MODULE VI

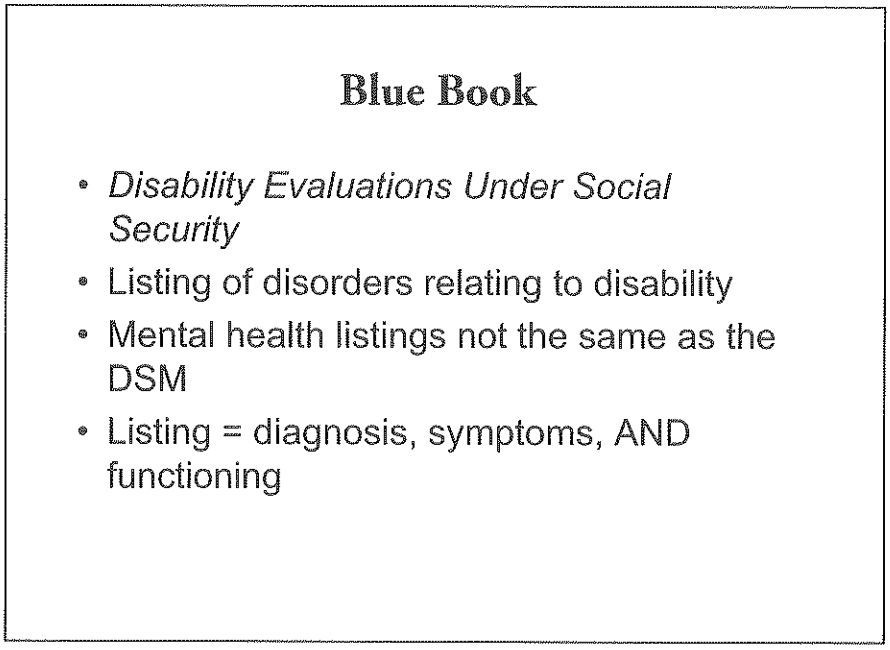
Medical Information on Mental Illness

Introduction

This module examines a variety of common mental illness diagnoses. In discussing each diagnosis, the focus will be to consider how the symptoms may affect the case manager's interaction with an individual, as well as how diagnoses are relevant in the application process. It is *not* meant to teach how to diagnose.

Module Topics

- Categories of Mental Impairments — The "Blue Book" or the "Listings"
- Diagnoses — Tips for Case Managers
- Commonly Used Medications to Treat Psychiatric Illness
- A Description of Mental Health Services



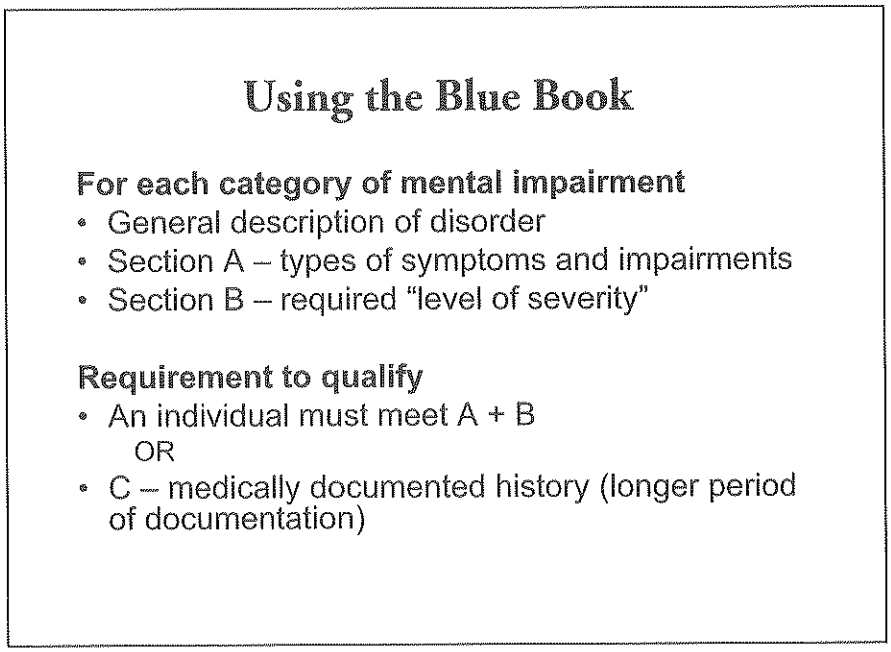
Blue Book — *Disability Evaluations Under Social Security*

Disability Evaluations Under Social Security provides a listing of disorders that relate to disability and the criteria for determining disability. It is commonly referred to as the "Blue Book" or the "Listings." It also presents "an overview of the disability programs administered by the SSA and the kinds of information health professionals can furnish to help ensure sound and prompt decisions on disability claims."

Diagnosis Is Not Enough

To be eligible for SSI and/or SSDI disability benefits, a diagnosis of a mental illness is not enough. People with bipolar disorder, schizophrenia, and major depression, to name some of the major illnesses, can — and do — work. Thus, the diagnosis alone provides little information regarding ability to work. The illness needs to be tied to functional impairment.

The Blue Book or the Listings can be found on-line at www.socialsecurity.gov/disability/professionals/bluebook. It is updated regularly.



Using the Blue Book

Using the Information in the Participant Guide

For each category of mental impairment

- An excerpt from the Blue Book Listings
- Key terminology related to the disorder
- Tips for working with a person with this disorder
- Tips for documenting impairment in functioning

Participant Guide

This *Participant Guide* provides information about each of the Blue Book categories of mental impairments. For each category, the *Participant Guide* provides

- The listing from the Blue Book
- A list of key terminology related to the disorder
- Tips for working with a person who has this disorder
- Tips for documenting disorders and impairment in functioning

Categories of Mental Impairments
(according to the Blue Book)

Organic Mental Disorders

Schizophrenia, Paranoia, and other Psychotic Disorders

Affective Disorders

Mental Retardation

Anxiety-Related Disorders

Somatoform Disorders

Personality Disorders

Substance Addiction Disorders

Autistic Disorder and Other Pervasive Developmental Disorders

Categories of Mental Impairments

This slide provides a list of the categories relating to mental illness listed in the Blue Book. While it is important to understand the symptoms relating to each diagnosis, it is more important to think about the person who has this diagnosis. Think about:

- What is most noticeable about serving this person?
- What symptoms/behaviors seem to be common?
- How do these symptoms/behaviors seem to affect the person's life and functioning?
- What is it like to provide services to a person with this disorder?
- What questions have arisen in working with this person that still need to be answered?

Note

See the Glossary at the end of the *Participant Guide* for definitions of technical terms.

12.02 Organic Mental Disorders

Excerpt From:
Disability Evaluations Under Social Security

12.02 Organic Mental Disorders

Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements of both A and B are satisfied, or when the requirements of C are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one (1) of the following:

1. Disorientation of time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or
4. Change in personality; or
5. Disturbance in mood; or
6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 IQ points from premorbid levels or overall impairment index clearly within the severely impaired range on a neuropsychological test (e.g., Luria-Nebraska, Halstead-Reitan, etc.).

AND

B. Resulting in at least two of the following:

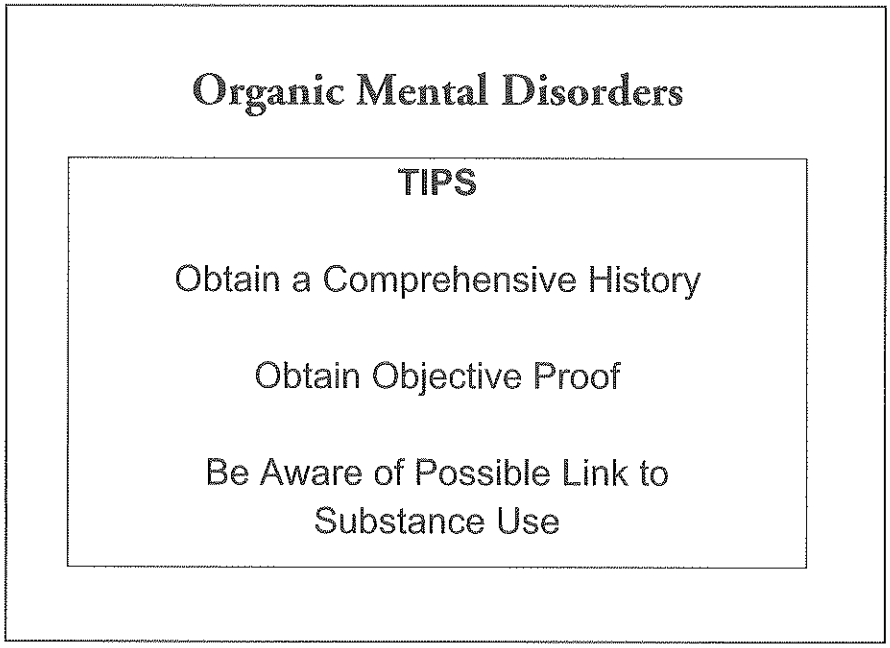
1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence or pace; or
4. Repeated episodes of decompensation, each of extended duration.

OR

C. Medically documented history of a chronic organic mental disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.



Tips for Working with People with Organic Mental Disorders

- Obtain a comprehensive history
  - Often a person who has an organic mental disorder displays impulsive, insensitive, and/or destructive actions
  - Initially, he or she may appear to have another illness
  - Obtaining a comprehensive history is a vital step toward making an accurate diagnosis and providing appropriate services
  - Such a history should include information on possible brain damage that may have resulted from accidents, abuse, injury, and/or substance use
  - Keep in mind that the majority of people who are homeless have histories of physical trauma that may result in organic or cognitive impairment
- Obtain objective proof
  - A case manager should keep in mind that medical or psychological testing (or other proof) is necessary to corroborate a diagnosis of organic mental disorder
- Be aware of the possible link to substance abuse
  - Long-term use of drugs and/or alcohol may cause significant brain damage

12.03 Schizophrenia, Paranoia, and Other Psychotic Disorders

Excerpt From:
Disability Evaluations Under Social Security

12.03 Schizophrenia, Paranoia, and other Psychotic Disorders

Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements of both A and B are satisfied, or when the requirements of C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or
2. Catatonic or other grossly disorganized behavior; or
3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
   a. Blunt affect; or
   b. Flat affect; or
   c. Inappropriate affect; or
4. Emotional withdrawal and/or isolation.

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence or pace; or
4. Repeated episodes of decompensation, each of extended duration.

OR

C. Medically documented history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Schizophrenia, Paranoia, and Other Psychotic Disorders

TIPS

Understand the Meaning Behind the Words

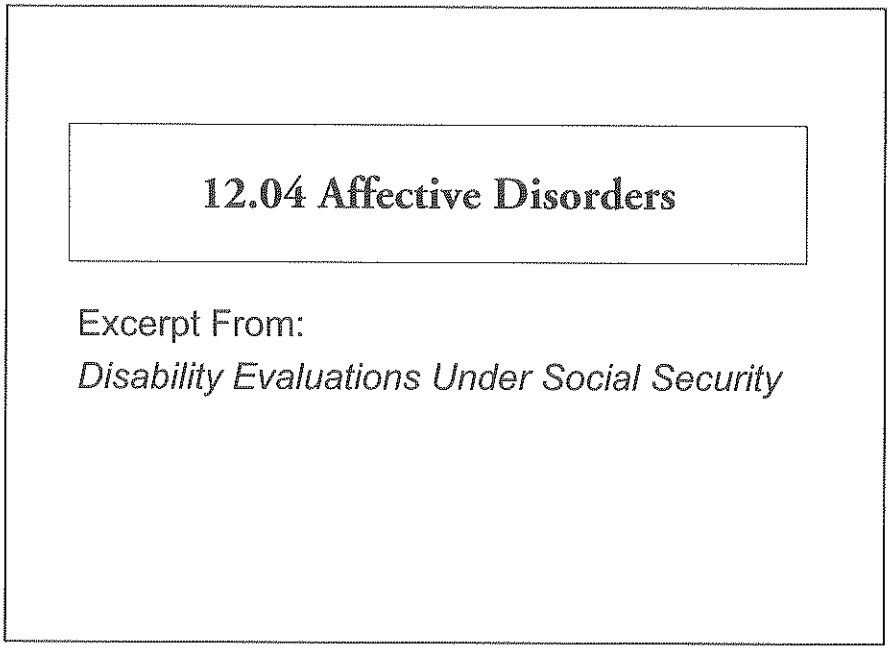
Be Aware of Personal Space

Look for Negative Symptoms

Be Alert to Different Responses

Tips for Working with People with Schizophrenia, Paranoia, and other Psychotic Disorders

- Understand the meaning behind the words
  - A person who has schizophrenia or another psychotic disorder often has conversations that are difficult to follow
  - It is usually not helpful to challenge the person on his or her lack of realistic perceptions and beliefs
- Be aware of personal space
  - A person with a psychotic disorder may have a different sense of personal boundaries or space; be sensitive to these boundaries and avoid violating them
- Look for negative symptoms
  - Along with "positive" symptoms, such as delusions, a person can exhibit what are known as "negative" symptoms, e.g., a lack of energy or motivation
- Be alert to different responses
  - Paranoia can be a symptom of schizophrenia or can be considered a disorder on its own, if certain criteria are met
  - Case managers should be aware of their own behavior and responses to avoid exacerbating the already heightened suspicion of individuals with paranoia
  - Be extremely clear about intentions and the help to be provided
  - Be as consistent as possible to help reduce mistrust and suspicion (e.g., keep scheduled appointments, follow through on promises)



12.04 Affective Disorders

Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements of both A and B are satisfied, or when the requirements of C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four (4) of the following:
    a. Anhedonia or pervasive loss of interest in most activities; or
    b. Appetite disturbance with change in weight; or
    c. Sleep disturbance; or
    d. Psychomotor agitation or retardation; or
    e. Decreased energy; or
    f. Feelings of guilt or worthlessness; or
    g. Difficulty concentrating or thinking; or
    h. Thoughts of suicide; or
    i. Hallucinations, delusions, or paranoid thinking; or
2. Manic syndrome characterized by at least three (3) of the following:
    a. Hyperactivity; or
    b. Pressure of speech; or
    c. Flight of ideas; or
    d. Inflated self-esteem; or
    e. Decreased need for sleep; or
    f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences that are not recognized; or

h. Hallucinations, delusions, or paranoid thinking; or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes).

AND

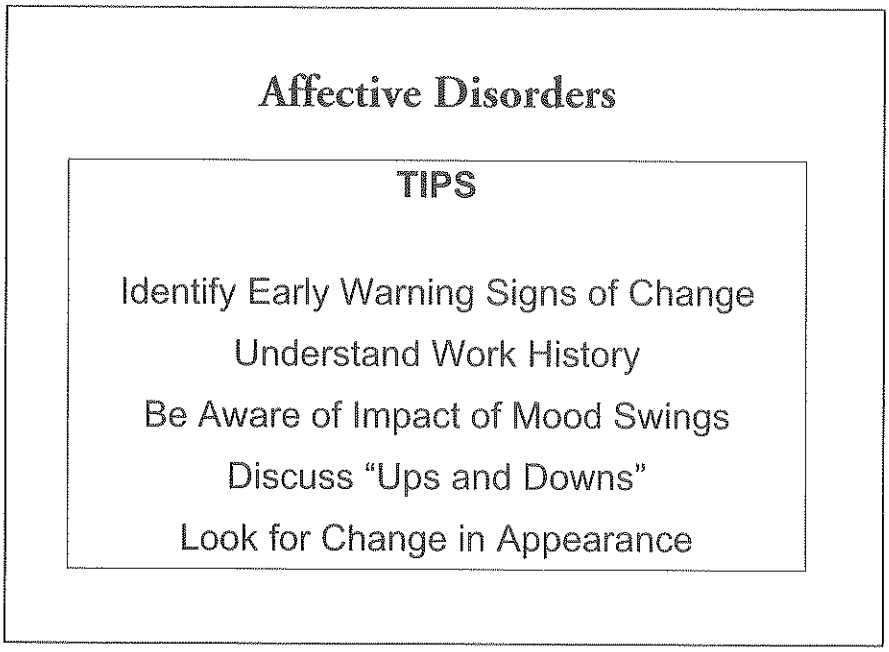
B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence or pace; or
4. Repeated episodes of decompensation, each of extended duration.

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.



Tips for Working with People with Affective Disorders

- Identify early warning signs of change
  - A person with bipolar disorder often experiences loss of behavioral control with mood shifts; actions that appear to be willful often are symptoms of the illness
  - Targeting early signs of mood shifts can help to manage the change
- Understand the work history
  - A comprehensive work history can provide a measurement of the vacillating course of a person's illness
  - Look for multiple jobs of short duration, a number of firings, or abrupt resignations
- Be aware of the impact of mood swings
  - Sometimes a person may have boundless energy and be quite irritable; at other times, the person may be very depressed with suicidal thoughts and behavior
  - To avoid succumbing to this feeling, develop strategies that help ease the situation and are empathic to the person's experience
- Discuss the "ups" and the "downs"
  - When documenting the effects of bipolar disorder, indicate how symptoms affect a person's behavior and ability to accomplish and manage daily functions
- Look for clues in appearance
  - Changes in appearance can offer clues, e.g. notable differences from typical style or lack of hygiene

12.05 Mental Retardation

Excerpt From:
Disability Evaluations Under Social Security

12.05 Mental Retardation

Mental retardation refers to significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of the impairment before age 22.

The required level of severity for these disorders is met when the requirements of A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;

OR

B. A valid verbal, performance, or full scale IQ of 59 or less;

OR

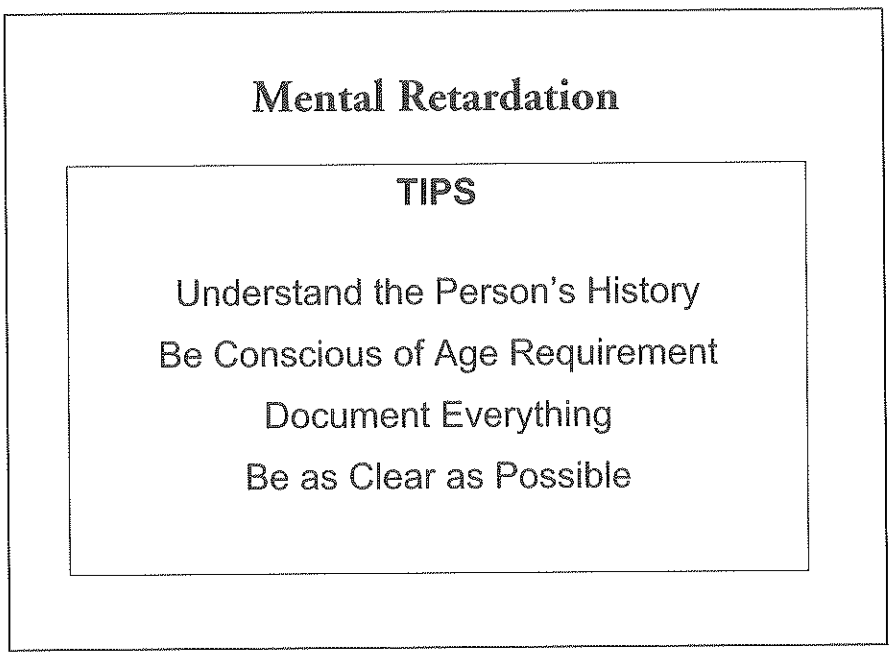
C. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or mental impairment imposing an additional and significant work-related limitation of function;

OR

D. A valid verbal, performance, or full scale IQ of 60 through 70, resulting in at least two (2) of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence or pace; or
4. Repeated episodes of decompensation, each of extended duration.



Tips for Working with People with Mental Retardation

- Understand the person's history
  - When working with a person with some cognitive impairment, a case manager needs to understand the person's past condition and what has changed
- Be conscious of the age requirement
  - Since the definition of mental retardation requires onset of the impairment before the person was 22 years old, discovering any treatment information before age 22 may be useful
- Document everything
  - Many people who are homeless have a variety of cognitive impairments but may not meet the requirements for mental retardation as defined by DDS
  - Identify the cognitive impairments, and include results of psychological or neuropsychological testing
- Be as clear as possible
  - When working with someone who has cognitive difficulties, be sure that the individual is able to follow the information or instructions
  - Split tasks into easy-to-follow steps
  - Be very clear about information such as meeting times, agendas, and who will be taking care of each step
  - Check with the individual often to assure that he or she understands the process

12.06 Anxiety-Related Disorders

Excerpt From:
Disability Evaluations Under Social Security

12.06 Anxiety-Related Disorders

In these disorders, anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one (1) of the following:

1. Generalized persistent anxiety accompanied by three (3) out of four (4) of the following signs or symptoms:
   a. Motor tension; or
   b. Autonomic hyperactivity; or
   c. Apprehensive expectation; or
   d. Vigilance and scanning; or
2. A persistent irrational fear of a specific object, activity, or situation, which results in a compelling desire to avoid the dreaded object, activity, or situation; or
3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average at least once a week; or
4. Recurrent obsessions or compulsions that are a source of marked distress; or
5. Recurrent and intrusive recollections of a traumatic experience that are a source of marked distress.

AND

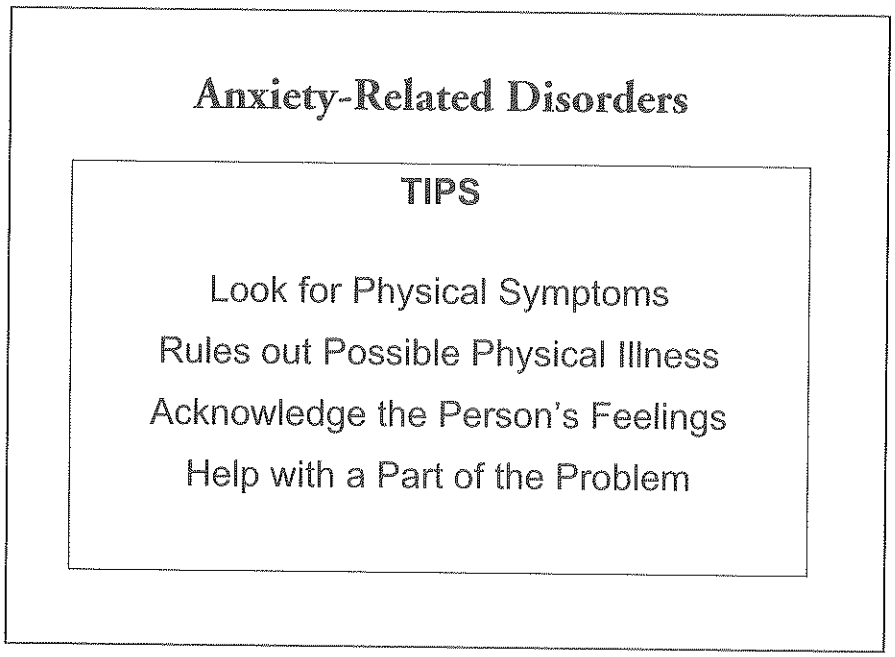
B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence or pace; or
4. Repeated episodes of decompensation, each of extended duration.

OR

C. Resulting in complete inability to function independently outside the area of one's home.



Tips for Working with People with Anxiety-Related Disorders

- Look for physical symptoms
  - Difficulty breathing, wringing hands, sweaty hands, shaking or trembling, and dizziness or faintness may signal anxiety
- Rule out possible physical illness
  - Physical examination is especially critical for people with anxiety, whose symptoms may be linked to physical illness
- Acknowledge the person's feelings
  - Acknowledge how overwhelming tension, worry, and fear must be
- Help with a part of the problem
  - Divide the application tasks into steps that the person can manage
- Trauma
  - Anxiety may involve a trauma history; PTSD falls under this listing
  - If a case manager is not skilled in discussing trauma with people, he or she should not do so
  - Case managers must ensure safety at all times when working with someone with trauma
  - Be certain that a person will be safe after discussing traumatic experiences
  - Elicit only enough information to understand a person's traumatic experiences and how they might affect the person's functioning

12.07 Somatoform Disorders

Excerpt From:
Disability Evaluations Under Social Security

12.07 Somatoform Disorders

Physical symptoms with no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied

A. Medically documented by evidence of one of the following:

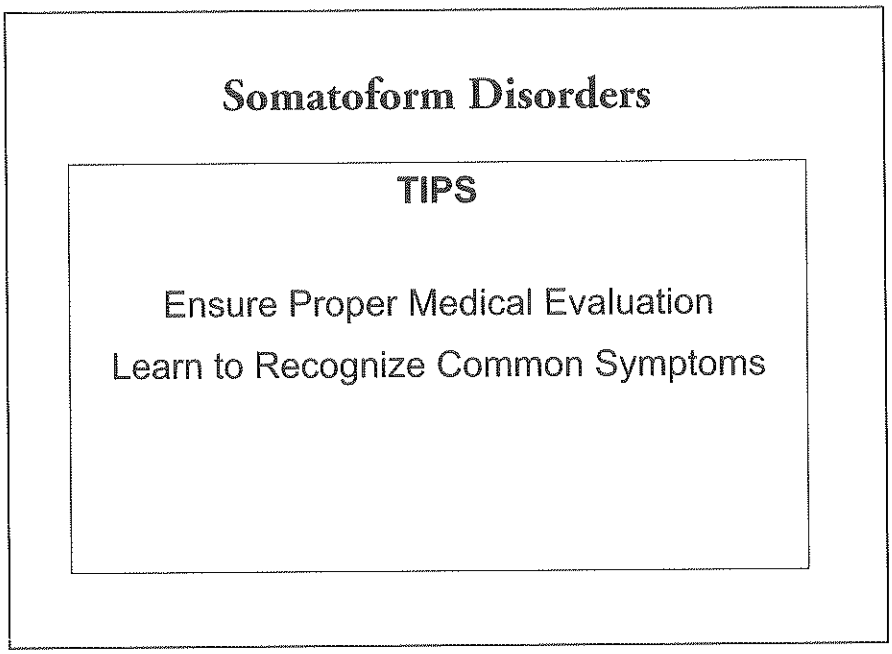
1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or
2. Persistent non-organic disturbance of one of the following:
   a. Vision; or
   b. Speech; or
   c. Hearing; or
   d. Use of a limb; or
   e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia); or
   f. Sensation (e.g., diminished or heightened).
3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury.

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence or pace; or
4. Repeated episodes of decompensation, each of extended duration.



Tips for Working with People with Somatoform Disorders

- Ensure proper medical evaluation
  - While somatoform disorders are not very common among people who are homeless, they do constitute a category within the DDS "Blue Book"
  - For an accurate determination to be made, the individual requires a thorough physical evaluation
- Learn to recognize common symptoms
  - Become familiar with physical health problems frequently seen in people who are homeless

12.08 Personality Disorders

Excerpt From:
Disability Evaluations Under Social Security

12.08 Personality Disorders

A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

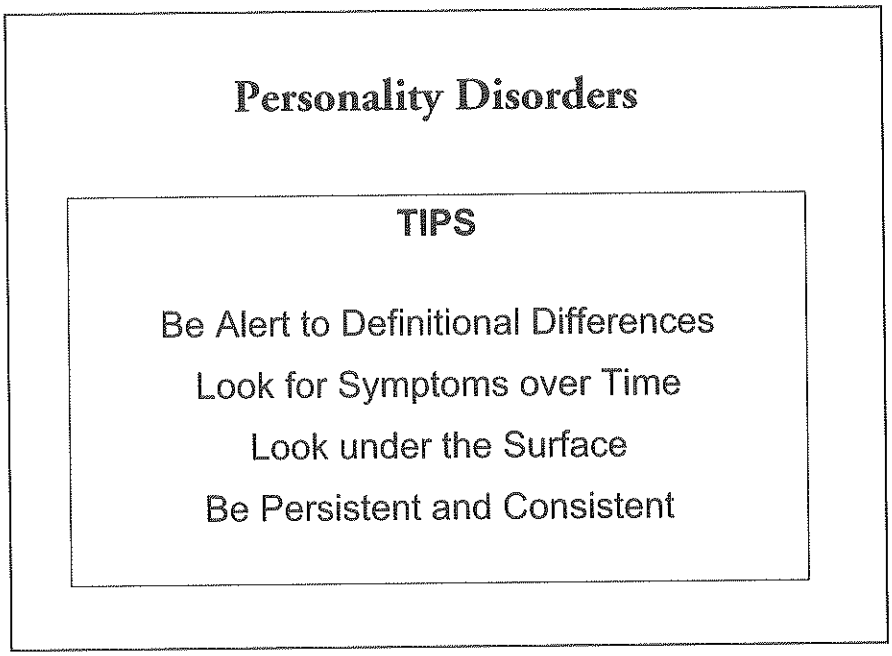
A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking; or
2. Pathologically inappropriate suspiciousness or hostility; or
3. Oddities of thought, perception, speech and behavior; or
4. Persistent disturbances of mood of affect; or
5. Pathological dependence, passivity or aggressivity; or
6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence or pace; or
4. Repeated episodes of decompensation, each of extended duration.



Tips for Working with People with Personality Disorders

- Be alert to definitional differences
  - Note that the definition and symptom criteria listed for personality disorders in the Blue Book do not match exactly the descriptions and information in either the *International Classification of Disorders (ICD-10)* or the *Diagnostic and Statistical Manual of Mental Disorders*
- Look for symptoms over time
  - Personality disorder diagnoses require a thorough understanding of a person's current and past functioning
- Look under the surface
  - Behavior is a means of coping and adaptation, often learned early in life
  - Behavior may result from trauma
  - Case managers may find some behaviors annoying; seek the meaning behind such behavior
- Be persistent and consistent

12.09 Substance Addiction Disorders

Excerpt From:
Disability Evaluations Under Social Security

12.09 Substance Addiction Disorders

Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any one of the following (A through I) are satisfied.

A. Organic mental disorders (evaluate under 12.02)

B. Depressive syndrome (evaluate under 12.04)

C. Anxiety disorders (evaluate under 12.06)

D. Personality disorders (evaluate under 12.08)

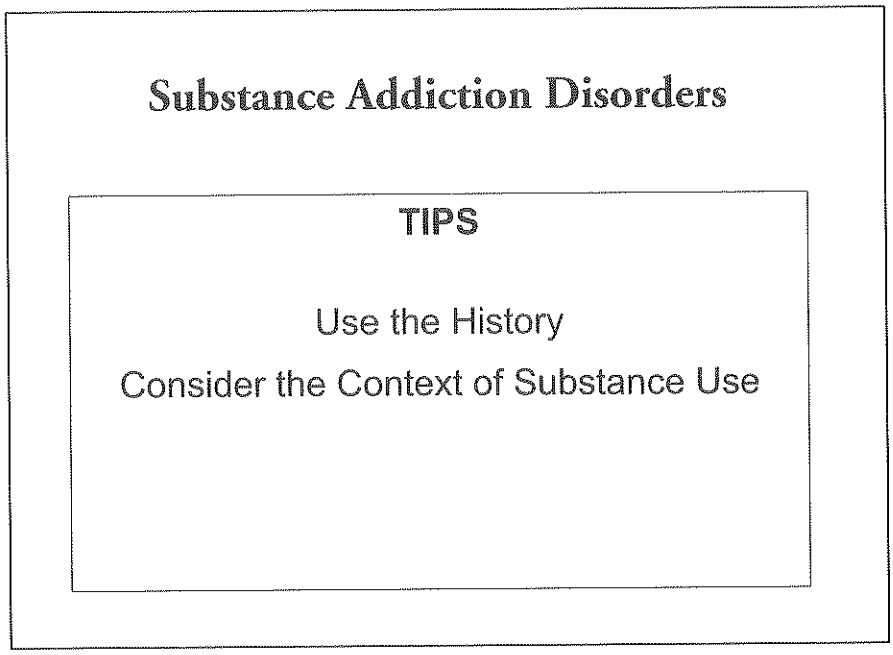
E. Peripheral neuropathies (evaluate under 11.14)

F. Liver damage (Evaluate under 5.05)

G. Gastritis (Evaluate under 5.04)

H. Pancreatitis (evaluate under 5.08)

I. Seizures (evaluate under 11.02 or 11.03)



Tips for Working with People with Substance Addiction Disorders

- Use the history
  - Discuss the person's substance use within the context of his or her experiences and life history
- Consider the context of substance use
  - Look at an individual's personal and psychiatric history, efforts to stop alcohol or drug use, and the repercussions from such efforts, as well as impact on psychiatric symptoms

Note

Navigating the complications of alcohol or drug use is difficult and requires careful judgment and assessment. Brainstorm with team members and get input from treatment providers to make an accurate assessment.

12.10 Autistic Disorder and Other Pervasive Developmental Disorders

Excerpt From:
Disability Evaluations Under Social Security

12.10 Autistic Disorder and other Pervasive Developmental Disorders

Characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Often, there is a markedly restricted repertoire of activities and interests, frequently are stereotyped and repetitive.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

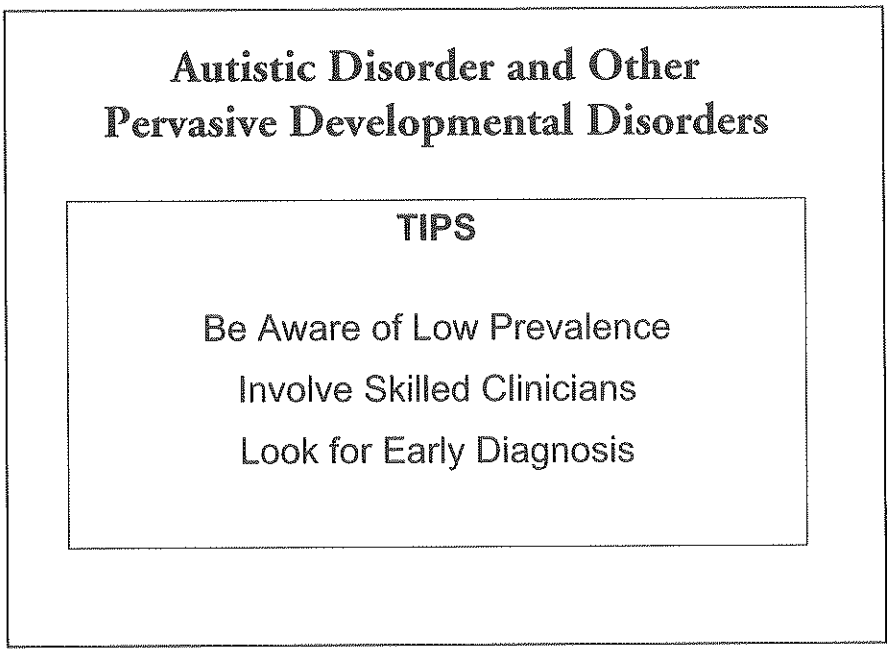
A. Medically documented findings of the following:

1. For autistic disorder, all of the following:
   a. Qualitative deficits in reciprocal social interaction; and
   b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity; and
   c. Markedly restricted repertoire of activities and interests; or
2. For other pervasive developmental disorders, both of the following:
   a. Qualitative deficits in reciprocal social interaction; and
   b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity.

AND

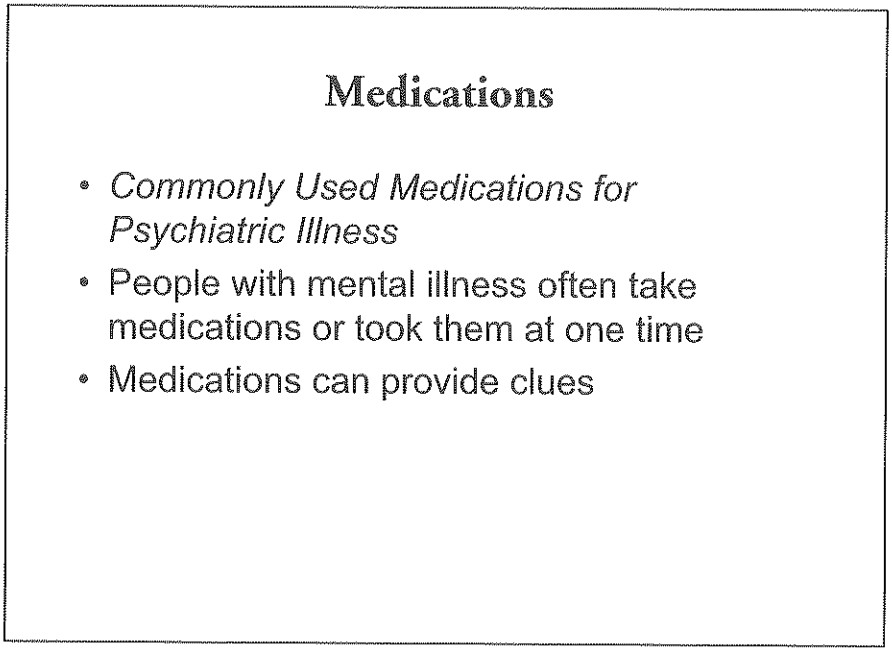
B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence or pace; or
4. Repeated episodes of decompensation, each of extended duration.



Tips for Working with People with Autistic Disorder and Other Pervasive Developmental Disorders

- Be aware of low prevalence
  - This category of mental impairments is not common in persons who are homeless
  - This is partly because people with these disorders frequently have significant difficulty managing on their own and/or because these disorders begin in childhood
- Involve skilled clinicians
  - Involvement of skilled clinicians in the evaluation of these disorders is critical
  - Thorough physical examinations should be done to rule out any medical condition that could contribute to the person's symptoms or illness
- Look for early diagnosis
  - Often, an individual with a pervasive developmental disorder has been diagnosed early in life
  - Complete medical histories can provide vital clues for a case manager and clinician considering these diagnoses



Medications Can Provide Clues

Note

A chart of *Commonly Used Medications for Psychiatric Illness* can be found on pages 37–38 of this module.

Mental Health Services

Treatment	Rehabilitation
Inpatient Hospitalization	Psychiatric Rehabilitation Day Program
Day Hospital Partial Hospital Day Treatment Intensive Outpatient	Vocational Services
Outpatient Mental Health Clinic	Residential Rehabilitation Supported Housing
Mobile Treatment Team	
Respite/Crisis Care Services	
Case Management/Community-Supported Program	

Types of Mental Health Services

Familiarity with different types of mental health services can be very beneficial when applying for disability benefits. Case managers familiar with these services are able to search more efficiently and effectively for necessary information.

Treatment

- Inpatient hospitalization

- Day hospital/partial hospital/day treatment/intensive outpatient

- Outpatient mental health clinic

- Mobile treatment team

Rehabilitation

- Psychiatric rehabilitation day program

- Vocational services

- Residential rehabilitation/supported housing

Other Supportive Services

- Respite/crisis services

- Case management/community-supported program

Summary

When thinking about diagnosis, consider:

- What needs to be addressed for SSI/SSDI purposes
- How understanding diagnosis informs practice and relationships with those we serve

Note

See Handy Tips on the next page before moving on to the next module.

Handy Tips

- Use this module as a reference for information about mental health diagnoses and terms. It also provides helpful hints for working with people who receive these diagnoses.
- Collaborate with someone who has clinical expertise and experience to understand and assess individuals, their illnesses, and the impact of illness on ability to work SGA.
- Maintain ongoing communication with the applicant's treatment team, including clinical consultants and supervisors.
- Focus on developing listening and observational skills. Be sure to understand a person's story from his or her perspective. If the story is not complete, it is essential to learn more.
- It is important to assess a person's ability to work and to ensure the accuracy of his or her diagnoses. Work collaboratively with treatment providers to take a "fresh look" at diagnoses and to ensure that service planning meets the person's needs.

  Example: People diagnosed with antisocial personality disorder often act impulsively, without regard to others. People with brain damage may also act impulsively and have difficulty assessing or limiting the consequences of their actions. Appropriate treatment depends upon accurate diagnosis.

- Case managers need a forum to address the difficulties and frustrations of this work, as well as the successes and rewards. Professional development should be encouraged and fostered through supervision and access to clinical expertise.

Commonly Used Medications for Psychiatric Illness

	Generic Name	Trade Name
Antipsychotics *(for psychotic symptoms)*	Aripiprazole	Abilify
	Chlorprothixene	Taractan
	Chlorpromazine	Thorazine
	Clozapine	Clozaril
	Fluphenazine	Prolixin
	Haloperidol	Haldol
	Loxapine	Loxitane/Daxolin
	Mesoridazine	Serentil
	Molindone	Moban
	Olanzapine	Zyprexa
	Perphenazine	Trilafon
	Prochlorperazine	Compazine
	Quetiapine	Seroquel
	Risperidone	Risperdal
	Thioridazine	Mellaril
	Thiothixine	Navane
	Trifluoperazine	Stelazine
	Ziprasidone	Geodon
Antidepressants *(for depression)* *(sometimes used for anxiety disorders or other medical problems)*	Amitriptyline	Elavil
	Amoxapine	Ascendin
	Bupropion	Wellbutrin
	Citalopram /Escitalopram	Celexa/Lexapro
	Clomipramine	Anafranil
	Desipramine	Norpramin
	Doxepin	Adapin/Sinequan
	Duloxetine	Cymbalta
	Fluoxetine	Prozac
	Fluvoxamine	Luvox
	Imipramine	Tofranil
	Isocarboxazid	Marplan
	Maprotiline	Ludiomil
	Mirtazapine	Remeron
	Nefazondone	Serzone
	Nortriptyline	Pamelor/Aventyl
	Paroxetine	Paxil
	Phenelzine	Nardil
	Protriptyline	Vivactil
	Sertraline	Zoloft
	Tranylcypromine	Parnate
	Trazodone	Desyrel
	Trimipramine	Surmontil
	Venlafaxine	Effexor

Commonly Used Medications for Psychiatric Illness continued

	Generic Name	Trade Name
Anxiolytics *(for anxiety)*	Alprazolam	Xanax
	Buspirone	Buspar
	Chlorazepate	Tranxene
	Chlordiazepoxide	Librium
	Clonazepam	Klonopin
	Diazepam	Valium
	Halazepam	Paxipam
	Hydroxyzine	Atarax
	Hydroxazine	Vistaril
	Lorazepam	Ativan
	Oxazepam	Serax
	Prazepam	Centrax
Anticonvulsants *(for seizures)* *(some are also used as mood stabilizers)*	Gabapentin	Neurontin
	Carbamazepine	Tegretol
	Lamotrigine	Lamictal
	Oxcarbazepine	Trieptal
	Phenytoin	Dilatin
	Tiagabine	Gabitril
	Topiramate	Topamax
	Valproic acid	Depakene/Depakote/Valproate
Mood Stabilizers	Lithium	Lithium Carbonate
		Lithobid
		Eskalith
For ADHD	Atomoxetine	Strattera
	Dextroamphetamine	Dexedrine
	1 & d-amphetamine	Adderall/Adderall XR
	Guanfacine	Tenex
	Methylphenidate	Ritalin/Concerta
	Modafinil	Provigil
	Pemoline	Cylert
For Side Effects of Antipsychotics	Amantadine	Symmetrel
	Benztropine	Cogentin
	Propranolol	Inderal
	Trihexyphenidyl	Artane
Hypnotics *(for sleep)*	Estazolam	ProSom
	Eszopiclone	Lunesta
	Flurazepam	Dalmane
	Temazepam	Restoril
	Triazolam	Halcion
	Zaleplon	Sonata
	Zolpidem	Ambien