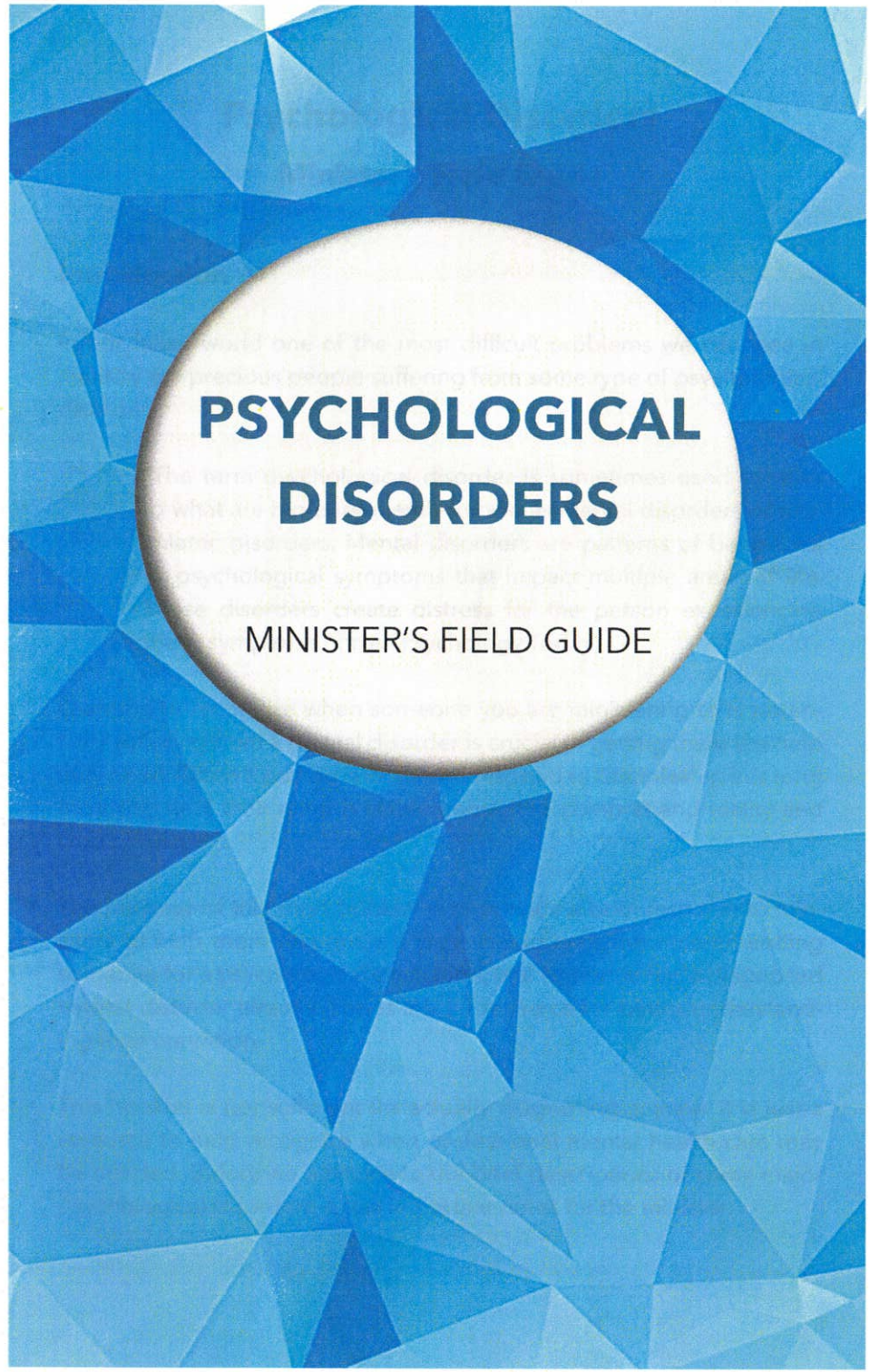
PSYCHOLOGICAL
DISORDERS
MINISTER'S FIELD GUIDE

Psychological Disorders

Minister's Field Guide

Introduction

In our fallen world one of the most difficult problems we can face in ministry are precious people suffering from some type of psychological disorder.

> "The term psychological disorder is sometimes used to refer to what are more frequently known as mental disorders or psychiatric disorders. Mental disorders are patterns of behavioral or psychological symptoms that impact multiple areas of life. These disorders create distress for the person experiencing these symptoms." (from Psychology Today)

Learning to recognize when someone you are ministering to is potentially suffering from a mental disorder is crucial in getting them the help they need. Often a person is unable to respond to discipleship in a long term way until their mind is stable enough to comprehend reality and God's Word.

The purpose of this short booklet is to provide a brief resource to ministers to help them recognize if they should consider recommending someone for a psychological evaluation, or if someone has a diagnosed mental disorder already. This is a brief resource for better understanding their condition.

This booklet is not sufficient for actually diagnosing anyone. It is just a resource to help recognize when professional mental health care may be needed. Before we advance to the brief descriptions of some major psychological disorders, a few important notes for the minister:

Prayer and Healing

It should be noted here that psychological disorders are not beyond God's healing power. We should always keep in mind, under the Holy Spirit's direction, that God may want to bring immediate healing to a person through prayer in the name of Jesus.

However, we must also keep in mind that often the Lord uses our trying circumstances to shape us and humble us in His hands. We should be open handed so that God may bring supernatural relief to a suffering person, or He may bring that relief medically, or, quite often, He does both.

Demonic Influence?

Demonic possession and mental disorders should not be confused. A mental disorder is a physical disorder which effects the brain, and thus, the mind of a person. Demonic presence is a spiritual condition that effects a person's mind. While a person suffering from mental illness may also suffer from demonic torment and need spiritual deliverance, it is crucial to use careful discernment so as not cause undue suffering on a person by calling something demonic which is physiological.

A Sober Mind

The end of all things is at hand; therefore be self-controlled and sober-minded for the sake of your prayers. ***1 Peter 4:7***

Be sober-minded; be watchful. Your adversary the devil prowls around like a roaring lion, seeking someone to devour. ***1 Peter 5:8***

A person may or may not receive full healing in this life. It is not until the Resurrection that we are promised an end to disease and disorders of all kinds. That being said, what we can contend for, and should contend for, in every way possible for the person we are ministering is that they

would have a sober mind, so that they can pray and seek God.

While we need to be open handed and humble about the method God may use to bring this about, whether supernatural or natural means, we should earnestly contend in prayer that any person we are ministering to would receive the sober mind necessary in following Jesus Christ.

Humility

Finally for this introduction, in the years I have ministered with those suffering from mental disorders the greatest key to success has been humility. Humility to listen to others. Humility to recognize their thinking is disordered and their perception of reality is broken. Humility to receive help– from God, from doctors, from friends and family. Humility to recognize and repent of sinful behaviors that exacerbate mental instability and suffering. As the Word of God says, *"God opposes the proud but gives grace to the humble"* ***James 4:6.***

Pray above all that the person you are ministering to, who is suffering from a mental disorder, would embrace the humility that attracts the grace of God in Jesus Christ. God's grace is more powerful than any sin or disorder.

For a concise, but very full, guide to this subject read *The Minister's Guide to Psychological Disorders and Treatments, second edition* by W. Brad Johnson and William L. Johnson.

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Disorders

The goal of the rest of this booklet is to give brief introductions to some of the most common forms of mental illness. With each, very short, intro there will be a list of "Key Indicators" which can help the minister to understand what may possibly be going on with a person so they can recommend them to a mental health professional and/or hospitalization.

Defining Terms

Here are definitions to some common terms used in psychological discussion:

Anxiety: Anxiety is an emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure.

Chronic: (of an illness) persisting for a long time or constantly recurring. (of a person) having an illness persisting for a long time or constantly recurring.

Depression (Depressed): Depression, in psychology, is a mood or emotional state that is marked by feelings of low self-worth or guilt and a reduced ability to enjoy life.

Disorder: A psychological disorder is a disorder of the mind involving thoughts, behaviors, and emotions that cause either self or others significant distress. Significant distress can mean the person is unable to function, meet personal needs on their own, or are a danger to themselves or others.

Mania (Manic): Excitement manifested by mental and physical hyperactivity, disorganization of behavior, and elevation of mood; specifically: the manic phase of bipolar disorder.

Psychotic: Psychosis is characterized by an impaired relationship with reality. It is a symptom of serious mental disorders. People who are psychotic may have either hallucinations or delusions.

Psychiatry: The study and treatment of mental illness, emotional disturbance, and abnormal behavior.

Psychology: The science of mind and behavior.

Overlapping Issues

Finally, it is important for us to realize that psychological disorders can overlap, meaning a person may struggle with several disorders at once. Therefore we must keep this in our minds as we seek to recognize mental illness in the lives of those we wish to help.

I. Anxiety Disorders: Anxiety can be defined as a general feeling of apprehension about possible danger. When anxiety becomes overwhelming or chronic it may be classified as an anxiety disorder. All anxiety disorders share a common characteristic: an unrealistic, irrational fear or anxiety of distressing or disabling intensity. Some anxiety disorders are characterized by extreme fear or panic. Panic is the emotional state of "fight or flight" in the sympathetic nervous system.

Anxiety has three primary components: 1. Physiological (biological), 2. Subjective (cognitive) and 3. Behavioral.

Symptoms can include: (1) sweating, (2) rapid heart rate, (3) shortness of breath, (4) nausea, (5) dizziness, (6) hot or cold flashes, (7) trembling, (8) dry mouth, and (9) difficulty swallowing.

1. Specific Phobias: A "phobia" is a persistent and disproportionate fear of some specific object or situation that present little

or no actual danger.

Key indicators for Specific Phobias:

i. Marked, excessive, unreasonable, and persistent fear of a specific object or situation (e.g., animals, storms, sight of blood, heights).
ii. Exposure to the object or situation provokes immediate anxiety response, which can be as severe as a panic attack.
iii. The person's anxiety is clearly out of proportion to the actual threat presented by the object or situation.
iv. The person avoids the feared object or situation if at all possible or else endures it with intense distress.
v. Avoiding the anxiety significantly disrupts the person's normal activities (e.g., work, school, social activities, relationships), or the person is quite distressed about having the fear.

2. Social Phobia (Social Anxiety Disorder): Socially phobic individuals are extremely anxious about being exposed to the scrutiny of others. They fear they will act in an embarrassing or humiliating manner in front of others.

Key indicators for Social Phobia:

i. A marked and ongoing fear of one or more social or performance-focused situations in which the person believes he or she will be evaluated or scrutinized by others.
ii. The person fears that he or she will act in a way that will be humiliating or embarrassing.
iii. When exposed to the feared social situation, the person experiences intense anxiety, which may be as severe as a panic attack.
iv. The person attempts to avoid the feared social situation

at all costs or endures it only with great discomfort.

v. Avoiding the anxiety significantly disrupts the person's normal activities (e.g., work, school, social activities, relationships), or the person is quite distressed about having the fear.

3. Panic Disorder and Agoraphobia: These two disorders are distinct psychiatric disorders that often coexist. People with Panic Disorder live in perpetual fear of experiencing a panic attack. For some, the attacks seem to come "out of the blue" with no apparent warning or trigger (uncued), while for others, the intense episodes are linked to a specific location or situation (e.g., driving over a bridge, flying in an airplane). These attacks often cause sufferers to comment that they feel they are "going crazy" or going to die.

Agoraphobia and panic disorder often occur together. In fact, agoraphobic avoidance of situations and places is often triggered by experiences of panic as well as the ongoing and increasing anxiety that the person will panic again in a crowded and inescapable situation.

Key indicators for Panic Disorder:

i. Unexpected and recurring panic attacks. Panic attacks typically last 10 minutes or less and involve intense fear or discomfort in which at least four of the following symptoms of panic are present: (1) palpitations, pounding heart rate; (2) sweating; (3) trembling or shaking; (4) sensations of shortness of breath or smothering; (5) feeling of choking; (6) chest pain or discomfort; (7) nausea or abdominal pain; (8) feeling dizzy, lightheaded, or faint; (9) feelings of unreality or feeling detached from oneself; (10) fear of losing control or going crazy; (11) fear of dying; (12) numbness or tingling sensations; (13) chills or hot flashes.

ii. Following the initial panic attack, the person may have persistent concerns about additional attacks, concern about the health implications of the attack, or a seriously restricted lifestyle in anticipation of further attacks.

iii. The attacks cannot be explained by substance abuse or other medical problems.

Key indicators for Agoraphobia:

i. The person is extremely anxious about being in situations in which escape might be difficult or embarrassing, or situations in which help may not be immediately available should a panic attack occur.

ii. The most commonly feared situations include being outside the home alone, being in open spaces, being in a crowd or standing in a line, or being in an enclosed space.

iii. The person can endure these situations only with great difficulty and usually requires a great deal of reassurance.

4. General Anxiety Disorder (GAD): People suffering from GAD have persistent, uncomfortable, uncontrollable anxiety, the source of which cannot be identified. It is characterized by chronic, excessive worry about many potential problems and catastrophes.

Key indicators for GAD:

i. Excessive anxiety and apprehension about a range of events or activities.

ii. The person finds it difficult to control worry.

iii. The anxiety or worry is usually associated with symptoms such as restlessness, fatigue, poor concentration, irritability, muscle tension, and sleep disturbance.

iv. The anxiety is usually severe enough to interfere with the person's work or relationships.

5. Obsessive-Compulsive Disorder (OCD): Persons suffering from OCD are caught in a vicious cycle of obsessions and compulsions. *Obsessions* are persistent, intrusive, unwanted, and inappropriate *thoughts* that cause the person significant anxiety and distress. Common obsessions include repeated thoughts about being contaminated by dirt, germs or toxins; fearful thoughts that something terrible is about to happen; aggressive or horrible impulses (killing a spouse, parent or child; shouting blasphemies in church); and sexual thoughts (pornographic images). *Compulsions* are either repetitive *behaviors* or mental activities, the goal of which is to reduce or avoid anxiety and distress–often produced by obsessions.

Key indicators for OCD:

i. The person has recurrent obsessions or compulsions.
ii. In most cases, the obsessions or compulsions cause substantial distress, take a great deal of the person's time, and seriously interfere with the person's normal routine and relationships.
iii. During the episodes, the person may or may not have insight about the excessive or unreasonable nature of the obsessions or compulsions.

II. Mood Disorders: Among the most common of all mental health problems in the United States, mood disorders make a person maladaptive to their environment. Emotions become very extreme and dominate the sufferers appearance and behavior. The emotional extremes range from soaring elation, or *mania*, to deep *depression*. Depression refers to feelings of extreme sadness and dejection, and mania refers to the experience of intense and unrealistic excitement and euphoria. Most people suffering from a mood disorder have a *unipolar* disorder,

which means they experience only depressive feelings. Others who experience both manic and depressive episodes are considered to suffer from *bipolar* disorder.

1. Major Depressive Disorder: The criteria for diagnosing major depression requires that individuals have numerous severe depressive symptoms, and that they cause significant distress and life impairment. Sufferers will have very depressed moods and/or loss of interest in pleasurable activities nearly all of the time. A major depressive episode is typically associated with changes in appetite, weight, and sleep. This condition should be taken very seriously, as roughly 3.5% of sufferers die as a result of suicide.

Key indicators for Major Depressive Disorder:

i. The person reports either seriously depressed mood or loss of interest or pleasure in usual activities for at least a two-week period.
ii. At least five of the following specific symptoms are present: (1) depressed mood most of the day, nearly every day; (2) markedly diminished interest in all or almost all activities most of the day; (3) significant weight loss, weight gain, or either decrease or increase in appetite every day; (4) insomnia or hypersomnia nearly every day; (5) obvious agitation or slowing in physical movements; (6) fatigue or loss of energy nearly every day; (7) feelings of worthlessness or excessive or inappropriate guilt nearly every day; (8) poor concentration or increased indecisiveness; (9) recurrent thoughts of death or committing suicide.
iii. These symptoms significantly interfere with the person's social well-being and his or her performance at work or school.

2. Dysthymia (Persistent Depressive Disorder): This is basically "mild and chronic depression." The forlorn character Eeyore in *Winnie the Pooh* is a classic example of the dysthymic character. Eeyore is rarely happy, hangs his head frequently, and generally expects things to go poorly. This is a milder but more chronic problem than major depression.

Key indicators for Dysthymia:

i. The person has depressed mood for most of the day, most of the time, as indicated by his or her own report or that of others.
ii. This low mood pattern has persisted for at least two years.
iii. While feeling depressed, the person reports at least two of the following: (1) poor appetite or overeating; (2) insomnia or hypersomnia; (3) low energy or fatigue; (4) low self-esteem; (5) poor concentration; (6) feelings of hopelessness.
iv. The person is not without the symptoms for more than two months.

3. Adjustment Disorder with Depressed Mood: Adjustment disorders involve the development of a significant emotional and/or behavioral syndrome that is clearly in response to an *identifiable stressor*. The sufferer who has lost a loved one, suffered a divorce, or been seriously injured may suffer an understandable and even predictable adjustment reaction to that stressful event. Someone suffering from an adjustment disorder with depressed mood may appear to have dysthymia or major depression. The critical difference is that the person with an adjustment disorder is responding to an identifiable loss or stressor.

Key indicators for Adjustment Disorder with Depressed Mood:

i. The person has developed depressive symptoms (see Dysthymia Key Indicators) within three months from the start of the stressor(s).
ii. These depressive symptoms and behaviors are either in excess of what could be expected following the stressor, or their presence impairs social relationships or occupational functioning.
iii. Once the stressor ceases, the symptoms do not persist for more than six months.
iv. The symptoms do not represent normal bereavement (which should not be diagnosed or considered pathologic).

4. Bipolar ("Manic-Depressive") Disorder: This disorder is distinguished from major depression by the presence of one striking and unique syndrome– the *manic episode*. *Mania* is an extreme mood condition, and it nearly always interferes with social and occupational functioning. A person who experiences a manic episode has a markedly elevated, euphoric, and expansive mood, often interrupted by occasional outbursts of irritability or even rage– especially when others refuse to go along with the sufferer's odd plans or behavior. Manic individuals may also have seemingly boundless energy and restless thoughts that seem to "race." Their speech is often extremely rapid, and they have great difficulty focusing on one topic. Persons with this disorder typically alternate between depressive episodes (see the Major Depressive Disorder Key Indicators) and manic (or, slightly milder, *hypomanic*) episodes, which will be less frequent and shorter in duration. Although mental health professionals differentiate between bipolar disorder *Type 1* (characterized by more extreme manic episodes– see following key indicators) and *Type 2* (characterized by somewhat less extreme hypomanic episodes but very predictable swings between hypomanic and

depressive episodes), it is often very difficult– and probably unnecessary– for a minister to try to differentiate between the two.

Key indicators for Bipolar Disorder:

i. For a period of at least one week, the person has persistently elevated, expansive, or irritable mood.
ii. During this time, at least three of the following symptoms are present: (1) inflated self-esteem or a grandiose assessment of oneself; (2) decreased need for sleep; (3) more speech, and speech that seems "pressured"; (4) racing thoughts; (5) distractibility; (6) increased goal-directed activity (socially, at work or school, or sexually) or increased physical-motor agitation; (7) excessive involvement in pleasurable activities that have high potential for painful consequences (e.g., unrestrained buying sprees, sexual indiscretions, foolish business investment).
iii. The person's relationships or work performance are impaired.
iv. There is typically some history of previous episodes of major depression (although it is possible to have manic episodes in the absence of depression).

III. Psychotic Disorders: These disorders represent the ultimate psychological breakdown. Sufferers who are psychotic will exhibit some of the most extreme and disturbed behaviors the minister will ever see. The term *psychosis* implies a profound loss of contact with reality. In essence, the psychotic person has become detached from basic connection points with the real world.

To people who interact with them, psychotic persons are bizarre, incomprehensible, and even frightening. Psychotic individuals are so detached from reality that they are sometimes not held responsible for acts committed while psychotic. Hospitalization and medication are nearly

always indicated.

1. Schizophrenia: This is a seriously debilitating disorder that occurs in all cultures. This disorder is among the most costly of world health problems with respect to financial loss, personal suffering, and treatment intensity. The cost of caring for schizophrenic persons in the United States each year exceeds 60 billion dollars. About 1 percent of the U.S. population suffers from schizophrenia. The word *schizophrenia* means "split mind," and the disorder is characterized by disorganized thought processes, lack of coherence between thought and emotion, and an inward movement away from reality. The disorder is particularly tragic because its onset is typically in late adolescence or early adulthood, and the prognosis for full remission is poor.

Schizophrenia typically develops gradually. The afflicted person becomes progressively more reclusive, loses interest in the outside world, and the capacity for emotional responsiveness declines. Although most cases show this gradual onset in late adolescence or early adulthood, a smaller percentage are more sudden in onset and may be triggered by a stressful life event. Although causes for schizophrenia are not well understood, research has confirmed a strong genetic component.

Schizophrenic symptoms are usually divided into *positive symptoms* and *negative symptoms*. Positive symptoms are behavioral excesses such as motor agitation, inappropriate emotional expression, disorganized speech and behavior, and the two hallmark symptoms of schizophrenia, *hallucinations* and *delusions*. Hallucinations are false perceptions such as voices, sights, or smells that no one else perceives. Delusions are clearly false beliefs such as "my thoughts are being broadcast to the CIA" or "someone is using microwaves to control me." Inappropriate emotional expression refers to such things as giggling when describing something morbid (e.g., the death of a family member). Disorganized speech refers to the fact that the schizophrenic's speech does not make sense (sometimes called "word salad").

Negative symptoms are behavioral deficits in such areas as emotional expression (flatness of expression), communicative speech (low verbal output), reactivity to the environment (withdrawal, fantasy, daydreaming), and goal-directed activities (apathy, poor hygiene).

Key indicators for Schizophrenia:

i. At least two of the following must have been present most of the time for at least one month: (1) delusions; (2) hallucinations; (3) disorganized speech; (4) disorganized behavior; (5) negative symptoms (see aforementioned text) such as loss of emotional expression.
ii. These symptoms cause interference in the person's social and/or occupational functioning.
iii. There must be continuous signs of the disturbance for at least six months (including at least one month of the aforementioned symptoms), perhaps followed by periods of less intense disturbance.

2. Delusional Disorder: This disorder is much less serious than schizophrenia. The psychotic person with this disorder may be able to function reasonably well both socially and at work. The hallmark symptom of delusional disorder is the presence of *delusions*, fixed beliefs that are not amenable to change in light of conflicting evidence, that persist at least for a month. A person who has other psychotic symptoms or has ever been diagnosed with schizophrenia cannot be diagnosed with this disorder.

The delusional person often feels singled out and taken advantage of, plotted against, stolen from, spied on, ignored, or otherwise mistreated. The delusions to which this person firmly clings involve situations that can conceivably occur in real life (e.g., being followed, poisoned, infected, loved at a distance, deceived by one's spouse or lover). The delusional system usually centers on only one of these themes.

Several subtypes of delusional disorder are as follows:

Persecutory type: The person believes that he or she, or a loved one, is being subjected to maltreatment such as spying, stalking, or spreading of false rumors. The person may take legal (or more hostile) actions against those believed to be responsible.

Jealous type: The person believes firmly that his or her sexual partner is being unfaithful.

Erotomanic type: Someone of higher status (e.g., a movie star) is believed to be deeply in love with the person and interfered in a sexual relationship (some people who "stalk" celebrities may fit this category).

Somatic type: This person has an unshakeable belief that he or she suffers from some physical illness– often of a very exotic nature (e.g., one's arm has been replaced by an alien appendage).

Grandiose type: The person has a fixed belief that he or she has extraordinary status, power, ability, talent, beauty, and so forth.

Key indicators of Delusional Disorder:

i. Delusions (extremely rigid bizarre thoughts) for at least six months.
ii. The person has never been schizophrenic.
iii. Aside from the impact of the delusions (e.g., rejection by others), there is no obvious impairment in functioning and behavior is not otherwise odd or bizarre.

3. Brief Psychotic Disorder: On very rare occasions, a person may become psychotic only for a brief time. In these unusual cases, the individual appears to be fine one day and delusional, disorganized, or hearing voices the next. The symptoms last only a short while, and the person can be expected to return to normal functioning again. The person does not have schizophrenia or a delusional disorder, but does evidence one or more of the common psychotic symptoms for a brief period of time. Most often, an identifiable stressor precipitates the psychosis (e.g., loss of a loved one, combat experience), but an identifiable stressor is not required for this brief disturbance to occur. Finally, there are some cases of these brief reactive states in women shortly after giving birth (postpartum onset).

Key indicators of Brief Psychotic Disorder:

i. The person experiences at least one of the following symptoms: (1) delusions; (2) hallucinations; (3) disorganized speech; (4) grossly disorganized behavior.
ii. Symptoms last for at least one day but less than one month.
iii. The person returns to a completely normal level of functioning.

IV. Neurocognitive Disorders: In contrast to other varieties of psychiatric impairment, *neurocognitive disorders* are nearly always a consequence of structural defects of damage to brain tissue– often the result of injury or disease. This loss of integrity of brain tissue (destruction of nerve cells in the brain) results in emotional and behavioral disorders that, at times, mimic other psychiatric problems. Neurocognitive disturbances are referred to as *organic* disorders. Delirium and neurocognitive disorders caused by dementia, traumatic brain injury, or other diseases always indicate damage, deterioration, imbalance, or infection of the brain.

Persons with "organic" brain disorders often share certain presenting symptoms, although these will vary in each case. Symptoms may include:

i. Memory impairment (especially for more recent events).
ii. Forgetting one's own identity or the identity of loved ones.
iii. Inability to learn new material.
iv. Poor judgment (behavior becomes improper or unethical).
v. Lack of initiation of behavior (e.g., working, conversing).
vi. Poor visual-spacial perception.
vii. Problems understanding and using language.

Some of the most common types of neurocognitive disorders are: (1) Delirium; (2) Neurocognitive Disorder Caused by Alzheimer's Disease; (3) Neurocognitive Disorder Caused by Traumatic Brain Injury.

V. Somatic Symptom Disorders: Depending on the size of one's religious community, it is nearly certain that some members will be suffering preoccupation, anxiety, and sometimes, constant rumination about physical illness. *Somatic symptom disorders*– previously called *somatoform* disorders– form a related cluster of syndromes with this common feature: the sufferer complains of physical problems or concerns about medical illness. Here is the catch: people with these disorders do *not* have an actual biological condition that can explain their physical symptoms. Sufferers with somatic symptoms disorders will tend to communicate psychological distress through physical complaints and to display a lengthy track record of seeking medical help for their unexplained symptoms. According to some estimates, persons with these syndromes may account for 23 percent of people with medically unexplained symptoms seeking medical care. Fixated on physical problems, unsatisfied with medical care, and prone to work about their condition ceaselessly, these sufferers may be a handful for their ministers.

Some of the most common Somatic Symptom Disorders are: (1) Somatic Symptom Disorder (hypochondriacs); (2) Illness Anxiety Disorder; (3)

Body Dysmorphic Disorder; (4) Factitious Disorder.

VI. Other Disorders: The following disorders are not classified together but represent a range of difficult psychological disorders. We will not be going in depth with each of these, simply providing brief definitions.

1. Post-traumatic Stress Disorder (PTSD): A psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape or other violent personal assault. People with PTSD continue to have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear or anger; and they may feel detached or estranged from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

2. Acute Stress Disorder: Acute stress disorder involves symptoms that last from three days to one month following exposure to one or more traumatic events. Symptoms develop after an individual experiences or sees an event involving a threat or actual death, serious injury, or physical violation to the individual or others. Symptoms fall into the five general categories of intrusion, negative mood, dissociation, avoidance, and arousal, and begin or worsen after the trauma occurred.

3. Dissociative Amnesia: Dissociative amnesia occurs when a person blocks out certain information, usually associated with a stressful or traumatic event, leaving him or her unable to remember important personal information. With this disorder, the degree of memory loss goes beyond normal forgetfulness and includes gaps in memory for long periods of time or of memories involving the traumatic event.

4. Dissociative Identity Disorder (Multiple Personality Disorder): Dissociative identity disorder (DID) is a severe condition in which two or more distinct identities, or personality states, are present in–and alternately take control of–an individual. Some people describe this as an experience of possession. The person also experiences memory loss that is too extensive to be explained by ordinary forgetfulness.

The following criteria must be met for an individual to be diagnosed with dissociative identity disorder:

- The individual experiences two or more distinct identities or personality states (each with its own enduring pattern of perceiving, relating to, and thinking about the environment and self). Some cultures describe this as an experience of possession.
- The disruption in identity involves a change in sense of self, sense of agency, and changes in behavior, consciousness, memory, perception, cognition, and motor function.
- Frequent gaps are found in memories of personal history, including people, places, and events, for both the distant and recent past. These recurrent gaps are not consistent with ordinary forgetting.
- These symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

5. Paranoid Personality Disorder: People with PPD are always on guard, believing that others are constantly trying to demean, harm, or threaten them. These generally unfounded beliefs, as well as their habits of blame and distrust, might interfere with

their ability to form close relationships.

6. Schizoid Personality Disorder: Schizoid personality disorder is characterized by a long-standing pattern of detachment from social relationships. A person with schizoid personality disorder often has difficulty expressing emotions and does so typically in very restricted range, especially when communicating with others. A person with this disorder may appear to lack a desire for intimacy, and will avoid close relationships with others. They may often prefer to spend time with themselves rather than socialize or be in a group of people. In laypeople terms, a person with schizoid personality disorder might be thought of as the typical "loner."

7. Histrionic Personality Disorder: Histrionic personality disorder (HPD) is defined by the American Psychiatric Association as a personality disorder characterized by a pattern of excessive attention-seeking emotions, usually beginning in early adulthood, including inappropriately seductive behavior and an excessive need for approval.

8. Borderline Personality Disorder: Borderline personality disorder (BPD) is a serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior. This instability often disrupts family and work life, long-term planning, and an individual's sense of identity.

People with BPD, originally thought to be at the "border" of psychosis and neurosis, suffer from difficulties with emotion regulation. While less well known than schizophrenia or bipolar disorder, BPD affects two percent of adults. People with BPD exhibit high rates of self-injurious behavior, such as cutting and, in severe cases, significant rates of suicide attempts and completed suicide. Impairment from BPD and suicide risk are greatest in the young-adult years and tend to decrease with age. BPD is more common in females than in males, with 75 percent of cases diagnosed among women.

VII. Psychiatric Medications

Antidepressant Medications

Selective Serotonin Reuptake Inhibitors: Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed antidepressants. They can ease symptoms of moderate to severe depression, are relatively safe and typically cause fewer side effects than other types of antidepressants do. SSRIs ease depression by increasing levels of serotonin in the brain. Serotonin is one of the chemical messengers (neurotransmitters) that carry signals between brain cells. SSRIs block the reabsorption (reuptake) of serotonin in the brain, making more serotonin available. SSRIs are called selective because they seem to primarily affect serotonin, not other neurotransmitters.

- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluoxetine (Prozac)
- Paroxetine (Paxil, Pexeva)
- Sertraline (Zoloft)
- Vilazodone (Viibryd)

Tricyclic Antidepressants: Tricyclic and tetracyclic antidepressants, also called cyclic antidepressants, are among the earliest antidepressants developed. They're effective, but they've generally been replaced by antidepressants that cause fewer side effects. However, cyclic antidepressants may be a good option for some people. In certain cases, they relieve depression when other treatments have failed.

Cyclic antidepressants are designated as tricyclic or tetracyclic, depending on the number of rings in their chemical structure – three (tri) or four (tetra). Cyclic antidepressants ease depression

by impacting chemical messengers (neurotransmitters) used to communicate between brain cells. Like most antidepressants, cyclic antidepressants work by ultimately effecting changes in brain chemistry and communication in brain nerve cell circuitry known to regulate mood, to help relieve depression.

Cyclic antidepressants block the absorption (reuptake) of the neurotransmitters serotonin (ser-o-TOE-nin) and norepinephrine (nor-ep-ih-NEF-rin), increasing the levels of these two neurotransmitters in the brain. Cyclic antidepressants also affect other chemical messengers, which can lead to a number of side effects.

- Amitriptyline
- Amoxapine
- Desipramine (Norpramin)
- Doxepin
- Imipramine (Tofranil)
- Nortriptyline (Pamelor)
- Protriptyline (Vivactil)
- Trimipramine (Surmontil)

Monoamine Oxidase Inhibitors: Monoamine oxidase inhibitors (MAOIs) were the first type of antidepressant developed. They're effective, but they've generally been replaced by antidepressants that are safer and cause fewer side effects.
Use of MAOIs typically requires diet restrictions because they can cause dangerously high blood pressure when taken with certain foods or medications. In spite of side effects, these medications are still a good option for some people. In certain cases, they relieve depression when other treatments have failed.

Antidepressants such as MAOIs ease depression by affecting chemical messengers (neurotransmitters) used to communicate between brain cells. Like most antidepressants, MAOIs work by ultimately effecting changes in the brain chemistry that are operational in depression.

An enzyme called monoamine oxidase is involved in removing the neurotransmitters norepinephrine, serotonin and dopamine from the brain. MAOIs prevent this from happening, which makes more of these brain chemicals available to effect changes in both cells and circuits that have been impacted by depression.
MAOIs also affect other neurotransmitters in the brain and digestive system, causing side effects. MAOIs are sometimes used to treat conditions other than depression, such as Parkinson's disease.

- Isocarboxazid (Marplan)
- Phenelzine (Nardil)
- Selegiline (Emsam)
- Tranylcypromine (Parnate)

Other Antidepressants

- Desyrel (Trazadone)
- Effexor (Venlafaxine)
- Remeron (Mirtazapine)
- Wellbutrin (Bupropion)

Antianxiety Medications: Anxiety is one of the most common human experiences. Anxiety disorders are frequently a concern of people who present for professional mental care. Some of these sufferers will have symptoms that are severe enough to merit consideration of anti anxiety medications. High levels of anxiety or prolonged anxiety can become incapacitating and make the activities of daily life quite difficult. Generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, and various phobias all may be significant enough to warrant a trial of antianxiety medication.

Antianxiety medications help to calm and relax the anxious person and

were originally called *tranquilizers* for this reason. The prevalence of anxiety disorders has made antianxiety medications widely prescribed psychotropic drugs.

Some medications for antianxiety have strong potential for physical and psychological addiction, such as *benzodiazepines* [Xanax (alprazolam); Valium (diazepam)]. Even more potentially addictive are *barbiturate* medications, which are no longer prescribed for anxiety. Also, *BuSpar* (buspirone), a major alternative to benzodiazepines, has less possibility of becoming addictive, but cannot be taken on short notice.

Antianxiety Agents

- Ativan (lorazepam)
- BuSpar (buspirone)
- Centrax (prazepam)
- Inderal (propranolol)
- Klonopin (clonazepam)
- Lexapro (escitalopram)
- Librium (chlordiazepoxide)
- Serax (oxazepam)
- Tenormin (atenolol)
- Tranxene (clorazepate)
- Valium (diazepam)
- Xanax (alphrazolam)

Antipanic Agents

- Klonopin (clonazepam)
- Paxil (paroxetine)
- Xanax (alphrazolam)
- Zoloft (sertaline)

Antiobsessive Agents

- Anafranil (clomipramine)
- Luvox (fluvoxamine)
- Paxil (paroxetine)
- Prozac (fluoxetine)
- Zoloft (sertaline)

Mood-Stabilizing Medications: Mood stabilizers can help to treat mania and to prevent the return of both manic and depressive episodes in bipolar disorder. They may also help for treat the mood problems associated with schizophrenia, such as depression.Some of these medicines are also used to treat some types of seizures. They are also known as anticonvulsants.

Mood stabilizers, especially lithium, valproic acid, and carbamazepine, may provide relief from acute episodes of mania or depression and can help prevent them from recurring.

All medicines have side effects. But many people don't feel the side effects, or they are able to deal with them. Ask your pharmacist about the side effects of each medicine you take. Side effects are also listed in the information that comes with your medicine.

- Depakene (valproic acid)
- Depakote (divalproex sodium)
- Eskalith (lithium carbonate)
- Lamictal (lamotrigine)
- Neurontin (gabapentin)
- Tegretol (carbamazepine)
- Zyprexa (olanzapine)

Antipsychotic Medications: Antipsychotics are drugs that are used to treat symptoms of psychosis such as delusions (for example, hearing voices), hallucinations, paranoia, or confused thoughts. They are used in the treatment of schizophrenia, severe depression and severe anxiety. Antipsychotics are also useful at stabilizing episodes of mania in people

with Bipolar Disorder.

Their main action is on dopamine receptors, reducing levels of excess dopamine. They may also affect levels of other neurotransmitters, namely acetylcholine, noradrenaline, and serotonin.

Older antipsychotics tend to be called typical antipsychotics, and antipsychotics that have been developed more recently are called atypical antipsychotics. Atypical antipsychotics are less likely to produce extrapyramidal side effects (such as tremor and Parkinson's-like symptoms) and tardive dyskinesia (abnormal, repetitive facial movements). Atypical antipsychotics are also more likely to improve cognitive function. Clozapine (classed as an atypical antipsychotic even though it is quite an old drug) also improves delusions and hallucinations and reduces the risk of suicide.

Typical Antipsychotics

- Haldol (haloperidol)
- Loxitane (loxapine)
- Mellaril (thioridazine)
- Moban (molindone)
- Navane (thiothixene)
- Orap (pimozide)
- Prolixin (fluphenazine)
- Stelazine (trifluoperazine)

Atypical Antipsychotics

- Clozaril (clozapine)
- Geodon (ziprasidone)
- Risperdal (risperdidone)
- Seroquel (quetiapine)
- Zyprexa (olanzapine)

Conclusion

Finally, there are a variety of disorders not addressed in this booklet: (1) Autism; (2) ADHD; (3) Eating Disorders, and others. However, far from being a "one stop shop" this booklet's main goal is to provide a quick reference guide to ministers as they preach the Gospel, make disciples and shepherd believers.

Remember, helping others with serious mental illness is a difficult task. Staying in prayer, relying on others for help, and keeping a clear mind is key to going the distance in helping someone reach stability in their mind and discipleship.

We pray that this booklet will be a blessing to you as you pour your life out for some the hurting and broken. Amen.