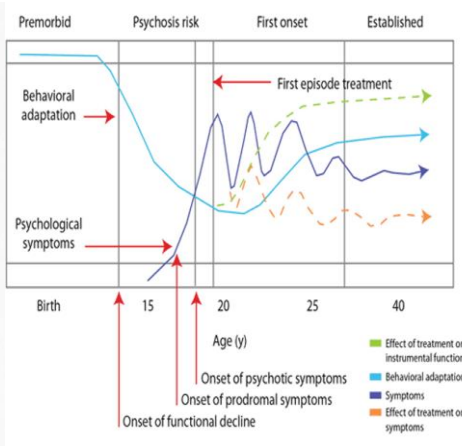
Initial age of onset: males 18, females 21

Disease often starts with “psychotic break”

Break = sudden emergence of symptoms, including psychosis, hallucinations, delusions

Early intervention at the time of FEP can reduce the lifetime severity/course of the illness

85



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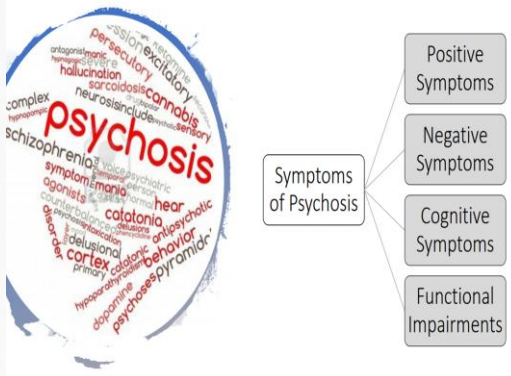
Typical Disease Progression of Major Mental Illness

Major Mental Illness is assumed to be a chronic, progressive and episodic disorder with typical co-morbid mental health and substance abuse problems

Stage	Symptoms	Intervention
Pre-Morbid	No symptoms present	Education about risk Genetic Counseling Avoid risk factors such as Stress, Substance Use
Initial Acute Episode	Typical onset 16 –25 Acute or Gradual Onset Confirmatory of MMI Risk	Medical emergency Reintegration
Initial Stabilization	Initial symptoms recede	Medical stabilization Increase orientation Patient Education
Initial Stable	Return to pre-morbid functioning	Education, rehabilitation, skill training, medication compliance & relapse prevention
Subsequent Episode	Return of symptomology May be acute or gradual	Medical re-stabilization Increase orientation Reintegration
Subsequent Stabilization	Symptoms recede Resumption of daily activities	Medical stabilization Increase orientation Patient Education "What went wrong?"
Long-Term Stable	Return to pre-morbid functioning with review of relapse prevention plan	Education, rehabilitation, skill training, medication compliance & relapse prevention

87



Slide courtesy of Laura Tully, Ph.D., UC Davis

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Schizophrenia, Positive Symptoms

Positive symptoms = added symptoms, including:

Persecutory: belief that others are out to get them

Grandiose: belief that they have special powers/prestige

Erotomanic: beliefs with a sexual/romantic focus

Religious: special sense of connection/purpose with God

Reference: unrelated events having special meaning just for me

89

Sensory Hallucinations in Schizophrenia

Sight:	**"I see my dog inside my cell"** **"I can't stop seeing my victim's face"**
Taste/gustatory:	**"Everything I eat tastes like metal"** **"They keep putting STD's in my mouth"**
Touch/tactile:	**"They are shooting me with X rays"** **"My legs keep burning – make it stop!"**
Smell:	**"My breath smells terrible-can't you smell it?"** **"My cellie stinks on purpose – I'm gonna get him."**
Aural:	**"Someone keeps calling my name – make it stop!"** **"The devil keeps on whistling at me"**

90

Negative Symptoms Schizophrenia

- Anhedonia = loss of interest or joy
- Avolition = lack of motivation
- Flat Affect = reduced emotionality
- Poverty of Speech = degraded speech
- Ability to self-monitor/care about social norms
- Sense of Self = loss of integrated "sense of self"

91

Anosognosia Schizophrenia

Greek for "without knowledge of the disease"

More than denial or lack of insight or self-awareness, it is an inability to perceive/understand deficits in functioning

Also observed in stroke, Alzheimer's, etc.

≥50% of patients with Schizophrenia, ≥40% Bipolar

Major impediment to treatment efforts

92

CBT Targets: Schizophrenia, continued

"They're always trying to control me by making me take meds"

"I can't trust anyone – I never know who is trying to get me "

"I just don't want to be bothered – I just want to be left alone"

"No one understands that God has a special plan just for me and needs my help"

"I feel so bad about myself; I've been broken ever since I got sick"

93

Schizophrenia

Prevalence
Rates range from .3 to .7%, more male than female cases
Occurrence of negative symptoms may be higher in males

Differential:
Schizoaffective Disorder requires major mood disorder (dep or mania)
Schizophreniform Disorders is of shorter duration (< 6 months)
Schizotypal PD has sub-threshold symptoms
PTSD requires a triggering event and re-experiencing
Substance intoxication is time-limited
TBI is less organized/thematic

94

Management: Schizophrenia

Client may have limited alliance, motivation and inconsistent follow-through

Provider may have to "suspend disbelief" about client' beliefs
Provider may have to broaden their definition about client
success

Helpful to educate yourself about the client's condition

Number one target for this population in medication compliance

95

Management of Hallucinations

Don't 'play along with hallucinations ("Yes, I see it too")

Validate their experience:
"I'm sorry, I'm not seeing/hearing what you are seeing/ hearing, but I believe that they are very real for you."

Validate their feelings:
"It must be really hard to see/hear things that other people don't, because they may not believe you."

Encourage them to cope/adopt:
"What you are seeing/hearing is stressful, but remember that you can fight to stay in charge/decide what's real."

96

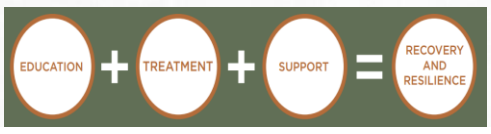
What works in the treatment of SPMI?

Motivational enhancement
Illness self-management
Social skills training
Behavioral family therapy
Supported employment & education
Assertive community treatment
Cognitive Rehabilitation
Social learning therapy
Cognitive-Behavior Therapy
Integrated treatment of dual diagnosis

97

Recovery research in SPMI

- **Recovery *possible* and documented for at least the last 40 years**
- **Recovery can occur *with or without* professional intervention**
- **Recovery involves more than symptom reduction; Recovery involves resumption of *valued roles/sense of well-being/esteem***



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Wellness Recovery Action Plan

(WRAP®) a personalized wellness and recovery system born out of and rooted in the principle of self-determination.

WRAP® a wellness/recovery approach that helps people to:
1) decrease/prevent intrusive/troubling feelings/ behaviors
2) increase personal empowerment;
3) improve quality of life; and
4) achieve their own life goals and dreams

https://mentalhealthrecovery.com/

99

Good Life Plan for: _____ date: _____

	GREEN	YELLOW	RED
Mental Health			
Academics			
Friends/Family			
Bottom Line			

100

Good Life Plan for: _____ date: _____

	GREEN	YELLOW	RED
Mental Health	Laughing (for real) Taking time to have fun Not hiding Actively taking care of myself	Spending more time alone/isolating Starts to hear buzzing/whispering Pretending to do school work (but not) Decreased self-care – "I stop caring" Denies problems – start resenting others	Haven't seen friends for days Work is getting done poorly Don't want to be alive Hearing whispered voices "I hate you" Don't even get out of bed
Academics			
Friends/Family			
Bottom Line			

101

Good Life Plan for: _High-functioning sample_ date: _3/3/21_

	GREEN	YELLOW	RED
Mental Health	Keeping goals and tracking progress consistently. Keeping busy. Getting enough sleep (7-8 hours) or Taking power naps when needed Eating good/healthy food consistently or making decisions to treat myself (junk food) Being active 1-2 hours a day Exercise/motion for 15-30min per day Getting stuff on my To-Do list done	Brain fog apparent Procrastinating on tasks Some sleep deprivation (5-7 hours/night) or taking naps out of necessity Eating fast food as coping mechanism more often Active 0-1 hours daily and getting exercise only every other day Procrastinating my to-do list	Only in non-productive thoughts Averaging little time in green, some in yellow. Indecision leads to depressive episodes. Not getting enough sleep (<5 hours) or taking naps out of necessity and preventing me from doing things in my day. Eating only fast/junk food No significant activity, not moving. To-do list is intimidating and only growing…
Academics	I am doing my classwork on time. I am practicing at least 12 hours a week. I am making progress on long-term personal projects	I am missing some deadlines but keeping my grades afloat. I am practicing between 8 & 12 hrs./week. Procrastinating on my long-term personal projects.	I am not making deadlines and am falling behind. I am practicing less than 8 hours per week. Not making any progress on my long-term personal projects for a stretch of time.
Friends/Family	I talk to my friends regularly. I talk to my parents on a weekly basis.	I talk to my friends on a weekly basis. I talk to my parents sporadically throughout the month.	I am not talking to anyone on a regular basis. I am in isolation both physically and mentally. Talk to my parents less than twice/month.
Bottom Line	Energy levels are good and I feel good. I feel like I am optimistic or realistic most of the time. I spend a little time cleaning every day. Listening to music daily.	My energy levels are in need of re-calibration via naps and breaks. I clean only every other day. Not listening to music.	My energy levels are consistently low and the naps and breaks are preventing me from getting work done. I clean less than once every 2-3 days. Not listening to music.

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Case Vignette: Schizophrenia

Keith is a 44 year-old male who believes that God has a special plan for his life – he's frustrated because he doesn't know the plan but thinks others are keeping the plan from him. Keith did prison time for robbing a bank, not to get money, but to force the police to "tell him the truth" (thinking they would know). After his release, Keith was arrested again by Capitol police after he received directions from George Bush 41 during the state of the Union, saying, "I have a message for you." While riding the bus to DC, Keith saw billboards urging him on his mission and was "freaked out" when convenience store clerks knew his name. Keith is tormented with fear that he may "miss out" on God's message leading him to his destiny. Keith regularly smokes MJ, saying it helps him think more clearly.

103

Survey Question: Schizophrenia Case Vignette

What is Keith's diagnosis?

a) Bipolar II disorder

b) Schizotypal Personality Disorder

c) Schizoaffective Disorder

d) Schizophrenia

e) A and B

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SPMI: Schizoaffective Disorder

A. An uninterrupted period of illness during which there is a major mood disorder (major depression or mania) concurrent with Criterion A of schizophrenia. Note: the major depressive episode must include Criterion A1: Depressed mood.

B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.

C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.

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Schizoaffective Disorder, continued

D. The disturbance is not attributable to the effects of a substance (e.g. a drug of abuse, a medication) or another medical condition.

Specifiers:

Bipolar Type: 295.70 (F25.0) This subtype applies if a manic episode is part of the presentation. Major depressive episodes may also occur.

Depressive Type: 295.70 (F25.1) This subtype applies if only major depressive episodes are part of the presentation.

106

CBT Targets: Schizoaffective Disorder

"I can't stop the voices in my head - it's making me feel depressed"

"When I get paranoid like this, I am sure my P.O. is trying to kill me and it makes me want to run away or get him first"

"When I get manic, I really want to use meth again and I don't care what happens or what it costs me"

"When I get down, I feel like it's a waste of time and money to keep taking my medications."

107

Treating consumers with Severe & Persistent Mental Illness

Make sure you understand the diagnosis

Manage your expectations – progress can be slow

Stay optimistic – consumers need hope in big doses

Celebrate small victories and empathize with challenges

Work closely with physician, treatment team and family members

Medication compliance is the key to treatment success

108

Schizoaffective Disorder

Prevalence:
.03%, or about one third the prevalence of schizophrenia
Higher incidence w/ first degree relative has psychotic spectrum dis.

Differential:
Cognitive symptoms don't persist in Mood Disorders w/psychotic feat
Schizophrenia does not diagnosable major mood disorder (Criterion C)

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Case Vignette: Schizoaffective Disorder

John is a 41 year-old who was in prison for murdering one of his friends, "stomping him to death." John believes that he has been "chosen by God to be a millionaire and have a beautiful wife." Because he believes this, he expects every woman he meets "may be the one." He has gotten in trouble for "stalking" women via media and in the community. John has periods of extremely high energy, where he will ride the exercise bike for 6-7 hours daily or show prominent agitation. John doesn't believe that he has mental health problems and runs when his psychologist appears. In the community, he liked to use methamphetamine. John has earned his way to Community Corrections twice but violated rules and had to be sent back to a secure institution.

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Survey Question: Schizoaffective Case Vignette

John's most likely diagnosis is:

a) Bipolar I Disorder

b) Schizophrenia

c) Schizoaffective Disorder

d) Histrionic Personality Disorder

e) Bipolar II

111

Bipolar Disorders

Mood disorders include disruptions of mood, both low mood (depression) and elevated mood (mania).

Bipolar conditions replaced "manic depressive" disorders – they are characterized by periods of elevated, problematic mood.

112

SPMI: Bipolar Disorders

Bipolar I: Formal manic episode is present
For a diagnosis of bipolar I disorder. The manic episode may have been preceded by, and may by followed by, hypomanic or major depressive episodes.

Bipolar II: formal manic episode is not present

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SPMI: Bipolar Disorder I

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to significant degree and represent a noticeable change from usual behavior:

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SPMI: Bipolar Disorder I, continued

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g. feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas of subjective experience that thoughts are racing.

115

SPMI: Bipolar Disorder I, continued

5. Distractibility (e.g., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g.. engaging in unrestrained buying sprees, sexual indiscretions or foolish business investments).

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CBT Targets: Bipolar Disorder I

"I've stayed up for the last three days re-categorizing all the books in my house: first alphabetically, then by author's last name and finally I rearranged all of them by protagonist's last name"

"I feel like I can take on anyone – line up the entire Nebraska football team and I'll kick all of their tails, every one of them"

"I found this great deal on Amazon, so I ordered all 1,583 of my Facebook friends this album by Slim Whitman! I don't have to worry because the bill doesn't even come till December!"

117

Bipolar I

Prevalence:
.06% in US; .6% across 11 other countries
Occurs in females slightly more frequently than males

Differential:
Requires a formal manic episode v Bipolar II
Anxiety disorders can mimic Bipolar, but are anxiety-focused
Panic attacks are more acute
PTSD can mimic Bipolar, but is reactive in nature/re-experiencing

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Notes: Bipolar Disorder I

Mood Stabilizers can be very effective treatments for bipolar.

Anti-depressants, which are really good for treating depression, can trigger manic episodes for persons with bipolar.

Mania increases risk for harm to both self and others

Mania resulting from anti-depressant treatment qualifies for Bipolar I

Talk therapy has limited effectiveness for a person in a manic episode

119

Bipolar: Bipolar II

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represents a noticeable change from usual behavior, and have been present to a significant degree:

120

Bipolar: Bipolar II

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested only after 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.

121

Bipolar: Bipolar II

5. Distractability (e.g. attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments.

122

Bipolar II

Prevalence:
Internationally, the 12 Month prevalence is .3%
In the U.S., the 12 month prevalence is .8%
Cumulatively, Bipolar I and Bipolar II prevalence is 1.8%
75% of Bipolar II's have anxiety disorder, 37% have substance use dis

Differential:
Bipolar I includes a history of formal mania
Major depressive may have manic features of shorter duration
Cyclothymia has multiple, sub-threshold manic/depressive episodes
Psychotic spectrum disorders all have periods of psychotic symptoms

123

Case Vignette: Bipolar I Disorder

Callie is a 20 year-old college student who is studying biology and hoping to be a medical doctors. She struggles with periods of low mood where she can't get out of bed/doesn't do any homework for days but also has times where she will stay up for several days with excess energy. Callie likes to drink and take risks when she is manic, adding to her problems. She recently threatened one of her professors after class – she has been referred to the UNL threat team and the County Attorney is considering charges. She has no legal history. You have been asked to assess her needs and make recommendations to the court regarding intervention options.

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Survey Question: Bipolar I Disorder Case Vignette

What is Callie's correct diagnosis?

a) Histrionic Personality Disorder

b) Schizophrenia

c) Bipolar I disorder

d) Bipolar II disorder

125

SPMI: Major Depression

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at one of the symptoms is either 1) depressed mood or 2) loss of interest of pleasure. Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly ever day, as indicated by either subjective report (e.g., feels sad, empty or hopeless) or observation made by others (e.g., appears tearful). Note: in children and adolescents, can be irritable mood.

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SPMI: Major Depression

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down.

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SPMI: Major Depression

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick.

8. Diminished ability to think/concentrate, or indecisiveness, nearly daily (by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

128

CBT Targets: Major Depression

"I'm totally worthless – no one has ever loved me."

"I only cause pain by being in the world – the world would be much better off if I was dead."

"If I commit suicide, all of my pain will stop."

"Things will never get any better, no matter what I do."

129

Notes: Major Depression

Provider must be very patient

Watch out for vicarious depression

Make sure you have a safety plan in place

Educate the consumer about their disorder

Helps to have a strong boundary and strong philosophy

Depressed consumers can challenge our own mental health

130

SPMI: Major Depression

Prevalence:
Approximately 7%; 3X common in 18-29 as those over 60
1.5 – 3X as common in women as in men

Differential Diagnosis:
Grief features loss/emptiness, MDD low mood/anhedonia
grief dysphoria likely to lessen over time
Not related to persisting substance use or withdrawal
does not exhibit psychotic symptoms on a persisting basis

131

Career Critical Incidents

"When your job breaks your heart"

132

Workplace Critical Incident (WHO)

An event out of the range of normal experience – one which is sudden and unexpected, involves the perception of a threat to life and can include elements of physical and emotional loss. Often such events are sufficiently disturbing to overwhelm, or threaten to overwhelm, a person's coping capacity. Most people would be severely shaken by a critical incident but are likely to recover from its impact with appropriate support.

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1. You've lost sight of your personal goals and aspirations.
2. Your work is stopping you from enjoying your life
3. Your relationships are suffering.
4. You *only* work for the money.

https://iheartintelligence.com/job-crushing-spirit/

137

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CCI Sharing Opportunity

Please share, if you are willing to, a story of a career critical incident or "near miss" from your experience?

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141

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Strategies to cope with CCI:

Acknowledge the loss

Rally around each other

Support uncertainty

Practice patience

Put yourself and your relationships first

Practice self-care and professional resilience

https://www.thecircleupexperience.com/2018/03/22/corporate-grief-workplace-breaks-heart/

143

Case Vignette: Career Critical Incidents

Janice is a mid-career mental health therapist – about half of her caseload is working with folks in drug court. Sherman is in the pilot project she developed for "intensive management" drug court. She is shocked to find that she is starting to have feelings for Sherman, a man several years younger than she and on probation for DUI. She is embarrassed that she reads his assignments with excitement, hoping that they mention her, and scheduling him late in the day when others have left the office. Janice is crushed when Sherman's P.O. says they are transferring his care to another agency after he alleged that she was "coming on to him." The case has damaged her reputation with the court/community of providers and her "intensive management" plan cancelled.

144

Survey Question: Career Critical Incident Case Vignette

What's most likely true in Janice's situation?

a) Sherman was scheming to "get her into trouble"

b) Janice may have been having "trouble at home"

c) Janice may have not been monitoring her warning signs

d) Janice's career is over – she will not recover

e) Janice has had a career critical incident and can recover.

145

Working with Mental Health and Criminogenic Factors in Justice-Involved Populations

Questions?

Mark Lukin, Ph.D.

mlukin2@unl.edu **402/472-7450**

IN OUR GRIT, OUR GLORY

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