**Mental Health Disorder Characteristics**

The following Mental Health Disorder information and characteristics are from the Diagnostic and Statistical Manual of Mental Disorders: DSM-5. The characteristics of Mental Health Disorders in this document do not include criteria, timelines, etc. necessary for diagnostic purposes. The characteristics included below are not intended for diagnosis or the treatment of Mental Health Disorders. It is to familiarize volunteers serving at the Upper Room Hotline with behavioral characteristics that may be associated with Mental Health Disorders. The intention of this training is to provide volunteers with an overview and description of these characteristics so that they are better equipped to understand and respond to callers that are in need of emotional and spiritual support.

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to common stressors or loss, such as a death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual as described above.

**Key Features of a Psychotic Disorder**

(Delusions) are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes e.g., persecutory, grandiose, etc. Delusions are deemed bizarre if they are clearly implausible and not understandable (Hallucinations) are perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control. They may occur in any sensory modality, but auditory hallucinations are the most common in schizophrenia and related disorders. Auditory hallucinations are usually experienced in voices that are perceived as distinct from the individual’s own thoughts. Hallucinations may be a normal part of religious experience in certain cultural contexts.

(Disorganized Thinking/Speech) is typically inferred from the individual’s speech. The individual may switch from one topic to another (derailment or loose associations). Answers to questions may be obliquely related or completely unrelated (tangentiality).

(Grossly Disorganized or Abnormal Motor Behavior) may manifest itself in a variety of ways ranging from childlike “silliness” to unpredictable agitation.

(Negative Symptoms) are symptoms that are prominent in schizophrenia. These symptoms may include: diminished emotional expression in the face, eye contact, intonation of speech, and movement of hands, head and face. There is a decrease in motivated self-initiated purposeful activities and speech output. There is often a decreased ability to experience pleasure from positive stimuli and a lack of interest in social interaction

**Major Depressive Disorder**

1. Depressive mood (e.g., feels sad, empty, hopeless, tearful).
2. Markedly diminished interest or pleasure in all or most activities.
3. Changes in weight (gain or loss).
4. Restlessness or no responding.
5. Insomnia or hypersomnia (difficulty sleeping or sleeping too much).
6. Fatigue or loss of energy.
7. Feelings of worthlessness or excessive guilt.
8. Diminished ability to think or concentrate or indecisiveness.

Symptoms may include recurrent thoughts of death, recurrent suicidal ideation, suicidal attempt or a specific plan for committing suicide.

The symptoms cause impairment in social, occupational and other important areas of functioning.

**Generalized Anxiety Disorder**

1. Excessive anxiety and worry (Apprehensive expectation)
2. Difficulty controlling worry
3. Restlessness or feeling keyed up or on edge
4. Being easily fatigued
5. Difficulty concentrating
6. Irritability
7. Muscle tension
8. Sleep disturbance

The anxiety, worry, or physical symptoms cause significant distress or impairment in social, occupational or other important areas of functioning.

**Panic Attack**

A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes. The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations or shortness of breath
5. Feelings of choking
6. Chest pain or discomfort
7. Nausea

 8. Feeling dizzy, unsteady, light headed, or faint

 9. Chills or heat sensations

 10. Numbness or tingling sensations

 11. Feelings of unreality or being detached from oneself

 12. Fear of losing control

 13. Fear of dying

 **Bipolar Disorder**

A mental health condition marked by alternating periods of elation and depression.

A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistent increased activity or energy.

1. Inflated self-esteem or grandiosity
2. Decreased need to sleep
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (e.g., attention to or easily drawn to unimportant or irrelevant external stimuli)
6. Increase in goal-directed activity or psychomotor agitation

Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investment

The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

The depressive phase of a Bipolar Disorder is described under the section labeled Major Depressive Disorder.

**Posttraumatic Stress Disorder**

Exposure to actual or Threatened death, serious injury, or sexual violence in one or more of the following ways:

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others
3. Learning that traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must be violent or accidental
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responder collecting human remains; police officers being repeatedly exposed to child abuse
5. Perception of one or more of the following intrusive symptoms associated with the traumatic event(s), beginning after traumatic event(s) occurred:
6. Unwanted upsetting memories
7. Nightmares
8. Flashbacks
9. Emotional distress after exposure to traumatic reminders
10. Physical reactivity after exposure to traumatic reminders
11. Avoidance of trauma related thoughts or feelings
12. Trauma-related thoughts or feelings
13. Trauma-related reminders
14. Negative thoughts or feelings that begin or worsen after the trauma, in the following ways:
15. Inability to recall key features of the trauma
16. Overly negative thoughts and assumptions about oneself or the world
17. Exaggerated blame of self or others for causing the trauma
18. Negative affect
19. Decreased interest in activities
20. Feeling isolated
21. Difficulty experiencing positive affect
22. Trauma-related arousal and reactivity that began or worsened after the trauma, in the following ways:
23. Irritability or aggression
24. Risky or destructive
25. Hypervigilance
26. Heightened startle reaction
27. Difficulty concentrating
28. Difficulty sleeping

**Addiction to Pornography**

While pornography is not specifically listed as an addiction in the DSM-5, there is much evidence to support the addictive influence on individuals that engage in its use and that this addictive influence increases with repeated use.

Both science and personal testimonies confirm that many people that start by occasionally viewing pornography later become compulsive users who feel trapped in a cycle of fantasy, ritual, acting out, and despair. Viewing pornography, usually combined with masturbation, directly affects the brain’s reward pathways and has been noted to have similar effect on the brain as cocaine does on a person with a drug addiction or as alcohol on a person with an alcohol addiction. After using pornography, the person craves more and over time seeks out a higher number of and/or more extreme images to get the same “high.” A person addicted to pornography may take increased risks to view it and may continue viewing it despite adverse consequences to self and others. (1)

1. Create in Me a Clean Heart-A Pastoral Response to Pornography. A Statement of the US Catholic Bishops, United States Conference of Catholic Bishops (December 2015), p.15