# MENTAL HEALTH IS A VERB

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## A Pocket Guide to Mental Health for Nursing Students

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## Part II. MENTAL DISORDERS

# INTRODUCTION

Welcome to our mental health nursing pocket guide for students! We have designed this text to be a nuts-and-bolts type reference interspersed with activities to help you digest the information.

Should you have any comments or questions, you may contact us via email.


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## ACKNOWLEDGMENTS


- Thank you to Drs. Bridley and Daffin for their work and sharing their resource! This text was adapted from Adapted from *Fundamentals of Psychological Disorders 2nd Edition* by Alexis Bridley, Ph.D. and Lee W. Daffin Jr., Ph.D. licensed under a Creative Commons Attribution 4.0 International License. Modifications: revised for clarity and flow. 
- Thank you to Ms. Cindy Gruwell, Health Sciences Librarian, for her expertise and guidance on this project!

- Thank you to Dr. Karen White-Trevino and Dr. William Mikulas for being leaders in Nursing and Psychology, respectively. Also, thank you both for your mentorship and kindness.
- Cover Image: "Human Brain 1839" by Vintage Medical (Canva.com)
- Thank you to our readers for embarking on this mental health nursing journey with us. We hope you enjoy the book!

**A few notes about organization and format:**

- This text uses the APNA Undergraduate Education Toolkit (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022) as a guiding framework for content organization.
- There is a focus on nursing problems, not nursing diagnoses, as this may help students prioritize patient needs and promote clinical reasoning. In addition, this shift to nursing problems is consistent with the National Council of State Boards of Nursing Clinical Judgment Measurement Model (NCJMM) (Ignatavicius & Silvestri, 2022).
- There is a variety of interactive elements. One of which is a glossary. Some key words are bolded in black font color to emphasize their role in mental health nursing. Other keywords are bolded in blue font color and are

included in the glossary. To access the glossary, click the blue bolded word.

**A few notes about the text's activities:**

- Various types of activities are included in this text to increase both short-term information processing and remote recall for applicational needs.
- Most learners are multi-modal learners. Hence, an emphasis on inclusion of various types of activities to meet your learning needs.
- At the end of each mental health diagnosis chapter (e.g., depression, anxiety, bipolar), you will be prompted to complete a concept map. Concept maps are an excellent way to digest information. See the short video below for a brief tutorial on concept map creation.

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=4#oembed-1*

University of Guelph Library. (2017, April 27). *How to create*

*a concept map* [Video]. YouTube. https://www.youtube.com/watch?v=sZJj6DwCqSU&t=1s

PART I

# FOUNDATIONAL CONCEPTS IN MENTAL HEALTH NURSING

PART I. FOUNDATIONAL CONCEPTS IN MENTAL HEALTH NURSING

# MODULE 1: MENTAL HEALTH VERSUS MENTAL ILLNESS

## MENTAL HEALTH VERSUS MENTAL ILLNESS

**Module Outline**

- Essentials for Education in Psychiatric-Mental Health
- Mental Health Versus Mental Illness
- The History of Mental Illness

**Module Learning Outcomes**

- Review essentials for mental health nursing education
- Differentiate mental health versus mental illness
- Explore the history of mental illness

## Undergraduate Education

## Mental Health Essentials

The American Psychiatric Nurses Association (APNA) developed the Essentials for Undergraduate Education in Psychiatric-Mental Health (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022). These essentials will guide as a framework for many of the topics throughout this book. Visit this resource to learn more about the APNA's Undergraduate Education Toolkit.

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## Mental Health Versus Mental Illness

A holistic view of health incorporates an individual's physical, mental, emotional, and spiritual well-being. Mental health applies to everyone and can affect other aspects of one's health and well-being. Envision mental health on a continuum, where mental health and mental illness are the anchors. Stress or stressful events are often related to mental illness exacerbations. **Social determinants of health** also contribute to one's place on the mental health continuum.

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=92#oembed-1*

Let's Learn Public Health. (2018). *What is public health?* [Video]. YouTube. https://youtu.be/t_eWESXTnic

How do we differentiate mental health from mental illness? The short answer is mental illness typically relates to deviance in behavior and/or dysfunction and/or distress in one's ability to carry out our typical day-to-day activities. For example, an individual experiencing increasing stress in a crisis situation such as being terminated from employment may feel and express suicidal thoughts. As healthcare professionals, we have a duty to report when an individual expresses intent to harm another person or themselves. We will discuss the legal implications within mental health nursing in another module.

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*https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=92#h5p-1*

Many people who need care never seek it out. Why is that? We already know that society dictates what is considered abnormal behavior through culture and social norms, and you can likely think of a few implications of that. Overlapping with prejudice and discrimination in terms of how people with mental disorders are treated is **stigma**, or negative stereotyping, labeling, rejection, and loss of status occur.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=92#h5p-3

## The History of Mental Illness

Abnormal behavior is often dictated by the culture or society a person lives in, and unfortunately, the past has not treated

the afflicted very well. In this section, we will examine how past societies viewed and dealt with mental illness.

**Prehistoric cultures** often held a supernatural view of mental illness and saw it as the work of evil spirits, demons, gods, or witches who took control of the person. This form of demonic possession often occurred when the person engaged in behavior contrary to the religious teachings of the time. Early Greek, Hebrew, Egyptian, and Chinese cultures used a treatment method called exorcism in which evil spirits were cast out through prayer, magic, flogging, starvation, having the person ingest horrible tasting drinks or noisemaking.

Rejecting the idea of demonic possession, Greek physician **Hippocrates** (460-377 B.C.) said that mental disorders were akin to physical ailments and had natural causes. Specifically, they arose from *brain pathology*, or head trauma/brain dysfunction or disease, and were also affected by heredity. He described four main fluids or humors that directed normal brain functioning and personality – *blood* which arose in the heart, *black bile* arising in the spleen, *yellow bile* or *choler* from the liver, and *phlegm* from the brain. Mental disorders occurred when the humors were in a state of imbalance such as an excess of yellow bile causing frenzy and too much black bile causing melancholia or depression. Hippocrates believed mental illnesses could be treated as any other disorder and focused on the underlying pathology.

During the **Middle Ages** with the increase in power of the Church and the fall of the Roman Empire, mental illness was

yet again explained as possession by the Devil and methods such as exorcism, flogging, prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of demonic influence. In extreme cases, the afflicted were exposed to confinement, beatings, and even execution.

The number of asylums, or places of refuge for the mentally ill where they could receive care, began to rise during the 16th century. Hospitals and monasteries were converted into asylums. Though the intent was benign in the beginning, as the facilities were overcrowded, the patients came to be treated more like animals than people. Patients were chained up, placed on public display, and often heard crying out in pain.

Reform in the United States started with the figure largely considered to be the father of American psychiatry, **Benjamin Rush** (1745-1813). Rush advocated for the humane treatment of the mentally ill, showing them respect, and even giving them small gifts from time to time. Despite this, his practice included treatments such as bloodletting and purgatives, the invention of the "tranquilizing chair," and reliance on astrology, showing that even he could not escape from the beliefs of the time.

Due to the rise of the moral treatment movement in both Europe and the United States, asylums became habitable places where those afflicted with mental illness could recover. The number of mental hospitals greatly increased, leading to staffing shortages and a lack of funds to support them. Waves of immigrants arriving in the U.S. after the Civil War

overwhelmed the facilities, and patient counts soared to 1,000 or more.

**Dorothea Dix** (1802-1887), a New Englander who observed the deplorable conditions suffered by the mentally ill while teaching Sunday school to female prisoners. Over the next 40 years, from 1841 to 1881, she motivated people and state legislators to do something about this injustice and raised millions of dollars to build over 30 more appropriate mental hospitals and improve others.

Check out the video below to learn more about Dorothea Dix and her influence within the profession of nursing.

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=92#oembed-2*

National League for Nursing. (2022). *NLN nursing edge unscripted saga-episode 2: Dorthea Dix.* [Video]. YouTube. https://youtube.com/watch?v=S3O37lm8FMI&si=EnSIkaIECMiOmarE

**Mental Health America** (MHA) provides education about people with mental illness and their need for care with

dignity. Today, MHA has over 200 affiliates in 41 states and employs 6,500 affiliate staff and over 10,000 volunteers.

By the end of the 19th century, it had become evident that mental disorders were caused by a combination of biological and psychological factors. As a society, we used to wait for a mental or physical health issue to emerge, then scramble to treat it. More recently, medicine and science have taken a prevention stance, identifying the factors that cause specific mental health issues and implementing interventions to stop them from happening, or at least minimize their deleterious effects.

Specific to the nursing profession, Linda Richards graduated from the New England Hospital for Women and Children in 1873 (Videbeck, 2020). She is known as the first psychiatric nurse and believed in parity of mental health care to physical care (Videbeck, 2020). The first psychiatric nursing textbook, *Nursing Mental Diseases* (Bailey, 1920), was written by Harriet Bailey in 1920. Hildegard Peplau, a nursing theorist, was instrumental in psychiatric nursing. She wrote *Interpersonal Relations in Nursing* as well as described the nurse-patient relationship (Videbeck, 2020). Watch the interview with Hildegard Peplau below.

*One or more interactive elements has been*

*excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=92#oembed-3*

American Psychiatric Association. (2018). *A conversation with Hildegard Peplau*. [Video]. YouTube. https://youtube.com/watch?v=Fdx5Dw-dkBg&si=EnSIkaIECMiOmarE

## Key Takeaways

You should have learned the following in this section:

- Mental disorders are characterized by psychological dysfunction, which causes physical and/or psychological distress or impaired functioning.
- Healthcare professionals have a duty to report when an individual expresses intent to harm another person or themselves.
- Stigma is negative stereotyping, labeling, rejection, and loss of status occur and take the

form of public or self-stigma, and label avoidance.

- Some of the earliest views of mental illness related to the work of evil spirits, demons, gods, or witches who took control of the person, and in the Middle Ages it was seen as possession by the Devil, and methods such as exorcism, flogging, prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of demonic influence.

The interactive slide show contained within this chapter showcasing the topics (What is Mental Health, What is Mental Wellness, and the Wellness Wheel) was adapted from UBC Student Health and Wellbeing Staff, Gillies, J., Johnston, B., Warwick, L., Devine, D., Guild, J., Hsu, A., Islam, H., Kaur, M., Mokhovikova, M., Nicholls, J. M., & Smith. C. (2021). Starting a conversation about mental health: Foundational training for students. BCcampus and licensed under a Creative Commons Attribution 4.0 International License. Modifications: revised for clarity and flow.

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# MODULE 2: THEORETICAL MODELS USED IN MENTAL HEALTH NURSING

## THEORETICAL MODELS USED IN MENTAL HEALTH NURSING

This module aligns with APNA's "Growth & Development" specific core nursing content (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

### Module Outline

- Utilizing Theory to Conceptualize and Prioritize Mental Health Nursing Care

### Module Learning Outcomes

- Review Leininger's Theory of Culture Care Diversity and Universality
- Describe Sigmund Freud's Personality Development
- Describe Ego Defense Mechanisms

- Describe Maslow's Hierarchy of Needs
- Describe Erik Erikson's Psychosocial Stages of Development

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## Leininger's Theory of Culture Care Diversity and Universality

Dr. Madeleine Leininger's Theory of Culture Care Diversity and Universality (Transcultural Nursing Society, 2022) supported a holistic view of health. Dr. Leininger's Sunrise Enabler incorporated the physiological, psychological, spiritual, social, and cultural facets of health in addition to other social determinants of health (Transcultural Nursing Society, 2022). Social determinants of health are environmental components such as neighborhood, education and access to education, employment, and healthcare access that affect individuals' health, outcomes, and health risks (Office of Disease Prevention and Health Promotion, 2021).

See Dr. Leininger's Sunrise Enabler here (Transcultural Nursing Society, 2022)

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## Sigmund Freud's Personality Development

According to Freud, our personality has three parts – the id, superego, and ego, and from these our behavior arises. First, the **id** is the impulsive part that expresses our sexual and aggressive instincts. It is present at birth, completely unconscious, and operates on the *pleasure principle*, resulting in selfishly seeking immediate gratification of our needs no matter what the cost. The second part of personality emerges after birth with early formative experiences and is called the **ego**. The ego attempts to mediate the desires of the id against the demands of reality, and eventually, the moral limitations or guidelines of the superego. It operates on the *reality principle*, or an awareness of the need to adjust behavior, to meet the demands of our environment. The last part of the personality to develop is the **superego**, which represents society's expectations, moral standards, rules, and represents our conscience. The three parts of personality generally work together well and compromise, leading to a healthy personality, but if the conflict is not resolved, intrapsychic conflicts can arise and lead to mental disorders.

## Ego Defense Mechanisms

Ego-defense mechanisms are in place to protect us and therefore can be adaptive coping mechanisms. However, ego-defense mechanisms are considered maladaptive coping mechanisms if they are misused and become our primary way of dealing with stress. They protect us from anxiety and operate unconsciously by distorting reality. Defense mechanisms include the following:

- **Repression** – When unacceptable ideas, wishes, desires, or memories are blocked from consciousness such as forgetting a horrific car accident that you caused. Eventually, though, it must be dealt with or the repressed memory can cause problems later in life.
- **Reaction formation** – When an impulse is repressed and then expressed by its opposite. For example, you are angry with your boss but cannot lash out at him, so you are super friendly instead. Another example is having lustful thoughts about a coworker than you cannot express because you are married, so you are extremely hateful to this person.
- **Displacement** – When we satisfy an impulse with a different object because focusing on the primary object may get us in trouble. A classic example is taking out your frustration with your boss on your wife and/or kids when you get home. If you lash out at your boss, you

could be fired. The substitute target is less dangerous than the primary target.

- **Projection** – When we attribute threatening desires or unacceptable motives to others. An example is when we do not have the skills necessary to complete a task, but we blame the other members of our group for being incompetent and unreliable.
- **Sublimation** – When we find a socially acceptable way to express a desire. If we are stressed out or upset, we may go to the gym and box or lift weights. A person who desires to cut things may become a surgeon.
- **Denial** – Sometimes, life is so hard that all we can do is deny how bad it is. An example is denying a diagnosis of lung cancer given by your doctor.
- **Identification** – When we find someone who has found a socially acceptable way to satisfy their unconscious wishes and desires, and we model that behavior.
- **Regression** – When we move from a mature behavior to one that is infantile. If your significant other is nagging you, you might regress by putting your hands over your ears and saying, "La la la la la la la..."
- **Rationalization** – When we offer well-thought-out reasons for why we did what we did, but these are not the real reason. Students sometimes rationalize not doing well in a class by stating that they really are not interested in the subject or saying the instructor writes impossible-to-pass tests.

- **Intellectualization** – When we avoid emotion by focusing on the intellectual aspects of a situation such as ignoring the sadness we are feeling after the death of our mother by focusing on planning the funeral.

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## Abraham Maslow's Hierarchy of Needs

Abraham Maslow's Hierarchy of Needs can be used to understand individuals' holistic health needs and prioritize nursing care. The needs are represented in a pyramid of five levels, where the base is basic needs and progresses upwards to higher needs (i.e., self-actualization) (Toney-Butler & Thayer, 2022). Individuals will be motivated to attend to basic needs, until those needs are met (Toney-Butler & Thayer, 2022). After basic needs are met, individuals may focus on higher-level needs (Toney-Butler & Thayer, 2022).

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=104#h5p-4

Read more about Maslow's Hierarchy of Needs here: https://www.simplypsychology.org/maslow.html.

Students may also be interested in this YouTube video (The School of Life, 2019) explanation of Maslow's Hierarchy of Needs.

## Erik Erikson Psychosocial Stages of Development

Erik Erikson described eight psychological and social stages of development that enable psychosocial growth and development (Videbeck, 2020).

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/

uwfmentalhealthnursing/?p=104#h5p-5

## Key Takeaways

You should have learned the following in this section:

- According to Freud, the personality had three parts (the id, ego, and superego)
- There are ten defense mechanisms to protect the ego such as repression and sublimation
- Maslow's Hierarchy of Needs can be used to identify and prioritize patients' needs
- Erik Erickson Psychosocial Stages of Development can provide the nurse with a sense of patients' psychosocial accomplishments and deficits.

# MODULE 3: CLINICAL ASSESSMENT, PROBLEMS, AND TREATMENT

## CLINICAL ASSESSMENT, PROBLEMS, AND TREATMENT

This module aligns with APNA's "Clinical Decision Making" specific core nursing content (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

### Module Outline

- Using the nursing process to guide mental health nursing care

## Module Learning Outcomes

- Describe the nursing process
- Discuss various treatment options

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# The Nursing Process

Traditionally, the nursing process involves assessment, diagnosis, planning outcomes, implementation, and evaluation (ADPIE). However, you may remember from the Introduction, this text will focus on Problems (see the Introduction for explanation). An interview with the patient will allow the nurse to gather crucial information for the assessment. When interacting with patients, it is imperative to be aware of the potential for transference and countertransference. **Transference** is the process through which patients transfer attitudes to the nurse. They may be positive and include friendly, affectionate feelings, or negative, and include hostile and angry feelings. **Countertransference** is a similar attitude transfer, but from the nurse to the patient.

Read more about the nursing process here: https://www.ncbi.nlm.nih.gov/books/NBK499937/ (Toney-Butler & Thayer, 2022).

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# Assessment

The nursing process is used to guide mental health nursing care. The first step of the nursing process is an **assessment.** In general, the nurse is gathering data, including:

- allergies and code status
- list of current medications (dose, frequency, route)
- current assessment of presenting signs/symptoms, any effects on daily functioning
- pertinent physical, surgical, and psychosocial history
- cultural, spiritual, sexual, and gender identity

An initial assessment serves as a baseline to inform future needs. The assessment involves the collection of subjective data (i.e., information from the patient or caregiver) and objective data (i.e., measurable data such as vital signs, intake and output, height and weight, and nurse's assessment). This collection of information involves critical thinking about the client's skills, abilities, personality characteristics, cognitive and emotional functioning, the social context in terms of environmental stressors that are faced, and cultural factors particular to them such as their language or ethnicity. Lastly, it is important to note that clinical assessment is ongoing.

## Mental Health Assessment

Specific to a mental health assessment, a nurse would also incorporate additional attention to a mental status

examination. A mental status examination is used to organize the information collected during the interview and systematically evaluate the patient through a series of questions assessing appearance and behavior. The latter includes grooming and body posture, thought processes and content to include disorganized speech or thought and false beliefs, mood and **affect** such that whether the person feels hopeless or elated, intellectual functioning to include speech and memory, and awareness of surroundings to include where the person is and what the day and time are. The exam covers areas not normally part of the interview and allows the mental health professional to determine which areas need to be examined further. See Voss and Das's (2021) resource for further explanation of the mental status examination.

### Additional Assessment Resources

- Nurses can utilize Dr. Leininger's Sunrise Enabler (Transcultural Nursing Society, 2022) as a tool to help guide assessment.
- **For a new admission**, students might find Toney-Butler and Unison-Pace's (2021) resource helpful.

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## Problems

Nursing students will notice patients' medical records may

often contain several diagnoses (e.g., medical and psychological). Diagnoses serve as a communication tool to members of the healthcare team and relay the patient's health needs as well as to insurance providers. Specific to mental health needs, the American Psychiatric Association (APA) publishes the most widely used classification system in the United States (i.e., *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA, 2022). The DSM is currently in its 5th edition Text-Revision (DSM-5-TR) and is produced by the American Psychiatric Association (APA, 2022). The DSM-5-TR is used to formally document the presence of a mental health diagnosis.

Nurses can use nursing diagnoses to document patient health needs. Nursing diagnoses are apart from medical diagnoses. The North American Nursing Diagnosis Association (NANDA) provides an official list of nursing diagnoses. Nursing diagnoses are used to describe actual or potential health problems related to a patient, family, or community (Toney-Butler & Thayer, 2022). Remember from Maslow's Hierarchy of Needs that basic needs should be met before higher level needs (Toney-Butler & Thayer, 2022). Nursing students can typically find NANDA's nursing diagnoses within a fundamental or medical surgical nursing text.

This text will focus on the problem statement of the nursing diagnosis. For example, in the nursing diagnosis statement: **Anxiety** related to situational crisis as evidenced by statement

of "I feel overwhelmed by the loss of my job!" Anxiety is the identified problem.

Watch "How to write a diagnosis.mov" (hawknurse, 2010) for further explanation of nursing diagnoses.

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## Planning Outcomes

Planning outcomes, sometimes seen written as "goals", are created to establish a positive health outcome. The patient's outcomes should be formed with the patient to ensure patient-centered care (Quality and Safety Education for Nurses, 2020).

**Outcomes/goals should be S.M.A.R.T.**:

- Specific
- Measurable or Meaningful
- Attainable or Action-Oriented
- Realistic or Results-Oriented
- Timely or Time-Oriented

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## Implementation

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of the text. You can view it online here:
https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=105#h5p-2

There are numerous approaches to mental health care. Some examples include Cognitive therapy, Cognitive-Behavioral Therapy (CBT), Complementary and Alternative Medicine (CAM), Psychopharmacology, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), and Psychosurgery. Knowing what the person's baselines are for different aspects of psychological functioning will help us to see when improvement occurs.

- Explore the Dimensions of Wellness Wheel above to gather ideas patients can help create mental health wellness throughout many aspects of their lives.

## Cognitive therapy/CBT

Cognitive therapy/CBT addresses one's thoughts and the effects of these thoughts on the patient's psychological well-being. CBT also explores the patient's thoughts, but expands analysis to the patient's behaviors with a focus on dysfunctional behavior patterns.

## Complementary Alternative Medicine (CAM)

CAM can be used in conjunction with traditional methods of mental health care. Patients may use CAM to help alleviate psychological symptoms still lingering despite traditional methods of treatment. Some examples of CAM methods are herbal medications, exercise, yoga, and meditation.

## Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a procedure wherein an electric stimulus is used to produce a generalized seizure. Patients are placed on a padded bed and administered a muscle relaxant to avoid injury during the seizures. ECT is not typically a first-line treatment option.

## Psychosurgery

Another option to treat mental disorders is to perform brain surgeries. In the past, we have conducted trephination and lobotomies, neither of which are used today. Today's techniques are much more sophisticated and have been used to treat schizophrenia, depression, and some personality and anxiety disorders. However, critics cite obvious ethical issues with conducting such surgeries as well as scientific issues.

## Transcranial Magnetic Stimulation

Transcranial magnetic stimulation (TMS) is a non-invasive procedure that uses low or high-intensity magnetic fields to stimulate brain tissue (Mann & Malhi, 2022). Repetitive transcranial magnetic stimulation (rTMS) refers to utilizing repetitive TMS pulses to a specific region of the brain (Mann & Malhi, 2022). TMS can be performed outpatient. The patient is alert and will feel a tapping sensation. Possible side effects include headache, neck pain, local pain, and transient tinnitus (Mann & Malhi, 2022). These side effects are typically mild and resolve in a short period of time (Mann & Malhi, 2022). Seizures are rare with higher incidence for those having epilepsy (Mann & Malhi, 2022).

## Psychopharmacology

Psychopharmacology refers to the use of medications that affect neurotransmitters. This topic is discussed further in the Psychopharmacology module.

### NAMI's Resources

Review the National Alliance on Mental Illness (NAMI) webpage for an overview of

the above mental health treatments (NAMI, 2022a).

## Evaluation

The final step in the nursing process is evaluation of interventions towards achievement of the outcomes ( Toney-Butler & Thayer, 2022). Evaluation is imperative as it provides information to maintain, modify, add additional, and/or stop current interventions.

### Key Takeaways

You should have learned the following in this section:

- Traditionally, the nursing process (ADPIE) is used to develop a nursing plan of care.

- Nursing diagnoses are not medical diagnoses. NANDA nursing diagnoses are used to form nursing care plans that can be complementary to or apart from medical diagnoses. In this text, we will focus on the identified problem of the nursing diagnosis
- The nursing process is an ongoing process to evaluate the patient's progress towards a state of holistic health.

# MODULE 4: PSYCHOPHARMACOLOGY

## PSYCHOPHARMACOLOGY

This module aligns with APNA's "Pharmacotherapeutics and basic principles of Pharmacology" specific core nursing content (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

### Module Outline

- Psychiatric Drugs and Deinstitutionalization
- Neurotransmitters
- Psychotropic Medication Classes

### Module Learning Outcomes

- Describe the role of neurotransmitters within the brain.
- Outline the classifications of psychotropic medications.
- Discuss each psychotropic class and associated side

effects.

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## Psychopharmacology

**Use of psychiatric drugs and deinstitutionalization**.

Beginning in the 1950s, psychiatric or psychotropic drugs were used for the treatment of mental illness and made an immediate impact. Though drugs alone cannot cure mental illness, they can improve symptoms and increase the effectiveness of treatments such as psychotherapy.

**Classes of psychiatric drugs** include:

- **Antidepressants**-treat depression and anxiety
- **Mood-Stabilizers**– treat bipolar disorder
- **Antipsychotics**-treat schizophrenia
- **Anxiolytics/Anti-Anxiety**-treat generalized anxiety disorder and panic disorder
- **Stimulants** –treat attention-deficit/hyperactivity disorder (ADHD)
- **Cholinesterase Inhibitors/N-methyl-D-aspartate (NMDA) Receptor Antagonists**-treat dementia

A result of the use of psychiatric drugs was deinstitutionalization or the release of patients from mental health facilities. This shifted resources from inpatient to

outpatient care and placed the spotlight back on the biological or somatogenic perspective. When people with severe mental illness do need inpatient care, it is typically in the form of short-term hospitalization.

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## Neurotransmitters

**Neurotransmitters.** What exactly are some of the neurotransmitters which are so critical for neural transmission, and why are they essential to our discussion of psychopathology? It is believed that neurotransmitter imbalances contribute to mental health imbalances. Sheffler et al. (2022) provides additional information on neurotransmitters here.

- **Dopamine** – controls voluntary movements and is associated with the reward mechanism in the brain
- **Serotonin** – regulates pain, sleep cycle, and digestion; leads to a stable mood, so low levels lead to depression
- **Endorphins** – involved in reducing pain and making the person calm and happy
- **Norepinephrine** – increases the heart rate and blood pressure and regulates mood
- **Gamma-aminobutyric acid (GABA)** – inhibitory; blocks the signals of excitatory neurotransmitters

responsible for anxiety and panic

- **Glutamate** – excitatory; associated with learning and memory
- **Histamine** – mediates homeostasis functions, promotes wakefulness, modulates feeding, and motivational behavior

Checkout this YouTube video: Introduction and Neurotransmitters Mnemonics (Memorable Psychopharmacology Lectures 1 & 2)

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# Psychopharmacology Classes

**Psychopharmacology and psychotropic drugs.** One option to treat severe mental illness is psychotropic medications. These medications fall under six major categories.

## Antidepressants

Antidepressants are used to treat depression, but also anxiety, insomnia, and pain. They typically require 4-8 weeks to reach full therapeutic benefit (National Institute of Mental Health, 2022). The most common types of antidepressants are **selective serotonin reuptake inhibitors (SSRIs)** and **serotonin-norepinephrine reuptake inhibitors (SNRIs)**

and **norepinephrine-dopamine reuptake inhibitors (NDRIs)** (National Institute of Mental Health, 2022). Examples of SSRIs include Citalopram, Paroxetine, and Fluoxetine (Prozac). **Tricyclic antidepressants** and **Monoamine Oxidase Inhibitors (MAOIs)** are two other older types of antidepressants. Tricyclics and MAOIs are not typically first-line options as they have more side effects compared to SSRIs and SNRIs. The common side effects of antidepressants are upset stomach, headache, and sexual dysfunction, but generally improve with time (National Institute of Mental Health, 2022).

**Antidepressants can increase suicide risk related to** a possible energy increase after initiation of the medication, but with continued feelings of depression. Therefore, individuals may then have the energy to carry out a suicide plan (Videbeck, 2020).

**Individuals prescribed MAOIs need to avoid foods containing high amounts of tyramine** (i.e., aged cheeses, aged/picked/smoked meats, beer, wine, yeast extracts, ginseng, sauerkraut, and avocado) to avoid MAOI toxicity (Garcia & Santos, 2022). MAOI toxicity can also occur with an overdose of an MAOI medication and a drug-drug interaction.

Potential signs and symptoms related to MAOI toxicity can vary from mild to life-threatening. Monoamine oxidase breaks down epinephrine, norepinephrine, dopamine, serotonin, and tyramine in the body. Excess of these substances can result in tachycardia, hyperthermia, myoclonus, hypertension, and agitation (Garcia & Santos, 2022). See this reference to read more about MAOI toxicity.

**Serotonin syndrome** a potentially is a rare, but potentially life-threatening, condition associated with serotonergic drugs that can result from proper medication use, drug interactions, or overdose (Simon & Keenaghan, 2022). Most cases are mild and will resolve within 24-72 hours after removing the precipitating medication (Simon & Keenaghan, 2022). The **signs and symptoms** include:

- Agitation
- Anxiety
- Restlessness
- Disorientation
- Diaphoresis

***Read more about Serotonin***

- Hyperthermia
- Tachycardia
- Nausea & Vomiting
- Tremor
- Muscle Rigidity
- Hyperreflexia
- Myoclonus

- Dilated Pupils
- Ocular Clonus
- Dry Mucous Membranes
- Flushed Skin
- Increased Bowel Sounds
- Bilateral Babinski Sign (Simon & Keenaghan, 2022).

***Syndrome here.***

## Anxiolytics

**Anxiolytics/Anti-anxiety medications** help with the symptoms of anxiety and include benzodiazepines (a class of sedative-hypnotic drugs) such as Clonazepam, Alprazolam, and Lorazepam. Anti-anxiety medications such as **benzodiazepines** are effective in relieving anxiety and take effect more quickly than the antidepressant medications (or buspirone) often prescribed for anxiety. However, there is a potential for dependence and tolerance to benzodiazepines if they are taken over a long period of time and may need higher and higher doses to get the same effect. **Side effects** include drowsiness, dizziness, nausea, difficulty urinating, and irregular heartbeat, to name a few. It is important to note that some SSRIs and SNRIs as well as beta blockers are used to treat anxiety (National Institute of Mental Health, 2022). Buspirone is an anxiolytic medication prescribed to treat

anxiety but requires 3-4 weeks to reach full therapeutic effect (National Institute of Mental Health, 2022).

**Benzodiazepines end in lam/pam.**
So, you might think **"call pam"** to help remember these medications.

## Stimulants

Stimulants increase one's alertness and attention and are frequently used to treat **Attention Deficit Hyperactivity Disorder (ADHD)**. They include Lisdexamfetamine, the combination of dextroamphetamine and amphetamine, and Methylphenidate. Stimulants are generally effective and produce a calming effect. Possible side effects include loss of appetite, headache, motor or verbal tics, and personality

changes such as appearing emotionless. There is a potential for abuse related to high feelings (Heldt, 2017). Additionally, stimulants may be associated with growth restriction and sleep disturbance; thus, both should be monitored (Heldt, 2017).

## Antipsychotics

**Antipsychotics (i.e., Neuroleptics)** were developed in the 1950s and are used to treat psychosis and diagnoses of Schizophrenia. Schizophrenia is characterized by the core signs/symptoms: delusions (false, fixed beliefs), hallucinations (any alterations in the five senses, most commonly hearing voices or seeing things that are not present), disorganized speech, disorganized behavior, and negative symptoms (i.e., deficits in emotional, cognitive, or social experiences) (Heldt, 2017). Antipsychotics are commonly divided into **Typical or 1st Generation antipsychotics** (e.g., chlorpromazine and haloperidol), **Atypical or 2nd Generation** (e.g., olanzapine and clozapine). There is also a **3rd Generation of antipsychotics**, but we will limit this discussion to 1st Gen and 2nd Gen. Common antipsychotics include Chlorpromazine, Haloperidol, Olanzapine, Quetiapine, and Risperidone. Individual antipsychotics may have a particular side effect profile. However, **extrapyramidal side effects (EPS)** can occur with the use of any antipsychotic.

In general, there are **two key differences between typical and atypical antipsychotics**:

1. the tendency for more EPS side effects in the 1st Generation/Typical
2. 1st Generation/Typical treat the positive more than the negative signs/symptoms of Schizophrenia. See the Schizophrenia chapter for a continued discussion of the characteristics of Schizophrenia.

## Extrapyramidal side effects

Extrapyramidal side effects (EPS) include acute dystonia, akathisia (i.e., restlessness), parkinsonism, and tardive dyskinesia (Heldt, 2017).

**EPS** side effects **ADAPT** over **hours, days, weeks, and years**.
**A**cute **D**ystonia – hours
**A**kathisia – days
**P**arkinsonism – weeks
**T**ardive Dyskinesia – years (Heldt, 2017).

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*

*https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=204#oembed-1*

O'Dell, E. (2016). *Recognizing extrapyramidal symptoms* [Video]. YouTube. https://youtube.com/watch?v=2xfu-d_aYWs&si=EnSIkaIECMiOmarE

## Tardive Dyskinesia

**Tardive (i.e., meaning tardy or late) dyskinesia** is associated with involuntary and rhythmic movements, typically of the perioral muscles (Heldt, 2017). Some of these movements may resemble grimacing, lip-smacking, or eye blinking (Heldt, 2017). If tardive dyskinesia is recognized, stop the antipsychotic and notify the provider.

## Neuroleptic Malignant Syndrome

**Neuroleptic malignant syndrome (NMS)** is a rare, yet potentially fatal, event. Historically, antipsychotics were referred to as neuroleptics and the reason behind the naming of this syndrome (Heldt, 2017). Heldt (2017) uses the mnemonic FEVER to represent the signs and symptoms associated with NMS.

**NMS** is:
**F**ever
**E**ncephalopathy
**V**ital sign instability
**E**levated WBC & CPK
**R**igidity (Heldt, 2017)

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=204#oembed-2*

Hippo Education. (2019). *Differences between serotonin syndrome and neuroleptic malignant syndrome* [Video]. YouTube. https://youtube.com/watch?v=jil8KcAGG8Y&si=EnSIkaIECMiOmarE

## Mood stabilizers

**Mood stabilizers** are used to treat bipolar disorder and, at times, depression, schizoaffective disorder, and disorders of

impulse control. A common example is **Lithium**; side effects include loss of coordination, hallucinations, seizures, and frequent urination. Lithium has a narrow therapeutic range (0.8-1.2) and therefore a high risk of toxicity (>2.0) (Heldt, 2017). **Lithium toxicity** ranges from mild to severe (Heyda et al., 2022). Heyda et al. (2022) note symptoms of lithium toxicity can include:

- nausea, vomiting, tremors, and fatigue (mild toxicity)
- confusion, agitation, delirium, tachycardia (moderate toxicity
- coma, seizures, hyperthermia, hypotension (severe toxicity)

**Lithium Risks**

1. Lithium has a narrow therapeutic range, increasing the risk of toxicity. Serum levels should be around 1.0 mEq/L (Videbeck, 2020).
2. Lithium is a teratogen and not recommended during pregnancy (Videbeck, 2020).
3. Lithium is excreted by the kidneys. It is a

salt in the human body and competes for the body's salt receptor sites. Lastly, low volume can increase lithium serum levels. For these reasons, patients should ingest adequate amounts of salt and water (Heyda et al., 2022).

## Cholinesterase Inhibitors/N-methyl D-aspartate (NMDA) Receptor Antagonists

**Cholinesterase Inhibitors** are used to treat mild to moderate Alzheimer's (National Institute on Aging, 2021). These medications prevent the breakdown of acetylcholine, a neurotransmitter related to memory and thinking (National Institute on Aging, 2021). Examples of cholinesterase inhibitor medications include galantamine, rivastigmine, and donepezil. Common side effects of these medications include nausea, vomiting, diarrhea, and weight loss (National Institute on Aging, 2021). Memantine, an **NMDA antagonist** medication, helps treat moderate to severe Alzheimer's disease by regulating glutamate (National Institute on Aging, 2021). Common side effects of memantine are dizziness, headache,

diarrhea, constipation, and confusion (National Institute on Aging, 2021).

For more information on psychotropic medications, please visit: https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=204#h5p-6

The use of these drugs has been generally beneficial to patients. Most report that their symptoms decline, leading them to feel better and improve their functioning. Also, long-term hospitalizations are less likely to occur as a result, though the medications do not benefit the individual in terms of improved living skills.

You should have learned the following in this section:

- Neurotransmitter imbalances can result in mental disorders
- SSRIs are a first-line treatment for depression
- MAOI toxicity can result from ingesting foods with tyramine
- Benzodiazepines can treat anxiety. Stimulants can treat ADHD. Both classes can be addictive
- Buspirone (non-Benzo) is effective for Generalized Anxiety Disorder
- Serotonin Syndrome and Neuroleptic Malignant Syndrome are both rare, but potentially fatal events
- Lithium is an effective mood stabilizer but has a narrow therapeutic range.

# MODULE 5-MENTAL HEALTH PROMOTION

## MENTAL HEALTH PROMOTION

This module aligns with key elements of APNA's "Health Promotion & Illness Prevention" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

### Module Outline

- Mental Health Promotion
- Self-Care
- Complementary and Alternative Medicine

### Module Learning Outcomes

- Describe mental health promotion.
- Explain the use of self-care to promote mental health and well-being.
- Discuss complementary and alternative approaches to

promote mental health and well-being.

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## Mental Health Promotion

**Mental health promotion** is a necessity to achieve mental health. Consider physical health, as nurses we know that there are modifiable risk factors (e.g., obesity, smoking, nutrition) that can decrease risk for cardiac events, stroke, and cancer. Likewise, patients can proactively support a state of mental health through self-care and the use of complementary/alternative medicine. Patients should check with their primary care provider before beginning an herbal medication regimen. However, other useful mental health promotion strategies include meditation, yoga, art, music, journaling, rest, dance or another exercise.

## Self-Care

**Self-care** is merely, just that, caring for oneself. Generally, as a society we are all busy and do not prioritize caring self-care. Business can translate to high stress levels. Increased stress in the body is associated with ill-health outcomes. An informal Google search "stress and health" will provide a host of returned entries documenting the effects of stress on and within the body. Chronic stress may also impact mental health

outcomes. Psychoimmunology is a new field of study that examines the effects of psychosocial stressors in the immune system (Videbeck, 2020).

As nurses, we certainly need to practice self-care. Please sit back and take a moment to listen to one of our colleague's, Dr. Karen White-Trevino, take on self-care and the crucial need for nurses to practice self-care.

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=735#oembed-1*

Mary Rockwood Lane. (2021). *Karen White-Trevino, DNP, RN* [Video]. YouTube. https://youtube.com/watch?v=SCWZrW0Wf1M&si=EnSIkaIECMiOmarE

## Complementary and Alternative Medicine

**Check out this resource for self-**

There are many resources for

**care:** https://www.peerhealthexchange.org/

complementary and alternative medicine specific to mental health. **Two safety factors** to consider are:

1. Always ensure the patient knows to check with their primary care provider before beginning a complementary therapy or alternative medicine. There is the potential with adverse medication interactions and/or physical contraindications for certain therapy.
2. As nurses our role is not to recommend any treatment, but to provide the information and let the patient make the choice that is best for them and their family. See the MODULE 7: THERAPEUTIC COMMUNICATION for a review on non-therapeutic communication.

**National Alliance on Mental Illness (NAMI) provides a resource for Complementary Health Approaches. Check it out here:** https://www.nami.org/About-Mental-Illness/Treatments/Complementary-Health-

## Approaches

Two of my personal CAM resources are meditation and yoga. Here are two excellent resources for that can get you started.

- Meditation: Dr. William Mikulas' ***Taming the Drunken Monkey book.***
- Yoga: Dr. Karen White-Trevino's **Nurse Mentoring Caritas: Yoga & Meditation** YouTube channel.

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=735#oembed-2*

Nursing Mentoring Caritas: Yoga & Meditation. (2022). *Trailer: nurses mentoring caritas* [Video]. YouTube. https://youtube.com/watch?v=OqbRGuI6eqM&si=EnSIkaIECMiOmarE

## Additional Resources

Check out some of the following resources:

- Centers for Disease Control and Prevention-Mental Health
- National Institute of Mental Health
- National Alliance on Mental Illness
- World Health Organization's Mental Health subpage

### Key Takeaways

You should have learned the following in this section:

- Mental health promotion is vital to achieving positive mental health outcomes.
- Self-care is a means to promote mental health and well-being.
- Nurses should routinely practice self-care.
- CAM methods can complement Western medicine. However, safety is key. Patients should check with their primary care provider before integrating CAM into their care regimen.

# MODULE 6: LEGAL AND ETHICAL ISSUES

## LEGAL AND ETHICAL ISSUES

This module aligns with key elements of APNA's "Ethical and Legal Principles" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

### Module Outline

- Legal Issues Related to Mental Illness
- Patient's Rights
- Ethical Issues Related to Mental Illness

### Module Learning Outcomes

- Describe how nursing interacts with law
- Describe issues related to voluntary versus involuntary commitment
- Outline patient's rights.
- Clarify concerns related to the therapist-client relationship

# Overview

In this module, we will tackle the issue of how nursing interacts with law. Our discussion will include topics related to voluntary versus involuntary commitment, patient's rights, and the patient-therapist relationship.

## Legal Issues Related to Mental Illness

Watch this video for a summary of nursing issues related to the law.

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=123#oembed-1*

Level Up RN. (2022). *Psychiatric mental health*

*nursing: introduction, patient rights* [Video]. YouTube. https://youtube.com/watch?v=ZsEyrOWH6Mk&si=EnSIkaIECMiOmarE

## Civil Commitment

When individuals with mental illness behave in erratic or potentially dangerous ways, to either themselves or others, then something must be done. Action involves **involuntary** commitment in a hospital or mental health facility and is done to protect the individual and express concern over their well-being, much like a parent would do for their child. An individual can **voluntarily** admit themselves to a mental health facility, and upon doing so, staff will determine whether or not treatment and extended stay are needed.

### Criteria for Involuntary Commitment

Though states vary in the criteria used to establish the need for **involuntary commitment**, some requirements are common across states.

1. First, the individual must present a clear danger to either themselves or others.
2. Second, the individual demonstrates they are unable to care for themselves or make decisions about whether treatment or hospitalization is necessary.
3. Finally, the individual believes they are about to lose control, and so, needs treatment or care in a mental health facility.

## Procedures in Involuntary Commitment

The process for involuntary commitment does vary a bit from state to state, but some procedures are held in common.

1. First, a family member, mental health professional, or primary care practitioner, may request that the court order an examination of an individual. If the judge agrees, two professionals, such as a mental health professional or physician, are appointed to examine the person in terms of their ability for self-care, need for treatment, psychological condition, and likelihood to inflict harm on self or others.
2. Next, a formal hearing gives the examiners a chance to testify as to what they found. Testimonials may also be provided by family and friends, or by the individual him/herself. Once testimonies conclude, the judge

renders judgment about whether confinement is necessary and, if so, for how long. Typical confinements last from 6 months to 1 year, but an indefinite period can be specified too. In the latter case, the individual has periodic reviews and assessments.

3. In emergencies, the process stated above can be skipped and short-term commitment made, especially if the person is an imminent threat to him/herself or others.

In an **emergency situation**, where an individual has expressed threats of harm to themselves or another person, most states have laws that permit involuntary commitment for 48-72 hours to ensure the patient's safety.

**Most states have laws that enable involuntary commitment (48-72 hours) of an individual, who has expressed a desire to harm themselves or another.**

## Patient's Rights

Patients admitted to a psychiatric treatment facility **maintain all their civil rights with one exception**; if they have been admitted involuntarily, they may not be

able to leave the facility (Videbeck, 2020). The following are several rights pertaining to patients and mental health treatment settings.

See this article (American Psychiatric Association, n.d.) for further reading.

A **summary of these rights** as included in Videbeck (2020) include:

- **Right to Information** related to treatment options, providers' qualifications, appeals and grievance procedures
- **Right to Refuse Treatment**
- **Right to Least Restrictive Environment to Meet Needs**
- **Choice of Providers**
- **Confidentiality**
- **Nondiscrimination**
- **Parity**
- **Hold Accountable Professionals and Payers** responsible for injury associated with incompetence, negligence, or unjustified decisions
- **Treatment is Determined by Professionals** not third-party payers

## The Therapist-Client Relationship

Two concerns are of paramount importance in terms of the therapist-client relationship. These include the following:

- **Confidentiality** – As you might have learned in an introductory nursing course, confidentiality guarantees that information about the patient is not disseminated without their consent. **Health Insurance Portability and Accountability Act (HIPAA)** also guides nurses' when and who should receive information concerning individuals admitted to a psychiatric treatment facility. See the resource located under "Additional Resources" below.
- **Duty to Warn** – In the 1976 *Tarasoff v. the Board of Regents of the University of California* ruling, the California Supreme Court said that a patient's right to confidentiality ends when there is a danger to the public, and that if a therapist determines that such a danger exists, there is an obligation to warn the potential victim. Tatiana Tarasoff, a student at UC, was stabbed to death by graduate student, Prosenjit Poddar in 1969, when she rejected his romantic overtures, and despite warnings by Poddar's therapist that he was an imminent threat. The case highlights the fact that therapists have a legal and ethical obligation to their clients but, at the same time, a legal obligation to society. How exactly should they

balance these competing obligations, especially when they are vague? The 1980 case of *Thompson v. County of Alameda* ruled that a therapist does not have a duty to warn if the threat is nonspecific.

## Additional Resources

***What resources are there for application of HIPAA within a mental health facility?***

- Check out this webpage to answer this question (U.S. Department of Health & Human Services, n.d.)

### Key Takeaways

You should have learned the following in this section:

- Civil commitment occurs when a person acts in potentially dangerous ways to themselves or others and can be initiated by the person (voluntary commitment) or another professional (involuntary commitment).
- Patients admitted involuntarily to a psychiatric treatment facility maintain all civil

rights with the exception of the right to leave. The American Psychiatric Association also established a Bill of Rights for mental health patients.

- There are two main concerns which are important where the therapist-client relationship is concerned – confidentiality and the duty to warn.

# MODULE 7: THERAPEUTIC COMMUNICATION



## THERAPEUTIC COMMUNICATION

This module aligns with key elements of APNA's "Communication Theory and Interpersonal Skills" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Therapeutic Communication
- Non-Therapeutic Communication

## Module Learning Outcomes

- Summarize therapeutic communication techniques

- Summarize non-therapeutic communication techniques

## Concepts

- Therapeutic Communication
- Empathy
- Rapport

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## Overview

This module will review therapeutic communication techniques for non-therapeutic communication techniques. Nurses use therapeutic communication and **empathy** to cultivate rapport and a therapeutic relationship with patients. Below is an overview of therapeutic versus non-therapeutic communication strategies.

> See Sharma and Gupta (2022) for further reading.

## Therapeutic Communication

## Strategies

Sharma and Gupta (2022) summarize **therapeutic communication strategies**. These include:

- **Open-ended questions**-ask open ended questions to learn more about the patient and enable a free-flow of information exchange; closed-ended questions can be used to focus on specific information
- **Active listening**-active listening involves behaviors such as making eye-contact and nodding
- **Non-verbal indicators**-be mindful of non-verbal indicators such as looking frequently at the clock/watch, toe-tapping, having an open body stance
- **Silence**-sitting with a patient during a difficult time and listening without interruption can be therapeutic
- **Reflecting**-the nurse repeats the patient's communication back to them; encourages the patient to reflect on their feelings

## Non-Therapeutic Communication Strategies

Summarization of Sharma and Gupta's (2022) **non-therapeutic communication** include:

- **Value judgements/Approval/Disapproval**-avoid interjecting one's biases and judgements, providing approval or disapproval of the patient's thoughts or actions
- **Negative body language**-avoid crossing arms, appearing distracting, and standing over the patient during engagement/conversation
- **Advice**-avoid providing a patient advice on recommended action(s)
- **False reassurance**-avoid false reassurance; can lead to mistrust, especially in the case that an expected outcome is not realized

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=1060#oembed-1*

Level Up RN. (2022). *Nurse/client relationship, therapeutic communication-psychiatric mental health nursing* [Video]. YouTube. https://youtube.com/watch?v=t_59thyrje8&si=EnSIkaIECMiOmarE

## Key Takeaways

You should have learned the following in this section:

- Use of therapeutic communication techniques and empathy helps the nurse build rapport and a therapeutic relationship with the patient
- Non-therapeutic communication actions can erode a therapeutic relationship

PART II

# MENTAL DISORDERS

2nd edition as of August 2020

## PART II. MENTAL DISORDERS

# MODULE 8: DEPRESSION

## DEPRESSION

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Assessment of Depressive Disorders
- Nursing Diagnoses Associated with Depressive Disorders
- Treatment of Depressive Disorders

## Module Learning Outcomes

- Describe the signs and symptoms of depressive disorders.
- Identify the common nursing diagnoses associated with depressive disorders.

- Summarize the treatment of depressive disorders.

## Concepts

- Mood
- Affect
- Safety
- Legal and Ethical Issues

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## Depressive Disorders

Depending on the text resource, a discussion of the diagnosis of Depression may be presented within a singular chapter as in this resource or within a chapter titled Mood Disorders. If the resource uses a Mood Disorders chapter, this will typically follow with a presentation of two distinct groups—individuals with depressive disorders and individuals with bipolar disorders. The key difference between the two mood disorder groups is episodes of mania/hypomania associated with Bipolar diagnosis.

The two most common types of depressive disorders are **Major Depressive Disorder** and **Persistent Depressive Disorder**. Persistent Depressive Disorder, previously known as Dysthymia, is a continuous and chronic form of depression.

While the symptoms of Persistent Depressive Disorder are very similar to Major Depressive Disorder, they are usually less acute, as symptoms tend to ebb and flow over a long period of time (more than two years).

**Below is an overview of a nurse's consideration for the assessment, problems, and treatment of depression**.

See Chand, Arif, et al. (2022) for further reading.

## Assessment

When making a diagnosis of depression, there is a wide range of symptoms that may be present. These symptoms can generally be categorized into four categories: mood, behavioral, cognitive, and physical symptoms.

### Mood

While clinical depression can vary in its presentation among individuals, most, if not all individuals with depression will report significant mood disturbances such as a depressed mood

for most of the day and/or feelings of ***anhedonia***, which is the loss of interest in previously interesting activities. **Affect** (i.e., the outward expression of mood) is typically blunted or flat. You might think of affect as you would emojis.

## Behavioral

Behavioral issues such as decreased physical activity and reduced productivity—both at home and work—are often observed in individuals with depression. They may lack motivation to complete tasks (i.e., **avolition**). This is typically where a disruption in daily functioning occurs as individuals with depressive disorders are unable to maintain their social interactions and employment responsibilities.

## Cognitive

It should not come as a surprise that there is a serious

disruption in cognition as individuals with depressive disorders typically hold a negative view of themselves and the world around them. They are quick to blame themselves when things go wrong, and rarely take credit when they experience positive achievements. Individuals with depressive disorders often feel worthless, which creates a negative feedback loop by reinforcing their overall depressed mood. Individuals with depressive disorder also report difficulty concentrating on tasks, as they are easily distracted from outside stimuli. Finally, thoughts of suicide and self-harm do occasionally occur in those with depressive disorders; this will be discussed in the epidemiology section in more detail.

### Physical

Changes in sleep patterns are common in those experiencing depression with reports of both hypersomnia and insomnia. Hypersomnia, or excessive sleeping, often impacts an individual's daily functioning as they spend the majority of their time sleeping as opposed to participating in daily activities (i.e., meeting up with friends, getting to work on time). Reports of insomnia are also frequent and can occur at various points throughout the night including difficulty falling asleep, staying asleep, or waking too early with the inability to fall back asleep before having to wake for the day. Although it is unclear whether symptoms of fatigue or loss/lack of energy (i.e., **anergia**) are related to insomnia issues, the fact that those experiencing hypersomnia also report

symptoms of fatigue suggests that these symptoms are a component of the disorder rather than a secondary symptom of sleep disturbance.

Additional physical symptoms, such as a change in weight or **appetite**/eating behaviors, are also observed. Some individuals who are experiencing depression report a lack of appetite, often forcing themselves to eat something during the day. On the contrary, others overeat, often seeking "comfort foods," such as those high in carbohydrates. Due to these changes in eating behaviors, there may be associated changes in weight.

Psychomotor agitation or retardation, which is the purposeless or slowed physical movement of the body (i.e., pacing around a room, tapping toes, restlessness, etc.) is also reported in individuals with depressive disorders. Finally, individuals may have poverty of speech (i.e., **alogia**).

- Think of **A Words** when assessing **S/S of depression**: **a**nergia, **a**nhedonia, **a**volition, **a**logia, **a**ppetite change, **a** change in sleep.
- Heldt (2017) uses the mnemonic **SIGECAPS** to remember the S/S of depression.

**S**leep Disturbance, **I**nterest (decreased), **G**uilt and/or hopelessness, **E**nergy (decreased), **C**oncentration (impaired), **A**ppetite (decreased), **P**sychomotor retardation, **S**uicidal thoughts

- It is imperative to **assess for suicidal/ homicidal thoughts**. Nurses should ask about suicidal/homicidal thoughts **in a matter-of-fact way.**

- ***"Are you having thoughts of harming yourself or someone else?"*** Followed by, ***"Do you have a plan to harm yourself or someone else?*** If the response is affirmative, ask about the plan and place the patient on **suicide precautions**.

## Instruments

The Major Depression Inventory (MDI) ("PsychTools", n.d.) can be used to assess major depression or degree of an individuals' depression

## Problems

Problems commonly associated with a Depression diagnosis are:

- Self-directed violence, the risk for
- Hopelessness
- Coping, ineffective
- Self-Esteem, chronic low

- Fatigue
- Nutrition, imbalanced, less than body requirements (Chand, Arif, et al., 2022).

## Treatment

Given that Major Depressive Disorder is among the most frequent and debilitating psychiatric disorders, it should not be surprising that the research on this disorder is quite extensive. Some treatment options include antidepressant medications, Cognitive-Behavioral Therapy (CBT), Interpersonal Therapy (IPT), and Electroconvulsive Therapy (ECT). ECT is typically not a first-line treatment but can be used for individuals not responding to medication therapy (Chand, Arif, et al., 2022).

See the Psychopharmacology chapter in this resource for the discussion on Antidepressant medications.

### Multimodal treatment

While both pharmacological and psychological treatment alone is very effective in treating depression, a combination of the two treatments may offer additional benefits, particularly

in the maintenance of wellness and long-term relief of symptoms. Additionally, multimodal treatment options may be helpful for individuals who have not achieved wellness in a single modality.

## Nursing Care

Nursing care is directed toward the assessment of the aforementioned mood, behavioral, cognitive, and physical signs and symptoms typically observed with depression.

**Typical Signs and Symptoms of Depression with example interventions:**

- Sleep disturbance-promote a safe, therapeutic environment conducive to rest and well-being.
- Interest/pleasure reduction-provide a nonjudgmental, supportive **therapeutic milieu**.
- Guilt feelings or thoughts of worthlessness-encourage expression of inward thoughts and feelings.
- Energy changes/fatigue-ensure a thorough assessment of potential causes of fatigue.
- Concentration/attention impairment-provide a low-stimulating, quiet environment for self-reflection.
- Appetite/weight changes-monitor daily weight; supplement nutrition with protein and finger foods as necessary.
- Psychomotor disturbances-ensure baseline assessment of psychomotor function; consult physical therapy if

needed.

- Suicidal thoughts-assess suicide risk daily and with any changes in behavior; implement suicide precautions with close monitoring as needed.
- Depressed mood-evaluate depressed mood rating on a numerical scale, where 1 is a low rating and 10 is a highly depressed mood.
- **All patients with depression should be evaluated for suicidal risk. Any suicide risk must be given prompt attention which could include hospitalization or close and frequent monitoring** (Chand, Arif, et al., 2022).

## Mental Health Promotion

There are various ways to promote mental health and well-being. Long-term treatment for depression should include mental health promotion approaches.

Some specific mental health promotion strategies discussed in Videbeck (2020) directed at mood disorders, including depression diagnoses and suicide risk include.

- Improve screening and diagnosis in primary care settings
- Create a crisis or relapse prevention plan
- Cultivate a social support network
- Incorporate behavioral changes that promote optimum health

- Encourage the patient to develop solutions.

Visit the MODULE 5-MENTAL HEALTH PROMOTION chapter to learn more about this topic.

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=108#oembed-1*

Dr. Tracey Marks. (2019). *How to tell if you're depressed* [Video]. YouTube. https://youtube.com/watch?v=XCAQHpXqIA8&si=EnSIkaIECMiOmarE

## Key Takeaways & Concept Map Activity

**You should have learned the following in this section:**

- Treatment of depressive disorders includes psychopharmacological options AND/OR

psychotherapy options including CBT and interpersonal therapy (IPT). A combination of the two main approaches often works best, especially in relation to the maintenance of wellness.

- Ask about suicidal/homicidal thoughts matter of factly "Are you having any thoughts of harming yourself or others?" If they answer affirmatively, ask about their plan to do so and notify the independent healthcare provider.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Depression.
- If needed, see the INTRODUCTION for a concept map tutorial.

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# MODULE 9: ANXIETY

## ANXIETY

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

### Module Outline

- Assessment of Anxiety Disorders
- Nursing Diagnoses Associated with Anxiety Disorders
- Treatment of Anxiety Disorders

### Module Learning Outcomes

- Describe the signs and symptoms of anxiety disorders.
- Identify the common nursing diagnoses associated with anxiety disorders.
- Summarize the treatment of anxiety disorders.

## Concepts

- Stress
- Safety
- Coping
- Legal and Ethical Issues

---

## Anxiety Disorders

The hallmark symptoms of anxiety-related disorders are excessive fear or worry related to behavioral disturbances. Fear is an adaptive response, as it often prepares your body for an impending threat. Anxiety, however, is more difficult to identify as it is often the response to a *vague* sense of threat. Anxiety can range from mild to moderate, to severe, and panic. In fact, mild anxiety can act as a motivator to prepare for an anticipated event (e.g., prepare for an upcoming test or job interview). A person with higher stages of anxiety such as severe and panic would need immediate intervention. It is important to recognize anxiety can occur with both positive or negative situations. For example, buying a house, graduating, having a baby, getting married are examples of events that are generally considered positive and associated with feelings of happiness and excitement, yet they may also induce feelings of stress and anxiety.

As you will see throughout the chapter, individuals may experience anxiety in many different forms. **Generalized anxiety disorder**, **(GAD)** the most common of the anxiety disorders, is characterized by a global and persistent feeling of anxiety. A **specific phobia** is observed when an individual experiences anxiety related to a specific object or subject. Similarly, an individual may experience **agoraphobia** when they feel fear specific to leaving their home and traveling to public places. **Social anxiety disorder** occurs when an individual experiences anxiety related to social or performance situations, where there is the possibility of being evaluated negatively. And finally, there is **panic disorder**, where an individual experiences recurrent panic attacks consisting of physical and cognitive symptoms.

**Below is an overview of a nurse's consideration for the assessment, problems, and treatment of anxiety**.

See Chand, Marwaha, et al., (2022) for further reading.


## Assessment

Signs and symptoms of anxiety vary widely. These symptoms can generally be categorized into four categories: mood, behavioral, cognitive, and physical symptoms. In general, anxiety can be caused by the interaction of various biopsychosocial factors (Chand, Marwaha, et al., 2022). Therefore, it is important to perform a comprehensive assessment and consider potential contributors to the individual's anxiety.

### Mood

Mood may be nervous, tense, fearful, edgy, impatient, and/or frustrated (Chand, Marwaha, et al., 2022).

## Behavioral

Individuals who are anxious may avoid certain situations, pursue a sense of safety, and/or exhibit various external characteristics such as restlessness, agitation, pacing, hyperventilation, appear motionless, and difficulty speaking (Chand, Marwaha, et al., 2022).

## Cognitive

Cognitive symptoms may include fears of losing control, physical injury, death, or negative evaluation by others (Chand, Marwaha, et al., 2022). Individuals with anxiety may also have frightening thoughts, mental images, or memories (Chand, Marwaha, et al., 2022). They may have poor concentration, confusion, narrowed attention, and difficulty speaking (Chand, Marwaha, et al., 2022). Individuals may also find themselves **ruminating** over a situation, an interaction, or an upcoming event. Watch the video below for an intervention to combat rumination.

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=112#oembed-1*

University of York. (2019). Breaking the wall of ruminative anxious thought [Video]. YouTube. https://youtube.com/watch?v=AD_Ay-mwLoc&si=EnSIkaIECMiOmarE

## Physical

Physiological symptoms associated with anxiety are increased heart rate, palpitations, shortness of breath, tachypnea, chest pain/pressure, diaphoresis, Gastrointestinal (GI) disturbances (e.g., nausea, upset stomach, diarrhea), trembling, weakness, faintness, rigidity, and dry mouth (Chand, Marwaha, et al., 2022). Essentially, anxiety activates the body's stress response (i.e., the sympathetic nervous system also known as the fight or flight system).

### Instruments

The Generalized Anxiety Disorder Screener-7 (GAD-7) can be used to assess anxiety issues (Rhoads, 2021).

## Problems

Problems commonly associated with an Anxiety diagnosis are:

- Inadequate management of mood and behavior
- Deficient knowledge
- Inadequate social skills
- Imbalance in social functioning (Chand, Marwaha, et al., 2022)

# Treatment

Recall from MODULE 4: PSYCHOPHARMACOLOGY Anxiolytics are the psychotropic class used to treat anxiety. Within that class, Benzodiazepines can be used for a situation requiring immediate pharmacological intervention. However, due to the tolerance and dependence associated with Benzodiazepines, this class is not ideal for the long-term treatment of anxiety. Selective serotonin-reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are generally considered to be first-line medication options for those with GAD. Unfortunately, none of these medications continue to provide any benefit once they are stopped; therefore, other effective treatment options such as Cognitive Behavior Therapy, relaxation training, and biofeedback are often encouraged before the use of pharmacological interventions.

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=112#oembed-2*

Level Up RN. (2022). Stress and general adaption syndrome, anxiety-psychiatric mental health nursing [Video]. YouTube. https://youtube.com/watch?v=s86DDGAqkS4&si=EnSIkaIECMiOmarE

## Mental Health Promotion

There are various ways to promote mental health and well-being. Long-term treatment for anxiety should include mental health promotion approaches.

Some specific strategies to promote mental health related to an Anxiety diagosis discussed in Videbeck (2020) include:

- Express thoughts and feelings
- Practice relaxation techniques such as deep breathing and meditation
- Exercise regularly
- Ensure plenty of rest and sleep
- Create realistic goals and expectations.

Visit the MODULE 5-MENTAL HEALTH PROMOTION chapter to learn more about this topic.

## Key Takeaways and Concept Map Activity

**You should have learned the following in this section:**

- All anxiety disorders share the hallmark symptoms of excessive fear or worry related to behavioral disturbances.
- Treatment options include benzodiazepines, CBT, and biofeedback.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Anxiety.
- If needed, see the INTRODUCTION for a concept map tutorial.

# MODULE 10: BIPOLAR

## BIPOLAR

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Assessment of Bipolar Disorders
- Nursing Diagnoses Associated with Bipolar Disorders
- Treatment of Bipolar Disorders

## Module Learning Outcomes

- Describe the signs and symptoms of bipolar disorders.
- Identify the common nursing diagnoses associated with bipolar disorders.
- Summarize the treatment of bipolar disorders.

## Concepts

- Mood
- Affect
- Safety
- Legal and Ethical Issues

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## Bipolar Disorders

There are two types of Bipolar Disorder- Bipolar I and Bipolar II. A diagnosis of Bipolar I Disorder is made when there is at least one **manic episode**. This manic episode can be preceded by or followed by a hypomanic or major depressive episode, however, diagnostic criteria for a manic episode is the *only* criteria that needs to be met for a Bipolar I diagnosis. A diagnosis of Bipolar II Disorder is made when there is a current or history of a **hypomanic episode** *and* a current or past major depressive episode. In simpler words, if an individual has ever experienced a manic episode, they qualify for a Bipolar I diagnosis; however, if the criteria has only been met for a hypomanic episode, the individual qualifies for a Bipolar II diagnosis.

**Below is an overview of a nurse's consideration for the assessment, problems, and treatment of Bipolar**.

See Jain and Mitra (2022) to read more about this topic.

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=586#oembed-1*

Psych Hub. (2022). *What is bipolar disorder?* [Video]. YouTube. https://youtube.com/watch?v=G9vkGCo7Gtg&si=EnSIkaIECMiOmarE

# Assessment

## Assessment of Mania

The signs and symptoms associated with a manic episode are:

- Increased activity or energy
- Appear excessively happy, often engaging haphazardly in sexual or personal interactions
- Rapid shifts in mood, also known as **mood lability**, ranging from happy, neutral, to irritable
- Inflated self-esteem or grandiosity, occasionally can appear delusional
- Require a decreased need for sleep, sleeping as little as a few hours a night yet still feeling rested, reduced need for sleep may also be a precursor to a manic episode, suggesting that a manic episode is to begin imminently
- Rapid, pressured speech, disorganized or incoherent speech
- Racing thoughts and flights of ideas.

In hypomania, the above signs and symptoms may be present, but are not as extreme as in mania.

The depressive mood phase in a Bipolar diagnosis is associated with the signs and symptoms previously discussed in MODULE 6: DEPRESSION.

## Instruments

The Mood Disorder Questionnaire (MDQ) can be used to assess mood disorder issues (Rhoads, 2021).

## Problems

Problems associated with a Bipolar diagnosis are:

- Risk for injury
- Imbalanced nutrition: less than body requirements
- Disturbed thought processes
- Self-Care deficit

## Treatment

Mood stabilizers such as Lithium are the psychotropic class used to treat Bipolar Disorders. Unfortunately, non-adherence to the medication regimen is often the issue with these patients. Patients diagnosed with Bipolar often desire the euphoric highs that are associated with manic and hypomanic episodes, leading them to forgo their medication. A combination of psychopharmacology and psychotherapy aimed at increasing the rate of adherence to medical treatment may be the most effective treatment option for bipolar I and II disorder. Other treatment options include newer antidepressants early in treatment. However, antidepressants may trigger a manic or hypomanic episode in bipolar patients. Because of this, the first-line treatment option for Bipolar Disorder is mood stabilizers, particularly Lithium. See MODULE 4: PSYCHOPHARMACOLOGY for a review of this topic.

**Lithium is the gold standard of treatment of bipolar disorder** (Jain & Mitra, 2022).


Social skills training and problem-solving skills are also helpful techniques to address in the therapeutic setting as individuals with bipolar disorder often struggle in this area.

## Mental Health Promotion

There are various ways to promote mental health and well-being. Long-term treatment for bipolar should include mental health promotion approaches.

Some specific strategies to promote mental health related to Mood disorders, including a Bipolar diagnosis include:

- Improve screening and diagnosis in primary care settings

- Create a crisis or relapse prevention plan
- Cultivate a social support network
- Incorporate behavioral changes that promote optimum health
- Encourage the patient to develop solutions (Videbeck, 2020).

Visit the MODULE 5-MENTAL HEALTH PROMOTION chapter to learn more about this topic.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=586#h5p-7

## Key Takeaways and Concept Map Activity

**You should have learned the following in this section:**

- A manic episode is characterized by a specific period of time in which an individual reports abnormal, persistent, or expansive irritable mood for nearly all day, every day, for at least

one week.

- Treatment of bipolar disorder involves mood stabilizers such as Lithium, psychological interventions, social skills training, and problem-solving skills.
- Medication adherence is a consideration in pharmacological treatment as individuals may be hesitant to extinguish euphoric feelings associated with mania.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Bipolar.
- If needed, see the INTRODUCTION for a concept map tutorial.

# MODULE 11: SOMATIC SYMPTOM AND RELATED DISORDERS

## SOMATICSYMPTOM AND RELATED DISORDERS

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Assessment of Somatic Symptom Disorder
- Nursing Diagnoses Associated with Somatic Symptom Disorder
- Treatment of Somatic Symptom Disorder

## Module Learning Outcomes

- Describe the signs and symptoms of Somatic Symptom Disorder.
- Identify the common nursing diagnoses associated with Somatic Symptom Disorder.
- Summarize the treatment of Somatic Symptom Disorders.

## Concepts

- Stress
- Coping
- Safety
- Legal and Ethical Issues

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## Overview

This chapter will focus on Somatic Symptom Disorder and provide an overview of Illness Anxiety Disorder, Conversion Disorder, Factitious Disorder, and Malingering.

Psychological disorders that feature somatic symptoms are often challenging to diagnose due to the internalizing nature of the disorder, meaning there is no real way for a clinician

to measure the somatic symptom. Furthermore, the somatic symptoms could take on many forms. For example, the individual may be *faking* the physical symptoms, *imagining* the symptoms, *exaggerating* the symptoms, or they could be real and triggered by external factors such as stress or other psychological disorders. The symptoms also may be part of a real medical illness or disorder, and therefore, the symptoms should be treated medicinally.

**All of the disorders within this chapter share a common feature:** there is a **presence of somatic symptoms associated with significant distress or impairment with the exception of factitious disorder and malingering.**

Oftentimes, individuals with a somatic disorder will present to their primary care physician with their physical complaints. Occasionally, they will be referred to clinical psychologists after an extensive medical evaluation concludes that a medical diagnosis cannot explain their current symptoms. As you will read further, despite their similarities, there are key features among the various disorders that distinguish them from one another.

## Somatic Symptom Disorder

Individuals with somatic symptom disorder (SSD) often present with multiple somatic symptoms at one time. Individuals with SSD often report excessive thoughts, feelings, or behaviors surrounding their somatic symptoms; thus, leading to distress and/or dysfunction (e.g., missing time from work) (D'Souza and Hooten, 2022). A lack of medical explanation is not needed for a diagnosis of SSD, as it is assumed that the individual's suffering is *authentic.* Somatic symptom disorder may be diagnosed when another medical condition is present, as these two diagnoses are not mutually exclusive.

Somatic symptom disorder patients generally present with significant worry about their illness. Because of their negative appraisals, they often fear that their medical status is more serious than it typically is, and high levels of distress are often reported. Oftentimes these patients will "shop" at different physician offices to confirm the seriousness of their symptoms. Anxiety and depression have high comorbidity with somatic symptom disorders.

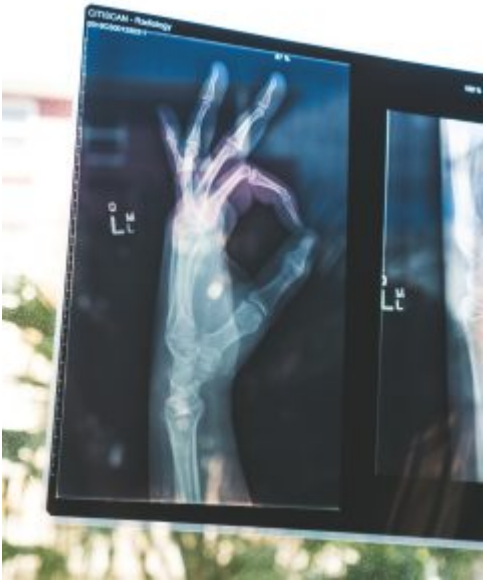
## Illness Anxiety Disorder

Illness anxiety disorder, previously known as **hypochondriasis**, involves an excessive preoccupation with having or acquiring a serious medical illness. The key

distinction between illness anxiety disorder and somatic symptom disorder is that an individual with illness anxiety disorder does not typically present with any somatic symptoms. Occasionally an individual will present with a somatic symptom; however, the intensity of the symptom is mild and does not drive the anxiety. Acquiring a serious illness drives concerns.

## Conversion Disorder

Conversion disorder occurs when an individual presents with one or more symptoms of voluntary motor or sensory function that are inconsistent with a medical condition (Peeling & Muzio, 2022). Common motor symptoms include weakness or paralysis, abnormal movements (e.g., tremors), and gait abnormalities (i.e., limping). Additionally, sensory symptoms such as altered, reduced, or absent skin sensations, and vision or hearing impairment are also reported in many individuals. The most challenging aspect of conversion disorder is the complex relationship with a medical evaluation. **The symptoms are not feigned or controlled by the individual** (Peeling & Muzio, 2022).



## Factitious Disorder

Factitious disorder, commonly referred to as ***Munchausen syndrome***, differs from the three previously discussed somatic disorders in that **there is deliberate falsification of medical or psychological symptoms of oneself or another, with the overall intention of deception.** While a medical condition may be present, the severity of impairment related to the medical condition is more excessive due to the individual's need to deceive those around them. Even more alarming is that this disorder is not only observed in the individual leading the deception— it can also be present in another individual, often a child or an individual with a compromised mental

status who is not aware of the deception behind their illness (also known as ***Munchausen by Proxy***). **Malingering** is the feigning of somatic or psychological signs and symptoms driven by external incentives (e.g., criminal charges, financial profit, work avoidance, medications).

## Psychological Factors Affecting Other Medical Conditions

Although previously known as psychosomatic disorders, the DSM-5 has identified physical illnesses that are caused or exacerbated by biopsychosocial factors as **psychological factors affecting other medical conditions**. This disorder is different than all the previously mentioned somatic-related disorders as the primary focus of the disorder is not the mental disorder, but rather the physical disorder. Some examples include:

- headaches (migraines and tension),
- gastrointestinal (ulcers and irritable bowel syndrome),
- insomnia,
- cardiovascular-related disorders (coronary heart disease and hypertension).

**Below is an overview of a nurse's consideration for the assessment, problems, and treatment of Somatic Symptom Disorder**.

See D'Souza and Hooten (2022) to read more about this topic.

## Assessment

Nurses will assess for three elements:

1. Somatic (physical) symptom(s) causing distress and/or dysfunction in the individual's life.
2. Dedication to persistent thoughts, feelings, and/or behaviors related to the somatic symptom(s) coupled with increased level of anxiety
3. Somatic symptoms are present > 6 months (D'Souza and Hooten, 2022).

## Problems

Problems associated with a Somatic Symptom diagnosis are:

- Risk for injury
- Ineffective coping
- Pain
- Anxiety

## Treatment

The primary goal is to help the patient cope with, not eliminate the somatic symptoms (D'Souza & Hooten, 2022). Providers should regularly see the patient and use caution when communicating the somatic symptoms are driven psychologically as patients will be resistant to this reasoning (D'Souza & Hooten, 2022). Cognitive-behavioral therapy (CBT) has been associated with the improvement of symptoms (D'Souza & Hooten, 2022).

### Psychopharmacology

Psychopharmacological interventions are rarely used due to possible side effects and unknown efficacy. Given that these individuals already have a heightened reaction to their physiological symptoms, there is a high likelihood that the side effects of medication would produce more harm than help. May be helpful for those individuals who have comorbid psychological disorders such as depression or anxiety (D'Souza and Hooten, 2022).

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=111#oembed-1*

Memorable Psychiatry and Neurology. (2022). *Somatization and somatic symptom disorder mnemonics* (memorable psychiatry lecture) [Video]. YouTube. https://youtube.com/watch?v=Lsyr_Qe1KC0&si=EnSIkaIECMiOmarE

## Key Takeaways and Concept Map Activity

**You should have learned the following in this section:**

- Somatic symptom disorder is characterized by the presence of multiple somatic symptoms, whether localized or diffused and specific or nonspecific, at one time which impacts daily functioning.
- Cognitive behavioral therapy is effective for somatic disorders.

- Psychopharmacological interventions are rarely used for somatic disorders due to the side effects of the medication that may cause more harm than good. When used, they deal with comorbid disorders such as depression or anxiety.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Somatic Symptom Disorder.
- If needed, see the INTRODUCTION for a concept map tutorial.

# MODULE 12: EATING DISORDERS

## EATING DISORDERS

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Assessment of Eating Disorders
- Problems Associated with Eating Disorders
- Treatment of Eating Disorders

## Module Learning Outcomes

- Describe the signs and symptoms of Eating Disorders
- Identify the common nursing problems associated with Eating Disorders
- Summarize the treatment of Eating Disorders.

## Concepts

- Nutrition
- Self
- Coping

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## Overview

In this chapter, we will discuss matters related to eating disorders to include their clinical presentation, problems, and treatment options. Our discussion will include an overview of anorexia nervosa, bulimia nervosa, and binge eating disorder, but will focus on the treatment of anorexia nervosa and bulimia nervosa.

Eating disorders are very serious, yet relatively common mental health disorders, particularly in Western society, where there is a heavy emphasis on thinness and physical appearance. While there is no exact cause for eating disorders, the combination of biological, psychological, and sociocultural factors has been identified as major contributors in both the development and maintenance of eating disorders. This chapter serves as an introduction to two of the most common eating disorders (i.e., anorexia nervosa and bulimia nervosa), their etiology, and treatment.

## Anorexia Nervosa

Balasundaram and Santhanam (2022) describe several key components of Anorexia Nervosa. Anorexia nervosa has two subtypes (restricting type and binge eating/purging type). The restricting type involves food restriction. **The binge eating**/purging involves consuming large amounts of food followed by a means of purging (i.e., self-induced vomiting or laxatives). Individuals may also use non-purging behaviors such as excessive exercise Anorexia nervosa leads to significantly low body weight relative to the individual's age, sex, and development. This restriction is often secondary to an intense fear of gaining weight or becoming fat, despite the individual's low body weight.

Some emotional and behavioral symptoms include dramatic weight loss, preoccupation with food, weight, calories, etc., frequent comments about feeling "fat," eating a restricted range of foods, makes excuses to avoid mealtimes, and often does not eat in public. Physical changes may include dizziness, difficulty concentrating, feeling cold, sleep problems, thinning hair/hair loss, and muscle weakness, to name a few.

## Bulimia Nervosa

Unlike anorexia nervosa where there is solely restriction of food, bulimia nervosa involves a pattern of recurrent binge eating behaviors. Individuals with bulimia nervosa often

report a sense of lack of control over-eating during these binge-eating episodes. While not always, these binge-eating episodes are usually followed by a feeling of disgust with oneself, which leads to a **compensatory behavior** in an attempt to rid the body of the excessive calories. These compensatory behaviors include vomiting, use of laxatives, fasting (or severe restriction), or excessive exercise.

**Signs and symptoms of bulimia nervosa** are similar to anorexia nervosa. These symptoms include but are not limited to hiding food wrappers or containers after a binging episode, feeling uncomfortable eating in public, developing food rituals, limited diet, disappearing to the bathroom after eating a meal, and drinking excessive amounts of water or non-caloric beverages. Additional physical changes include weight fluctuations both up and down, difficulty concentrating, dizziness, sleep disturbance, and possible dental problems due to purging post binge eating episode.

Symptoms of bulimia nervosa typically present later in development- late adolescence or early adulthood. Similar to anorexia nervosa, bulimia nervosa initially presents with mild restrictive dietary behaviors; however, episodes of binge eating interrupt the dietary restriction, causing bodyweight to rise around normal levels. In response to weight gain, patients engage in compensatory behaviors or purging episodes to reduce body weight. This cycle of restriction, binge eating, and calorie reduction often occurs for years before seeking help.

## Binge-Eating Disorder (BED)

**Binge-Eating Disorder** is similar to Bulimia Nervosa in that it involves recurrent binge eating episodes along with feelings of lack of control during the binge-eating episode; however, these episodes are *not* followed by a compensatory behavior to rid the body of calories.

**Below is an overview of a nurse's consideration for the assessment, problems, and treatment of eating disorders.**

See Balasundaram and Santhanam (2022) to read more about this topic.

# Assessment

Assessment of an individual with a known or suspected eating disorder will typically reveal the patterns of behavior from the following characteristics. Please note some characteristics are common to a particular eating disorder and will be denoted in the paratheses following the characteristic.

- Extremely underweight (Anorexia Nervosa)
- Amenorrhea, osteopenia, brittle hair/nails, dry skin, constipation, hypotension, bradycardia, hypothermia, lanugo hair, infertility, or muscle wasting (Anorexia Nervosa)
- Underweight, normal weight or slightly overweight (Bulimia Nervosa)
- Sore throat, swollen salivary glands, tooth decay, acid reflux, severe dehydration, electrolyte imbalance, and hormonal disturbances (Bulimia Nervosa)
- Intense fear of weight gain
- Distorted body image
- Food restriction, binging, or use of compensatory behaviors
- Preoccupation with food and weight (Balasundaram and Santhanam, 2022).

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=115#oembed-1*

National Eating Disorders Association. (2018). *Warning signs & symptoms of an eating disorder* [Video]. YouTube.

https://youtube.com/watch?v=nJMtReAg1DI&si=EnSIkaIECMiOmarE

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=115#h5p-9

### Instruments

The Eating Attitudes Test inventory can evaluate eating disorder treatment outcomes (Videbeck. 2020).

## Problems

Problems associated with an Eating disorder diagnosis are:

- Ineffective coping
- Risk for injury
- Altered nutrition

## Treatment

The immediate goal for the treatment of anorexia nervosa is weight gain and recovery from malnourishment. This is often

established via an intensive outpatient program, or if needed, through an inpatient hospitalization program where caloric intake can be managed and controlled. Both the inpatient and outpatient programs use a combination of therapies and support to help restore proper eating habits. Just as anorexia nervosa treatment initially focuses on weight gain, the first goal of bulimia nervosa treatment is to eliminate binge eating episodes and compensatory behaviors. Of the most common (and successful) treatments are Enhanced Cognitive-Behavioral Therapy (CBT-E) and Family-Based Therapy (FBT). Psychopharmacological agent may be used to help with comorbid diagnoses such as depression and anxiety.

## CBT-E

CBT-E is the first line treatment for eating disorders (Balasundaram and Santhanam, 2022). Some of the behavioral strategies include recording eating behaviors—hunger pains, quality and quantity of food—and emotional behaviors—feelings related to the food. In addition to these behavioral strategies, it is also important to address the maladaptive thought patterns associated with their negative body image and desire to control their physical characteristics. Changing the *fear* related to gaining weight is essential in recovery.

## FBT

FBT is also an effective treatment approach, often used as a component of individual CBT, especially for children and adolescents with the disorder. FBT is especially helpful for helping children and adolescents diagnosed with anorexia nervosa (Balasundaram and Santhanam, 2022).

## Psychotropics

Fluoxetine is approved to treat Bulimia Nervosa and Binge eating disorders (Balasundaram and Santhanam, 2022). Other psychotropic classes such as antidepressants, antipsychotics, and mood stabilizers may treat comorbid psychiatric diagnoses (Balasundaram and Santhanam, 2022).

## Nutritional Therapy

Nutrition therapy is indicated for all eating disorders. If indicated, supplemental nutrition will typically include nasogastric feeding or total parenteral nutrition in the case of gastrointestinal dysfunction (Balasundaram and Santhanam, 2022). Refeeding should be a gradual process with a weight gain goal of 2 to 3 lbs. a week (Balasundaram and Santhanam, 2022). It is also imperative to monitor electrolyte levels.

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=115#oembed-2*

Psych Hub. (2020). *Treatment for eating disorders* [Video]. YouTube. https://youtube.com/watch?v=n9o_ZtUlsgI&si=EnSIkaIECMiOmarE

## Additional Resource

Check out the website below to learn more about eating disorders.

- National Eating Disorders Association (NEDA)

### Key Takeaways and Concept Map Activity

**You should have learned the following in this section:**

- Anorexia nervosa involves the restriction of food, which leads to significantly low body weight relative to the individual's age, sex, and development, and an intense fear of gaining weight or becoming fat.
- Bulimia nervosa is characterized by a pattern of recurrent binge eating behaviors.
- Binge-eating disorder is characterized by recurrent binge eating episodes along with a feeling of lack of control but no compensatory behavior to rid the body of the calories.
- Some treatment options for eating disorders include CBT-E, FBT, and Nutrition therapy.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Eating Disorders.
- If needed, see the INTRODUCTION for a concept map tutorial.

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# MODULE 13: SUBSTANCE ABUSE AND ADDICTION

## SUBSTANCE ABUSE AND ADDICTION

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

### Module Outline

- Assessment of Substance Abuse and Addiction
- Problems Associated with Substance Abuse and Addiction
- Treatment of Substance Abuse and Addiction

# Module Learning Outcomes

- Describe the signs and symptoms of Substance Abuse and Addiction
- Identify the common nursing problems associated with Substance Abuse and Addiction
- Summarize the treatment of Substance Abuse and Addiction

# Concepts

- Addiction
- Behavior
- Coping
- Safety

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# Overview

This chapter cover matters related to substance-related and addictive disorders. Our discussion will include substance intoxication, substance use disorder, and substance withdrawal. Substance abuse, in general, has a high comorbidity rate within itself (meaning abuse of multiple different substances), as well as with other mental health

disorders. Individuals diagnosed with a mental health disorder may turn substances for self-medication and coping (Rebar et al., 2020). If a patient has both a mental health disorder and a substance use disorder, this may be referred to as a dual diagnosis (National Alliance on Mental Illness, 2020).

What are substances? Substances are any ingested materials that cause temporary cognitive, behavioral, or physiological symptoms within the individual. Substance intoxication symptoms vary greatly and are dependent on the type of substance ingested. Specific substances and their effects will be discussed later in the module.

Repeated use of these substances or frequent substance intoxication can develop into a long-term problem known as **substance abuse.** Abuse typically occurs when an individual consumes the substance for an extended period and develops a **tolerance** to the ingested substance. As tolerance builds, additional physical and psychological symptoms present, often causing significant disturbances in an individual's personal and professional life. Individuals with substance abuse are often spending a significant amount of time engaging in activities that revolve around their substance use, thus spending less time in recreational activities that once consumed their time. Sometimes, there is a desire to reduce or abstain from substance use. However, cravings and **withdrawal** symptoms often prohibit this from occurring on one's own attempts. Detoxification from some substances, including prescription medications, may require **tapering**. Common withdrawal

symptoms include but are not limited to cramps, anxiety attacks, sweating, nausea, tremors, and hallucinations. Depending on the substance and the tolerance level, most withdrawal symptoms last anywhere from a few days to a week. For those with extensive substance abuse or abuse of multiple substances, withdrawal should be closely monitored in a hospital setting to avoid severe consequences such as seizures, stroke, or even death.

## Types of Substances Abused

The most commonly abused substances can be divided into three categories based on how they impact one's physiological state: depressants, stimulants, and hallucinogens/cannabis/combination.

### Depressants

Depressant substances such as alcohol, sedative-hypnotic drugs, and opioids are known to have an inhibiting effect on one's central nervous system; therefore, they are often used to alleviate tension and stress. Unfortunately, when used in large amounts, they can also impair an individual's judgment and motor activity.

While **alcohol** is one of the only legal (over the counter) substances we will discuss, it is also the most commonly consumed substance. The "active" substance of alcohol, *ethyl*

*alcohol*, is a chemical that is absorbed quickly into the blood via the lining of the stomach and intestine. Once in the bloodstream, ethyl alcohol travels to the central nervous system (i.e., brain and spinal cord) and produces *depressive* symptoms such as impaired reaction time, disorientation, and slurred speech.

The effect of ethyl alcohol in moderation allows for an individual to relax, engage more readily in conversation, and in general, produce a confident and happy personality. However, when consumption is increased or excessive, the central nervous system is unable to metabolize the ethyl alcohol adequately, and adverse effects begin to present. Symptoms such as blurred vision, difficulty walking, slurred speech, slowed reaction time, and sometimes, aggressive behaviors are observed.

**Sedative-Hypnotic drugs**, more commonly known as **anxiolytic drugs,** have a calming and relaxing effect on individuals. When used at a clinically appropriate dosage, they can have a sedative effect, thus making them a suitable drug for treating anxiety-related disorders.

**Opioids** are naturally occurring, derived from the sap of the opium poppy. Opioids are unique in that they provide both euphoria and drowsiness. Tolerance to these drugs builds quickly, thus resulting in an increased need of the medication to produce desired effects. This rapid tolerance is also likely responsible for opioids' highly addictive nature. Opioid withdrawal symptoms can range from restlessness, muscle

pain, fatigue, anxiety, and insomnia. Unfortunately, these withdrawal symptoms, as well as intense cravings for the drug, can persist for several months, with some reports up to years.

## Stimulants

The two most common types of stimulants abused are cocaine and amphetamines. Unlike depressants that reduce the activity of the central nervous system, stimulants have the opposite effect, increasing the activity in the central nervous system. Physiological changes that occur with stimulants are increased blood pressure, heart rate, pressured thinking/speaking, and rapid, often jerky behaviors. Because of these symptoms, stimulants are commonly used for their feelings of euphoria, to reduce appetite, and prevent sleep.

Similar to opioids, **cocaine** is extracted from a South American plant—the coca plant—and produces feelings of energy and euphoria. Low doses can produce feelings of excitement, talkativeness, and euphoria; however, as the amount of ingested cocaine increases, physiological changes such as rapid breathing, increased blood pressure, and excessive arousal can be observed.

Crack is a derivative of cocaine that is formed by combining cocaine with water and another substance (commonly baking soda) to create a solid structure that is then broken into smaller pieces. Because of this process, it requires very little cocaine to make crack, thus making it a more affordable drug. Coined for the crackling sound that is produced when it is smoked, it is

also highly addictive, likely due to the fast-acting nature of the drug.

**Amphetamines** are manufactured in a laboratory setting. Currently, the most common amphetamines are prescription medications such as Ritalin, Adderall, and Dexedrine (prescribed for sleep disorders). These medications produce an increase in energy and alertness and reduce appetite when taken at clinical levels. However, when consumed at larger dosages, they can produce intoxication similar to psychosis, including violent behaviors. *Methamphetamine*, a derivative of amphetamine, is often abused due to its low cost and feelings of euphoria and confidence.

Caffeine is consumed in coffee, energy drinks, soft drinks, chocolate and tea. While caffeine is often consumed in moderate dosages, caffeine intoxication and withdrawal can occur. In fact, an increase in caffeine intoxication and withdrawal have been observed with the simultaneous popularity of energy drinks.

## Hallucinogens/Cannabis/ Combination

The final category includes both hallucinogens and cannabis-both of which produce sensory changes after ingestion. While hallucinogens are known for their ability to produce more severe delusions and hallucinations, cannabis also has the capability of producing delusions or hallucinations; however, this typically occurs only when large amounts of cannabis are

ingested. More commonly, cannabis has been known to have stimulant and depressive effects, thus classifying itself in a group of its own due to the many different effects of the substance.

**Hallucinogens** come from natural sources and have been involved in cultural and religious ceremonies for thousands of years. Synthetic forms of hallucinogens have also been created—most common of which are *PCP*, *Ketamine, LSD*, and *Ecstasy*. In general, hallucinogens produce powerful changes in sensory perception. Depending on the type of drug ingested, effects can range from hallucinations, changes in color perception, or distortion of objects. Interestingly, the effect of hallucinogens can vary both between individuals, as well as *within* the same individual. This means that the same amount of the same drug may produce a positive experience one time, but a negative experience the next time.

Similar to hallucinogens and a few other substances, **cannabis** is also derived from a natural plant—the hemp plant. Many external factors impact the potency of cannabis, such as the climate it was grown in, the method of preparation, and the duration of storage. Of the active chemicals within cannabis, **tetrahydrocannabinol (THC)** appears to be the single component that determines the potent nature of the drug. Various strains of marijuana have varying amounts of THC; hashish contains a high concentration of THC, while marijuana has a small concentration. **Cannabidiol (CBD)** and THC both are derived from the hemp plant (marijuana). Both

THC and CBD act on the body's cannabinoid receptors, located throughout the central and peripheral nervous systems. However, CBD does not is non-psychotropic and is not associated with the euphoric characteristics of THC (Jahan and Burgess, 2022).

It is not uncommon for substance abusers to consume more than one type of substance at a time. This **combination** of substance use can have dangerous results depending on the interactions between substances. For example, if multiple depressant drugs (i.e., alcohol, benzodiazepines, and/or opiates) are consumed at one time, an individual is at risk for severe respiratory distress or even death due to the compounding depressive effects on the central nervous system. Additionally, when an individual is under the influence of one substance, judgement may be impaired, and ingestion of a larger amount of another drug may lead to an accidental overdose. Finally, the use of one drug to counteract the effects of another drug—taking a depressant to combat the effects of a stimulant—is equally as dangerous as the body is unable to regulate homeostasis.

**Below is an overview of a nurse's consideration for the assessment,**

**problems, and treatment of personality disorders.**

See Jahan and Burgess, 2022 to read more about this topic.

## Assessment

When gathering data for a thorough assessment, effective communication strategies are imperative. Wu and Baker (2022) present several key communication initiatives to use when communicating with an individual diagnosed with a substance abuse disorder and gathering information specific to the substance abuse. An overview of these communication strategies are presented below.

### Overview of Communication Strategies

- Be professional, but avoid medical jargon (e.g., instead of "illicit" drugs, use "street" or "recreational") to facilitate the patient's understanding
- Be mindful of non-verbal communication which can

affect a patient's perception of you as their healthcare provider

- Assume a neutral position and refrain from spontaneous judgments, especially in the case of interacting with a patient presenting with irrigation or anger
    - Attempt to identify the cause of their emotion, acknowledge their feelings, and address the situation
- Use a patient-centered approach by communicating with **person-first language**, involve the patient in their healthcare decisions, and allow an opportunity to ask questions
- Reduce patient anxiety by informing patients that substance use questions are routine questions asked to all patients and provide an explanation as to the pertinence of the information to their healthcare (e.g., to proactively address risk for ETOH withdrawal)

## Signs and Symptoms of Substance Abuse and Addiction

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*can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=116#oembed-1*

Memorable Psychiatry and Neurology. (2022). *Addiction and substance use disorder mnemonics (memorable psychiatry lecture)* [Video]. YouTube. https://youtube.com/watch?v=IQxVzaRiFPI&si=EnSIkaIECMiOmarE

## Problems

Problems associated with a Substance Abuse and Addiction diagnosis include:

- Ineffective Denial
- Ineffective Coping
- Powerlessness

## Treatment

Given the large number of the population affected by substance abuse, it might be anticipated that there are many different approaches to treat substance use disorder.

## Biological

**Detoxification.** Detoxification refers to the medical supervision of withdrawal from a specified drug. While most detoxification programs are inpatient for increased monitoring, some programs allow for outpatient detoxification, particularly if the addiction is not as severe. Unfortunately, relapse rates are high for those engaging in detoxification programs, particularly if they lack any follow-up psychological treatment. Specific to alcohol detoxification, the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) is used to monitor alcohol withdrawal symptoms (Jahan and Burgess, 2022).

**Complete this online learning course to better understand the applicaton of CIWA-Ar.**

**Agonist drugs.** As researchers continue to learn more about both the mechanisms of substances commonly abused, as well as the mechanisms in which the body processes these substances, alternative medications are created to essentially replace the drug in which the individual is dependent on. These **agonist drugs** provide the individual

with a "safe" drug that has a similar chemical make-up to the addicted drug.

**Antagonist drugs.** Unlike agonist drugs, **antagonist drugs** block or change the effects of the addictive drug. The most commonly prescribed antagonist drugs are Disulfiram and Naloxone. Disulfiram is often given to individuals trying to abstain from alcohol as it produces significant negative effects (i.e., nausea, vomiting, increased heart rate, and dizziness) when coupled with alcohol consumption. Similar to Disulfiram, Naloxone is used for individuals with opioid abuse. Naloxone acts by binding to endorphin receptors, thus preventing the opioids from having the intended euphoric effect. This type of treatment requires appropriate medical supervision to ensure the safety of the patient. Complete the activity below to familiarize yourself with medications used for substance abuse treatment.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=116#h5p-10

**Relapse prevention training.** Relapse prevention training is essentially what it sounds like—identifying potentially high-risk situations for relapse and then learning behavioral skills and cognitive interventions to prevent the

occurrence of a relapse. Early in treatment, the clinician guides the patient to identify any interpersonal, intrapersonal, environmental, and physiological risks for relapse. Once these triggers are identified, the clinician works with the patient on cognitive and behavioral strategies such as learning effective coping strategies, enhancing self-efficacy, and encouraging mastery of outcomes. Additionally, psychoeducation about how substance abuse is maintained, as well as identifying maladaptive thoughts and learning cognitive restructuring techniques, helps the patient make informed choices during high-risk situations. Finally, role-playing these high-risk situations in session allows patients to become comfortable engaging in these effective coping strategies that enhance their self-efficacy and ultimately reducing the chances of a relapse.

## Sociocultural

**Alcoholics Anonymous (AA). AA** and **Twelve Step Traditions** as a way to help guide members in spiritual and character development. Due to the popularity of the treatment program, other programs such as **Narcotics Anonymous** and **Cocaine Anonymous** adopted and adapted the Twelve Steps for their respective substance abuse. Similarly, **Al-Anon** and **Alateen** are two support groups that offer support for families and teenagers of individuals struggling with alcohol abuse.

The overarching goal of AA is abstinence from alcohol. In order to achieve this, the participants are encouraged to "take

one day at a time." In using the 12 steps, participants are emboldened to admit that they have a disease, that they are powerless over this disease, and that their disease is more powerful than any person. Therefore, participants turn their addiction over to God and ask Him to help right their wrongs and remove their negative character defects and shortcomings. The final steps include identifying and making amends to those who they have wronged during their alcohol abuse.

> **Do this**: Google "find an aa meeting near me" or "na meetings."

**Residential treatment centers.** Another type of treatment similar to self-help is **residential treatment programs.** In this placement, individuals are completely removed from their environment and live, work, and socialize within a drug-free community while also attending regular individual, group, and family therapy. The types of treatment used within a residential program varies from program to program, with most focusing on cognitive-behavioral and behavioral techniques. Several also incorporate **12-step programs** into treatment, as many patients transition from a residential treatment center to a 12-step program post discharge. As one would expect, the residential treatment goal

is abstinence, and any evidence of substance abuse during the program is grounds for immediate termination.

## Additional Resource

Check out the website below to learn more about substance abuse in connection with mental health disorders.

Substance Abuse and Mental Health Services Administration (SAMSHA)

Meeting Guide is a free meeting finder app on Google Play and the App Stores (General Service Office of Alcoholics Anonymous, 2022).

### Key Takeaways and Concept Map Activity

You should have learned the following in this section:

- There are many substances that have abuse and addiction potential. They include
    - Depressants include alcohol, sedative-hypnotic drugs, and opioids
    - Stimulants include cocaine and amphetamines, but caffeine as well.

    - Hallucinogens come from natural sources and produce powerful changes in sensory perception.
    - Cannabis is also derived from a natural plant and produces psychoactive effects.

- Substance abuse coupled with a mental health diagnosis is known as a dual diagnosis.
- There is various treatment option for substance abuse and addiction such as Biological and Sociocultural treatment options.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Substance Abuse.
- If needed, see the INTRODUCTION for a concept map tutorial.

# MODULE 14: SCHIZOPHRENIA

## SCHIZOPHRENIA

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Assessment of Schizophrenia
- Problems Associated with Schizophrenia
- Treatment of Schizophrenia

## Module Learning Outcomes

- Describe the signs and symptoms of Schizophrenia
- Identify the common nursing problems associated with Schizophrenia
- Summarize the treatment of Schizophrenia

## Concepts

- Cognition
- Psychosis
- Mood and Affect
- Safety

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## Overview

In this chapter, we will focus on the presentation and treatment of the Schizophrenia diagnosis. Other diagnoses related to Schizophrenia include Schizophreniform disorder, Schizoaffective disorder, and Delusional disorder. These disorders are defined by one of the following main symptoms: delusions, hallucinations, disorganized thinking (speech), disorganized or abnormal motor behavior, and negative symptoms. Individuals diagnosed with schizophrenia may also experience **psychosis**. Psychosis episodes make it difficult for individuals to perceive and respond to environmental stimuli, causing a significant disturbance in everyday functioning. Collectively, symptoms associated with Schizophrenia are commonly categorized as positive and negative symptoms.

The hallmark symptoms of schizophrenia include the presentation of at least two of the following: delusions, hallucinations, disorganized speech, disorganized/abnormal

behavior, or negative symptoms. These symptoms create significant impairment in an individual's ability to engage in normal daily functioning such as work, school, relationships with others, or self-care.

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Memorable Psychiatry and Neurology. (2022). Psychosis & schizophrenia mnemonics (memorable psychiatry lecture) [Video]. YouTube. https://youtube.com/watch?v=pUIiq9Yzltg&si=EnSIkaIECMiOmarE

**Below is an overview of a nurse's consideration for the assessment, problems, and treatment of eating disorders.**

See Calabrese et al. (2022) to read more about this topic.

# Assessment

## Positive signs and symptoms

**Positive signs and symptoms** can be summarized as alterations in the person that are not typically present in someone not having a Schizophrenia diagnosis. Positive signs and symptoms include:

- **Hallucinations.** Hallucinations can occur in any of the five senses: hearing (auditory hallucinations), seeing (visual hallucinations), smelling (olfactory hallucinations), touching (tactile hallucinations), and tasting (gustatory hallucinations). Additionally, they can occur in a single modality or present across a combination of modalities (e.g., having auditory and visual hallucinations). Individuals may recognize that their hallucinations are not real and attempt to engage in normal behavior while simultaneously combating ongoing hallucinations. ***Important Note:*** If an individual reports having hallucinations (e.g., seeing something that is not there or hearing voices), do not state that you see or hear the hallucination nor should you tell the patient that they do not see/hear the hallucination. Rather, you should respond empathetically such as "that must be frightening."
- **Delusions**. Delusions are "fixed, false beliefs fixed, false

beliefs for which a person lacks insight into, even in the face of evidence that proves contrary to their validity" (Calabrese et al., 2022). Delusions may take on themes such as persecutory (i.e., belief that someone is trying to hurt them), grandiose (i.e., an inflated view of oneself), erotomaniac (i.e., belief that a person is in love with them), referential (i.e., belief that things seen/heard in the environment relate to them) (Calabrese et al., 2022).

- **Disorganized thinking**. Among the most common cognitive impairments displayed in patients with schizophrenia are disorganized thought, communication, and speech. More specifically, thoughts and speech patterns may appear to be circumstantial or tangential. For example, patients may give unnecessary details in response to a question before they finally produce the desired response. While the question is eventually answered in circumstantial speech patterns, in tangential speech patterns the patient never reaches the point. Another common cognitive symptom is speech retardation, where the individual may take a long time before answering a question. Derailment, or the illogical connection in a chain of thoughts, is another common type of disorganized thinking. Although not always, derailment is often seen in illogicality, or the tendency to provide bizarre explanations for things. These types of distorted thought patterns are often related to **concrete thinking**. That is, the individual is focused on one

aspect of a concept or thing and neglects all other aspects.

- **Disorganized/Abnormal motor behavior.** Psychomotor symptoms can also be observed in individuals with schizophrenia. These behaviors may manifest as awkward movements or even ritualistic/ repetitive behaviors.
- **Catatonic behavior.** Catatonic behavior, the decreased or complete lack of reactivity to the environment, is among the most commonly seen disorganized motor behavior in schizophrenia. There runs a range of **catatonic** behaviors.

## Negative signs and symptoms

**Negative signs and symptoms** can be summarized as alterations in the person that are typically present in someone not having a Schizophrenia diagnosis. Negative symptoms often present before positive symptoms

**Hallucinations: Do not agree with seeing/ hearing the experience but respond empathetically. For example, "that must**

**be scary."**

and may remain once positive symptoms remit. There are six main types of negative symptoms seen in patients with schizophrenia. Such symptoms include:

- **Affective flattening.** Affective flattening is the reduction in emotional expression, reduced display of emotional expression
- **Alogia.** Alogia is the poverty of speech or speech content
- **Anhedonia.** Anhedonia is the inability to experience pleasure
- **Apathy.** Apathy is the general lack of interest
- **Asociality.** Asociality is the lack of interest in social relationships
- **Avolition.** Avolition is the lack of motivation for goal-directed behavior
- **Anergia.** Anergia is a lack of energy.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=120#h5p-8

# Problems

Problems associated with a Schizophrenia diagnosis include:

- Impaired verbal communication
- Impaired thought process
- Altered sensory perception
- Impaired social interaction
- Interrupted family process
- Ineffective coping

# Treatment

A combination of psychopharmacological, psychological, and family interventions is the most effective treatment in managing schizophrenia symptoms. However, antipsychotics are the gold standard of treatment psychosis and psychotic disorders (Calabrese et al., 2022). An individual diagnosed with Schizophrenia will likely require lifelong treatment and care.

## Psychopharmacological

Among the first antipsychotic medications used for the treatment of schizophrenia was Thorazine. Due to the harsh side effects of conventional antipsychotic drugs, newer,

arguably more effective *second-generation* or *atypical* antipsychotic drugs have been developed. In fact, side effects may be related to medication adherence. Therefore, nurses should ask and educate about potential side effects that may need to be reported to the independent healthcare provider. In general, antipsychotics have been more efficacious at treating positive symptoms versus negative symptoms (Calabrese et al., 2022). Remember, nursing and medical care should be tailored to meet a patient's individual needs. See the MODULE 4: PSYCHOPHARMACOLOGY for a review of antipsychotics.

## Psychological Interventions

**Cognitive Behavioral Therapy (CBT).** As discussed in previous chapters, the goal of treatment is to identify the negative biases and attributions that influence an individual's interpretations of events and the subsequent consequences of these thoughts and behaviors.

**Social Skills Training.** Given the poor interpersonal functioning among individuals with schizophrenia, social skills training is another type of treatment commonly suggested to improve psychosocial functioning. Research has indicated that poor interpersonal skills not only predate the onset of the disorder but also remain significant even with the management of symptoms via antipsychotic medications.

Social support has been identified as a protective factor and helps patients relate to others (Calabrese et al., 2022). Learning how to interact with others appropriately (e.g., establish eye contact, engage in reciprocal conversations, etc.) through role-play in a group therapy setting is one effective way to teach positive social skills.

## Family Interventions

The overall goal of family interventions is to reduce the stress on the individual that is likely to elicit the onset of symptoms. Educating families on the course of the illness, as well as ways to recognize onset of psychotic symptoms, is important to ensure optimal recovery.

### Key Takeaways and Concept Map Activity

You should have learned the following in this section:

- Schizophrenia is characterized by delusions, hallucinations, disorganized speech, disorganized/abnormal behavior, or negative symptoms.
- Positive versus negative signs/symptoms are

differentiated by remembering that the former at not normally present in a typical individual.
- Antipsychotics are the psychotropic medication class used to treat Schizophrenia.
- Psychological treatment options include CBT and Social Skills Training.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Schizophrenia.
- If needed, see the INTRODUCTION for a concept map tutorial.

# MODULE 15: PERSONALITY DISORDERS

## PERSONALITY DISORDERS

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Assessment of Personality Disorders
- Problems Associated with Personality Disorders
- Treatment of Personality Disorders

## Module Learning Outcomes

- Describe the signs and symptoms of Personality Disorders
- Identify the common nursing problems associated with

Personality Disorders
- Summarize the treatment of Personality Disorders.

## Concepts

- Self
- Behavior
- Coping

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## Overview

In this module, we will cover matters related to personality disorders to include their clinical presentation, epidemiology, comorbidity, etiology, and treatment options. Our discussion will include Clusters A, B, and C.

| | | |
|---|---|---|
| **Cluster A** | odd/eccentric cluster | Paranoid, Schizoid, and Schizotypal |
| **Cluster B** | dramatic, emotional, or erratic cluster | Antisocial, Borderline, histrionic, and narcissistic |
| **Cluster C** | anxious/fearful cluster | Avoidant, Dependent, and Obsessive-Compulsive |

Personality disorders have four defining features, which include *distorted thinking patterns*, *problematic emotional responses*, *over-* or *under-regulated impulse control*, and *interpersonal difficulties*. While these four core features are universal among all ten personality disorders, the DSM-5 divides the personality disorders into three different clusters based on symptom similarities.

To meet the criteria for any personality disorder, the individual must display the pattern of behaviors in *adulthood.* Children cannot be diagnosed with a personality disorder. Some children may present with similar symptoms, such as poor peer relationships, odd or eccentric behaviors, or peculiar thoughts and language; however, a formal personality disorder diagnosis cannot be made until the age of 18. Nurses most often come across the Antisocial and Borderline personality disorders in the psychiatric setting (Videbeck, 2020). Individuals diagnosed with a personality disorder may continue to have difficulties related to the personality disorder in young and middle adulthood, but typically decline as age increases to 40's and 50's (Videbeck, 2020). It is common for those diagnosed with a personality disorder to have another coexisting mental health diagnosis (Videbeck, 2020).

*One or more interactive elements has been excluded from this version of the text. You*

*can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=118#oembed-1*

Memorable Psychiatry and Neurology. (2022). *Personality disorder mnemonics (memorable psychiatry lecture)* [Video]. YouTube. https://youtube.com/watch?v=U6Y9WTyPgG0&si=EnSIkaIECMiOmarE

**Below is an overview of a nurse's consideration for the assessment, problems, and treatment of personality disorders.**

See Fariba et al. (2022) to read more about this topic.

## Assessment

Personality disorders are typically associated with traits that are inflexible and maladaptive and are related to significant

functional impairment or subjective distress (Videbeck, 2020). There is a wide range of maladaptive and/or dysfunctional behavior or personality characteristics associated with a personality disorder. Some of these behaviors and characteristics coupled with each personality disorder are summarized below from the Fariba et al. (2022) resource.

- **Paranoid** – suspicious and distrustful
- **Schizoid** – reclusive, difficulty in forming personal relationships, blunted affect
- **Schizotypal** – bizarre behavior/speech/thought content, inappropriate affect, abnormal visual experiences
- **Antisocial** – violate social norms and others' rights, impulsive, volatile, reckless, aggressive, manipulative
- **Borderline** – labile mood, unstable intense relationships, fear abandonment, self-harm
- **Histrionic** – attention-seeking, increased concern of physical appearance, come across sexually promiscuous
- **Narcissistic** – self-centered, egotistical grandiosity, lack empathy, overly sensitive to criticism, sense of entitlement
- **Avoidant** – low self-esteem, may desire social connection, but avoid social relationships
- **Dependent** – dependent on others for emotional validation
- **Obsessive** – perfectionists, inflexible, overly

conscientious, mildly constricted affect

**What is your personality type? Take this free personality test.** Click here.

## Problems

The problems that may be associated with a personality disorder diagnosis include:

- Ineffective coping
- Risk for non-suicidal self-injury
- Social isolation
- Risk for suicide

## Treatment

Videbeck (2020) explained treatment of personality disorders may be difficult. **Treatment difficulties** are explained by several reasons, including:

1. One's personality and associated behaviors are deeply ingrained

2. When change occurs, it is slow
3. Many do not recognize their behaviors as dysfunctional or maladaptive
4. There is no specific medication to change personality.

Videbeck (2020) identified a few **general interventions** for nurses to help patients diagnosed with a personality disorder are to:

1. Cultivate a therapeutic relationship and use therapeutic communication techniques to help role model appropriate social interactions.
2. Help clients identify inappropriate or dysfunctional thoughts and/or behaviors and encourage replacement with positive behaviors and adaptive coping mechanisms.
3. Use **cognitive restructuring** (e.g., thought-stopping and positive self-talk).

Specific signs and symptoms may warrant psychotropic medication treatment. For example, a patient diagnosed with a Cluster C personality disorder may benefit from an SSRI to treat underlying anxiety (Fariba et al., 2022). Additional treatment options for an individual diagnosed with a personality disorder may include psychotherapy, cognitive-behavioral therapy (CBT), social skills training, and group therapy (Fariba et al., 2022).

## Key Takeaways and Concept Map Activity

You should have learned the following in this section:

- Personality disorders share the features of distorted thinking patterns, problematic emotional responses, over- or under-regulated impulse control, and interpersonal difficulties and divide into three clusters.
- Many diagnosed with a personality disorder have another coexisting mental health diagnosis.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Personality Disorders.
- If needed, see the INTRODUCTION for a concept map tutorial.

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# MODULE 16: NEUROCOGNITIVE DISORDERS

## NEUROCOGNITIVE DISORDERS

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Assessment of Neurocognitive Disorders
- Problems Associated with Neurocognitive Disorders
- Treatment of Neurocognitive Disorders

## Module Learning Outcomes

- Describe the signs and symptoms of Neurocognitive

Disorders
- Identify the common nursing problems associated with Neurocognitive Disorders
- Summarize the treatment of Neurocognitive Disorders

## Concepts

- Cognition
- Coping
- Safety

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## Overview

In this module, we will cover matters related to neurocognitive disorders to include their clinical presentation, assessment, and treatment options. Our discussion will include Dementia and Delirium. The treatment for dementia will focus on Alzheimer's disease as this is the most common subtype of dementia (Rhoads, 2021).

### Dementia

Within the DSM-V-TR dementia is referred to as Major Neurocognitive Disorder (Buser and Cruz, 2022; Emmady et

al., 2022). It is important to understand dementia is not synonymous to Alzheimer's disease. Rather, dementia is the broader term referring to "significant cognitive decline in one or more areas (learning and memory, language, executive functioning, complex attention, perceptual-motor, or social cognition) (Buser and Cruz, 2022). Subtypes of a Major Neurocognitive Disorder include Alzheimer's, Vascular, Substance Induced, Traumatic Brain Injury, HIV, Parkinson's Disease, Lewy Bodies, Prion Disease, Huntington's Disease, and Frontotemporal Degeneration (Buser and Cruz, 2022). The diagnosis can be further characterized as mild, moderate, or severe (Buser and Cruz, 2022; Videbeck, 2020).

## Alzheimer's Disease

Alzheimer's disease is the most prevalent neurodegenerative disorder. While the primary symptom of Alzheimer's disease is the gradual progression of impairment in cognition but does not present with a change in level of consciousness (Videbeck, 2020). The risk for Alzheimer disease increases with age (Videbeck, 2020).

Alzheimer's disease is defined by the onset of symptoms. Early-onset Alzheimer's disease occurs before the age of 65. While only a small percentage of individuals experience early onset of the disease, those that do experience early disease progression appear to have a more genetically influenced condition and a higher rate of family members with the disease.

Late-onset Alzheimer's disease occurs after the age of 65 and has less of a familial influence.

## Delirium

Delirium is characterized by an acute onset with "...disturbance in attention, orientation, and cognition (memory, language, and perception) (Buser and Cruz, 2022). Disturbances in attention are often manifested as difficulty sustaining, shifting, or focusing attention. Additionally, an individual experiencing an episode of delirium will have a disruption in cognition, including confusion of setting. Disorganized thinking, incoherent speech, and hallucinations and delusions may also be observed during periods of delirium. The onset of delirium is abrupt, occurring for several hours. Symptoms can range from mild to severe and can last from days to several months.

**Below is an overview of a nurse's consideration for the assessment, problems, and treatment of neurocognitive disorders.**

See Emmady et al. (2022) [Dementia] and De

Lourdes Ramirez Echeverria et al. (2022) [Delirium]to read more about this topic.

## Assessment

Clinically, Dementia and Delirium can present similarly, but there are a few distinctions. Look at the chart below for a side-by-side comparison of these two diagnoses. This chart was adapted from Videbeck's (2020) table 24.1 "Comparison of Delirium and Dementia."

# Dementia Versus Delirium

| Characteristic | Dementia | Delirium |
|---|---|---|
| Onset | Insidious | Rapid |
| Duration | Progressive | Acute |
| Level of Consciousness | Not Affected | Impaired |
| Memory | Progressive from Short-term Memory (STM) to Long-Term Memory | STM Impairment |
| Speech | Not Affected Initially, Progresses to Aphasia | Possibly Slurred, Rambles, Pressured, or Irrelevant |
| Thought Processes | Impaired, Eventually Lost Ability | Disorganized |
| Perception | Possible Paranoia, Hallucinations, Illusions | Possible Visual/ Tactile Hallucinations, Delusions |
| Mood | Early (Depressed & Anxious)<br><br>Later (Labile & Angry Outbursts) | Possibly Anxious, Fearful, Weeping, or Irritable |

## Dementia

Alzheimer's Dementia accounts for approximately 70% of the cases of dementia (Emmady et al., 2022). Individuals may have a combination of contributing causes. Emmady et al. (2022) indicate the risk factors for late-onset dementia are age, family history, and genetic susceptibility. The authors also provided several modifiable risk factors that contribute to the occurrence of dementia. These modifiable risk factors are uncontrolled diabetes, mid-life obesity, hypertension, hyperlipidemia, and smoking (Emmady et al., 2022).

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=122#oembed-1*

RegisteredNurseRN. (2022). *Alzheimer's disease (dementia) nursing: symptoms, treatment, stages, pathophysiology NCLEX* [Video]. YouTube. https://youtube.com/watch?v=lql93382Hv8&si=EnSIkaIECMiOmarE

## Delirium

The etiology of delirium can be related to a number of factors. Essentially, delirium is an acute state of confusion (De Lourdes Ramirez Echeverria et al., 2022).

De Lourdes Ramirez Echeverria et al. (2022) provide several examples of associated factors that include:

- substance intoxication or withdrawal
- medication side effects
- infection
- surgery
- metabolic derangements
- pain
- constipation or urinary retention

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=122#oembed-2*

Osmosis from Elsevier. (2017). *Delirium-causes, symptoms, diagnosis, treatment & pathology* [Video]. YouTube.

https://youtube.com/watch?v=qmMYsVaZ0zo&si=EnSIkaIECMiOmarE

### Instruments

The **Mini-Mental State Exam** and the **Mini-Cog** are two instruments that may be used to assess for potential cognitive impairment and the need for a full evaluation (Alzheimer's Association, 2022). The Mini-Cog may also be used to assess delirium (Rhoads, 2021). The **Confusion Assessment Method (CAM)** can evaluate delirium risk (De Lourdes Ramirez Echeverria et al., 2022; Rhoads, 2021).

## Problems

The problems that may be associated with a neurocognitive disorder include:

- Impaired Memory
- Acute Confusion
- Chronic Confusion
- Self-Care Deficit

# Treatment

## Delirium

The major goal of delirium treatment is to identify the underlying cause. De Lourdes Ramirez Echeverria et al. (2022) and Rhoads (2021) provided several nursing interventions to help treat delirium. These interventions include:

**The main treatment goal for delirium is to identify and treat the underlying cause**.

- Maintain safety
- Promote daytime activity and stimulation
- Assist in sleep hygiene
- Correct sensory deficits (e.g., ensure patient has access to personal eyeglasses and hearing aids)
- Decrease stimuli when possible
- Provide care for bladder and bowel needs
- Monitor intake and output
- Orient the patient and re-orient during interactions (e.g., in acute care settings update the communication board in the patient's hospital room).

## Dementia

As aforementioned, the explanation of treatment for dementia will focus on the treatment of Alzheimer's disease as it is the most commonly seen form of dementia (Rhoads, 2021). Emmady et al. (2022) indicate cognitive function can be optimized by:

- Promoting adequate sleep
- Consuming an anti-inflammatory diet
- Ensuring adequate exercise
- Treating hearing or vision loss
- Minimizing stress
- Maintaining healthy blood sugar, cholesterol, and blood pressure levels.

## Pharmacological

Pharmacological interventions for Alzheimer's disease, and more specifically medications designed to target acetylcholine and glutamate, the primary neurotransmitters affected by the disease, have been the most effective treatment options in alleviating symptoms and reducing the speed of cognitive decline. Remember, there is no medication to stop or cure this disease. Specific medications such as *donepezil* (Aricept), *rivastigmine* (Exelon), *galantamine* (Razadyne), and *memantine* (Namenda) are prescribed to slow the progression

of Alzheimer's disease (Rhoads, 2021). See the MODULE 4: PSYCHOPHARMACOLOGY chapter for a review of these medications.

## Support for Caregivers

Supporting caregivers is an important treatment option to include as the emotional and physical toll on caring for an individual with a neurocognitive disorder is often underestimated. It is important that medical providers routinely assess caregivers' psychosocial functioning, and encourage caregivers to participate in caregiver support groups, or individual psychotherapy to address their own emotional needs.

## Additional Resources

See the Alzheimer's Association website for more information.

### Key Takeaways and Concept Map Activity

You should have learned the following in this section:

- The rate of occurrence of delirium and

dementia increases with age.

- Delirium is a state of acute confusion.
    - The main goal is to identify and treat the underlying cause.
- Major neurocognitive disorder (i.e., dementia) is characterized by a significant gradual decline in both overall cognitive functioning as well as the ability to independently meet the demands of daily living.
    - The most common type of is Alzheimer's disease.
- Pharmacological interventions for Alzheimer's disease target the neurotransmitters acetylcholine and glutamate.
- Caregivers may benefit from support groups.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Neurocognitive Disorders.
- If needed, see the INTRODUCTION for a concept map tutorial.

# MODULE 17: CHILDHOOD DISORDERS



## CHILDHOOD DISORDERS

This module aligns with key elements of APNA's "Growth & Development" and "Clinical Decision Making" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Assessment of Childhood Disorders
- Problems Associated with Childhood Disorders
- Treatment of Childhood Disorders

## Module Learning Outcomes

- Describe the signs and symptoms of Childhood Disorders
- Identify the common nursing problems associated with

Childhood Disorders
- Summarize the treatment of Childhood Disorders

## Concepts

- Development
- Coping
- Safety

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## Overview

In this module, we will cover matters related to childhood disorders to include their clinical presentation, assessment, and treatment options. Our discussion will include Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), and Intellectual Disability (ID). Duckworth (2022) reported half of mental health disorders begin by the age of 14 years and three quarters by the age of 25 years. Children may experience similar mental health diagnoses as adults. However, assessment and diagnosis of a mental health issue in childhood presents with challenges.

Videbeck (2020) lists several reasons psychiatric disorders are not easily diagnosed in children compared to adults; these reasons are:

- May lack abstract cognitive and language skills to describe their symptomology
- Have a limited sense of stable and normal sense of self related to constant developmental changes; thus, may not be able to discriminate unusual versus typical/expected feelings/sensations
- Abnormal or problematic behaviors may vary dependent on developmental stage and/or age

## ADHD

**ADHD** is characterized by cognitive and functional deficits. Clinically, this typically presents as issues with

- inattention
- hyperactivity
- and impulsiveness (Magnus et al., 2022; Videbeck, 2020).

**ADHD Diagnosis: look for consistency in signs and symptoms in multiple settings**

Historically, ADHD has been misdiagnosed. Alternative explanations for abnormal child behavior may be related to another mental health diagnosis (i.e., not ADHD, but another

diagnosis) or stressful family situations (e.g., divorce) (Videbeck, 2020). The key is to look for consistency in signs and symptoms in multiple settings with various caregivers (Magnus et al., 2022; Videbeck, 2020). In puberty, ADHD may result in behaviors such as skipping class, interpersonal relationship difficulties, and risk-taking (Videbeck, 2020). Lastly, it is a myth that children will outgrow ADHD. Instead, untreated, ADHD can result in adulthood dysfunction (e.g., work performance) (Magnus et al., 2022).

**with various caregivers.**

## ASD

**ASD** presents with repetitive schemes affecting behaviors, interests, or activities which may be present in early childhood or, alternatively, the child may begin with typical development, but then may have a regression of skills (Mughal et al., 2022). Diagnostically, Rhoads (2021) provides an overview of the DSM-5 signs and symptoms of ASD affect the three areas of abnormal or impairment in social interactions, communication impairment, and restricted repetitive or stereotyped behavior patterns. Keep in mind, at this time, there is no cure, nor is there any specific medication for ASD; rather, certain psychotropic medications may be used to treat

underlying behaviors (e.g., Risperidone and Aripiprazole) (Rebar et al., 2020). Early identification and treatment of ASD may improve outcomes (Mughal et al., 2022).

**ASD presents with impairments in social interactions, communicati on, and restricted or repetitive behaviors.**

Videbeck (2020) provide **typical behaviors** observed in ASD; these are:

- Avoids eye contact
- A preference to be alone
- Delay in speech and language
- Obsessive interests
- Word/phrase repetition
- Lack of interest or pretend play
- Distressed by minor changes in routine
- Hand-flapping, body rocking or spinning
- Uncommon reactions to sensory experiences

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*

*https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=1017#oembed-1*

Level Up RN. (2022). *ADHD and autism-pediatric nursing-nervous system disorders* [Video]. YouTube. https://youtube.com/watch?v=PzFpNWZwl3Q&si=EnSIkaIECMiOmarE

## ID

An individual diagnosed with an **ID** has limitations in intellectual function and adaptive behavior beginning at birth (Lee et al., 2022). A deficit in intellectual functioning may impact one's ability to logically reason or solve problems, learn, verbal skills (Lee et al., 2022). Deficits in adaptive behavior are related to social/interpersonal, conceptual (e.g., time), and practical skills (e.g., activities of daily living) (Lee et al., 2022). An intelligence quotient (IQ) of 70 or below with adaptive function impairment is suggestive of an ID (Lee et al., 2022).

**ID** affects

intellectual function and adaptive behavior.

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=1017#oembed-2*

Psych Hub. (2022). *What is IDD?* [Video]. YouTube. https://youtube.com/watch?v=rymHXQmiugI&si=EnSIkaIECMiOmarE

Below is an overview of a nurse's consideration for the assessment, problems, and treatment of neurodevelopmental disorders.

See Magnus et al. (2022) [ADHD], Mughal et al. (2022) [ASD], and Lee et al. (2022) for further reading.

# Assessment

Mental health assessment in adults is largely dependent on keen behavior observation, use of therapeutic communication techniques, and a rapport with the patient. These skills are equally, if not slightly more imperative when assessing and caring for children with mental health issues.

## Instruments

- Conners Parent and Teacher Rating Scale (ADHD)
- Pervasive Developmental Disorders Screening Test (ASD)
- The Reiss Scales (ID)

# Problems

The problems that may be associated with childhood disorders include:

- Risk for Injury
- Impaired Social Interaction
- Impaired Verbal Communication

# Treatment

There are four general treatment considerations for childhood disorders.

1. First and foremost, always ensure the child's safety.
2. Early identification and treatment are key to promote a child's mental health.
3. Focus on strengths, not just problems.
4. Provide parental support and make referrals as needed.

## ADHD

Those diagnosed with ADHD need help to manage inattentiveness, hyperactivity, and impulsivity. As mentioned in the previous paragraph, safety is priority. Children diagnosed ADHD may act without thinking of their safety. In the acute care setting, stimulant medications are first-line treatment options (e.g., Methylphenidate/Ritalin) and non-stimulants tend to be the 2nd line of treatment (e.g., Atomoxetine/Strattera) (Rhoads, 2020). See the MODULE 4: PSYCHOPHARMACOLOGY for a review of these medications.

Consider using behavior modification and reward for desired behavior (Rhoads, 2020). Some interventions specific to chronic care include:

- Limit distractions, when completing homework
- Help the child organize their environment
- Keep tasks simple and use simple instructions (Rhoads, 2020).

## ASD

In general, for the best treatment outcomes a highly structured and specialized treatment plan works best (Mughal et al., 2022; Rhoads, 2020). Rhoads (2020) indicates a multi-faceted treatment program might entail:

- Behavioral and communication approaches (e.g., positive reinforcement and social skills training)
- Biomedical and dietary approaches (e.g., medications used to treat problem behaviors or underlying conditions)
- Community support and parent training (e.g., teach family about ASD and management strategies)
- Specialized therapies (e.g., speech, occupational, and physical therapy)
- Complementary approaches (e.g., music, play, art, and animal therapy)

## ID

Individuals diagnosed with an ID benefit from an interprofessional approach (e.g., physician, psychiatrist, neurologist, speech pathologist, special nurse educator, social worker, and pharmacist) and multimodal interventions such as educational support, behavioral intervention (e.g., CBT, vocational training, family education, governmental resources), and psychotropic medications (if there is a co-existing condition such as aggressive behavior) (Lee et al., 2022).

## Summary of Key Nursing Interventions for ADHD, ASD, and ID

(Summarized from Magnus et al., 2022; Mughal et al., 2022; Rebar et al., 2020; Rhoads, 2021; Videbeck, 2020).

| | **Summary of Key Nursing Interventions** | |
|---|---|---|
| **ADHD** | **ASD** | **ID** |
| Reduce distractions in environment | Provide a safe environment; learn triggers that may induce outbursts; mitigate anxiety escalation by diversionary activities; consider using a reward system for behavior modification | Provide a safe environment; prevent self-injury |
| Use simple language and concrete directions | Monitor language; child's interpretation may be concrete/literal | Use simple language and concrete directions |
| Divide complex tasks into small sequences | Learn child's verbal/nonverbal communication style; use a picture board | Determine strengths and abilities; create an individualized plan to enhance capabilities; teach adaptive skills (e.g., ADLs) |
| Provide positive feedback | Maintain a regular/predictable daily routine; prepare the child for any changes in routine | Provide positive feedback about self and daily accomplishments; encourage independence as much as possible |

| | | |
|---|---|---|
| Allow breaks | If prone to self-injurious behavior, provide a helmet or protective padding | Set supportive limits on activities, if needed; teach and role model social interactions |

## Additional Resources

- Check out the resources listed on the Society for Adolescent Health and Medicine website.

### Key Takeaways and Concept Map Activity

You should have learned the following in this section:

- ADHD is characterized by inattention, hyperactivity, and impulsivity
    - When considering a diagnosis of ADHD, look for consistency in signs and symptoms in multiple settings with various caregivers
    - Psychotropic classes included stimulants and nonstimulants
- ASD is characterized by social interactions,

communication, and repetitive or stereotyped behavior impairments

    - There is no cure or specific medication for ASD. However, specific medications may be used to treat problematic behaviors

- ID affects intellectual function and adaptive behavior

    - There is no cure or specific medication for ID. Medications may be used to control aggressive behavior

- General nursing considerations: safety is a priority, learn how the child best communicates, promote self-confidence and independence as much as possible with a consideration for safety.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Childhood Disorders.
- If needed, see the INTRODUCTION for a concept map tutorial.

# MODULE 18: PSYCHIATRIC EMERGENCIES

## PSYCHIATRIC EMERGENCIES

This module aligns with key elements of APNA's "Growth & Development", "Clinical Decision Making", and "Health Care Settings" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

### Module Outline

- Assessment of Psychiatric Emergencies
- Problems Associated with Psychiatric Emergencies
- Treatment of Psychiatric Emergencies

### Module Learning Outcomes

- Define and identify types of crises
- Identify the common nursing problems associated with Psychiatric Emergencies

- Summarize the treatment of Psychiatric Emergencies

## Concepts

- Behavior
- Coping
- Safety
- Legal Issues

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## Overview

In this module, we will discuss matters related to psychiatric emergencies to include their clinical presentation, assessment and treatment variations. Rhoads (2021) indicates a psychiatric emergency involves thoughts, feelings, or actions that require immediate therapeutic intervention. Some examples of psychiatric emergencies include:

- Suicide
- Agitated/aggressive patients
- Rape
- Disaster
- Panic attack
- Delirium
- Neuroleptic malignant syndrome (NMS)

- Serotonin syndrome
- Overdose and withdrawal (Rhoads,2021).

Our discussion will consist of types of crises, suicide, aggression/violence, and abuse/neglect. Prior to discussing these clinical disorders, we will explain crises, as well as identify common crises types.

## Crises

Crises are individualistic and can relate to a positive or negative event that creates stress. Some individuals may be able to manage a crisis, provided they have access to sufficient resources (e.g., adaptive coping mechanism, social support, financial means, insurance, and community organizations). However, if an individual is experiencing multiple stressors and/or crises, they may not successfully manage a crisis. As the old adage advises, ***an ounce of prevention is worth a pound of cure.*** Specific to a crisis or psychiatric emergency, it is best to have a plan. Videbeck (2020) indicates specific types of crises generally fall into three categories:

- **Maturational** or developmental crises (e.g., leaving home, marriage, having a baby)
- **Situational** or unanticipated/sudden events (e.g., death of a loved one, job loss, physical/emotional illness)
- **Adventitious** or social crises (e.g., natural disasters,

terrorist attacks, and violent crimes)

**Three factors typically influence an individual's experience of a crisis**.

1. Perception of the event
2. Emotional support availability
3. Coping mechanism availability (Videbeck, 2020).

NAMI (2022b) provides several resources for navigating crises; these will be featured in this module. The first of these resources is below "Navigating a Mental Health Crisis" (2022b).

Below is an overview of a nurse's consideration for the assessment, problems, and treatment of psychiatric emergencies.

See NAMI's Resource "Navigating a Mental Health Crisis" (2022b), Thomas and Reeves(2022), and Carlson (2022) for further reading.

# Assessment

Nurses should consider two key components when assessing an individual experiencing a psychiatric emergency.

1. Ensure the safety of everyone involved, including the nurse's safety, patient safety, and safety of others in the environment
2. Attempt to identify the specific situation/event leading to the crisis

## Suicide

An individual's expression of **suicidal ideation** should always be taken seriously and requires immediate intervention. In

many acute clinical settings, it is routine practice to ask each patient about suicidal or homicidal thoughts on admission and daily with each set of vital signs. Videbeck (2020) provides a list of suicide myths. Let's summarize these myths.

# Summarization of Suicide Myths

| Myth | Facts |
|---|---|
| People who talk about suicide, do not act on suicidal thoughts. | Individuals often communicate suicidal ideation and inner feelings of helpless/ hopelessness; these should always be taken seriously. |
| Individuals who talk suicide will only hurt themselves. | Individuals may hurt themselves, but may also, impulsively or plan, hurt others. |
| You can't help someone who wants to hurt themselves. | Individuals may have mixes feelings about suicide and hurting others. Intervention can most certainly help individuals get the help they need. |
| Mentioning "suicide" promotes the idea of suicide to the individual. | Asking about suicide does not cause an individual, who is not suicidal, to become a suicide risk. |
| Ignoring or challenging expressed suicide thoughts will result in a reduction of actual suicide behaviors. | Suicidal gestures should never be ignored, challenged, or dismissed. All expressions of suicide should be taken seriously and require immediate intervention. Inquire about the situation that is prompting the suicidal thoughts. The person may feel relieved that help is imminent. |

| | |
|---|---|
| Individuals, who were a suicide a risk, will always be a suicide risk. | Individuals, who complete suicide, typically have attempted suicide in the past. However, proper support and adaptive coping mechanisms can help individuals with suicidal ideation learn to become emotionally secure and learn adaptive ways to resolve problems. |

See NAMI's (2022b) resource below for warning signs of crisis and interventions.


## Aggression and Violence

Anger is a normal human emotion. However, when anger

leads to aggression and violence, this becomes a situation requiring immediate intervention and de-escalation. Rhoads (2021) provides a list of behaviors indicative of warnings signs that may lead to violence. Some of these behaviors include:

- Tense or angry facial expressions
- Restlessness, body tension, or pacing
- Increased speech volume and erratic movements
- Prolonged eye contact
- Withdrawal or refusal to communicate
- Violent-themed delusions or hallucinations
- Verbal threats or violent gestures
- Verbalization of anger or violent feelings.

## Abuse and Neglect

**Abuse** involves acts of commission (e.g., physical, sexual, verbal, emotional) and neglect involves acts of omission (e.g., physical, medical, education, social, emotional) (Heldt, 2021). Nurse should be aware of warning signs of abuse and neglect. Carefully read over the summarization table below created from Videbeck's (2020) resource. This table is not exhaustive.

**Warning Signs of Abuse and Neglect**

| Child | Elder |
|---|---|
| Serious injuries with no trauma history | Frequent injuries and seeking medical assistance at several locations |
| Delay in seeking treatment | Reluctance to seek treatment or denial of injury |
| Provided injury history is inconsistent with severity of injury | Disorientation or grogginess (possible misuse of medications) |
| Inconsistency or change to child history during evaluation | Fear or nervousness around family member or caregiver |
| Unusual injuries based on age and developmental level | Isolation from friends/family; sudden lack of contact from outside friends/family |
| High occurrence of UTIs or injuries to genitalia/rectum | Withdrawal, depression, helplessness, anger, or agitation |
| Unreported old injuries | Unpaid bills, sudden sale or disposal of property/belongings |
| Poor personal hygiene | Poor personal hygiene; presence of rashes, sores, or lice |

## Problems

The problems that may be associated with psychiatric emergencies include:

- Risk for Suicide
- Ineffective Coping

- Hopelessness
- Risk of violence against self or others

## Treatment

Generally, nurses cannot prevent an individual's experience of crises. However, nurses can help mitigate the detrimental effects of crisis. To facilitate effective navigation of crises, nurses should:

- Help individuals consider alternate perceptions of the crisis (e.g., growth opportunity)
- Assist the individual in recognizing and utilizing existing support systems
- Cultivate new methods of adaptive coping mechanisms (Videbeck, 2020).

If an individual expresses thought of self-harm or harm to another person, this typically results admission to an acute psychiatric treatment facility. Admission to an acute psychiatric care facility can be on a **voluntary** or **involuntary** basis. In the U.S., most states have laws addressing civil commitment or involuntary admission (Videbeck, 2020). Typically, these laws allow detaining for 48-72 hours, until a legal determination can be made as to the individual's threat of harm to themselves or others (Videbeck, 2020).

## Suicide

Individuals verbalizing suicidal thoughts are typically admitted to an in-patient psychiatric treatment facility. Upon admission to an acute care facility, patients and their belongings are searched. Acute care organizations typically have policies that delineate unsafe items (e.g., sharp objects, shoelaces, belts, and lighters). Generally, they are issued a hospital gown or scrubs and their belongings are stored until they are discharged from the facility. Single use personal care items are issued on an as needed basis by the facility. Within the acute care environment, nurses should use suicide safety precautions with individuals verbalizing suicidal thoughts. The goal is to ensure a safe environment for the patient.

Videbeck (2020) provides guidance on implementing **suicide safety precautions**. Depending on the organization's policy, these precautions may include:

**The goal of suicide safety precautions is to ensure a safe environment.**

- Removal of any items that could be used for harm (e.g., sharp objects, belts, shoelaces, metal objects, pens/pencils, clothing with drawstrings)
- One-to-one observation (i.e., in direct sight by staff at all

times)
- Other considerations: finger foods for meals, no private rooms

## Aggression/Violence

Interventions specific to aggression and violence entail careful consideration of the patient's legal right to a least restrictive environment to meet their needs (Videbeck, 2020). Least restrictive environment has two main implications.

1. If outpatient treatment is sufficient, inpatient treatment is not warranted
2. Restraints and seclusion are only used if absolutely necessary (Videbeck, 2020).

### How can nurses manage aggressive behavior?

Always make sure to follow institutional policy for management of aggressive or violent patients. Below is an outline of the steps nurses can use to intervene with an aggressive patient (Videbeck, 2020). When reading over these steps, **picture a ladder** to remind you that these are progressive interventions and uphold the patient's right to a least restrictive environment. Meaning, if verbal de-escalation (the bottom rung of the ladder) is sufficient in averting violent behavior there is no need to continue intervention

progression, including use of restraints (the highest rung of the ladder).

**Patients have a right to a least restrictive environment.**

1. Ensure scene safety, when in doubt do not act alone
2. Attempt verbal de-escalation-use a calm, firm voice
3. Direct the patient to take a voluntary time-out in a quiet area
4. Inform the patient aggressive behavior is not acceptable
5. Offer PRN medications to help the patient return to a calm state (e.g., Lorazepam)
6. Provide a "show of force/strength" (i.e., gather 4-6 team members to remain in sights with patient interactions;

this may be enough to take control of the situation. If the patient continues to escalate to violent behavior, these staff will help to ensure safety should restraints and/or seclusion become necessary

7. Use of restraint and/or seclusion per institutional policy with a consideration for the Joint Commission standards
8. Debrief: Ask the patient about any triggers and alternatives to avoid future patient violent behavior; hold a debriefing session for all involved staff to discuss elements of the situation that were handled well, needed improvement, and any ideas to enhance defusing (Videbeck, 2020).

## Abuse and Neglect

As we have noted in the previous psychiatric emergencies, the safety and well-being of all involved is essential and the first priority; this is no different in an abuse and/or neglect patient situation. Again, do not act alone. If you are a nurse responding to a situation in the community, enlist the help of local law authorities. Do not attempt intervene in a situation without help. You cannot not predict human behavior and a situation can precipitate into imminent danger in a matter of seconds. Nurses are generally named in state's mandatory reporting laws. Meaning, as nurses we have a duty to protect the safety and well-fare of certain vulnerable populations (e.g.,

children, elderly, and dependent adults) by reporting known or suspected abuse/neglect (Carlson, 2022).

There are **three main considerations for a nurse's role in abuse/neglect situations.**

1. Ensure safety
2. Know your state's mandatory reporting laws
3. Make referrals as needed (e.g., social support services)

Most states mandate, nurses have a legal duty to report known or suspected abuse/neglect of children, elders, and dependent adults.

## General Nursing Considerations for a Psychiatric Emergency

Let's consider a few tenets to consider for **psychiatric emergency interventions.**

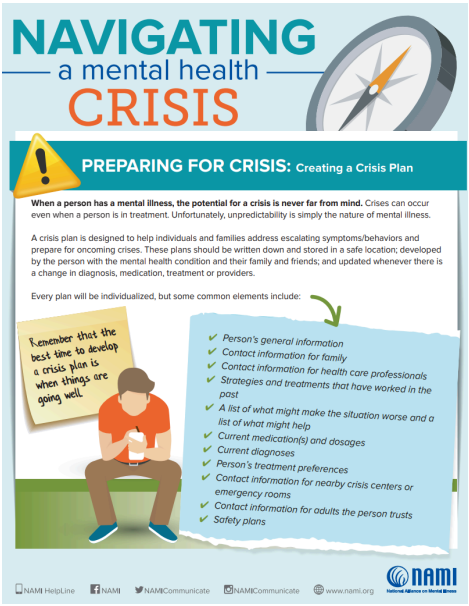
- **Safety is priority**. In the event of a safety concern, do not act alone.
    - In the acute care environment, follow the institution's protocols for a psychiatric emergency.
    - In the community, **call 911 or 988** (the National

Suicide and Crisis Lifeline).

- Patients have a legal right to a **Least Restrictive environment**. See the MODULE 6: LEGAL AND ETHICAL ISSUES module for more on this topic.
- Specific to agitated patients, **rapid de-escalation** is the primary goal (Heldt, 2021). If possible, verbally de-escalate the situation initially. Implement **additional de-escalating strategies** (e.g., offer a medication and show of force/strength) prior to using restraints. **Remember, restraints are always a last resort**. Heldt (2021) indicates restraints are associated with physical and mental harm/psychological trauma. Physical harm may include physical injury, organ damage, and death (Heldt, 2021).
- If possible, help patients **create a crisis plan**. In fact, this is sound advice for everyone. See "Create a Plan" below.

## CREATE A PLAN

Help individuals **create a plan of action** to help arm them with the tools to navigate a psychiatric emergency. See Nami's (2022b) resource below. Nurses might also consider recommending individuals complete a psychiatric advance directive. See "Additional Resources" below.




## Additional Resources

- Check out the National Resource Center on Psychiatric Advance Directives website
- Consider reading this World Health Organization article (World Health Organization, 2022) for an international perspective on mental health and emergencies

## Key Takeaways and Concept Map Activity

You should have learned the following in this section:

- Crises are individualistic. Meaning, depending on resource availability, what constitutes or results in a crisis for one, may not for another.
- Crises can be classified into three categories (i.e., Maturational, Situational, and Adventitious)
- Individuals expressing suicidal thoughts should always be taken seriously and require immediate action.
- Related to psychiatric emergencies, safety is always the first priority. It is often best practice to not act alone. In the acute care setting, it is crucial that nurses take care to ensure the safety of the patient as well as all within the environment, including healthcare staff and other patients.
- Patients are legally entitled to a least restrictive environment. Verbal de-escalation is the first step in intervention.
- Know your state's position on mandatory

reporting laws. Typically, nurses are state mandated to report known or suspected abuse/neglect of children, elderly, and dependent adults.

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Psychiatric Emergencies.
- If needed, see the INTRODUCTION for a concept map tutorial.

# MODULE 19: GRIEF AND LOSS

## GRIEF AND LOSS

This module aligns with key elements of APNA's "Clinical Decision Making", "Patient Care Roles", and "Cultural, Ethnic, and Spiritual Concepts" (American Psychiatric Nurses Association Education Council, Undergraduate Branch, 2022).

## Module Outline

- Assessment of Grief and Loss
- Problems Associated with Grief and Loss
- Treatment of Grief and Loss

## Module Learning Outcomes

- Summarize the types of Grief and Loss
- Describe the signs and symptoms of Grief and Loss
- Review Kubler-Ross five stages of grief

- Identify the common nursing problems associated with Grief and Loss
- Summarize the treatment of Grief and Loss

## Concepts

- End of Life
- Spiritual
- Grief and Loss

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## Overview

Grief and loss are universal concepts. Meaning, all of humanity experiences grief and loss at some point across the lifespan. This module will summarize key factors related to grief and loss; namely, these are the types of grief, signs and symptoms of grief, Kubler-Ross' Five Stages of Grief, common nursing problems, and treatment considerations.

## Types of Loss

Generally, a loss precipitates the experience of grief. The experience of grief is normal response to losing something. The **types of loss** can be understood within Maslow's

Hierarchy of Needs theoretical framework (Videbeck, 2020). See the MODULE 2: THEORETICAL MODELS USED IN MENTAL HEALTH NURSING for a review of this theory. Let's look at this application.

- Physiological Loss (e.g., loss of a limb)
- Safety Loss (e.g., loss of a home)
- Loss of Security and Sense of Belonging (e.g., death of a loved one)
- Loss of Self-Esteem (e.g., job loss)
- Self-Actualization Loss (e.g., loss of hope for future goals)

## Types of Grief

The experience of grief is a normal to loss. However, **two types of grief may be troublesome**. These two types are:

- **Anticipatory Grief**-experienced before the actual loss
- **Complicated Grief**-grief suppression, prolonged experience of grief, or disproportionate grief experience
- **Disenfranchised Grief**-inability to openly acknowledge the loss or grief (e.g., related to social stigma) (Oates and Maani-Fogelman; 2022; Videbeck, 2020).

Individuals may be at **increased risk or vulnerable for**

**experiencing complicated grieving** for several reasons. Some of these reasons are:

- The loss is the death of a spouse, child, or parent (especially as a child/adolescent)
- Low self-esteem
- Perception of the loss (Oates and Maani-Fogelman; 2022; Videbeck, 2020).

## Kubler-Ross Stages of Grief

Elisabeth Kubler-Ross defined **five stages of grieving.** However, keep in mind that while these are typical stages of grief. The experience of grief and loss is individualistic. A person does not necessarily progress through these stages in sequence. A person may also regress to a previous stage or experience stages together. The five grief stages are:

1. **Denial**-shock and disbelief related to the loss
2. **Anger**-may feel anger towards God or others
3. **Bargaining**-asking God or fate to delay the loss
4. **Depression**-acute awareness of the loss
5. **Acceptance**-comes to terms with the loss (Oates and Maani-Fogelman; 2022; Videbeck, 2020).

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing/?p=1328#oembed-1*

Level Up RN. (2022). *Crises, loss, and grief-psychiatric mental health nursing principles* [Video]. YouTube. https://youtube.com/watch?v=HqzuxJl6BNc&si=EnSIkaIECMiOmarE

Below is an overview of a nurse's consideration for the assessment, problems, and treatment for grief and loss.

See Oates and Maani-Fogelman (2022) for further reading.

## Assessment

It is not uncommon for individuals to express a variation of signs and symptoms to grief. Reviewing Kubler-Ross' Five

Stages of Grief will allow you to anticipate the clinical presentation of grief.

Videbeck (2020) indicates typical **universal signs and symptoms of grief** are:

- Shock and social disorientation
- Attempts to continue the relationship
- Anger with those believed to be responsible
- Mourning

The **signs and symptoms of complicated grief** include:

- Intense sorrow and rumination of the loss
- Inability to concentrate on other things besides the loss
- Intense and persistent longing for the deceased

## Problems

The problems that may be associated with childhood disorders include:

- Ineffective Coping
- Grieving
- Risk for Complicated Grieving

## Treatment

The main treatment goal for nurses is to **provide comfort and support** for the patient and family. Let's summarize some **specific strategies** for nurses to help grieving patients and families.

- May use silence and listen; may encourage sharing of memories or feelings
- Don't assume an understanding of the individual's/family's spiritual or cultural grieving process, but can encourage the individual/family to express what is meaningful to them
    - Caveat: may not be able to accommodate practices that may compromise organizations policy or pose health risk to other patients (e.g., burning incense). Check the institutional policy.
- Allow **adaptive denial**
- Offer food, but do not pressure to eat
- Encourage the bereaved to care for themselves
- Respect the individual's/family's beliefs and grieving process
- Encourage the acceptance of support (Oates and Maani-Fogelman; 2022; Videbeck, 2020).

## Additional Resources

Check out the resources listed on:

- CDC's Grief and Loss webpage
- The Center for Prolonged Grief at Columbia University webpage.

### Key Takeaways and Concept Map Activity

You should have learned the following in this section:

- The experience of grief and loss is universal to all humanity
- Types of loss can be summarized using Maslow's Hierarchy of Needs
- Types of griefs that may be associated with a maladaptive response to a loss include: Anticipatory, Disenfranchised, and Complicated Grief
- Nurses should provide comfort and support to grieving individuals and families

**Concept Map Activity**

- Create a concept map that depicts the assessment and treatment of Grief and Loss.
- If needed, see the INTRODUCTION for a concept map tutorial.

# REFERENCES


**References**

Alzheimer's Association. (2022). *Cognitive assessment tools*. Retrieved December 28, 2022, from https://www.alz.org/professionals/health-systems-medical-professionals/clinical-resources/cognitive-assessment-tools

American Psychiatric Association. (n.d.). Endorsement of principles for the provision of mental health and substance abuse treatment services: a bill of rights. In *American Psychiatric Association*. Retrieved January 3, 2023, from https://www.psychiatry.org/getattachment/d735fd73-6a06-4342-9c78-0f67db1f0184/Position-2007-Bill-of-Rights.pdf

American Psychiatric Association. (2022a). *Diagnostic and statistical manual of mental disorders (DSM-5-TR)*. Retrieved July 29, 2022, from https://www.psychiatry.org/psychiatrists/practice/dsm

American Psychological Association. (2022b). *APA dictionary of psychology*. Retrieved November 30, 2022, from https://dictionary.apa.org

American Psychiatric Nurses Association Education Council, Undergraduate Branch. (2022). Crosswalk toolkit: Defining and using psychiatric-mental health nursing skills in

undergraduate nursing education. Retrieved from https://www.apna.org/resources/undergraduate-education-toolkit/

Bailey, H. (1920). *Nursing mental diseases*. The Macmillan Company.

Balasundaram, P., & Santhanam, P. (2022). Eating disorders [E-book]. In *StatPearls*. StatPearls Publishing.

Brock, H., & Hany, M. (2022). Obsessive-compulsive disorder [E-book]. In *StatPearls*. StatPearls Publishing.

Buser, S., & Cruz, L. (2022). *DSM-5-TR insanely simplified: unlocking the spectrums within DSM-5-TR and ICD-10*. Chiron Publications.

Calabrese, J., Khalili, Y.A., & Shaheen, K. (2022). Psychosis (nursing) [E-book]. In *StatPearls*. StatPearls Publishing.

Carlson, K. (2022, November 15). *Understanding a nurse's role as a mandated reporter*. NurseJournal. Retrieved January 3, 2023, from https://nursejournal.org/resources/understanding-nurses-role-as-a-mandated-reporter/

Centers for Disease Control and Prevention (CDC). (2022). Social determinants of health. Retrieved October 24, 2022, from https://www.cdc.gov/chronicdisease/programs-impact/sdoh.htm

Chand, S.P., Arif, H., & Kutlenios, R.M. (2022). Depression (Nursing) [E-book]. In *StatPearls*. StatPearls Publishing.

Chand, S.P., Marwaha, R., & Bender, R.M. (2022).

Depression (Nursing) [E-book]. In *StatPearls.* StatPearls Publishing.

De Lourdes Ramirez Echeverria, M., Schoo, C., Paul, M., & Doerr, C. (2022). Delirium (nursing) [E-book]. In *StatPearls*. StatPearls Publishing.

Duckworth, K. (2022). *You are not alone: the NAMI guide to navigating mental health——with advice from experts and wisdom from real people and families*. Zando.

Emmady, P.D, Schoo, C., Tadi, P., & Pozo, E.D. (2022). Major neurocognitive disorder (dementia) (nursing) [E-book]. In *StatPearls*. StatPearls Publishing.

Fariba, K.A, Gupta, V., & Kass, E. (2022). Personality disorder [E-book]. In *StatPearls*. StatPearls Publishing.

Garcia, E., & Santos, C. (2022). Monoamine oxidase inhibitor toxicity [E-book]. In *StatPearls*. StatPearls Publishing.

General Service Office of Alcoholics Anonymous. (2022). *Meeting guide*. Alcoholics Anonymous. Retrieved December 22, 2022, from https://www.aa.org/meeting-guide-app

Guild, J., Hsu, A., Islam, H., Kaur, M., Mokhovikova, M., Nicholls, J. M., & Smith. C. (2021). Starting a conversation about mental health: Foundational training for students. BCcampus.

hawknurse. (2010, August 24). *How to write a nursing diagnosis.mov* [Video]. YouTube. https://www.youtube.com/watch?v=JyAaQ5hILSs

Heldt, J. (2017). *Memorable psychopharmacology*. Jonathan Heldt.

Heyda, S.E., Avula, A., & Swoboda, H. B.(2022). Lithium toxicity [E-book]. In *StatPearls*. StatPearls Publishing.

Ignatavicius, D. D., & Silvestri, L. (2022). *Getting ready for the next-generation NCLEX® (NGN): how to shift from the nursing process to clinical judgment in nursing*. Elsevier Education. https://evolve.elsevier.com/education/expertise/next-generation-nclex/ngn-transitioning-from-the-nursing-process-to-clinical-judgment/

Jahan, A.R., & Burgess, D.M. (2022). Substance use disorder [E-book]. In *StatPearls*. StatPearls Publishing.

Jain, A., & Mitra, P. (2022). Bipolar affective disorder [E-book]. In *StatPearls*. StatPearls Publishing.

Lee, K., Cascella, M., & Marwaha, R. (2022). Intellectual disability [E-book]. In *StatPearls*. StatPearls Publishing.

Magnus, W., Nazir, S., Anilkumar, A.C., & Shaban, K. (2022). Attention deficit hyperactivity disorder [E-book]. In *StatPearls*. StatPearls Publishing.

Mann, S. K., & Malhi, N.K. (2022). Repetitive transcranial magnetic stimulation [E-book]. In *StatPearls*. StatPearls Publishing.

Mental Health America. (2022). *Person-centered language*. Retrieved December 8, 2022, from https://www.mhanational.org/person-centered-language

Mughal, S., Faizy, R.M., Saadabadi, A., & Doerr, C.

(2022). Autism spectrum disorder (nursing) [E-book]. In *StatPearls*. StatPearls Publishing.

National Alliance on Mental Illness (NAMI). (2020, May). Substance use disorders. NAMI National Alliance on Mental Illness. Retrieved December 8, 2022, from https://www.nami.org/about-mental-illness/common-with-mental-illness/substance-use-disorders

National Alliance on Mental Illness (NAMI). (2022a). *Treatments*. NAMI National Alliance on Mental Illness. Retrieved August 1, 2022, from https://www.nami.org/About-Mental-Illness/Treatments

National Alliance on Mental Illness (NAMI). (2022b). *Navigating a mental health crisis*. NAMI National Alliance on Mental Illness. Retrieved December 29, 2022, from https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis

National Institute on Aging. (2021, July 8). How Is Alzheimer's disease treated? Retrieved August 23, 2022, from https://www.nia.nih.gov/health/how-alzheimers-disease-treated

National Institute of Mental Health. (2022, June). Mental health medications. National Institute of Mental Health (NIMH). Retrieved August 29, 2022, from https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2359

Oates, J. R., & Maani-Fogelman, P.A. (2022). Nursing grief and loss [E-book]. In *StatPearls*. StatPearls Publishing.

Office of Disease Prevention and Health Promotion. (2021, August). *Social determinants of health*. Social Determinants of Health – Healthy People 2030. Retrieved July 21, 2022, from https://health.gov/healthypeople/priority-areas/social-determinants-health

Peeling, J. L., & Muzio, M.R. (2022). Conversion disorder [E-book]. In *StatPearls*. StatPearls Publishing.

Petiprin, A. (2020). *Madeleine Leininger – nursing theorist*. Nursing Theory. Retrieved July 21, 2022, from https://nursing-theory.org/nursing-theorists/Madeleine-Leininger.php

*PsychTools*. (n.d.). PsychTools. https://www.psychtools.info/

Quality and Safety Education for Nurses (QSEN). (2020). *Competencies*. QSEN Institute. Retrieved August 1, 2022, from https://qsen.org/competencies/

Rebar, C. R., Gersch, C., & Heimgartner, N. M. (Eds.). (2020). *Psychiatric nursing made incredibly easy!* (3rd ed.). Wolters Kluwer.

Rhoads, J. (Ed.). (2021). *Clinical Consult to Psychiatric Mental Health Management for Nurse Practitioners, Second Edition – A Convenient, Practical, and Portable Guide of the Major DSM-5 Disorders* (2nd ed.). Springer Publishing Company, LLC.

Sharma, N., & Gupta, V. (2022). Therapeutic communication [E-book]. In *StatPearls*. StatPearls Publishing.

Sheffler, Z. M., Reddy, V., & Pillarisetty, L.S. (2022). Physiology, neurotransmitters [E-book]. In *StatPearls*. StatPearls Publishing.

Simon, L. V., & Keenaghan, M. (2022). Serotonin syndrome [E-book]. In *StatPearls*. StatPearls Publishing.

The School of Life. (2019, April 10). *Why Maslow's hierarchy of needs matters* [Video]. YouTube. https://www.youtube.com/watch?v=L0PKWTta7lU

Thomas, R., & Reeves, M. (2022). Mandatory reporting laws [E-book]. In *StatPearls*. StatPearls Publishing.

Toney-Butler, T. J., & Unison-Pace, W.J. (2021). Nursing admission assessment and examination [E-book]. In *StatPearls*. StatPearls Publishing.

Toney-Butler, T. J., & Thayer, J.M. (2022). Nursing process [E-book]. In *StatPearls*. StatPearls Publishing.

Transcultural Nursing Society. (2022). *Theories/Models – Transcultural Nursing Society*. Transcultural Nursing Society: Many Cultures One World. Retrieved July 20, 2022, from https://tcns.org/theoriesandmodels/

UBC Student Health and Wellbeing Staff, Gillies, J., Johnston, B., Warwick, L., Devine, D., Guild, J., Hsu, A., Islam, H., Kaur, M., Mokhovikova, M., Nicholls, J. M., & Smith. C. (2021). Starting a conversation about mental health: Foundational training for students. BCcampus

U.S. Department of Health & Human Services. (n.d.). *Information related to mental and behavioral health, including opioid overdose*. HHS.gov. Retrieved January 3,

2023, from https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html

Videbeck, S. L. (2020). *Psychiatric-mental health nursing* (8th ed.). Wolters Kluwer.

Voss, R.M., & Das, J.M. (2021). Mental status examination [E-book]. In *StatPearls*. StatPearls Publishing.

World Health Organization. (2022, March 16). *Mental health in emergencies*. Retrieved January 3, 2023, from https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies

Wu, K., & Baker, J. (2022). Patient communication in substance abuse disorders [E-book]. In *StatPearls*. StatPearls Publishing.