Nursing: Mental Health and Community Concepts

Nursing: Mental Health and Community Concepts - 2e

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The 2nd edition is currently in progress and will be fully released by June 30, 2025. The book link will not be changed.

ERNSTMEYER & CHRISTMAN - OPEN RESOURCES FOR NURSING (OPEN RN)

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Introduction

This is the second edition of the *Nursing Mental Health & Community Concepts* OER textbook that has been developed specifically for prelicensure nursing students. Content is based on the Wisconsin Technical College System (WTCS) statewide nursing curriculum for the Nursing Mental Health & Community Concepts course (543-114), the 2023 NCLEX-RN Test Plan,[1], the American Psychiatric Nurses Association Education Council's *Crosswalk Toolkit: Defining and Using Psychiatric-Mental Health Nursing Skills in Undergraduate Nursing Education,*[2] and the Wisconsin Nurse Practice Act.[3]

This book discusses mental health and community health concepts while emphasizing stress management techniques, healthy coping strategies, referrals to community resources, and other preventative interventions. Nursing care for individuals with specific mental health and substance use disorders is examined, and the nurse's role in community health needs assessments and caring for vulnerable populations is introduced.

Overall updates to the second edition were made based on feedback received from a WTCS faculty workgroup and include the following:

- Learning objectives were updated based on revised WTCS state curriculum.
- Content including DSM-5 criteria and definitions was updated with

1. NCSBN. (n.d.). *Test plans*. https://www.nclex.com/test-plans.page
2. American Psychiatric Nurses Association Education Council, Undergraduate Branch. (2016). *Crosswalk toolkit: Defining and using psychiatric-mental health nursing skills in undergraduate nursing education*. https://www.apna.org/resources/undergraduate-education-toolkit/
3. Wisconsin State Legislature. (2024). *Chapter 6: Standards of practice for registered nurses and licensed practical nurses*. Board of Nursing. https://docs.legis.wisconsin.gov/statutes/statutes/441

content from DSM-5-TR.
- Content based on the ANA Code of Ethics was updated to reflect the 2025 edition.
- Hyperlinks to supplementary information were updated.
- Nursing process sections were standardized across all chapters based on content originally included in Chapter 4 ("Application of the Nursing Process to Mental Health Care"). The NCSBN Clinical Judgment Measurement Model steps were included in parentheses next to the steps of the nursing process (e.g., Recognize Cues, Analyze Cues, Generate Solutions, Take Action, and Evaluate Outcomes). The "Assessment" sections were standardized and include Mental Status Examination, Psychosocial Assessment, a sample PQRSTU assessment with client responses for assessing the reason they are seeking health care, Suicide and Self Injury Screening, Cultural Assessment, Spiritual Assessment with sample client responses, and Lifespan Considerations. The "Implementation" sections include tables summarizing nursing interventions based on categories of the APNA Implementation Standard and common physiological concerns. Communication tips were also included with rationale.
- New Next Generation-style case studies were added to every chapter to help students develop clinical judgment and prepare for the NCLEX.
- Several supplementary YouTube videos were added to enhance student comprehension of the content.

Here is a document summarizing the updates made to the second edition.

The following YouTube video provides a quick overview of how to navigate the online version.

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

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Standards and Conceptual Approach

The Open RN *Nursing Mental Health and Community Concepts, 2e* textbook is based on several external standards and uses a conceptual approach.

External Standards

American Nurses Association (ANA)

The ANA establishes Standards for Professional Nursing Practice and the Code of Ethics for Nurses.[1,2]

- https://www.nursingworld.org/ana/about-ana/standards/

American Psychiatric Nurses Association (APNA)

The APNA advances the science and education of psychiatric-mental health nursing. APNA is committed to the practice of psychiatric-mental health nursing, health and wellness promotion through identification of mental health issues, prevention of mental health problems, and the care and treatment of persons with mental health disorders.[3]

- https://www.apna.org/

American Psychiatric Nurses Association Education Council, Undergraduate Branch

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
2. American Nurses Association. (2025). *Code of ethics for nurses*. American Nurses Association. https://codeofethics.ana.org/provisions
3. American Psychiatric Nurses Association. https://www.apna.org/

The APNA created a toolkit to help define and integrate psychiatric-mental health nursing content into undergraduate nursing curricula.[4]

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

Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental health and substance use disorders and their families. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities and draws advice from public members and professionals in the field of substance abuse and mental health.[5]

- https://www.samhsa.gov/

The National Council Licensure Examination for Registered Nurses: NCLEX-RN Test Plans

The NCLEX-RN test plans are updated every three years to reflect fair, comprehensive, current, and entry-level nursing competency.[6]

4. American Psychiatric Nurses Association Education Council, Undergraduate Branch. (2016). *Crosswalk toolkit: Defining and using psychiatric-mental health nursing skills in undergraduate nursing education.* https://www.apna.org/resources/undergraduate-education-toolkit/
5. Substance Abuse and Mental Health Services Administration. (n.d.). *Strategic plan FY2019-FY2023*. https://www.samhsa.gov/sites/default/files/samhsa_strategic_plan_fy19-fy23_final-508.pdf
6. NCSBN. (n.d.). *Test plans*. https://www.nclex.com/test-plans.page

- https://www.ncsbn.org/nclex.htm

The National League of Nursing (NLN): Competencies for Graduates of Nursing Programs

NLN competencies guide nursing curricula to position graduates in a dynamic health care arena with practice that is informed by a body of knowledge to help ensure the public receives safe, quality care.[7]

- https://www.nln.org/education/nursing-education-competencies/competencies-for-graduates-of-nursing-programs

American Association of Colleges of Nursing (AACN): The Essentials: Competencies for Professional Nursing Education

The AACN provides a framework for preparing individuals as members of the discipline of nursing, reflecting expectations across the trajectory of nursing education and applied experience.

- https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

Quality and Safety Education for Nurses (QSEN) Institute: Prelicensure Competencies

Quality and safety competencies include knowledge, skills, and attitudes to be developed in nursing prelicensure programs. QSEN competencies include patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.[8]

7. National League of Nursing. *Competencies for graduates of nursing programs*. https://www.nln.org/education/nursing-education-competencies/competencies-for-graduates-of-nursing-programs

8. QSEN. (n.d.). *About*. https://qsen.org/about-qsen/

- https://qsen.org/competencies/

Wisconsin State Legislature, Administrative Code Chapter N6

The Wisconsin Administrative Code governs the Registered Nursing and Practical Nursing professions in Wisconsin.[9]

- https://docs.legis.wisconsin.gov/code/admin_code/n/6

Healthy People 2030

Healthy People 2030 envisions a society in which all people can achieve their full potential for health and well-being across the life span. Healthy People provides objectives based on national data and includes social determinants of health.[10]

- https://health.gov/healthypeople

Conceptual Approach

The Open RN *Nursing Mental Health and Community Concepts, 2e* textbook incorporates the following concepts:

- **Holism.** Florence Nightingale taught nurses to focus on the principles of holism, including wellness and the interrelationship of human beings and their environment. This textbook encourages holistic nursing care by addressing the impact of social determinants of health (SDOH) on mental

9. Wisconsin State Legislature. (2018). *Chapter 6: Standards of practice for registered nurses and licensed practical nurses*. Board of Nursing. https://docs.legis.wisconsin.gov/statutes/statutes/441
10. Healthy People 2030. (n.d.). *Social determinants of health*. U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

health.

- **Evidence-Based Practice (EBP).** Evidence-based practices are referenced by footnotes throughout the textbook. To promote the development of digital literacy, hyperlinks are provided to credible, free online resources that supplement content. The Open RN textbooks will be updated as new EBP is established and after the release of updated NCLEX Test Plans every three years.
- **Clinical Judgment.** Associated unfolding case studies are written to reflect the NCSBN Clinical Judgment Measurement Model used on the NCLEX-RN. Formative assessments encourage students to recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action, and evaluate outcomes.[11]
- **Cultural Competency.** Nurses have an ethical obligation to practice with cultural humility and provide culturally responsive care to the clients and communities they serve based on the ANA Code of Ethics[12] and the ANA Scope and Standards of Practice.[13]
- **Safe, Quality, Patient-Centered Care.** Content reflects the priorities of safe, quality, patient-centered care.
- **Clear and Inclusive Language.** Clear language is used based on preferences expressed by prelicensure nursing students to enhance understanding of complex concepts.[14] "They" is used as a singular

11. Dickison, P., Haerling, K. A., & Lasater, K. (2019). Integrating the national council of state boards of nursing clinical judgment model into nursing educational frameworks. *Journal of Nursing Education*. *58*(2), 72-78. https://doi.org/10.3928/01484834-20190122-03

12. American Nurses Association. (2025). *Code of ethics for nurses.* American Nurses Association. https://codeofethics.ana.org/provisions

13. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

14. Verkuyl, M., Lapum, J., St-Amant, O., Bregstein, J., & Hughes, M. (2020).

pronoun to refer to a person whose gender is unknown or irrelevant to the context of the usage, as endorsed by APA style. It is inclusive of all people and helps writers avoid making assumptions about gender.[15]

- **Open-Source Images and Fair Use**. Images are included to promote visual learning. Students and faculty can reuse open-source images by following the terms of their associated Creative Commons licensing. Some images are included based on Fair Use as described in the "Code of Best Practices for Fair Use and Fair Dealing in Open Education" presented at the OpenEd 2020 conference. Refer to the footnotes of images for source and licensing information throughout the text.
- **Open Pedagogy.** Students are encouraged to contribute to the Open RN project in meaningful ways by reviewing content for clarity and assisting in the creation of open-source images.[16]

Supplementary Materials

Several supplementary resources are provided with this textbook:

- Links to supplementary videos promote student understanding of concepts and procedures.
- Online, interactive, and written learning activities in every chapter provide immediate formative feedback.
- Critical thinking questions encourage the development of clinical judgment as students apply content to authentic client care scenarios.

Healthcare students' use of an e-textbook open educational resource on vital sign measurement: A qualitative study. *Open Learning: The Journal of Open, Distance and e-Learning*. https://doi.org/10.1080/02680513.2020.1835623

15. American Psychological Association. (2021). *Singular "They."* https://apastyle.apa.org/style-grammar-guidelines/grammar/singular-they

16. The Open Pedagogy Notebook by Steel Wagstaff is licensed under CC BY 4.0

- Formative Next Generation-style case studies are provided in every chapter to help students prepare for the NCLEX-RN.
- Free downloadable textbook versions can be downloaded from the home page for offline use.
- Affordable soft cover print versions can be purchased from Kendall-Hunt Publishing Company

PART I

CHAPTER 1 FOUNDATIONAL MENTAL HEALTH CONCEPTS

1.1 Introduction

Learning Objectives

- Identify safety/protective interventions for the client and others
- Identify safety/protective concerns for the nurse
- Explain various mental health treatment approaches
- Support diversity across the lifespan in client-centered care

Mental health is an important part of everyone's overall health and well-being. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood to adolescence and through adulthood.[1] This chapter will provide an overview of mental health, mental illness, and mental health nursing. As with all areas of nursing, when caring for a person with a mental health diagnosis, it is important to focus on client-centered care and evaluate the effectiveness of care in terms of the highest level of functioning that person is able to achieve.

Reflective Questions

1. Centers for Disease Control and Prevention. (2025). *About mental health*. https://www.chttps://www.cdc.gov/mental-health/about/index.htmldc.gov/mental-health/?CDC_AAref_Val=https://www.cdc.gov/mentalhealth/index.htm

As we begin this chapter, reflect on the following questions:

1. How do you define mental health?
2. How do you define mental illness?
3. How can you tell the difference between someone experiencing general mental health challenges and someone with a mental illness by looking at how they function day to day?
4. Consider how you communicate with clients. Taking into consideration individual differences, which therapeutic communication techniques have you found to be the most effective? What factors have you found interfere with effective communication, and how do you address them in practice?
5. How does ineffective communication impact client care? How can it affect your nursing license or create legal implications?

1.2 Mental Health and Mental Illness

Mental health is an essential component of health. The World Health Organization (WHO) defines **health** as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. **Mental health** is a state of well-being in which an individual realizes their own abilities, copes with the normal stresses of life, works productively, and contributes to their community. The promotion, protection, and restoration of mental health is a vital concern of individuals, nurses, communities, and societies throughout the world.[1]

According to the American Psychiatric Association, **mental illness** is a health condition involving changes in emotion, thinking, or behavior (or a combination of these) associated with emotional distress and problems functioning in social, work, or family activities.[2] The term mental illness is an older term that is often used interchangeably with mental health disorders. The term mental health disorders is a more modern clinical term used in diagnostic manuals like the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)*.

Mental illness is common in the United States. Nearly one in five (19 percent) of adults experience some form of mental illness, one in twelve (8.5 percent) have a substance use disorder, and one in 24 (4 percent) have a serious mental illness.[3]

1. World Health Organization. (2018). *Mental health: Strengthening our response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
2. American Psychiatric Association. (n.d.). *What is mental illness?* https://www.psychiatry.org/patients-families/what-is-mental-illness
3. American Psychiatric Association. (n.d.). *What is mental illness?* https://www.psychiatry.org/patients-families/what-is-mental-illness

Mental health disorders increase the risk of chronic physical illnesses, such as heart disease, diabetes, respiratory diseases, cancer, and strokes, and can lead to thoughts and intentions of suicide.[4] Suicide is a common symptom associated with mental illness and is the second leading cause of death in Americans aged 15-34.[5]

View the following YouTube video on An Update About WHO's Special Initiative on Mental Health[6]: WHO Special Initiative on Mental Health: An update on the latest figures, learnings, and challenges

Mental Health Continuum

Mental health fluctuates over the course of an individual's life span and can

4. Scott, K. M., Lim, C., Al-Hamzawi, A., Alonso, J., Bruffaerts, R., Caldas-de-Almeida, J. M., Florescu, S., de Girolamo, G., Hu, C., de Jonge, P., Kawakami, N., Medina-Mora, M. E., Moskalewicz, J., Navarro-Mateu, F., O'Neill, S., Piazza, M., Posada-Villa, J., Torres, Y., & Kessler, R. C. (2016). Association of mental disorders with subsequent chronic physical conditions: World mental health surveys from 17 countries. *JAMA Psychiatry, 73*(2), 150-8. https://doi:10.1001/jamapsychiatry.2015.2688.

5. Centers for Disease Control and Prevention. (2025). *About mental health*. https://www.cdc.gov/mental-health/about/index.html

6. World Health Organization. (2023, December 6). *WHO special initiative on mental health: An Update on the latest figures, learnings, and challenges* [Video]. YouTube. All rights reserved. https://youtu.be/ti7OIMq7V9I

range from well-being to emotional problems and/or mental illness as indicated on the **mental health continuum** illustrated in Figure 1.1.[7,8,9]

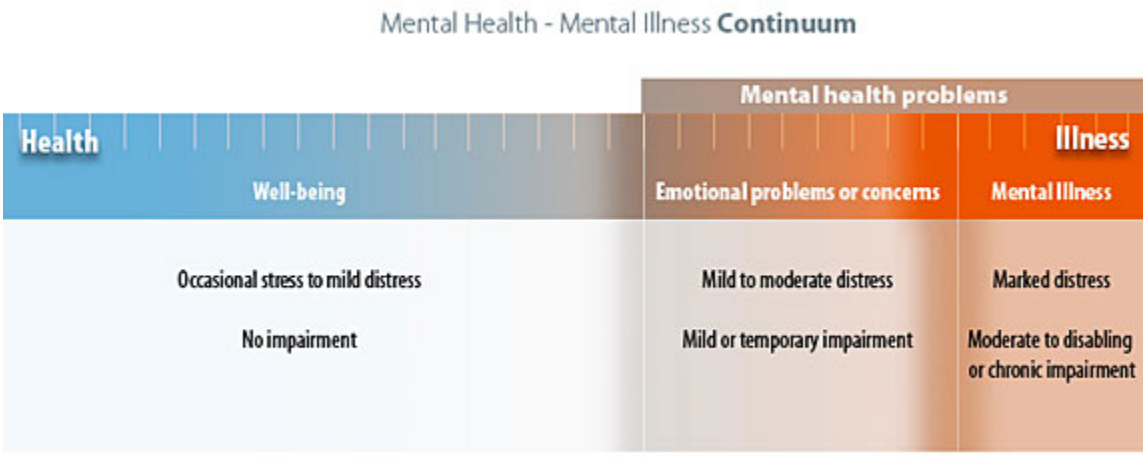

Figure 1.1 Mental Health Continuum (Used with permission.)

Well-being is in the "healthy" range of the mental health continuum in which individuals are experiencing a state of good mental and emotional health. They may experience stress and discomfort resulting from occasional

7. "continuum.jpg" by University of Michigan is used with permission. Access the original at https://hr.umich.edu/benefits-wellness/health-well-being/mhealthy/faculty-staff-well-being/mental-emotional-health/mental-emotional-health-classes-training-events/online-tutorial-supervisors/section-1-what-you-need-know-about-mental-health-problems-substance-misuse

8. William, S. (2021). The continuum between temperament and mental illness as dynamical phases and transitions. *Frontiers in Psychiatry, 11*, 1617. https://doi.org/10.3389/fpsyt.2020.614982

9. University of Michigan Human Resources. (n.d.). *Section 1: What you need to know about mental health problems and substance misuse*. https://hr.umich.edu/benefits-wellness/health-well-being/mhealthy/faculty-staff-well-being/mental-emotional-health/mental-emotional-health-classes-training-events/online-tutorial-supervisors/section-1-what-you-need-know-about-mental-health-problems-substance-misuse

problems of everyday life, but they are able to cope effectively with these stressors and experience no impairments to daily functioning.

On the other end of the mental health continuum are mental health problems where individuals have progressively more difficulty coping with problems and stressors. Within this range are two categories: emotional problems/concerns and mental illness. For individuals experiencing emotional problems, discomfort has risen to a level of mild to moderate distress, and they are experiencing mild or temporary impairments in functioning, such as insomnia, lack of concentration, or loss of appetite. As their level of distress increases, they may seek treatment and often start with visiting their primary health care provider.

Emotional problems are classified as a mental illness when a person experiences significant distress, along with moderate to severe impairment in daily functioning at work, school, or home. This diagnosis is made when the individual meets specific clinical criteria and their symptoms cannot be better explained by a medical condition or substance use. Mental illness includes relatively common disorders, such as depression and anxiety, as well as less common disorders such as schizophrenia. Mental illness is characterized by alterations in thinking, mood, or behavior. The term **serious mental illness** refers to mental illness that causes disabling functional impairment that substantially interferes with one or more major life activities. The Americans With Disabilities Act defines **major life activities** as, "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working."[10] Examples of serious mental illnesses that commonly interfere with major life activities include major

10. Office of Federal Contract Compliance Programs. (2009). *ADA Amendments Act of 2008 frequently asked questions*. U.S. Department of Labor. https://www.dol.gov/general/topic/disability/ada

depressive disorder, schizophrenia, and bipolar disorder.[11] Individuals with serious mental illnesses may experience long-term impairments ranging from moderate to disabling in nature, but many can lead productive lives with effective treatment. For example, roughly half of schizophrenia clients recovered or significantly improved over the long-term, suggesting that functional remission is possible.[12,13]

Mental health providers, such as psychiatrists, psychologists, therapists, social workers, or advanced practice mental health nurses, use the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR*) published by the American Psychiatric Association to assess a client's signs and symptoms and determine a mental health diagnosis. The manual lists diagnostic criteria including feelings, behaviors, and time frames to be officially classified as a mental health disorder.[14]

While the exact number of mental health disorders can vary slightly depending on the classification system used, the DSM-5-TR lists approximately 157 distinct disorders.[15] People can experience different types of

11. American Psychiatric Association. (n.d.). *What is mental illness?* https://www.psychiatry.org/patients-families/what-is-mental-illness

12. Vita, A., & Barlati, S. (2018). Recovery from schizophrenia: Is it possible? *Current Opinion in Psychiatry, 31*(3), 246–255. https://doi.org/10.1097/YCO.0000000000000407

13. Rakitzi, S., Georgila, P., & Becker-Woitag, A. P. (2021). The recovery process for individuals with schizophrenia in the context of evidence-based psychotherapy and rehabilitation: A systematic review. *European Psychologist, 26*(2), 96–111. https://doi.org/10.1027/1016-9040/a000400

14. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR*.

15. Borgogna, N. C., Owen, T., & Aita, S. L. (2024). The absurdity of the latent

mental health disorders, and different disorders can occur at the same time or vary in intensity over time. Mental illness can be ongoing, occur over a short period of time, or be episodic (i.e., it comes and goes with discrete beginnings and ends).[16]

> Read more information about specific mental health disorders at the Medline Plus *Mental Health and Behavior* webpage.

Assessing Dysfunction and Impairment

Mental health disorders have been defined as a type of dysfunction that causes distress or impaired functioning and deviates from typical or expected behavior according to societal or cultural standards. This definition includes three components referred to as dysfunction, distress, and deviance.[17]

Dysfunction includes disturbances in a person's thinking, emotional regulation, or behavior that reflects significant dysfunction in psychological, biological, or developmental processes underlying mental functioning. In other words, dysfunction refers to a breakdown in cognition, emotion, and/or behavior. For instance, an individual experiencing the delusion of being an all powerful deity demonstrates a breakdown in cognition, as their thought processes are disconnected from reality. An individual who is unable to

disease model in mental health: 10,130,814 ways to have a DSM-5-TR psychological disorder. *Journal of Mental Health*. *33*(4):451-459. doi: 10.1080/09638237.2023.2278107

16. Centers for Disease Control and Prevention. (2025). *About mental health*. *https://www.cdc.gov/mental-health/about/index.html*

17. Worthy, L. D., Lavigne, T., & Romero, F. (2025). *Culture and psychology*. Maricopa Community College. https://open.maricopa.edu/culturepsychology/

experience pleasure has a breakdown in emotion, and an individual who is unable to leave home and attend work due to fear of having a panic attack is exhibiting a breakdown in behavior.[18]

Distress refers to psychological and/or physical pain. Simply put, distress refers to suffering. For example, the loss of a loved one causes anyone to experience emotional pain, distress, and a temporary impairment in functioning. **Impairment** refers to a limited ability to engage in activities of daily living (i.e., they cannot maintain personal hygiene, prepare meals, or pay bills) or participate in social events, work, or school. Impairment can also interfere with the ability to perform important life roles such as a caregiver, parent, or student.[19]

Deviance refers to behavior that violates social norms or cultural expectations because one's culture determines what is "normal." When a person is described as "deviant," it means they are not following the stated and unstated rules of their society (referred to as **social norms**).[20]

Nurses complete and document initial and ongoing assessments of dysfunction, distress, and behavior associated with an individual's diagnosed mental health disorder. The World Health Organization Disability Assessment Scale (WHODAS) is a recommended tool for assessing impairments resulting from mental illness.[21] The **WHODAS** is a generic assessment instrument that

18. Worthy, L. D., Lavigne, T., & Romero, F. (2025). *Culture and psychology*. Maricopa Community College. https://open.maricopa.edu/culturepsychology/

19. Worthy, L. D., Lavigne, T., & Romero, F. (2025). *Culture and psychology*. Maricopa Community College. https://open.maricopa.edu/culturepsychology/

20. Worthy, L. D., Lavigne, T., & Romero, F. (2025). *Culture and psychology*. Maricopa Community College. https://open.maricopa.edu/culturepsychology/

21. Office of Federal Contract Compliance Programs. (2009). *ADA Amendments Act of 2008 frequently asked questions*. U.S. Department of Labor.

provides a standardized method for measuring health and disability across cultures.[22] The WHODAS assesses functioning in six domains: cognition, mobility, self-care, getting along, life activities, and participation.[23]

> View the WHODAS 2.0 webpage.

The Global Assessment of Functioning (GAF) was historically used to rate the seriousness of a mental illness and measure how symptoms affect an individual's day-to-day life on a scale of 0 to 100. It is an overall (global) measure of how clients are doing and rates psychological, social, and occupational functioning on the continuum from mental well-being to serious mental illness. The higher the score, the better the daily functioning. The GAF was omitted from the *DSM-5-TR* because it had questionable validity

https://www.dol.gov/agencies/ofccp/faqs/americans-with-disabilities-act-amendments

22. World Health Organization. (2012). *Measuring health and disability: Manual for WHO disability assessment schedule (WHODAS 2.0).* [Manual]. https://www.who.int/publications/i/item/measuring-health-and-disability-manual-for-who-disability-assessment-schedule-(-whodas-2.0)

23. National Academies of Sciences, Engineering, and Medicine. (2016). *Measuring specific mental illness diagnoses with functional impairment: Work-shop summary* [PDF]. J. C. Rivard and K. Marton, Rapporteurs. Committee on National Statistics and Board on Behavioral, Cognitive, and Sensory Sciences, Division of Behavioral and Social Sciences and Education. Board on Health Sciences Policy, Institute of Medicine. The National Academies Press. http://elibrary.pcu.edu.ph:9000/digi/NA02/2016/21920.pdf

and reliability, but some government agencies and insurance companies continue to include it in paperwork to assess client functioning.[24]

Recovery

Mental illness is treatable. Research shows that people with mental illness can get better, and many recover completely.[25] The majority of individuals with mental illness continue to function in their daily lives. **Recovery** refers to a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[26] Dimensions that support a life in recovery include the following:

- **Health:** Overcoming or managing one's disease(s), as well as living in a physically and emotionally healthy way
- **Home:** Having a stable and safe place to live
- **Purpose:** Participating in meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors; and the independence, income, and resources to participate in society
- **Community:** Enjoying relationships and social networks that provide support, friendship, love, and hope

Early Signs of Mental Health Problems

Mental health problems are common. We all experience problems and stressors from daily living at the mild end of the mental health continuum,

24. Smith, M. (2025). *What is the global assessment of functioning (GAF) scale?* WebMD. https://www.webmd.com/mental-health/gaf-scale-facts

25. Centers for Disease Control and Prevention. (2025). *About mental health.* https://www.cdc.gov/mental-health/about/index.html

26. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services.* https://www.ncbi.nlm.nih.gov/books/NBK207201/

and each year one in five Americans experience mental illness.[27] Nurses in all care settings must recognize signs and symptoms of diagnosed and undiagnosed emotional and mental health problems in clients. Each mental health disorder has specific signs and symptoms, but common signs of mental health problems in adults and adolescents are as follows[28]:

- Excessive worrying or fear
- Excessive sad or low feelings
- Confused thinking or problems concentrating and learning
- Extreme mood changes, including uncontrollable "highs" or feelings of euphoria
- Prolonged or strong feelings of irritability or anger
- Avoidance of friends and social activities
- Difficulty understanding or relating to other people
- Changes in sleeping habits or feeling tired and low energy
- Changes in eating habits, such as increased hunger or lack of appetite
- Changes in sex drive
- Disturbances in perceiving reality, referred to as hallucinations (i.e., when a person senses things that don't exist in reality)
- Inability to perceive changes in one's own feelings, behavior, or personality (i.e., lack of insight)
- Misuse of substances like alcohol, drugs, or prescription medications
- Multiple physical ailments without obvious causes (such as headaches, stomachaches, or vague and ongoing "aches and pains")
- Thoughts of suicide
- Inability to carry out daily activities or handle daily problems and stress
- Intense fear of weight gain or being overly concerned with appearance

27. National Alliance on Mental Illness. (2023). *Mental health by the numbers*. https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/

28. National Alliance on Mental Illness. (n.d.). *Warning signs and symptoms*. https://nami.org/About-Mental-Illness/Warning-Signs-and-Symptoms

Mental health problems can also be present in young children. Because children are still learning how to identify and talk about thoughts and emotions, their most obvious symptoms are behavioral or complaints of physical symptoms. Behavioral symptoms in children can include the following[29]:

- Changes in school performance
- Excessive worry or anxiety, for example, fighting to avoid going to bed or school
- Hyperactive behavior
- Frequent nightmares or a marked change in sleeping habits
- Frequent disobedience or aggression
- Frequent temper tantrums

View the following YouTube video about warning signs of mental health problems[30]: 10 Common Warning Signs of a Mental Health Condition

Cultural Impact

Culture is a complex context of knowledge, beliefs, and behaviors that provide structure to specific ethnic, racial, religious, geographic, or social groups. Culture encompasses the personal identity, language, thoughts,

29. National Alliance on Mental Illness. (n.d.). *Warning signs and symptoms*. https://nami.org/About-Mental-Illness/Warning-Signs-and-Symptoms

30. NAMI. (2015, February 2). *10 common warning signs of a mental health condition* [Video]. YouTube. All rights reserved. https://youtu.be/zt4sOjWwV3M

communications, actions, customs, beliefs, values, and institutions of a variety of groups of people, as well as smaller groups of individuals within a larger community. Cultural values and beliefs impact how a person views certain ideas or behaviors. In the case of mental health, it can impact whether or not the individual seeks help, the type of help sought, and the support available. Every individual has different cultural beliefs and faces a unique journey to recovery. In general, historically marginalized communities in the United States are less likely to access mental health treatment, or they wait until symptoms are severe before seeking assistance.[31]

Four ways that culture can impact mental well-being are the following[32]:

- **Cultural stigma.** Every culture has a different perspective on mental health, and many cultures have a stigma surrounding mental health. Mental health challenges may be considered a weakness and something to hide, which can make it harder for those struggling to talk openly and ask for help. For example, in some Asian cultures, mental health challenges are often viewed as a sign of weakness or a failure to meet familial or societal expectations. For instance, a young woman in Japan might experience severe depression due to the pressure of excelling academically and meeting the high standards of her family. She may feel discouraged from openly discussing her condition, believing it reflects poorly on their upbringing or family reputation.
- **Describing symptoms.** Culture can influence how people describe or feel about their symptoms. It can affect whether someone chooses to recognize and talk openly about physical symptoms, emotional

31. Mental Health First Aid. (2019). *Four ways culture impacts mental health.* National Council for Mental Wellbeing. https://www.mentalhealthfirstaid.org/2019/07/four-ways-culture-impacts-mental-health/

32. Mental Health First Aid. (2019). *Four ways culture impacts mental health.* National Council for Mental Wellbeing. https://www.mentalhealthfirstaid.org/2019/07/four-ways-culture-impacts-mental-health/

symptoms, or both. For example, members of the Amish community are typically stoic and endure physical and emotional pain without complaining.

- **Community support.** Cultural factors can determine how much support someone gets from their family and community when it comes to mental health. Because of existing stigma, it can be challenging for individuals to find mental health treatment and support. For example, in a close-knit Latinx community, the value placed on family unity and support is a central cultural norm. A young man begins experiencing anxiety and panic attacks and decides to confide in his family. However, when he brings up the idea of seeking therapy, his parents are skeptical, and a trusted elder—a respected family friend—dismisses the idea, saying that mental health struggles are a sign of personal weakness and can be overcome with willpower.
- **Resources.** When looking for mental health treatment, it can be difficult to find resources and treatment options that take into account a specific culture's concerns and needs. For example, A Somali immigrant living in the United States begins experiencing symptoms of post-traumatic stress disorder (PTSD) due to their experiences during the civil war in their home country. They want to seek help but face several barriers related to their cultural concerns and needs. While they find a few local clinics offering mental health services, none have therapists who are familiar with Somali culture, language, or the unique traumas faced by refugees. The therapists use approaches that the individual feels are disconnected from their values, such as emphasizing individualistic coping mechanisms rather than community-based healing, which is more aligned with their culture.

Nurses can help clients by understanding the role culture plays in their mental health. They should also be aware of how their own culture might impact their perception of their client's mental health status. This represents cultural humility. **Cultural humility** is a lifelong process of self-reflection and self-critique whereby individuals actively engage in learning about different

cultural perspectives while acknowledging the limitations of their own knowledge.

- Read more about cultural diversity and providing culturally responsive care in the "Diverse Patients" chapter of Open RN *Nursing Fundamentals*.
- Read more about improving your cultural competency at "Improving Cultural Competency for Behavioral Health Professionals"

Causes of Mental Illness

Mental health researchers have developed several theories to explain the causes of mental health disorders, but they have not reached consensus. One factor in which they all agree is that an individual is not at fault for the condition, and they cannot simply turn symptoms on or off at will. There are likely several factors that combine to trigger a mental health disorder, including environmental, biological, and genetic factors.[33] Another significant role in the development and exacerbation of mental illness is psychological factors, which include both interpersonal and coping mechanisms. Interpersonal conflicts include chronic interpersonal stress, such as disagreements, rejections, and feeling let down, can significantly contribute to mental health issues. These stressors are associated with increased negative affect, which in turn can lead to various health problems, including

33. University of Michigan Human Resources. (n.d.). *Section 1: What you need to know about mental health problems and substance misuse*. https://hr.umich.edu/benefits-wellness/health-well-being/mhealthy/faculty-staff-well-being/mental-emotional-health/mental-emotional-health-classes-training-events/online-tutorial-supervisors/section-1-what-you-need-know-about-mental-health-problems-substance-misuse

anxiety and depression. Interpersonal problems are particularly impactful in conditions like anxious depression, where dysfunctional attitudes mediate the relationship between interpersonal stress and anxiety symptoms. An individual's coping mechanisms reflect the way a person deals with stress and adversity. Coping mechanisms can either mitigate or exacerbate mental health problems. Mal-adaptive coping strategies, such as emotion-focused coping, can worsen psychological distress and increase the likelihood of mental disorders.[34]

Environmental Factors

Individuals are affected by broad social and cultural factors, as well as by unique factors in their personal environments. Social factors such as racism, discrimination, poverty, and violence (often referred to as "social determinants of health") can contribute to mental illness.

> Read more about addressing social determinants of health in the "Advocacy" chapter of Open RN *Nursing Management and Professional Concepts*.

Additionally, it is estimated that 61% of adults have experienced early **adverse childhood experiences (ACEs)** such as abuse, neglect, or growing up in a household with violence, mental illness, substance misuse, incarceration, or divorce. Chronic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems,

34. Woo, J., Whyne, E. Z., & Steinhardt, M. A. (2024). Psychological distress and self-reported mental disorders: The partially mediating role of coping strategies. *Anxiety Stress Coping, 37*(2), 180-191. doi: 10.1080/10615806.2023.2258805

mental illness, and substance misuse in adulthood.[35,36] See Figure 1.2[37] for an image of adverse childhood experiences.

35. University of Michigan Human Resources. (n.d.). *Section 1: What you need to know about mental health problems and substance misuse*. https://hr.umich.edu/benefits-wellness/health-well-being/mhealthy/faculty-staff-well-being/mental-emotional-health/mental-emotional-health-classes-training-events/online-tutorial-supervisors/section-1-what-you-need-know-about-mental-health-problems-substance-misuse

36. National Human Trafficking Training and Technical Assistance Center. (n.d.). *The original ACE study*. https://nhttac.acf.hhs.gov/soar/eguide/stop/adverse_childhood_experiences

37. "ACEs.png" by unknown author for Centers for Disease Control and Prevention is licensed in the Public Domain. Access for free at https://www.cdc.gov/injury/pdfs/priority/ACEs-Strategic-Plan_Final_508.pdf

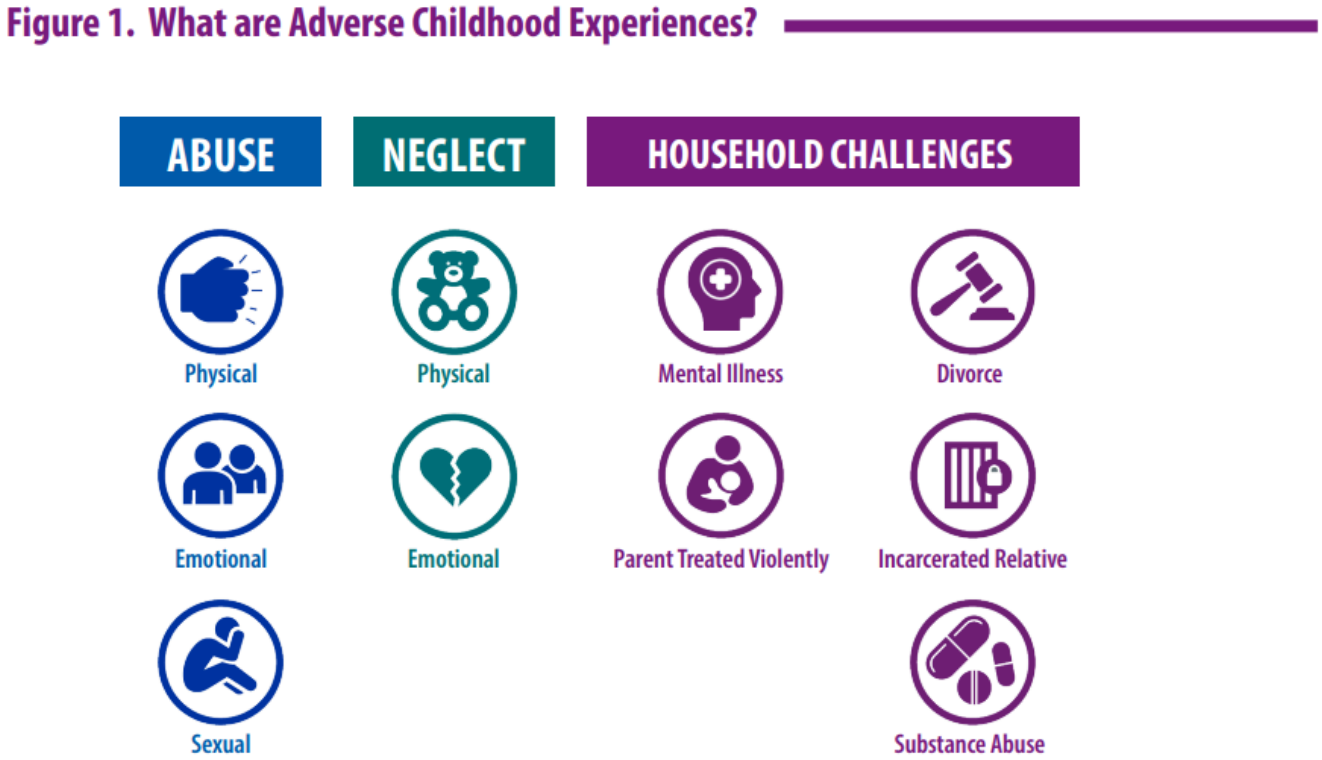

Figure 1.2 Adverse Childhood Experiences (ACEs)

Individual trauma resulting from an event, series of events, or set of circumstances that is experienced as physically or emotionally harmful can have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[38] Read more about ACEs and addressing individual trauma in the "Introduction to Trauma-Informed Care" section of this chapter.

> Visit the following PDF and take the Adverse Childhood

38. U.S. Department of Health & Human Services. (2020). *Strategic goal 3: Strengthen the economic and social well-being of Americans across the lifespan.* https://www.hhs.gov/about/strategic-plan/strategic-goal-3/index.html

> Experiences Questionnaire for Adults to better understand how previous experiences can affect one's well-being.

Current stressors such as relationship difficulties, the loss of a job, the birth of a child, a move, or prolonged problems at work can also be important contributory environmental factors.[39]

> Read more about stress in the "Stress, Coping, and Crisis Intervention" chapter.

Biological Factors

Scientists believe the brain can have an imbalance of neurotransmitters, such as dopamine, acetylcholine, gamma-aminobutyric acid (GABA), norepinephrine, glutamate, and serotonin, resulting in changes in behavior, mood, and thought. While causes of fluctuations in brain chemicals aren't fully understood, contributing factors can include physical illness, hormonal changes, reactions to medication, substance misuse, diet, and stress.[40]

39. University of Michigan Human Resources. (n.d.). *Section 1: What you need to know about mental health problems and substance misuse*. https://hr.umich.edu/benefits-wellness/health-well-being/mhealthy/faculty-staff-well-being/mental-emotional-health/mental-emotional-health-classes-training-events/online-tutorial-supervisors/section-1-what-you-need-know-about-mental-health-problems-substance-misuse

40. University of Michigan Human Resources. (n.d.). *Section 1: What you need to*

> Read more about neurotransmitters and the central nervous system in the "Psychotropic Medications" chapter.

Some studies also suggest that depressive and bipolar disorders are accompanied by immune system dysregulation and inflammation.[41]

Genetics

There appears to be a hereditary pattern to some mental illnesses. For example, individuals with major depressive disorder often have parents or other close relatives with the same illness. Research continues to investigate genes involved in specific disorders so that treatment can be effectively targeted to the individual.[42]

know about mental health problems and substance misuse. https://hr.umich.edu/benefits-wellness/health-well-being/mhealthy/faculty-staff-well-being/mental-emotional-health/mental-emotional-health-classes-training-events/online-tutorial-supervisors/section-1-what-you-need-know-about-mental-health-problems-substance-misuse

41. Kraybill, O. (2019). Inflammation and mental health symptoms. *Psychology Today*. https://www.psychologytoday.com/us/blog/expressive-trauma-integration/201905/inflammation-and-mental-health-symptoms

42. University of Michigan Human Resources. (n.d.). *Section 1: What you need to know about mental health problems and substance misuse*. https://hr.umich.edu/benefits-wellness/health-well-being/mhealthy/faculty-staff-well-being/mental-emotional-health/mental-emotional-health-classes-training-events/online-tutorial-supervisors/section-1-what-you-need-know-about-mental-health-problems-substance-misuse

View the following YouTube video on causes of mental illness[43]: Understanding the Biology of Mental Illness

WHO Guidelines for Mental Health Care

Nurses protect and promote the mental well-being of all individuals and address the needs of individuals diagnosed with mental disorders. The World Health Organization (WHO) published the *Mental Health Intervention Guide* for nurses and primary health care providers that provides evidence-based guidance and tools for assessing and managing priority mental health and substance use disorders using clinical decision-making protocols. Essential principles for providing mental health care include promoting respect and dignity for the individuals seeking care; using effective communication skills to ensure care is provided in a nonjudgmental, non-stigmatizing, and supportive manner; and conducting comprehensive assessments.[44]

Promoting Respect and Dignity

Individuals with mental health and substance use conditions should be treated with respect and dignity in a culturally appropriate manner. Health care professionals should promote the preferences of people with mental health and substance use disorders and support them, their family members, and their loved ones in an inclusive and equitable manner. The following box contains tips discussed in the WHO *Mental Health Intervention Guide*.

43. Alabama Department of Health. (2011, July 29). *Understanding the biology of mental illness* [Video]. YouTube. All rights reserved. https://youtu.be/LLUoG9Se77w .

44. World Health Organization. (2019). mhGAP intervention guide – version 2.0. https://www.who.int/publications/i/item/9789241549790

Tips for Supporting Individuals with Mental Illness[45]

Do:

- Treat people with mental health and substance use conditions with respect and dignity.
- Protect confidentiality.
- Ensure privacy.
- Advocate for individual preferences.
- Provide access to information and explain the proposed treatment risks and benefits in writing when possible.
- Make sure the person provides consent to treatment.
- Promote autonomy and independent living in the community.
- Provide access to decision-making options.

Don't:

- Discriminate against people with mental health and substance use conditions.
- Make decisions for or on behalf of individuals.
- Use overly technical language when explaining proposed treatment.

In addition to the tips discussed in the WHO *Mental Health Intervention Guide*, nurses should approach individuals with compassion and provide emotional support in order to foster dignity and respect in their care of

45. World Health Organization. (2019). mhGAP intervention guide – version 2.0. https://www.who.int/publications/i/item/9789241549790

individuals with mental illness and substance use disorders. It is also important to provide holistic care, focusing on treating the unique needs of the individual and acknowledging their unique experience. Nurses should also refrain from imposing their personal or cultural values on their clients.

Using Effective Communication Skills

Using effective communication skills promotes quality mental health care for all individuals. Tips for effective communication from the WHO *Mental Health Intervention Guide* are described in the following box.

Effective Communication Tips for Quality Mental Health Care[46]

- **Create an environment that facilitates open communication.**
    - Meet the person in a private space, if possible.
    - Be welcoming and conduct introductions in a culturally appropriate manner.
    - Use culturally appropriate eye contact, body language, and facial expressions that facilitate trust.
    - Explain to adults that information discussed during the visit will be kept confidential. (Special considerations regarding "conditional confidentiality" and mandatory reporting for minors are discussed in the "Childhood and

46. World Health Organization. (2019). mhGAP intervention guide – version 2.0. https://www.who.int/publications/i/item/9789241549790

Adolescence Disorders" chapter.)
    - If caregivers are present, suggest speaking with the client alone (except for young children) and obtain consent from the client to share clinical information.
    - When interviewing a young person, consider having another person present who identifies with the same gender to maintain feelings of a psychologically safe environment.

- **Involve the person.**
    - Include the person (and with their consent, their caregivers and family members) in all aspects of assessment and management as much as possible. This includes children, adolescents, adults, and older adults.

- **Start by listening.**
    - Actively listen. Be empathic and sensitive. (Read more about active listening in the "Therapeutic Communication and the Nurse-Client Relationship" chapter.)
    - Allow the person to speak without interruption.
    - Be patient and ask for clarification of unclear information.
    - For children, use language that they can understand. For example, ask about their interests (toys, friends, school, etc.).
    - Convey that you understand their feelings and situation.

- **Be friendly, respectful, and nonjudgmental.**
    - Always be respectful.
    - Be nonjudgmental about an individual's behaviors and appearances.
    - Remain calm and professional.
- **Use good verbal communication skills.**
    - Use simple language. Be clear and concise. Avoid medical terminology only understood by health care professionals.
    - Use open-ended questions and other therapeutic communication techniques. (Read more about specific techniques in the "Therapeutic Communication and the Nurse-Client Relationship" chapter.) For example:
        - Use open-ended questions: "Tell me more about what happened?"
        - Summarize: "So, your brother pushed you off your bike and then laughed when you fell and started crying?"
        - Clarify: "To clarify, were you at home or a neighbor's house when this happened?"
    - Summarize and repeat key points at the end of the conversation.
    - Allow the person to ask questions about the information provided. For example, "What questions do you have about what we have

discussed today?"

- **Respond with sensitivity when people disclose traumatic experiences (e.g., sexual assault, violence, or self-harm).**
    - Thank the person for sharing this sensitive information.
    - Show extra sensitivity when discussing difficult topics.
    - Remind the person that what they tell you will only be shared with the immediate treatment team to provide the best possible care.
    - Acknowledge that it may have been difficult for the person to disclose the information.

THERAPEUTIC RELATIONSHIP

In all nursing care, the therapeutic relationship with the client is essential. This is especially so in psychiatric care, where the therapeutic relationship is considered to be the foundation of client care and healing.[47] Although nurse generalists are not expected to perform advanced psychiatric interventions, all nurses are expected to engage in compassionate, supportive relationships

47. Ross, C. A., & Goldner, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*(6), 558-567. https://doi.org/10.1111/j.1365-2850.2009.01399.x

with their clients and use therapeutic communication as part of the "art of nursing."[48]

The nurse-client relationship establishes trust and rapport with a specific purpose. It facilitates therapeutic communication and engages the client in decision-making regarding their plan of care. Read more about therapeutic communication and the nurse-client relationship in the "Therapeutic Communication and the Nurse-Client Relationship" chapter.

Conducting Comprehensive Assessments

Clients undergo comprehensive assessments related to their disorder, including mental status examination, psychosocial assessment, physical examination, and review of laboratory results. Specific nursing assessments are further discussed in the "Application of the Nursing Process in Mental Health Care" chapter as well in each "Disorder" chapter. Persons with severe mental health and substance use disorders are two to three times more likely to die of preventable disease like infections and cardiovascular disorders, so it is also important for nurses to advocate for the medical treatment of existing physical disorders.[49]

View the WHO's Mental Health Gap Intervention Guide.

48. Centers for Disease Control & Prevention. (2025). *Managing stress*. https://www.cdc.gov/mental-health/living-with/index.html

49. World Health Organization. (2019). mhGAP intervention guide – version 2.0. https://www.who.int/publications/i/item/9789241549790

1.3 Introduction to Trauma-Informed Care

Individuals may experience trauma during their lifetimes that can have a lasting impact on their mental health. **Trauma** results from an event, series of events, or set of circumstances that are experienced by an individual as physically or emotionally harmful and can have lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. Events may be human-made, such as war, terrorism, sexual abuse, violence, or medical trauma; or they can be the products of nature (e.g., flooding, hurricanes, and tornadoes).

It's not just the event itself that determines if it is traumatic, but the individual's experience of the event. Two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways. Various biopsychosocial and cultural factors influence an individual's immediate response and long-term reactions to trauma. For example, one's personal history, support system, coping mechanisms, personality traits, age and developmental stage, etc. all can influence trauma response. For most individuals, regardless of the severity of the trauma, the effects of trauma are met with **resilience**, defined as the ability to rise above circumstances or meet challenges with fortitude. Resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events.[1]

Trauma can affect people of any culture, age, gender, or sexual orientation. Individuals may also experience trauma even if the event didn't happen to them. A traumatic experience can be a single event, a series of events, or adverse childhood experiences (ACEs). Review information about ACEs in the "Mental Health and Mental Illness" section of this chapter. There has been an increased focus on the ways in which trauma, psychological distress, quality of life, health, mental illness, and substance misuse are linked. For example, the

1. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services*. https://www.ncbi.nlm.nih.gov/books/NBK207201/

terrorist attacks of September 11, 2001, the wars in Iraq and Afghanistan, disastrous hurricanes, and the COVID pandemic have moved traumatic experiences to the forefront of national consciousness. Trauma can affect individuals, families, groups, communities, specific cultures, and generations. It can overwhelm an individual's ability to cope; stimulate the "fight, flight, or freeze" stress reaction; and produce a sense of fear, vulnerability, and helplessness.[2]

> Read more information about the stress reaction in the "Stress, Coping, and Crisis Intervention" chapter.

For some people, reactions to a traumatic event are temporary, whereas other people have prolonged reactions to trauma with enduring mental health consequences, such as post-traumatic stress disorder, anxiety disorder, substance use disorder, mood disorder, or psychotic disorder. Others may exhibit culturally mediated physical symptoms referred to as **somatization**, in which psychological stress is expressed through physical concerns such as chronic headaches, pain, and stomachaches. Traumatic experiences can significantly impact how an individual functions in daily life and how they seek medical care.[3] Nurses must keep in mind to not interject their own experiences or perspectives because something minor to them may be major to the client.

Individuals may not recognize the significant effects of trauma or may avoid the topic altogether. Likewise, nurses may not ask questions that elicit a

2. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services*. https://www.ncbi.nlm.nih.gov/books/NBK207201/
3. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services*. https://www.ncbi.nlm.nih.gov/books/NBK207201/

client's history of trauma. They may feel unprepared to address trauma-related issues proactively or struggle to effectively address traumatic experiences within the constraints of their agency's policies.[4]

By recognizing that traumatic experiences are closely tied to mental health, nurses can provide trauma-informed care and promote resilience. **Trauma-informed care (TIC)** is a strengths-based framework that acknowledges the prevalence and impact of traumatic experiences in clinical practice. TIC emphasizes physical, psychological, and emotional safety for both survivors and health professionals and creates opportunities for survivors to rebuild a sense of control and empowerment (i.e., resilience).[5] TIC acknowledges that clients can be retraumatized by unexamined agency policies and practices and stresses the importance of providing client-centered care rather than applying general treatment approaches.[6]

TIC enhances therapeutic communication between the client and the nurse. It decreases risks associated with misunderstanding clients' reactions or underestimating the need for referrals for trauma-specific treatment. TIC encourages client-centered care by involving the client in setting goals and planning care that optimizes therapeutic outcomes and minimizes adverse effects. Clients are more likely to feel empowered, invested, and satisfied when they receive TIC.[7]

4. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services.* https://www.ncbi.nlm.nih.gov/books/NBK207201/
5. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services.* https://www.ncbi.nlm.nih.gov/books/NBK207201/
6. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services.* https://www.ncbi.nlm.nih.gov/books/NBK207201/
7. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services.* https://www.ncbi.nlm.nih.gov/books/NBK207201/

Implementing TIC requires specific training, but it begins with the first contact a person has with an agency. It requires all staff members (e.g., receptionists, direct client-care staff, nurses, supervisors, and administrators) to recognize that an individual's traumatic experiences can greatly influence their receptivity and engagement with health services. It can affect their interactions with staff, as well as their responsiveness to care plans and interventions.[8]

View the following YouTube video on trauma-informed approach to health care[9]: Dr. Pickens Explains Trauma-Informed Approach

Read more details about trauma-informed care (TIC) in the "Trauma, Abuse, and Violence" chapter.

8. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services.* https://www.ncbi.nlm.nih.gov/books/NBK207201/

9. Washington State Health Care Authority. (2019, June 24). *Dr. Pickens explains trauma-informed approach* [Video]. YouTube. All rights reserved. https://youtu.be/6syEFO4OSFU

1.4 Stigma

Despite a recent focus on mental health in the United States, there are still many harmful attitudes and misunderstandings surrounding mental illnesses that can cause people to ignore their mental health and make it more difficult for them to reach out for help.[1,2] **Stigma** has been defined as a cluster of negative attitudes and beliefs that motivates the general public to fear, reject, avoid, and discriminate against people with mental health disorders.[3]

It estimated that nearly two-thirds of people with diagnosable mental health disorders do not seek treatment due to the stigma of mental illness. The *U.S. Surgeon General's Report* in 1999 was a milestone report that sought to dispel the stigma of mental illness and its impact on those seeking care.[4] The National Alliance on Mental Illness (NAMI) seeks to improve the lives of those

1. Centers for Disease Control and Prevention. (2025). *Mental health stigma*. https://www.cdc.gov/mental-health/stigma/

2. Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 1*(1), 16-20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489832/

3. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2004). *School materials for a mental health friendly classroom: Training package* [PDF]. SAMHSA Pub. No. P040478M. Substance Abuse and Mental Health Services Administration. https://www.prevention.org/Resources/2e2ba6ce-1e47-40ec-b49d-f7952b1f95a1/School%20Materials%20for%20a%20Mental%20Health%20Friendly%20Classroom.pdf

4. Hegner, R. E. (2000). Dispelling the myths and stigma of mental illness: The surgeon general's report on mental health. *Issue Brief*, 754. https://www.ncbi.nlm.nih.gov/books/NBK559750/

with mental illness and reduce stigma through education, support, and advocacy. NAMI encourages people to share their stories to discredit stereotypes, break the silence, and document discrimination.[5]

> View SAMHSA's Mental Health: Get the Facts to review myths and facts about mental health

However, stigma and negative attitudes toward mental illness can still be found among nurses. A review of nursing literature by Ross and Golder explored negative attitudes and discrimination towards mental illness in the nursing profession. Several studies from a variety of countries indicated that health care professionals can be classified in three categories in relation to stigma, including "'stigmatizers," "the stigmatized," and "de-stigmatizers." "Stigmatizers" refer to nurses in medical settings with stereotypical attitudes towards clients with mental illnesses, psychiatric-mental health nurses, and/or psychiatry. Nurses classified as "the stigmatized" have mental health disorders or perceive stigma regarding their roles as psychiatric-mental health nurses. "De-stigmatizers" actively work to reduce stigma surrounding mental health disorders. The authors found that many nurses share commonly held stereotypical beliefs portrayed in the media. For example, clients with mental health disorders have been portrayed in the media as dangerous, unpredictable, violent, or bizarre, and these portrayals can cause fearful attitudes. Nurses in the studies were also concerned about inadvertently saying or doing "the wrong thing" or "setting off" uncontrollable behavior. Many nurses in general medical settings felt they lacked the skills to confidently and competently manage behavioral symptoms of clients with mental health disorders. The authors of the review reported that nursing

5. Abderholden, S. (2019). *It's not stigma, it's discrimination* [Blog]. National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/March-2019/It-s-Not-Stigma-It-s-Discrimination

literature supports additional mental health education for entry-level nurses and practicing nurses to enhance their knowledge base on mental health.[6]

Nurses can reduce stigma and advocate for a client's needs and dignity by establishing a therapeutic nurse-client relationship. Nursing actions that can be taken include participating in or facilitating training on mental health awareness as well providing education and awareness about mental health disorders to clients, families, and communities. A therapeutic nurse-client relationship is essential in all settings, but it is especially important in mental health care where the therapeutic relationship is considered the foundation of client care and healing. Although nurse generalists are not expected to perform advanced psychiatric-mental health nursing interventions, all nurses are expected to engage in compassionate, supportive relationships with their clients.[7] In fact, in *Nursing: Scope and Standards of Practice (2021)*, the American Nurses Association states, "The nursing profession, rooted in caring relationships, demands that nurses reflect unconditional positive regard for every patient."[8]

6. Ross, C. A., & Goldner, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*(6), 558-567. https://doi.org/10.1111/j.1365-2850.2009.01399.x

7. Ross, C. A., & Goldner, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*(6), 558-567. https://doi.org/10.1111/j.1365-2850.2009.01399.x

8. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

- Read more about establishing a therapeutic nurse-client relationship in the "Therapeutic Communication and the Nurse-Client Relationship" chapter.

The first step in resolving stigma is to become aware of one's personal beliefs. Take the survey in the following box to become more aware of your own attitudes and biases toward mental health care.

- Visit the following PDF document and take the Personal Attitudes Survey (page 8) from the Mental Health and High School Curriculum Guide by the Canadian Mental Health Association.

1.5 Boundaries

Boundaries are limits we set as individuals that define our levels of comfort when interacting with others. Personal boundaries include limits in physical, sexual, intellectual, emotional, material, and financial areas of our lives. Boundaries promote psychological safety in relationships at work, home, and with partners by protecting one's well-being and limiting the stress response. For example, if you come away from a meeting or conversation with someone feeling depleted, anxious, or tense, consider if your boundaries were crossed. A lack of healthy personal boundaries can lead to emotional and physical fatigue.[1]

Five major types of personal boundaries include the following[2]:

- **Physical:** Physical boundaries refer to one's personal space, privacy, and body. For example, some people are comfortable with public displays of affection (hugs, kisses, and hand-holding), while others prefer not to be touched in public.
- **Sexual:** Sexual boundaries refer to one's comfort level with intimacy and attention of a sexual nature. This can include sexual comments and touch, not just sexual acts.
- **Intellectual:** Intellectual boundaries refer to one's thoughts and beliefs. Intellectual boundaries are not respected when someone dismisses another person's ideas and opinions.
- **Emotional:** Emotional boundaries refer to a person's feelings. For example, an individual might not feel comfortable sharing feelings with

1. Pattemore, C. (2021). *10 ways to build and preserve better boundaries*. PsychCentral. https://psychcentral.com/lib/10-way-to-build-and-preserve-better-boundaries#types

2. Pattemore, C. (2021). *10 ways to build and preserve better boundaries*. PsychCentral. https://psychcentral.com/lib/10-way-to-build-and-preserve-better-boundaries#types

another person and prefer to share information gradually over time.
- **Material:** Physical and financial limits that we set around our personal possessions, space, and resources.
- **Financial:** Financial boundaries refer to how one prefers to spend or save money.

When caring for clients with mental health disorders, it is common to notice problems with setting appropriate boundaries. For example, a client experiencing bipolar disorder may exhibit a lack of financial and sexual boundaries. When they are experiencing a manic episode, they may spend thousands of dollars on a credit card over a weekend or have sexual relations with someone they just met. Another example of boundary issues is an individual with a depressive disorder who is treated poorly by their partner but does not leave or assert boundaries because they don't feel that they deserve to be treated any better.

Nurses must establish professional boundaries with all clients while also maintaining a respectful and caring relationship. Due to their professional role, nurses have authority and access to sensitive information that can make clients feel vulnerable. *A Nurses Guide to Professional Boundaries* by the National Council of State Boards of Nursing (NCSBN) states that it is the nurse's responsibility to use clinical judgment to determine and maintain professional boundaries. Nurses should limit self-disclosure of personal information and avoid situations where they have a personal or business relationship with a client. The difference between a caring nurse-client relationship and an over-involved relationship can be difficult to discern, especially in small communities or in community health nursing where roles may overlap. In these circumstances, it is important for the nurse to openly acknowledge their dual relationship and emphasize when they are performing in a professional capacity. Signs of inappropriate boundaries include the following[3]:

3. National Council of State Boards of Nursing. (2025). *Professional boundaries.*

- Self-disclosing intimate or personal issues with a client
- Engaging in behaviors that could be interpreted as flirting
- Keeping secrets with a client
- Believing you are the only one who truly understands or can help the client
- Spending more time than is necessary with a particular client
- Speaking poorly about colleagues or your employment setting with the client and/or their family
- Showing favoritism to a particular client
- Meeting a client in settings outside of work
- Contacting a client and/or their family members using social media
- Developing a social or romantic relationship with a client
- Sharing personal contact information
- Displaying excessive emotional attachment to the client
- Sharing confidential information about the client with unauthorized individuals.
- Making treatment decisions based on personal feelings rather than client needs

Establishing professional boundaries with clients diagnosed with mental health disorders is essential due to the vulnerability of the client population, as well as the behavioral manifestations of some disorders. For safety purposes, all healthcare workers should keep their last name, home address, personal telephone number, and social media handles private.

View the NCSBN video: "Professional Boundaries in Nursing."

https://www.ncsbn.org/nursing-regulation/practice/professional-boundaries.page

- Read *A Nurse's Guide to Professional Boundaries* PDF from the National Council of State Boards of Nursing (NCSBN)

1.6 Establishing Safety

Suicidal thoughts are a common symptom of mental health disorders and typically resolve with effective treatment. However, despite increased national attention on mental health care and efforts to reduce stigma, there has been no significant decline in suicide rates in the United States. Suicide remains a leading cause of death nationwide, highlighting the persistent gap between awareness and measurable outcomes.[1] Given this reality, establishing a safe and supportive environment for individuals experiencing suicidal ideation is not only a clinical priority but also a moral imperative. This includes consistent risk assessments, staff training, safety planning, and reducing access to lethal means, all of which are essential strategies for suicide prevention in health care and community settings.

Recognizing Risk Factors for Suicide

Everyone can help prevent suicide by recognizing risk factors for suicide and intervening appropriately. Warning signs of suicide include client statements or nurse observations of the following[2]:

- Previous suicide attempt(s)
- History of depression or other mental illness
- Serious illness or chronic pain
- Criminal/legal problems
- Job/financial problems or loss
- Impulsive or aggressive tendencies

1. The Joint Commission. (2025). *Behavioral health care and human services: National patient safety goals.* https://www.jointcommission.org/standards/national-patient-safety-goals/behavioral-health-care-national-patient-safety-goals/

2. Centers for Disease Control and Prevention. (2024). *Risk and protective factors for suicide*. https://www.cdc.gov/suicide/risk-factors/

- Substance use
- Current or prior history of adverse childhood experiences
- Sense of hopelessness
- Violence victimization or perpetration

See Figure 1.3[3] for five action steps for anyone to take to prevent suicide in someone experiencing suicidal thoughts or ideations. Nurses can educate others to take the following steps if they believe someone may be in danger of suicide[4]:

- Call 911 if danger for self-harm seems imminent.
- Ask the person if they are thinking about killing themselves. Although asking this question can feel invasive, it is common for individuals with mental health problems to share their thoughts and plans regarding suicide. Asking them about suicide will not "put the idea into their head" or make it more likely that they will attempt suicide. In fact, by responding appropriately, you can help save their life by asking this question.
- Listen without judging and show you care.
- Stay with the person or make sure the person is in a private, secure place with another caring person until you can get further help.
- Remove any objects that could be used in a suicide attempt.
- Call or text 988 to reach the new nationwide Suicide and Crisis Line for a direct connection with compassionate, accessible care and support for anyone experiencing mental health-related distress.

3. "5actionsteps_t.jpg" by unknown author for National Institute of Mental Health is licensed in the Public Domain. Access for free at https://www.nimh.nih.gov/health/topics/suicide-prevention

4. Substance Abuse and Mental Health Services Administration. (2021). *Help prevent suicide.* https://www.samhsa.gov/suicide

Figure 1.3 Preventing Suicide

Establishing a Safe Care Environment for Clients

In addition to encouraging these general action steps to prevent suicide, nurses can further prevent suicide by establishing a safe care environment. Establishing a safe care environment is a priority nursing intervention.

Reducing the risk for suicide is one of the National Patient Safety Goals for Behavioral Health Care established by The Joint Commission. New requirements were established in 2020 that apply to clients in psychiatric hospitals, clients being evaluated or treated for behavioral health conditions as their primary reason for care in general hospital units or critical access hospitals, and all clients who express **suicidal ideation** during their course of care.[5] These requirements include performing an environmental risk assessment, screening for suicidal ideation, assessing suicide risk, documenting risk of suicide, developing a safety plan, following evidence-based written policies and procedures, providing information on follow-up

5. The Joint Commission. (2025). *Behavioral health care and human services: National patient safety goals*. https://www.jointcommission.org/standards/national-patient-safety-goals/behavioral-health-care-national-patient-safety-goals/

care on discharge, and monitoring effectiveness of these actions in preventing suicides. These requirements are discussed in further detail in the following subsections.[6]

> Read more about suicide prevention at Joint Commission's Suicide Prevention webpage.

Perform Environmental Risk Assessment

An **environmental risk assessment** identifies physical environment features that could be used by clients to attempt suicide. Nurses implement actions to safeguard individuals identified at a high risk of suicide from environmental risks, such as continuous monitoring, routinely removing objects from rooms that could be used for self-harm, assessing objects brought into a facility by clients and visitors, and using safe transportation procedures when moving clients to other parts of the hospital.

In psychiatric hospitals and on psychiatric units within general hospitals, additional measures are taken to prevent suicide by hanging by removing anchor points, door hinges, and hooks. The Veteran's Health Administration showed that the use of a Mental Health Environment of Care Checklist to facilitate a thorough, systematic environmental assessment reduced the rate of suicide from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions.[7]

6. The Joint Commission. (2019). *R3 report | Requirement, rationale, reference* [PDF]. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf
7. The Joint Commission. (2019). *R3 report | Requirement, rationale, reference* [PDF]. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf

- Read more about the VA Mental Health at the Mental Health Environment of Care Checklist (MHEOCC) webpage[8]

Screen for Suicidal Ideation with a Validated Tool

Clients being evaluated or treated for mental health conditions often have suicidal ideation (i.e., thoughts of killing themselves). Additionally, clients being treated for medical conditions often have coexisting mental health disorders or psychosocial issues that can cause suicidal ideation. Therefore, all clients aged 12 and older admitted for acute health care should be screened for suicidal ideation with a validated tool. An example of a validated screening tool is the Patient Safety Screener.[9,10] View more information about the Patient Safety Screener tool in the following boxes.

- Visit the Suicide Prevention Resource Center's webpage to read

8. U.S. Department of Veterans Affairs. (2021). *VHA national center for patient safety.* https://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp

9. The Joint Commission. (2019). *R3 report | Requirement, rationale, reference* [PDF]. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf

10. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk.* https://sprc.org/micro-learning/patientsafetyscreener

more about the The Patient Safety Screener: A Brief Tool to Detect Suicide Risk[11]

View the following YouTube video on administering the Patient Safety Screener:[12] The Patient Safety Screener 3

Assess Suicide Risk

An evidence-based **suicide risk assessment** should be completed on clients who have screened positive for suicidal ideation. Clients with suicidal ideation vary widely in their risk for a suicide attempt depending upon whether they have a plan, intent, or past history of attempts. An in-depth assessment of clients who screen positive for suicide risk must be completed to determine how to appropriately keep them safe from harm. Assessment for suicide risk includes asking about their suicidal ideation (i.e., thoughts of suicide), if they have a plan for committing suicide, their intent on completing the plan, previous suicidal or self-harm behaviors, risk factors, and protective factors.[13]

11. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk.* https://sprc.org/micro-learning/the-patient-safety-screener-a-brief-tool-to-detect-suicide-risk/

12. SPRC. (2018, April 26). *The Patient Safety Screener 3* [Video]. YouTube. All rights reserved. https://youtu.be/4GmGiRBMnYc

13. The Joint Commission. (2019). *R3 report | Requirement, rationale, reference*

When assessing for a suicide plan, notice if the plan is specific and the method they plan to use. The risk of acting on suicide thoughts increases with a specific plan. The risk also increases if the plan includes use of a lethal method that is accessible to the client.

An example of an evidence-based suicide risk assessment tool that anyone can use with anyone, anywhere is the Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS). Read more about the C-SSRS in the following box. The C-SSRS uses a series of simple, plain-language questions that anyone can ask. The answers help identify if a person is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. Examples of questions include the following[14]:

- Have you had thoughts of killing yourself?
- Have you thought about how you might do this?
- Have you done anything, started to do anything, or prepared to do anything to end your life?

Columbia Suicide Severity Rating Scale (C-SSRS)[15]

[PDF]. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf

14. The Columbia Lighthouse Project. (n.d.). *Identify risk. Prevent suicide.* https://cssrs.columbia.edu/

15. The Columbia Lighthouse Project. (n.d.). *Identify risk. Prevent suicide.* https://cssrs.columbia.edu/

Read more about using the C-SSRS at Columbia Lighthouse Project web site.

View the following YouTube video on C-SSRS[16] at Saving Lives Worldwide – A Call to Action – The Columbia Lighthouse Project

Develop a Safety Plan

If a client is assessed as high risk for suicide, a safety plan (or crisis response plan) should be created in collaboration with the client. A **safety plan** is a prioritized written list of warning signs, coping strategies, and sources of support that clients can use before or during a suicidal crisis. The plan should be brief, in the client's own words, and easy to read. After the plan is developed, the nurse should problem solve with the client to identify barriers or obstacles to using the plan. It should be discussed where the client will keep the safety plan and how it will be located during a crisis.[17,18]

16. The Columbia Lighthouse Project. (2016, October 19). *Saving lives worldwide – A call to action – The Columbia Lighthouse Project* [Video]. YouTube. All rights reserved. https://youtu.be/csPPsstf2og

17. Western Interstate Commission for Higher Education. (2008). *Safety planning guide* [PDF Handout]. https://www.sprc.org/sites/default/files/SafetyPlanningGuide%20Quick%20Guide%20for%20Clinicians.pdf

18. Schuster, H., Jones, N., & Qadri, S. F. (2021). Safety planning: Why it is essential on the day of discharge from in-patient psychiatric hospitalization in reducing future risks of suicide. *Cureus, 13*(12), e20648. https://doi.org/10.7759/cureus.20648

- Read the Safety Planning Guide PDF by the Western Interstate Commission for Higher Education.[19]

Document Level of Risk for Suicide

After suicide screening and suicide risk are assessed, it should be documented and communicated with the treatment team, along with the plan to keep the client safe. It is vital for all health care team members caring for the client to be aware of their level of risk and plans to reduce that risk as they provide care.[20] Nurses complete documentation regarding the level of a client's suicide risk and associated interventions every shift or more frequently as needed, depending upon the client status.

Follow Written Policies and Procedures

Nurses must strictly follow agency policies and procedures addressing the care of individuals who are identified at risk for suicide to keep them safe. The Joint Commission's National Patient Safety Goal 15.01.01 Reduce the Risk for Suicide requires screening of all clients being evaluated for behavioral health conditions ages 12 and older. For example, in some suicide cases reported to The Joint Commission, the root cause was a failure of staff to adhere to

19. Western Interstate Commission for Higher Education. (2008). *Safety planning guide* [PDF]. https://www.sprc.org/sites/default/files/SafetyPlanningGuide%20Quick%20Guide%20for%20Clinicians.pdf

20. The Joint Commission. (2019). *R3 report | Requirement, rationale, reference* [PDF]. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf

agency policies, such as one-to-one monitoring for clients identified as high risk for suicide.[21]

Provide Information for Follow-Up Care on Discharge

Nurses should provide written information at discharge, in addition to the safety plan, regarding follow-up care to clients identified at risk for suicide and share it with their family members and loved ones as appropriate. Studies have shown that a client's risk for suicide is high after discharge from psychiatric inpatient or emergency department settings. Developing a safety plan with the client and providing the number of crisis call centers can decrease suicidal behavior after the client leaves the care of the organization.[22]

Monitor Effectiveness of Suicide Prevention Interventions

The effectiveness of policies and protocols regarding suicide prevention should be evaluated on a periodic basis as part of overall quality improvement initiatives of the agency.[23] Research demonstrates implementation of the Zero Suicide Model results in lower suicidal behaviors.

21. The Joint Commission. (2019). *R3 report | Requirement, rationale, reference* [PDF]. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf
22. The Joint Commission. (2019,). *R3 report | Requirement, rationale, reference* [PDF]. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf
23. The Joint Commission. (2019). *R3 report | Requirement, rationale, reference* [PDF]. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf

Zero Suicide Toolkit[24]

- Read the American Psychiatric Association *Psych News Alert*, "'Zero Suicide' Practices at Mental Health Clinics Reduce Suicide Among Patients".
- Visit the Zero Suicide Toolkit webpage.

View the following WHO YouTube video[25] on preventing suicide by health care workers:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingmhcc/?p=73#oembed-1

Establishing a Safe Care Environment for Nurses and Other Health Care Team Members

The American Nurses Association states, "No staff nurse should have to deal

24. Zero Suicide. (n.d.). *Zero suicide toolkit*. https://zerosuicide.edc.org/toolkit/zero-suicide-toolkitsm

25. World Health Organization (WHO). (2019, October 8). *Preventing suicide: Information for health workers* [Video]. YouTube. Licensed in the Public Domain. https://youtu.be/Fy7n8SfwS_A

with violence in the workplace, whether from staff, clients, or visitors."[26]

Workplace violence is the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty. The impact of workplace violence can range from psychological issues to physical injury or even death. Violence can occur in any workplace and among any type of worker, but the risk for nonfatal violence resulting in days away from work is greatest for health care workers.[27] Research indicates the rate of physical assaults on nurses is 13.2 per 100 nurses per year, and 25% of psychiatric nurses experienced disabling injuries from client assault. Many experts believe these figures are under represented and that most incidents of violence go unreported.[28] See Figure 1.4[29] for an illustration of safety first.

26. American Nurses Association. (n.d.). *Safety on the job*. https://www.nursingworld.org/practice-policy/work-environment/health-safety/safety-on-the-job/

27. Centers for Disease Control and Prevention. (2024). *About workplace violence*. https://www.cdc.gov/niosh/violence/about/?CDC_AAref_Val=https://www.cdc.gov/niosh/topics/violence/default.html

28. Centers for Disease Control and Prevention. (2024). *About workplace violence*. https://www.cdc.gov/niosh/topics/violence/training_nurses.html

29. "Safety-First–Arvin61r58.png" by unknown author at freesvg.org is licensed under CC0 1.0. Access for free at https://freesvg.org/safety-first

Figure 1.4 Safety First

Safety strategies for nurses providing client care include the following[30]:

- **Dress for Safety**
  - Tuck away long hair so that it can't be grabbed
  - Avoid piercings or necklaces that can be pulled
  - Avoid overly tight clothing that can restrict movement or overly loose clothing or scarves that can be caught
  - Use breakaway safety lanyards for glasses, keys, or name tags
  - Do not wear your stethoscope around your neck

- **Be Aware of Your Work Environment**
  - When in a room with a client or visitor who is demonstrating warning signs of escalation, position yourself between the door and the client so you can exit quickly if needed
  - Note exits and emergency phone numbers, especially if you float to

30. Centers for Disease Control and Prevention. (2024). About w*orkplace violence*. https://www.cdc.gov/niosh/topics/violence/training_nurses.html

other areas
    - Recognize that confusion, background noises, and crowding can increase clients' stress levels
    - Be aware that mealtimes, shift changes, and transporting clients are times of increased disruptive behaviors

- **Be Attuned to Client Behaviors**
    - Most violent behavior is preceded by warning signs, including verbal cues and nonverbal cues. The greater the number of cues, the greater the risk for violence. Be aware of these verbal and nonverbal cues indicating a client's potential escalation to violence:

        - **Verbal Cues**
            - Speaking loudly or yelling
            - Swearing
            - Using a threatening tone of voice

        - **Nonverbal and Behavioral Cues**
            - Evidence of confusion or disorientation
            - Irritability or easily angered
            - Boisterous behavior (i.e., overly loud, shouting, slamming doors)
            - Disheveled physical appearance (i.e., neglected hygiene)
            - Holding arms tightly across chest
            - Clenching fists
            - Heavy breathing
            - Pacing or agitated, restlessness
            - Looking terrified (signifying fear and high anxiety)
            - Staring with a fixed look
            - Holding oneself in an aggressive or threatening posture
            - Throwing objects
            - Exhibiting sudden changes in behavior or signs of being under the influence of a substance

- **Use Violence Risk Assessment Tools**
  - Use risk assessment tools to evaluate individuals for potential violence, enabling all health care providers to share a common frame of reference and understanding. This minimizes the possibility that communications regarding a person's potential for violence will be misinterpreted. These tools can be used as an initial assessment upon admission to determine potential risk for violence and repeated daily to assist in predicting imminent violent behavior within the next 24 hours. See sample risk assessment tools in the box at the end of this section.

- **Be Attuned to Your Own Responses**
  - Be aware of your own feelings, responses, and sensitivities and pay attention to your instincts. For example, your "fight or flight" response can be an early warning sign of impending danger to get help or get out.
  - Be aware of how you express yourself and how others respond to you. Those who know you well may respond differently than strangers. Effective therapeutic communication skills are an essential tool in preventing violence.
  - Use self-awareness and acknowledge if you have a personal history of abuse, trauma, or adverse childhood experiences (ACEs) that can affect how you respond to situations.
  - If coworkers are engaging in abusive behaviors, consider if you are exhibiting similar behaviors.
  - Be aware that fatigue can diminish your alertness and your ability to respond appropriately to a challenging situation.

- **Check Your Cultural Biases**
  - A key aspect of self-awareness is recognizing how our own particular cultural heritage, values, and belief systems affect how we respond to our clients and coworkers and how they, in turn, respond to us.

Sample Violence Risk Assessment Tools from the CDC:

- Triage Tool PDF
- Indicator for Violent Behavior PDF
- Assault and Homicidal Danger Assessment Tool PDF

If travelling to a home setting as a home health nurse, additional safety strategies are as follows[31]:

- Review agency files to confirm that a background check was done on a client regarding any history of violence or crime, drug or alcohol abuse, and mental health diagnoses. Also, check to see if a client's family member has a record of violence or arrest.
- If entering a situation assessed as potentially dangerous, you should be accompanied by a team member who has training in de-escalation and crisis intervention.
- Always carry a charged cell phone.
- Make sure someone always knows where you are.
- Have a code word to use with your office or coworkers to let them know you're in trouble if you can't call the police.

The CDC offers a free, online course called Workplace Violence Prevention for Nurses to better understand the scope and nature of violence in the workplace. Access the

31. Centers for Disease Control and Prevention. (2024). About w*orkplace violence*. https://www.cdc.gov/niosh/topics/violence/training_nurses.html

free CDC course on workplace violence with nurse videos at the Workplace Violence Prevention for Nurses webpage

Read more about crisis interventions in the Stress, Coping, and Crisis Intervention chapter.

1.7 Psychiatric-Mental Health Nursing

What is Psychiatric-Mental Health Nursing?

Registered nurses (RNs) in a variety of settings provide care for clients with medical illnesses who may also be experiencing concurrent mental health disorders. Nurses who specialize in psychiatric-mental health nursing promote clients' well-being through prevention strategies and client education, while also using the nursing process to provide care for clients with mental health and substance use disorders.[1] According to the American Psychiatric Nurses Association, psychiatric-mental health nurse specialists perform the following activities[2]:

- Partner with individuals to achieve their recovery goals
- Provide health promotion and maintenance
- Conduct intake screening, evaluation, and triage
- Provide case management
- Teach self-care activities
- Administer and monitor mental functioning and behavior treatment regimens
- Practice crisis intervention and stabilization
- Engage in psychiatric rehabilitation and intervention
- Educate clients, families, and communities
- Coordinate care
- Work within interdisciplinary teams

Within the specialty of psychiatric-mental health nursing, there is an

1. American Psychiatric Nurses Association. (n.d.). *About psychiatric-mental health nursing*. https://www.apna.org/about-psychiatric-nursing/
2. American Psychiatric Nurses Association. (n.d.). *About psychiatric-mental health nursing*. https://www.apna.org/about-psychiatric-nursing/

opportunity to become board certified. Eligibility requirements include a bachelor's degree, two years of full-time work, 30 hours of continuing education, and passing a certification exam. The nurse earns the credential of PMH-BC (Psychiatric-Mental Health-Board Certified) or RN-BC.

Psychiatric-mental health advanced practice registered nurses (PMH-APRN) and nurse practitioners (PMHNP-BC) are registered nurses with a Master of Science in Nursing (MSN) or Doctor of Nursing Practice (DNP) degree in psychiatric nursing. PMH-APRNs perform the following activities:

- Provide individual, group, couples, and/or family psychotherapy
- Prescribe medication for acute and chronic illnesses
- Conduct comprehensive assessments
- Provide clinical supervision
- Diagnose, treat, and manage chronic or acute illness
- Provide integrative therapy interventions
- Order, perform, and interpret lab tests and other diagnostic studies
- Provide preventative care, including screening
- Develop policies for programs and systems
- Make referrals for health problems outside their scope of practice
- Perform procedures

Standards of Psychiatric-Mental Health Nursing

The American Psychiatric Nurses Association establishes standards of practice in psychiatric-mental health nursing that are built on the ANA Scope and Standards of Practice (2021). These standards are published in the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* document.[3] The standards are very similar to the ANA Scope and Standards of

3. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

Practice, with additional activities included in the *Intervention* standard of care. These interventions will be further discussed in the "Implementation" section of the "Application of the Nursing Process in Mental Health Care" chapter.

> Read the *About Psychiatric-Mental Health Nursing* webpage to learn more about the American Psychiatric Nursing Association.

There are specific legal and ethical considerations that apply to caring for clients with mental illness. See the "Legal and Ethical Considerations in Mental Health Care" chapter for further information.

Treatment Settings

Treatment settings for mental health illnesses vary based on the severity and complexity of the condition, as well as the resources available. These settings can be broadly categorized into several types:

Primary Care Settings

Mild to moderate mental health conditions are often managed in primary care settings. This includes the integration of mental health services within primary care practices, where general practitioners may provide initial assessments, prescribe medications, and offer brief counseling.

Outpatient Services

These settings are suitable for individuals who require regular, but not intensive, mental health care. Outpatient clinics provide services such as psychotherapy, medication management, and follow-up visits. Community mental health teams often operate in these settings to offer coordinated care.

Clients often initially visit their primary care provider when concerned about their mental health. If a client has a more severe disorder, they are typically referred to specialized psychiatric care providers such as psychiatrists, psychiatric-mental health advanced practice registered nurses/nurse practitioners, psychologists, social workers, counselors, or other licensed therapists.

Day Treatment Programs

These programs provide a higher level of care than outpatient services but do not require overnight stays. They are designed for individuals who need intensive treatment during the day but can return home in the evening.

Inpatient Care Settings

Clients with acute mental health symptoms, or those who are at-risk for hurting themselves or others, may be hospitalized. They are often initially seen in the emergency department for emergency psychiatric care. Clients may seek voluntary admission, or in some situations, may be involuntarily admitted after referral for emergency evaluation by law enforcement, schools, friends, or family members. This setting is for individuals with severe mental health conditions that require 24-hour care and supervision. Inpatient treatment focuses on crisis stabilization, safety, and rapid discharge planning. It is important to note that individuals with suicidal ideation who are not medically stable may be admitted to medical surgical units for care. Specialized units may exist for different populations, such as children, adolescents, and those with dual diagnoses. Read more about involuntary admissions in the "Patient Rights" section of the "Legal and Ethical Considerations in Mental Health Care" chapter.

Acute-care psychiatric units in general hospitals are typically locked units on a separate floor of the hospital with the purpose of maintaining environmental safety for its clients. State-operated psychiatric hospitals serve clients who have chronic serious mental illness. They also provide court-related care for

criminal cases where the client was found “not guilty by reason of insanity.” This judgment means the client was deemed to be so mentally ill when they committed a crime that they cannot be held responsible for the act, but instead require treatment.[4]

Community-Based Services

Community-based services include mobile crisis response teams, intensive in-home therapies, and therapeutic foster care. These services aim to provide support in the least restrictive environment possible, helping individuals remain in their communities while receiving necessary care.

Telepsychiatry

This modality extends mental health services to remote or underserved areas, providing access to psychiatric care through telecommunication technologies. It is particularly useful in community settings such as schools and correctional facilities.

4. Halter, M. J. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

1.8 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
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1

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https://wtcs.pressbooks.pub/nursingmhcc/?p=86#h5p-1

2

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1. "MH Therapeutic Foundations Glossary Cards" by OpenRN is licensed under CC BY-NC 4.0

2. "MH Therapeutic Question Set 1" by OpenRN is licensed under CC BY-NC 4.0

online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=86#h5p-3

3

- Test your clinical judgment with a NCLEX Next-Generation style case study: Chapter 1, Case Study 1 [4]

3. "MH Therapeutic Question Set 3" by OpenRN is licensed under CC BY-NC 4.0

4. "MH Therapeutic Foundations Case Study" by Kellea Ewen is licensed under CC BY-NC 4.0

I Glossary

Adverse childhood experiences (ACEs): Traumatic circumstances experienced during childhood such as abuse, neglect, or growing up in a household with violence, mental illness, substance use, incarceration, or divorce.

Boundaries: Limits that we set as individuals that define our levels of comfort when interacting with others. Personal boundaries include limits in physical, sexual, intellectual, emotional, sexual, and financial areas of our lives.

Culture: A complex context of knowledge, beliefs, and behaviors that provide structure to specific ethnic, racial, religious, geographic, or social groups.

Cultural humility: A lifelong process of self-reflection and self-critique whereby individuals actively engage in learning about different cultural perspectives while acknowledging the limitations of their own knowledge.

Deviance: Behavior that violates social norms or cultural expectations because one's culture determines what is "normal."

Distress: Psychological and/or physical pain.

Dysfunction: Disturbances in a person's thinking, emotional regulation, or behavior that reflects significant dysfunction in psychological, biological, or developmental processes underlying mental functioning.

Environmental risk assessment: Identification of physical environment features that could be used to attempt suicide in clients identified as at a high risk for suicide.

Health: A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Impairment: A limited ability to engage in activities of daily living (i.e., they cannot maintain personal hygiene, prepare meals, or pay bills) or participate in social events, work, or school.

Major life activities: Activities of daily living such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.[1]

Mental health: A state of well-being in which an individual realizes their own abilities, copes with the normal stresses of life, works productively, and contributes to their community.[2]

Mental health continuum: A continuum of mental health, ranging from well-being to emotional problems to mental illness.

Mental illness: A health condition involving changes in emotion, thinking, or behavior (or a combination of these) associated with emotional distress and problems functioning in social, work, or family activities.[3]

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[4]

1. Office of Federal Contract Compliance Programs. (2009). *ADA Amendments Act of 2008 frequently asked question*s. U.S. Department of Labor. https://www.dol.gov/agencies/ofccp/faqs/americans-with-disabilities-act-amendments

2. World Health Organization. (2018). *Mental health: Strengthening our response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

3. American Psychiatric Association. (n.d.). *What is mental illness?* https://www.psychiatry.org/patients-families/what-is-mental-illness

4. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services*. https://www.ncbi.nlm.nih.gov/books/NBK207201/

Resilience: The ability to rise above circumstances or meet challenges with fortitude.[5]

Safety plan: A prioritized written list of coping strategies and sources of support that clients can use before or during a suicidal crisis. The plan should be brief, in the client's own words, and easy to read. After the plan is developed, the nurse should problem solve with the client to identify barriers or obstacles to using the plan. It should be discussed where the client will keep the safety plan and how it will be located during a crisis.

Serious mental illness: Mental illness that causes disabling functional impairment that substantially interferes with one or more major life activities. Examples of serious mental illnesses that commonly interfere with major life activities include major depressive disorder, schizophrenia, and bipolar disorder.[6]

Social norms: Stated and unstated rules of an individual's society.

Stigma: A cluster of negative attitudes and beliefs that motivates the general public to fear, reject, avoid, and discriminate against people with mental health disorders.

Suicidal ideation: Thoughts of killing oneself.

Suicide risk assessment: Identifying the risk of a client dying by suicide by assessing suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.

Trauma: An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful and can have lasting

5. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services.* https://www.ncbi.nlm.nih.gov/books/NBK207201/

6. American Psychiatric Association. (n.d.). *What is mental illness?* https://www.psychiatry.org/patients-families/what-is-mental-illness

adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

Trauma-informed care (TIC): A strengths-based framework that acknowledges the prevalence and impact of traumatic experiences in clinical practice. TIC emphasizes physical, psychological, and emotional safety for both survivors and health professionals and creates opportunities for survivors to rebuild a sense of control and empowerment referred to as resilience.[7]

Well-being: The "healthy" range of the mental health continuum where individuals are experiencing a state of good mental and emotional health.

Workplace violence: The act or threat of violence, ranging from verbal abuse to physical assaults, directed toward persons at work or on duty.

World Health Organization Disability Assessment Scale (WHODAS): A generic assessment instrument that provides a standardized method for measuring health and disability across cultures.

7. Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services*. https://www.ncbi.nlm.nih.gov/books/NBK207201/

PART II

CHAPTER 2 THERAPEUTIC COMMUNICATION AND THE NURSE-CLIENT RELATIONSHIP

2.1 Introduction

Learning Objectives

- Identify advanced therapeutic communication techniques
- Describe barriers to effective therapeutic communication
- Explore guidelines for effective communication during telehealth

Nurses engage in compassionate, supportive, professional relationships with their clients as part of the "art of nursing."[1] This chapter will review the nurse-client relationship, therapeutic communication, and motivational interviewing. It will also introduce guidelines for effective communication during telehealth.

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Communication Standard of Professional Performance

The Standard of Professional Performance for *Communication* established by the American Nurses Association (ANA) is defined as, "The registered nurse communicates effectively in all areas of professional practice."[1] See the following box for the competencies associated with the *Communication* standard.

ANA's Communication Competencies

The registered nurse:

- Assesses one's own communication skills and effectiveness.
- Demonstrates cultural humility, professionalism, and respect when communicating.
- Assesses communication ability, health literacy, resources, and preferences of health care consumers to inform the interprofessional team and others.
- Uses language translation resources to ensure effective communication.
- Incorporates appropriate alternative strategies to communicate effectively with health care consumers who have visual, speech, language, or communication difficulties.
- Uses communication styles and methods that demonstrate caring, respect, active listening, authenticity, and trust.
- Conveys accurate information to health care consumers,

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

families, community stakeholders, and members of the interprofessional team.
- Advocates for the health care consumer and their preferences and choices when care processes and decisions do not appear to be in the best interest of the health care consumer.
- Maintains communication with interprofessional team members and others to facilitate safe transitions and continuity in care delivery.
- Confirms with the recipient if the communication was heard and if the recipient understands the message.
- Contributes the nursing perspective in interactions and discussions with the interprofessional team and other stakeholders.
- Promotes safety in the care or practice environment by disclosing and reporting concerns related to potential or actual hazards or deviations from the standard of care.
- Demonstrates continuous improvement of communication skills.

Review basic communication concepts for nurses in the "Communication" chapter in Open RN *Nursing Fundamentals*.

Nurse-Client Relationship

Establishment of the therapeutic nurse-client relationship is vital in nursing care. Nurses engage in compassionate, supportive, professional relationships

with their clients as part of the "art of nursing."[2] This is especially true in psychiatric care, where the therapeutic relationship is considered to be the foundation of client care and healing.[3] The **nurse-client relationship** establishes trust and rapport with a specific purpose; it facilitates therapeutic communication and engages the client in decision-making regarding their plan of care.

Therapeutic nurse-client relationships vary in depth, length, and focus, and are influenced based on the care setting. Brief therapeutic encounters might last only a few minutes and focus on the client's immediate needs, safety, current feelings, or behaviors. For example, in the emergency department setting, a nurse may therapeutically communicate with a client in crisis who recently experienced a situational trauma. During longer periods of time, such as inpatient care, nurses work with clients in setting short-term goals and outcomes that are documented in the nursing care plan and evaluated regularly. In long-term care settings, such as residential facilities, the therapeutic nurse-client relationship may last several months and include frequent interactions focusing on behavior modification.

Read more about crisis and crisis intervention in the "Stress, Coping, and Crisis Intervention" chapter.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

3. Ross, C. A., & Goldner, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*(6), 558-567. https://doi.org/10.1111/j.1365-2850.2009.01399.x

Phases of Development of a Therapeutic Relationship

The nurse-client relationship goes through three phases. A well-known nurse theorist named Hildegard Peplau described these three phases as orientation, working, and termination.[4]

ORIENTATION PHASE

During the brief orientation phase, clients may realize they need assistance as they adjust to their current status. Simultaneously, nurses introduce themselves and begin to obtain essential information about clients as individuals with unique needs, values, beliefs, and priorities. During this brief phase, trust is established, and rapport begins to develop between the client and the nurse. Nurses ensure privacy when talking with the client and providing care and respect the client's values, beliefs, and personal boundaries.

A common framework used for introductions during client care is AIDET, a mnemonic for Acknowledge, Introduce, Duration, Explanation, and Thank You.

- **Acknowledge:** Greet the client by the name documented in their medical record. Make eye contact, smile, and acknowledge any family or friends in the room. Ask the client their preferred way of being addressed. For example, knock gently and enter the room calmly. Approach with a non-threatening demeanor and open body language. "Hello, Alex. I see you've just arrived—welcome. I know being here might feel overwhelming at first, but I'm really glad you're here. May I ask how you'd like to be addressed and what pronouns you use?"

4. Hagerty, T. A., Samuels, W., Norcini-Pala, A., & Gigliotti, E. (2018). Peplau's theory of interpersonal relations: An alternate factor structure for patient experience data? *Nursing Science Quarterly, 30*(2), 160-167. https://dx.doi.org/10.1177%2F0894318417693286

- **Introduce:** Introduce yourself by your name and role. Build trust by being transparent and personable. For example, “My name is Jordan, and I’m the registered nurse assigned to support you today. My role is to help make sure you feel safe, listened to, and supported throughout your stay.”
- **Duration:** Estimate a timeline for how long it will take to complete the task you are doing. Provide structure without adding pressure, acknowledging the client’s emotional state. For example, “Right now, I’d like to spend about 15–20 minutes getting to know you a little better and going over a few admission questions. We’ll talk about how you’re feeling, your goals for being here, and how we can support you best.”
- **Explanation:** Explain step by step what to expect next and answer questions. Be clear and gentle, inviting collaboration. For example, “We’ll talk in a private space so you can share as much or as little as you’re comfortable with. I’ll ask about what brought you in, what’s been going on recently, and your support system. You’re welcome to take breaks or let me know if anything feels too much.”
- **Thank You:** At the end of the encounter, thank the client and ask if anything is needed before you leave. Affirm the client’s effort and courage in showing up. In an acute or long-term care setting, ensure the call light is within reach and the client knows how to use it. If family members are present, thank them for being there to support the client as appropriate. For example, ““Thank you for sharing your time with me today—it takes real strength to take this step. Before I go, is there anything I can get for you? I’ll make sure you know how to reach me if you need anything.”

WORKING PHASE

The majority of a nurse’s time with a client is spent in the working phase of the therapeutic relationship. This is where trust deepens, and meaningful progress toward health and well-being begins. During this phase, nurses use active listening to understand the client’s needs, values, and goals, starting with open-ended questions to explore the reason for seeking care. Assessment findings are used to develop or refine the nursing plan of care and to guide client education that is tailored to the individual. For example, after using the AIDET framework to greet and orient a new client like Alex, a

nurse might say: “Alex, thank you again for sharing some of your story with me earlier. I know being here is a big step. Based on what you’ve told me so far, I’d like to talk through a few ideas together that could help you feel supported during your stay.”

If a care plan has already been initiated, the nurse uses this phase to implement targeted interventions aimed at both short-term relief and long-term outcomes. As the relationship strengthens, clients begin to see nurses as educators, counselors, and trusted care providers—not just clinical staff. In Alex’s case, the nurse might continue: “Can you tell me more about what led you to seek care today and what you’re hoping will be different by the time you leave? Your voice really matters here—we’ll create a plan together that feels realistic and helpful for you.”

This collaborative approach is essential. Nurses use therapeutic communication techniques—such as reflection, clarification, silence, and motivational interviewing—to help clients become more aware of their thoughts, emotions, and options. Through nonjudgmental feedback, the nurse supports the client in exploring and clarifying their goals, strengths, and coping strategies.[5] For example, the nurse might gently reflect: “It sounds like you’ve been trying to manage everything on your own, and it’s been exhausting. It’s okay to need help—being here is a brave step.” In these moments, the nurse not only delivers clinical care but also fosters emotional healing and client empowerment. The working phase is where healing conversations and actions come together, providing a foundation for meaningful change and lasting outcomes.

5. Hagerty, T. A., Samuels, W., Norcini-Pala, A., & Gigliotti, E. (2018). Peplau’s theory of interpersonal relations: An alternate factor structure for patient experience data? *Nursing Science Quarterly, 30*(2), 160-167. https://dx.doi.org/10.1177%2F0894318417693286

TERMINATION PHASE

The termination phase marks the conclusion of the therapeutic nurse-client relationship. It typically occurs at the end of a shift, during a transfer, or at discharge from care. When the working phase has been effective, the client's goals have been addressed collaboratively through the efforts of the client, nurse, and interprofessional team. This final phase provides an opportunity for reflection, reinforcement, and closure—essential for empowering the client to move forward independently with confidence.

In Alex's case, after several days of support and progress, the nurse prepares to end the therapeutic relationship at the end of the shift and as Alex nears discharge. The nurse approaches the conversation with sensitivity and structure. "Alex, I want to take a few minutes to talk with you before I end my shift. It's been a privilege working with you this week, and I want to thank you for the trust you've placed in me."

Because clients may sometimes attempt to return to the working phase to delay separation, the nurse remains aware and gently holds space for any emotions that arise. "I know transitions can bring up a lot of feelings. It's normal to feel a mix of relief, nervousness, or even sadness. Would it be helpful to talk through any of that together before I go?"

The nurse encourages Alex to reflect on progress and reinforces the client's strengths. "You've worked incredibly hard to identify what matters most to you, and you've been honest and brave every step of the way. Remember when we first talked and you weren't sure if you even belonged here? Now look at how far you've come—recognizing your needs, setting goals, and planning next steps."

Together, they review discharge goals and available community supports. "Before you leave, we've set up a follow-up appointment with the outpatient team for next Tuesday. I've also included a few community support groups you might want to explore. These resources are here to walk with you as you continue building on the work you started here."

The nurse concludes the relationship with warmth, professionalism, and

closure. “Alex, thank you again for allowing me to be part of your care. I truly believe in your ability to keep moving forward. If you ever need support again, know that it’s okay to reach out.”

This approach to the termination phase helps ensure that the client leaves with a clear sense of accomplishment, continuity of care, and confidence in their ability to self-advocate and engage support systems. It also models a healthy ending to a professional relationship—an important skill for both clients and nurses.

2.3 Therapeutic Communication

Therapeutic communication has roots going back to Florence Nightingale, who insisted on the importance of building trusting relationships with individuals. She taught that therapeutic healing resulted from nurses' presence with clients.[1] Since then, several professional nursing associations have highlighted therapeutic communication as one of the most vital elements in nursing. In psychiatric settings, effective communication has been shown to reduce violence against healthcare staff, highlighting its importance in maintaining a safe and supportive environment.[2] **Therapeutic communication** is a type of professional communication defined as the purposeful, interpersonal, information-transmitting process that leads to client understanding and participation.[3] Read an example of a nurse using therapeutic communication in the following box.

Example of Nurse Using Therapeutic Listening

1. Karimi, H., & Masoudi Alavi, N. (2015). Florence Nightingale: The mother of nursing. *Nursing and Midwifery Studies, 4*(2), e29475. https://doi.org/10.17795/nmsjournal29475

2. Amara, S. S, Hansen, B., & Torres, J. (2024). Revisiting therapeutic communication as an evidence-based intervention to decrease violence by patients against staff on psychiatric wards – A quality improvement project. *Issues in Mental Health Nursing 45*(12), 1340-1352. doi: 10.1080/01612840.2024.2414744.

3. Abdolrahimi, M., Ghiyasvandian, S., Zakerimoghadam, M., & Ebadi, A. (2017). Therapeutic communication in nursing students: A Walker & Avant concept analysis. *Electronic Physician, 9*(8), 4968–4977. https://doi.org/10.19082/4968

Ms. Z. is a nurse (as simulated in Figure 2.1)[4] who enjoys interacting with clients. When she goes to clients' rooms, she greets them and introduces herself and her role in a calm tone. She kindly asks clients about their concerns and problems and notices their reactions. She provides information and answers their questions. Clients perceive that she wants to help them. She treats clients professionally by respecting boundaries and listening to them in a nonjudgmental manner. She addresses communication barriers and respects clients' cultural beliefs. She notices clients' health literacy and ensures they understand her messages and client education. As a result, clients trust her and feel as if she cares about them, so they feel comfortable sharing their health care needs with her.[5]

4. "beautiful african nurse taking care of senior patient in wheelchair" by agilemktg1 is in the Public Domain.

5. Abdolrahimi, M., Ghiyasvandian, S., Zakerimoghadam, M., & Ebadi, A. (2017). Therapeutic communication in nursing students: A Walker & Avant concept analysis. *Electronic Physician, 9*(8), 4968–4977. https://doi.org/10.19082/4968

Figure 2.1 Nursing Using Therapeutic Communication

Therapeutic communication is different from social interaction. Social interaction does not have a goal or purpose and includes casual sharing of information, whereas therapeutic communication has a goal or purpose for the conversation. An example of a nursing goal using therapeutic communication is, “The client will share feelings or concerns about their treatment plan by the end of the conversation.”

Therapeutic communication includes active listening, professional touch, and a variety of therapeutic communication techniques.

Active Listening

Listening is an important part of communication. There are three main types of listening, including competitive, passive, and active listening. Competitive listening occurs when we are mostly focused on sharing our own point of view instead of listening to someone else. Passive listening occurs when we

are not interested in listening to the other person, and we assume we understand what the person is communicating correctly without verifying their message. During **active listening**, we communicate both verbally and nonverbally that we are interested in what the other person is saying while also actively verifying our understanding with them. For example, an active listening technique is to restate what the person said and then verify our understanding is correct. This feedback process is the major difference between passive listening and active listening.[6]

Nonverbal communication is an important component of active listening. **SOLER** is a mnemonic for establishing good nonverbal communication with clients. SOLER stands for the following[7]:

- **S: S**itting and squarely facing the client
- **O:** Using **o**pen posture (i.e., avoid crossing arms)
- **L: L**eaning towards the client to indicate interest in listening
- **E:** Maintaining good **e**ye contact
- **R:** Maintaining a **r**elaxed posture

Touch

Professional touch is a powerful way to communicate caring and empathy if done respectfully while also being aware of the client's preferences, cultural beliefs, and personal boundaries. Nurses use professional touch when assessing, expressing concern, or comforting clients. For example, simply holding a client's hand during a painful procedure can effectively provide comfort.

6. Libretext. (2022). *Human Resources (Dias)*. https://socialsci.libretexts.org/Bookshelves/Communication/Book:_Human_Relations_(Dias)

7. Stickley, T. (2011). From SOLER to SURETY for effective non-verbal communication. *Nurse Education in Practice, 11*(6), 395–398. https://doi.org/10.1016/j.nepr.2011.03.021

For individuals with a history of trauma, touch can be negatively perceived, so it is important to always ask permission before touching. Inform the person before engaging in medical procedures requiring touch such as, “May I hold your arm still during the blood draw?”

Nurses should avoid using touch with individuals who are becoming agitated or experiencing a manic or psychotic episode because it can cause escalation. It is also helpful to maintain a larger interpersonal distance when interacting with an individual who is experiencing paranoia or psychosis.

Therapeutic Communication Techniques

There are a variety of therapeutic techniques that nurses use to engage clients in verbalizing emotions, establishing goals, and discussing coping strategies. See Table 2.3a for definitions of various therapeutic communication techniques discussed in the *American Nurse*, the official journal of the American Nurses Association.

Table 2.3a Therapeutic Communication Techniques[8]

8. American Nurse. (n.d.). *Therapeutic communication techniques*. https://www.myamericannurse.com/therapeutic-communication-techniques/

Therapeutic Techniques	Definition	Examples
Acceptance	Acceptance acknowledges a client's emotions or message and affirms they have been heard. Acceptance isn't necessarily the same thing as agreement; it can be enough to simply make eye contact and say, "I hear what you are saying." Clients who feel their nurses are listening to them and taking them seriously are more likely to be receptive to care.	Client: "I hate taking all this medicine. It makes me feel numb." Nurse (making eye contact): "Yes, I understand."
Clarification	Clarification asks the client to further define what they are communicating. Similar to active listening, asking for clarification when a client says something confusing or ambiguous is important. It helps nurses ensure they understand what is actually being said and can help clients process their ideas more thoroughly.	Client: "I feel useless to everyone and everything." Nurse: "I'm not sure I understand what you mean by useless. Can you give an example of a time you felt useless?"
Focusing	Focusing on a specific statement made by a client that seems particularly important prompts them to discuss it further. Clients don't always have an objective perspective on their situation or past experiences, but as impartial observers, nurses can more easily pick out important topics on which to focus.	Client: "I grew up with five brothers and sisters. We didn't have much money, so my mom was always working and never home. We had to fend for ourselves, and there was never any food in the house." Nurse: "It sounds as if you experienced some stressful conditions growing up."

Exploring	Exploring gathers more information about what the client is communicating.	Client: “I had to lie when I found out a dark secret about my sister.” Nurse: “If you feel comfortable doing so, tell me more about the situation and your sister’s dark secret.”
Giving Recognition	Giving recognition acknowledges and validates the client’s positive health behaviors. Recognition acknowledges a client’s behavior and highlights it without giving an overt compliment. A compliment can sometimes be taken as condescending, especially when it concerns a routine task like making the bed.	Nurse: “I noticed you took all of your medications.”
Open-Ended Questions/ Offering General Leads	Using open questions or offering general leads provides keywords to “open” the discussion while also seeking more information. Therapeutic communication is most effective when clients direct the flow of conversation and decide what to talk about. Giving clients a broad opening such as “What’s on your mind today?” or “What would you like to talk about?” is a good way to encourage clients to discuss what’s on their mind.	Client: “I’m unsure of what to do next.” Nurse: “Tell me more about your concerns.”
Paraphrasing	Paraphrasing rephrases the client’s words and key ideas to clarify their message and encourage additional communication.	Client: “I’ve been way too busy today.” Nurse: “Participating in the support groups today has kept you busy.”

Presenting Reality	Presenting reality restructures the client's distorted thoughts with valid information.	Client: "I can't go in that room; there are spiders on the walls." Nurse: "I see no evidence of spiders on the walls."
Restating	Restating uses different word choices for the same content stated by the client to encourage elaboration.	Client: "The nurses hate me here." Nurse: "You feel as though the nurses dislike you?"
Reflecting	Reflecting asks clients what they think they should do, encourages them to be accountable for their own actions, and helps them come up with solutions.	Client: "Do you think I should do this new treatment or not?" Nurse: "What do you think the pros and cons are for the new treatment plan?"
Providing Silence	Providing silence allows quiet time for self-reflection by the client.	The nurse does not verbally respond after a client makes a statement, although they may nod or use other nonverbal communication to demonstrate active listening and validation of the client's message.
Making Observations	Observations about the appearance, demeanor, or behavior of clients can help draw attention to areas that might pose a problem for them.	Nurse: "You look tired today." Client: "I haven't been getting much sleep lately because of so many racing thoughts in my head at night."

Offering Self/Providing Presence	Offering self provides support by being present. Inpatient care can be lonely and stressful at times. When nurses provide presence and spend time with their clients, it shows clients they value them and are willing to give them time and attention.	Offering to simply sit with clients for a few minutes is a powerful way to create a caring connection.
Encouraging Descriptions of Perceptions	Asking about perceptions in an encouraging, nonjudgmental way is important for clients experiencing sensory issues or hallucinations. It gives clients a prompt to explain what they're perceiving without casting their perceptions in a negative light. It is also important to establish safety by ensuring the hallucinations are not encouraging the client to harm themselves or others.	The client looks distracted and frightened as if they see or hear something. Nurse: "It looks as though you might be hearing something. What do you hear now?" or "It looks as if you might be seeing something. What does it look like to you?"
Encouraging Comparisons	Encouraging comparisons helps clients reflect on previous situations in which they have coped effectively. In this manner, nurses can help clients discover solutions to their problems.	Nurse: "It must have been difficult when you went through a divorce. How did you cope with that?" Client: "I walked my dog outside a lot." Nurse: "It sounds as though walking your dog outside helps you cope with stress and feel better?"
Offering Hope	Offering hope encourages a client to persevere and be resilient.	Nurse: "I remember you shared with me how well you coped with difficult situations in the past."

Offering Humor	Humor can lighten the mood and contribute to feelings of togetherness, closeness, and friendliness. However, it is vital for the nurse to tailor humor to the client's sense of humor.	Nurse: "Knock, knock." Client: "Who's there?" Nurse: "Orange." Client: "Orange who?" Nurse: "Orange you glad to see me?" (Laughs with the client) Or Nurse (smiling after finishing teaching and inserting the IV): "Well, not too bad for my first time, right?" (Pauses for dramatic effect, then adds) "Kidding! I've done this a hundred times—just wanted to keep things exciting!"
Confronting	Confronting presents reality or challenges a client's assumptions. Nurses should only apply this technique during the working phase after they have established trust. Confrontation, when used correctly, can help clients break destructive routines or understand the state of their current situation.	Client: "I haven't drunk much this year." Nurse: "Yesterday you told me that every weekend you go out and drink so much you don't know where you are when you wake up."

Summarizing	Summarizing demonstrates active listening to clients and allows the nurse to verify information. Ending a discussion with a phrase such as "Does that sound correct?" gives clients explicit permission to make corrections if they're necessary.	Client: "I don't like to take my medications because they make me tired, and I gain a lot of weight." Nurse: "You haven't been taking your medications this month because of the side effects of fatigue and weight gain. Is that correct?"

Nontherapeutic Responses

Nurses must be aware of potential barriers to communication and avoid nontherapeutic responses. Nonverbal communication such as looking at one's watch, crossing arms across one's chest, or not actively listening may be perceived as barriers to communication. Nontherapeutic verbal responses often block the client's communication of feelings or ideas. See Table 2.3b for a description of nontherapeutic responses to avoid.

Table 2.3b Nontherapeutic Responses[9,10]

9. Abdolrahimi, M., Ghiyasvandian, S., Zakerimoghadam, M., & Ebadi, A. (2017). Therapeutic communication in nursing students: A Walker & Avant concept analysis. *Electronic Physician, 9*(8), 4968–4977. https://doi.org/10.19082/4968

10. Sharma, N. P., & Gupta, V. (2023). Therapeutic communication. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK567775/

Nontherapeutic Response	Description	Examples
Asking Personal Questions	Asking personal questions that are not relevant to the situation is not professional or appropriate. Don't ask questions just to satisfy your curiosity.	Nontherapeutic: "Why have you and Mary never gotten married?" Therapeutic: "How would you describe your relationship with Mary?"
Giving Personal Opinions	Giving personal opinions takes away the decision-making from the client. Effective problem-solving must be accomplished by the client and not provided by the nurse.	Nontherapeutic: "If I were you, I would put your father in a nursing home to reduce your stress." Therapeutic: "Let's explore options for your father's care."
Changing the Subject	Changing the subject when someone is trying to communicate with you demonstrates lack of empathy and blocks further communication. It communicates that you don't care about what they are sharing.	Nontherapeutic: "Let's not talk about your insurance problems; it's time for your walk now." Therapeutic: "After your walk, let's look into what is going on with your insurance company."

Stating Generalizations and Stereotypes	Generalizations and stereotypes can threaten nurse-client relationships.	Nontherapeutic: "Older adults are always confused." Therapeutic: "Tell me more about your concerns about your father's confusion."
Providing False Reassurances	When a client is seriously ill or distressed, the nurse may be tempted to offer false hope with statements that everything will be alright. These comments can discourage further expressions of a client's feelings.	Nontherapeutic: "You'll be fine; don't worry." Therapeutic: "It must be difficult not to know what will happen next. What can I do to help?"
Showing Sympathy	Sympathy focuses on the nurse's feelings rather than the client. It demonstrates pity rather than trying to help the client cope with the situation.	Nontherapeutic: "I'm so sorry about your amputation; I can't imagine losing my leg due to a car crash." Therapeutic: "The loss of your leg is a major change. How do you think this will affect your life?"

Asking "Why" Questions	A nurse may be tempted to ask the client to explain "why" they believe, feel, or act in a certain way. However, clients and family members can interpret "why" questions as accusations and become defensive. It is best to rephrase a question to avoid using the word "why."	Nontherapeutic: "Why are you so upset?" Therapeutic: "You seem upset. Tell me more about that."
Approving or Disapproving	Nurses should not impose their own attitudes, values, beliefs, and moral standards on others while in the professional nursing role. Judgmental messages contain terms such as "should," "shouldn't," "ought to," "good," "bad," "right," or "wrong." Agreeing or disagreeing sends the subtle message that a nurse has the right to make value judgments about the client's decisions. Approving implies that the behavior being praised is the only acceptable one, and disapproving implies that the client must meet the nurse's expectations or standards. Instead, the nurse should assist the client to explore their own values, beliefs, goals, and decisions.	Nontherapeutic: "You shouldn't consider elective surgery; there are too many risks involved." Therapeutic: "You are considering having elective surgery. Tell me more about the pros and cons of surgery."

Giving Defensive Responses	When clients or family members express criticism, nurses should listen to the message. Listening does not imply agreement. To discover reasons for the client's anger or dissatisfaction, the nurse should listen without criticizing, avoid being defensive or accusatory, and attempt to defuse anger.	Client: "Everyone is lying to me!" Nontherapeutic: "No one here would intentionally lie to you." Therapeutic: "You believe people have been dishonest with you. Tell me more about what happened." (After obtaining additional information, the nurse may elect to follow the chain of command at the agency and report the client's concerns for follow-up.)
Providing Passive or Aggressive Responses	Passive responses serve to avoid conflict or sidestep issues, whereas aggressive responses provoke confrontation. Nurses should use assertive communication.	Nontherapeutic: "It's your fault you are feeling ill because you didn't take your medicine." Therapeutic: "Taking your medicine every day can prevent these symptoms from returning."

Arguing	Arguing against client perceptions denies that they are real and valid. They imply that the other person is lying, misinformed, or uneducated. The skillful nurse can provide information or present reality in a way that avoids argument.	Nontherapeutic: "How can you say you didn't sleep last night when I heard you snoring!" Therapeutic: "You don't feel rested this morning? Let's talk about ways to improve the quality of your rest."

See the following box for a summary of tips for using therapeutic communication and avoiding common barriers to therapeutic communication.

Tips for Effective Therapeutic Communication

- Establish a goal for the conversation.
- Be self-aware of one's nonverbal behaviors and communication
- Observe the client's nonverbal behaviors and actions as 'cues' for assessments and planning interventions.
- Avoid self-disclosure of personal information and use professional boundaries. (Review boundary setting in the "Boundaries" section of Chapter 1.)
- Be client-centered and actively listen to what the client is expressing (e.g., provide empathy, not sympathy; show respect; gain the client's trust; and accept the person as who they are as an individual).
- Be sensitive to the values, cultural beliefs, attitudes, practices, and problem-solving strategies of the client.

- Use open-ended questions and active listening to encourage client expression and build trust.
- Recognize themes in a conversation (e.g., Is there a theme emerging of poor self-esteem, guilt, shame, loneliness, helplessness, hopelessness, or suicidal thoughts?).

Common Barriers to Therapeutic Communication

- Using a tone of voice that is disengaged, condescending, or disapproving.
- Using medical jargon or too many technical terms.
- Asking yes/no questions instead of open-ended questions.
- Continually asking "why," causing the client to become defensive or feel challenged by your questions.
- Using too many probing questions, causing the client to feel you are interrogating them, resulting in defensiveness or refusal to talk with the nurse.
- Lacking awareness of one's biases, fears, feelings, or insecurities.
- Causing sensory overload in the client with a high emotional level of the content.
- Giving advice.
- Blurring the nurse-client relationship boundaries (e.g., assuming control of the conversation, disclosing personal information, practicing outside one's scope of practice).

Recognizing and Addressing Escalation

When communicating therapeutically with a client, it is important to

recognize if the client is escalating with increased agitation and becoming a danger to themselves, staff, or other clients. When escalation occurs, providing safety becomes the nurse's top priority. Read more information in the "Crisis and Crisis Intervention" section of the "Stress, Coping, and Crisis Intervention" chapter.

Cultural Considerations

Recall the discussion from Chapter 1 on how cultural values and beliefs can impact a client's mental health in many ways. Every culture has a different perspective on mental health. For many cultures, there is stigma surrounding mental health. Mental health challenges may be considered a weakness and something to hide, which can make it harder for those struggling to talk openly and ask for help. Culture can also influence how people describe and feel about their symptoms. It can affect whether someone chooses to recognize and talk openly about physical symptoms, emotional symptoms, or both. Cultural factors can determine how much support someone gets from their family and community when it comes to mental health.[11]

Nurses can help clients understand the role culture plays in their mental health by encouraging therapeutic communication about their symptoms and treatment. For example, a nurse should ask, "Can you tell me more about how your culture influences your values and beliefs?" or Can you tell me more about how your culture influences your options for treatment?"

- Read more about providing culturally responsive care in the

11. Mental Health First Aid. (2019). *Four ways culture impacts mental health*. National Council for Mental Wellbeing. https://www.mentalhealthfirstaid.org/2019/07/four-ways-culture-impacts-mental-health/

- "Diverse Clients" chapter of Open RN *Nursing Fundamentals, 2e*.

2.4 Motivational Interviewing

Client education and health promotion are core nursing interventions. **Motivational interviewing (MI)** is a communication skill used to elicit and emphasize a client's personal motivation for modifying behavior to promote health. MI has been effectively used for several health issues such as smoking cessation, diabetes, substance use disorders, and adherence to a treatment plan.[1]

The spirit of motivational interviewing is a collaborative partnership between nurses and clients, focused on client-centered care, autonomy, and personal responsibility. It is a technique that explores a client's motivation, confidence, and roadblocks to change. During motivational interviewing, nurses pose questions, actively listen to client responses, and focus on where the client is now with current health behavior and where they want to be in the future.[2]

Motivational interviewing uses these principles[3]:

- **Express empathy.** Use reflective listening to convey acceptance and a nonjudgmental attitude. Rephrase client comments to convey active listening and let clients know they are being heard.
- **Highlight discrepancies.** Help clients become aware of the gap between

1. Rubak, S., Sandbaek, A., Lauritzen, T., & Christensen, B. (2005). Motivational interviewing: A systematic review and meta-analysis. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners, 55*(513), 305–312. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1463134/

2. Droppa, M., & Lee, H. (2014). Motivational interviewing: A journey to improve health. *Nursing, 44*(3), 40–46. https://doi.org/10.1097/01.NURSE.0000443312.58360.82

3. Droppa, M., & Lee, H. (2014). Motivational interviewing: A journey to improve health. *Nursing, 44*(3), 40–46. https://doi.org/10.1097/01.NURSE.0000443312.58360.82

their current behaviors and their values and goals. Present objective information that highlights the consequences of continuing their current behaviors to motivate them to change their behavior.

- **Adjust to resistance.** Adjust to a client's resistance and do not argue. The client may demonstrate resistance by avoiding eye contact, becoming defensive, interrupting you, or seeming distracted by looking at their watch or cell phone. Arguing can place the client on the defensive and in a position of arguing against the change. Focus on validating the client's feelings.
- **Understand motivations.** Uncover a client's personal reasons for making behavioral changes and build on them.
- **Support self-efficacy.** Encourage the client's optimistic belief in the prospect of change and encourage them to commit to positive behavioral changes. Ask clients to elaborate on past successes to build self-confidence and support self-efficacy.
- **Resist the reflex to provide advice.** Avoid imposing your own perspective and advice.

When implementing motivational interviewing, it is important to assess the client's readiness for change. Motivational interviewing is especially useful for clients in the contemplation stage who are feeling ambivalent about making change. Recall these five stages of behavioral change[4]:

- **Precontemplation:** Not considering change.
- **Contemplation:** Ambivalent about making change.
- **Preparation:** Taking steps toward implementing change.
- **Action:** Actively involved in the change process.
- **Maintenance:** Sustaining the target behavior.

4. Droppa, M., & Lee, H. (2014). Motivational interviewing: A journey to improve health. *Nursing, 44*(3), 40–46. https://doi.org/10.1097/01.NURSE.0000443312.58360.82

Identify clients who are ambivalent about making a behavioral change or following a treatment plan by listening for the phrase, "Yes, but." The "but" holds the key for opening the conversation about ambivalence. For example, a client may state, "I want to take my medication, but I hate gaining weight." The content in the sentence after the "but" reveals the client's personal roadblock to making a change and should be taken into consideration when planning outcomes and interventions.[5]

See the following box for an example of a nurse using motivational interviewing with a client.

Example of Motivational Interviewing[6]

Mr. L. had been in treatment for bipolar I disorder with medication management and supportive therapy for many years. He had a history of alcohol dependence but was in full recovery. Mr. L. was admitted to the intensive care unit with a toxic lithium level. He had been seen in the emergency room the preceding evening and was noted to have a very high blood alcohol level. The next day the nurse asked the client about his alcohol use using motivational interviewing.

Client: I am so sick of everyone always blaming everything on my drinking!

5. Droppa, M., & Lee, H. (2014). Motivational interviewing: A journey to improve health. *Nursing, 44*(3), 40–46. https://doi.org/10.1097/01.NURSE.0000443312.58360.82

6. Griffith, L. J. (2008). The psychiatrist's guide to motivational interviewing. *Psychiatry*, *5*(4), 42–47. https://www.ncbi.nlm.nih.gov/pubmed/19727309

Nurse (Using reflective listening): You seem pretty angry about the perception that you were hospitalized because you had been drinking.

Client: You better believe it! I am a man! I can have a few drinks if I want to!

Nurse: (Expressing empathy and acceptance): You want to be respected even when you are drinking.

Client: I have had some trouble in the past with drinking, but that is not now. I can quit if I want to! Compared to what I used to drink, this is nothing.

Nurse (Rolling with resistance): So, you see yourself as having had drinking problems in the past, but the drinking you've done recently is not harmful for you.

Client: Well, I guess I did end up in the hospital.

Nurse (Using open-ended questioning): Tell me more about what happened.

Client: I was pretty angry after an argument with my girlfriend, and I decided to buy a bottle of whiskey.

Nurse (Exploring): And then?

Client: Well, I meant to have a couple of shots, but I ended up drinking the whole fifth. I really don't remember what happened next. They said I nearly died.

Nurse (Summarizing): So, after many years of not drinking, you decided to have a couple of drinks after the argument with your girlfriend, but unintentionally drank enough to have a blackout and nearly die.

Client: I guess that does sound like a problem...but I don't want anyone else telling me whether or not I can drink!

Nurse (Emphasizing autonomy): If you would be able to go back in time, would you like to approach the situation the same or differently?

View the following supplementary YouTube videos about motivational interviewing:

- Introduction to Motivational Interviewing[7]
- Motivational Interviewing – Good Example – Alan Lyme[8]

Complete Western Region Public Health Training Center's Motivational Interviewing course and receive a certificate of completion.

7. Matulich, B. (2013, May 30). *Introduction to motivational interviewing* [Video]. YouTube. All rights reserved. https://youtu.be/s3MCJZ7OGRk

8. TheRETAchannel. (2013, July 18). *Motivational interviewing – Good example – Alan Lyme* [Video]. YouTube. All rights reserved. https://youtu.be/67I6g1I7Zao

2.5 Teletherapy and Telehealth

Telehealth is the use of digital technologies to deliver medical care, health education, and public health services by remotely connecting multiple users in separate locations. Nurses must be aware of potential barriers affecting client use of telehealth (such as lack of Internet access or lack of support for individuals learning new technologies), as well as state and federal policies regarding telehealth and using their nursing license across state lines.

> Read more about telehealth licensing requirements and interstate compacts at the Telehealth.hss.gov webpage.

Teletherapy is mental health counseling over the phone or online with videoconferencing. COVID-19 has led to reduced access to medical and mental health care, so delivering behavioral health care via telehealth is one way to address this issue. When using teletherapy, nurses should treat clients as if they are sitting across from them and focus on eye contact and empathetic expressions to build a connection, just as one would do during a face-to-face encounter.[1] Effective teletherapy involves adherence to professional guidelines, appropriate training, managing technology, ensuring privacy, and engaging caregivers when necessary.

Group therapy can also be accomplished via telehealth. Connecting clients through telehealth creates a group dynamic that can build community, reduce feelings of isolation, and offer new perspectives. Group therapy via telehealth can create a sense of belonging and build a trusted support system.

1. Telehealth.HHS.gov. (2024). *Telehealth for behavioral health care*. Health Resources & Services Administration. https://telehealth.hhs.gov/providers/telehealth-for-behavioral-health/individual-teletherapy/

Here are a few guidelines for group therapy telehealth sessions[2]:

- **Prescreen group members:** Group members may have various needs, experiences, or personalities. It is helpful to screen each potential client to ensure every member can benefit from group therapy and that their needs match the goals of the group.
- **Require completion of online consent forms:** Group telehealth sessions involve multiple people and are conducted outside of a controlled setting like an office. Client consent forms should be required and available online. The consent forms should outline any associated risks, benefits, and limits to confidentiality.
- **Develop group guidelines:** Make clear ground rules covering what is acceptable and what is not acceptable. Some common ground rules include requiring all participants to have their camera on, attend from a room where they can be alone during the session, and use the digital "raise hand" feature (or raise their hand) when they want to speak. Prohibiting recording of the session is a common ground rule to protect confidentiality. Address logistical topics like how many missed sessions are allowed and how to contact the group leader(s).
- **Select your settings and technology:** Choose the telehealth video platform that best suits your needs for encryption and privacy, user controls, and more. Go through all of the settings ahead of time to select the options that provide the highest level of privacy. Think about what will help you and the group communicate effectively such as screen sharing options or a virtual whiteboard.
- **Be engaging:** When you are on screen instead of in person, it is even more important to be conscious of the group dynamic and take steps to keep group members interested, energized, and engaged. Start with introductions and greetings using first names only for privacy. Make eye

2. Telehealth.HHS.gov. (2024). *Telehealth for behavioral health care*. Health Resources & Services Administration. https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-behavioral-health/group-teletherapy

contact with group members by looking into the camera and use body language and hand gestures to help express your ideas. Build in moments for clients to interact and contribute to the conversation, such as breakout rooms or paired discussions.

- **Group participation:** Some group members might be more willing to talk than others. Make sure to pause so that everyone has a chance to contribute to the discussion. Let participants know that they can always decide to pass if they do not want to talk when they are called upon.

2.6 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=194#h5p-4

1

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=194#h5p-6

2

An interactive H5P element has been excluded from this version of the text. You can view it

1. “MH Therapeutic Communications Glossary Cards” by OpenRN is licensed under CC BY-NC 4.0

2. “MH Therapeutic Communications Drag and Drop” by OpenRN is licensed under CC BY-NC 4.0

online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=194#h5p-9

3

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=194#h5p-10

4

Test your clinical judgment with a NCLEX Next-Generation style question: Chapter 2, Assignment 1 [5]

3. "MH Therapeutic Communication Question Set 1" by OpenRN is licensed under CC BY-NC 4.0

4. "MH Therapeutic Communications Querstion Set 2" by OpenRN is licensed under CC BY-NC 4.0

5. "MH Next-Generation Style Question " by OpenRN is licensed under CC BY-NC 4.0

- Test your clinical judgment with a NCLEX Next-Generation style question: Chapter 2, Assignment 2 [6]

- Test your clinical judgment with a NCLEX Next-Generation style case study: Chapter 2, Case Study [7]

- **Telehealth Virtual Simulations**
  These virtual, screen-based simulations demonstrate telehealth phone calls made by nurses to clients who were recently hospitalized and live in rural areas. It is assumed the clients may not have internet access and may experience barriers to accessing care due to their geographical location. During each virtual simulation, the student has the opportunity to make decisions on how to best use therapeutic communication to establish rapport and gain trust with the client, while also

6. "MH Next-Generation Style Question " by OpenRN is licensed under CC BY-NC 4.0

7. "MH Next-Generation Therapeutic Communication Case Study " by Kellea Ewen is licensed under CC BY-NC 4.0

- considering the potential impact of the client's cultural beliefs and social determinants of health. Immediate feedback and rationale are provided for correct and incorrect answers as the student proceeds through the simulation. The first telehealth visit is a post-hospitalization welcome call where the nurse follows up on client concerns post-hospitalization. During the second telehealth call, the nurse identifies the client's specific learning needs. During the third telehealth visit, the nurse evaluates the effectiveness of the health teaching provided. The virtual simulations can be accessed by clicking on the following links.[8]

Client 1 : Alejandro Hernandez, Hispanic Male with Heart Failure: Visit 1 – Visit 2 – Visit 3
Client 2: Chen Xiulan, Asian Female with COPD: Visit 1 – Visit 2 – Visit 3
Client 3: Carolyn Smith, Caucasian Female with Mild Dementia and Chronic Kidney Disease: Visit 1 – Visit 2 – Visit 3
Client 4: Dakotah Thunderhawk, Native American Male Post-Cerebrovascular Accident: Visit 1 – Visit 2 – Visit 3
Client 5: Marian Johnson, African American Female with Diabetes and Amputation: Visit 1 – Visit 2 – Visit 3

9

8. "Telehealth Virtual Simulations" by OpenRN is licensed under CC BY-NC 4.0

9. This workforce product was funded by a grant awarded by the U.S. Department of Labor's Employment and Training Administration. The product was created by the grantee and does not necessarily reflect the official position of the U.S. Department of Labor. The U.S. Department of Labor makes no guarantees, warranties, or assurances of any kind, express or implied, with respect to such information, including any

information on linked sites and including, but not limited to, accuracy of information or its completeness, timeliness, usefulness, adequacy, continued availability, or ownership.

II Glossary

Active listening: Communicating both verbally and nonverbally that we are interested in what the other person is saying while also actively verifying our understanding with them.

Motivational interviewing (MI): A communication skill used to elicit and emphasize a client's personal motivation for modifying behavior to promote health.

Nurse-client relationship: A relationship that establishes trust and rapport with a specific purpose of facilitating therapeutic communication and engaging the client in decision-making regarding their plan of care.

SOLER: A mnemonic for effective nonverbal communication that stands for the following[1]:

- S: Sit and squarely face the client
- O: Open posture
- L: Lean towards the client to indicate interest in listening
- E: Eye contact
- R: Relax

Telehealth: The use of digital technologies to deliver medical care, health education, and public health services by remotely connecting multiple users in separate locations.

Teletherapy: Mental health counseling over the phone or online with videoconferencing tools.

Therapeutic communication: A type of professional communication defined

1. Stickley, T. (2011). From SOLER to SURETY for effective non-verbal communication. *Nurse Education in Practice, 11*(6), 395–398. https://doi.org/10.1016/j.nepr.2011.03.021

as the purposeful, interpersonal, information-transmitting process that leads to client understanding and participation.[2]

2. Abdolrahimi, M., Ghiyasvandian, S., Zakerimoghadam, M., & Ebadi, A. (2017). Therapeutic communication in nursing students: A Walker & Avant concept analysis. *Electronic Physician, 9(*8), 4968–4977. https://doi.org/10.19082/4968

PART III

CHAPTER 3 STRESS, COPING, AND CRISIS INTERVENTION

3.1 Introduction

Learning Objectives

- Describe the role of stress in exacerbating symptoms of mental health disorders
- Identify safety/protective interventions for the client and others
- Provide health teaching on stress management techniques and adaptive coping strategies
- Recognize the use of defense mechanisms
- Recognize a client in crisis
- Describe crisis intervention

Nurses support the emotional, mental, and social well-being of all clients experiencing stressful events and those with acute and chronic mental illnesses.[1] This chapter will review stressors, stress management, coping strategies, defense mechanisms, and crisis intervention.

1. NCLEX. (n.d.). *Test plans*. https://www.nclex.com/test-plans.page

3.2 Stress

Everyone experiences stress during their lives. High levels of stress can cause symptoms like headaches, back pain, and gastrointestinal symptoms. Chronic stress can contribute to the development of chronic illnesses, as well as acute physical illnesses, due to decreased effectiveness of the immune system and impact on the hypothalamic-pituitary-adrenal (HPA) axis. The HPA impact is discussed in greater detail below. It is important for nurses to recognize signs and symptoms of stress in themselves and others, as well as encourage effective stress management strategies. This section begins with an overview of the stress response and its signs and symptoms, followed by a discussion of stress management techniques.

We will begin this section by reviewing the stress response and signs and symptoms of stress and then discuss stress management techniques.

Stress Response

Stressors are any internal or external event, force, or condition that results in physical or emotional stress.[1] The body's sympathetic nervous system (SNS) responds to actual or perceived stressors with the "fight, flight, freeze, or fawn" stress response. Several reactions occur during the **stress response** that help the individual to achieve the purpose of either fighting or running.

Several physiological changes occur:

- The respiratory, cardiovascular, and musculoskeletal systems activate to increase breathing, heart rate, and blood pressure, ensuring oxygenated blood reaches the muscles.
- The liver releases glucose to provide energy for immediate action.
- Pupils dilate to enhance vision.
- Sweating prevents overheating due to increased muscle activity.

1. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

- The digestive system slows, redirecting blood flow to essential muscles.

These responses are coordinated by the hypothalamic-pituitary-adrenal (HPA) axis, which releases hormones like epinephrine, norepinephrine, and glucocorticoids (including cortisol, the "stress hormone"). These hormones target SNS receptors throughout the body, ensuring a rapid, systemic reaction.[2]

In the "fawn" response, which is particularly common in individuals exposed to relational trauma, the body may still activate stress-related pathways, but the behavioral focus shifts toward pleasing or placating others to prevent harm. Though less visibly physical, fawning is still driven by the same biological systems seeking safety in a perceived threat.

Once the threat subsides, the parasympathetic nervous system (PNS) counteracts the SNS, restoring the body to its pre-stress state. See Figure 3.1 for a comparison of SNS and PNS effects.

2. Betts, J. G., Young, K. A., Wise, J. A., Johnson, E., Poe, B., Kruse, D. H., Korol, O., Johnson, J. E., Womble, M., & DeSaix, P. (2022). *Anatomy and physiology 2e*. OpenStax. https://openstax.org/books/anatomy-and-physiology-2e/pages/1-introduction

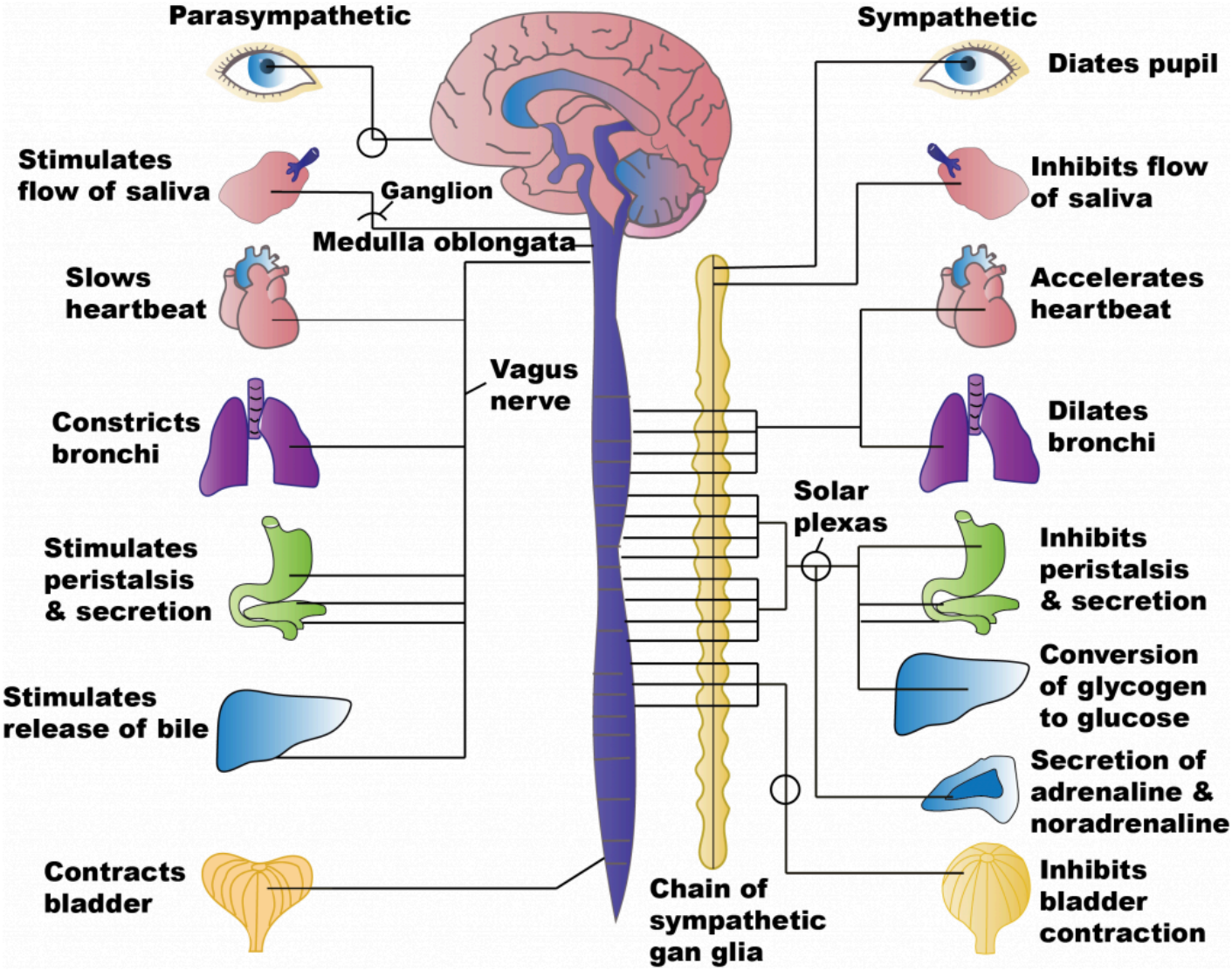

Figure 3.1 SNS and PNS Simulation

Signs and Symptoms of Chronic Stress

Nurses are often the first to notice signs and symptoms of stress and can help make their clients aware of these symptoms. Common signs and symptoms of chronic stress are as follows[3,4]:

3. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A. L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body*. American Psychological Association. https://www.apa.org/topics/stress/body

4. Kelly, J. F., & Coons, H. L. (2019). *Stress won't go away? Maybe you are suffering*

- Irritability
- Fatigue
- Headaches
- Difficulty concentrating
- Rapid, disorganized thoughts
- Difficulty sleeping
- Digestive problems
- Changes in appetite
- Feeling helpless
- A perceived loss of control
- Low self-esteem
- Loss of sexual desire
- Nervousness
- Frequent infections or illnesses
- Vocalized suicidal thoughts

Effects of Chronic Stress

The “fight or flight or freeze” stress response prepares the body to react quickly to immediate threats. However, exposure to long-term stress can cause serious effects on the cardiovascular, musculoskeletal, endocrine, gastrointestinal, and reproductive systems.[5]

Cardiovascular System: Sustained increases in heart rate, blood pressure, and stress hormones contribute to arterial inflammation, raising the risk of hypertension, heart attack, and stroke.[6]

from chronic stress. American Psychological Association. https://www.apa.org/topics/stress/chronic

5. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A. L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body.* American Psychological Association. https://www.apa.org/topics/stress/body

6. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A.

Musculoskeletal System: During acute stress, muscles tense and relax once the threat passes. However, chronic stress keeps muscles in a constant state of tension, which may contribute to stress-related disorders. For example tension and migraine headaches are linked to persistent muscle tightness in the shoulders, neck, and head. Musculoskeletal pain in the lower back and upper extremities has been associated with job-related stress.[7]

Endocrine & Immune Systems: In acute stress, cortisol provides energy to cope with immediate challenges. However, chronic stress weakens the immune system, increasing susceptibility to conditions such as chronic fatigue, metabolic disorders (e.g., diabetes, obesity), depression, and immune dysfunction.[8]

Gastrointestinal System: Chronic stress can disrupt eating patterns, leading to eating much more or much less than usual. It may also cause:

- Acid reflux, often due to increased consumption of food, alcohol, or tobacco.
- Bowel irregularities—stress can induce muscle spasms in the bowel and affect how quickly food moves through the gastrointestinal system, leading to diarrhea or constipation.
- Aggravation of chronic gastrointestinal disorders (e.g., inflammatory bowel disease, irritable bowel syndrome) due to factors such as increased

L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body.* American Psychological Association. https://www.apa.org/topics/stress/body

7. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A. L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body.* American Psychological Association. https://www.apa.org/topics/stress/body

8. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A. L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body.* American Psychological Association. https://www.apa.org/topics/stress/body

nerve sensitivity, disturbed microbiota, altered gastrointestinal motility, and/or disrupted immune function.[9]

Reproductive System: Excess cortisol can disrupt normal reproductive function in both men and women.

Men: Chronic stress can affect testosterone production, resulting in:

- Reduced libido, erectile dysfunction, or impotence.
- Impaired sperm production and maturation.
- Decreased sperm quality—studies indicate that, compared to men who did not experience stressful events in the past year, those who experienced two or more stressful events within the same period had:
  - Lower sperm motility.
  - A reduced percentage of sperm with normal morphology (size and shape).[10]

Women: Chronic stress can affect reproductive health, leading to:

- Menstrual irregularities, including absent or irregular cycles, more painful periods, and changes in cycle length.
- Worsened premenstrual symptoms, such as cramping, fluid retention, bloating, negative mood, and mood swings.
- Reduced sexual desire.
- Impaired fertility and pregnancy health—stress can negatively impact:

9. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A. L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body.* American Psychological Association. https://www.apa.org/topics/stress/body

10. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A. L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body.* American Psychological Association. https://www.apa.org/topics/stress/body

- A woman's ability to conceive.
- Pregnancy health and postpartum recovery.
- Fetal development.
- Maternal-infant bonding following delivery.
- The risk of postpartum depression.[11]

Adverse Childhood Experiences

Adults with adverse childhood experiences or exposure to adverse life events often experience ongoing chronic stress with an array of physical, mental, and social health problems throughout adulthood. Some of the most common health risks include physical and mental illness, substance use disorder, and a high level of engagement in risky sexual behavior.[12]

As previously discussed in Chapter 1, **adverse childhood experiences (ACEs)** include sexual abuse, physical abuse, emotional abuse, physical neglect, emotional neglect, parental loss, or parental separation before the child is 18 years old. Individuals who have experienced four or more ACEs are at a significantly higher risk of developing mental, physical, and social problems in adulthood. Research has established that early life stress is a predictor of smoking, alcohol consumption, and drug dependence. Adults who experienced ACEs related to maladaptive family functioning (parental mental illness, substance use disorder, criminality, family violence, physical and sexual abuse, and neglect) are at higher risk for developing mood, substance abuse, and anxiety disorders. ACEs are also associated with an increased risk of the

11. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A. L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body.* American Psychological Association. https://www.apa.org/topics/stress/body

12. Amnie, A. G. (2018). Emerging themes in coping with lifetime stress and implication for stress management education. *SAGE Open Medicine, 6*. https://doi.org/10.1177%2F2050312118782545

development of malignancy, cardiovascular disease, metabolic syndrome, and other chronic debilitating conditions.[13]

Stress Management

Recognizing signs and symptoms of stress allows individuals to implement stress management strategies. Nurses can educate clients about effective strategies for reducing the stress response. Relaxation techniques and other stress-relieving activities have been shown to effectively reduce muscle tension, decrease the incidence of stress-related disorders, and increase a sense of well-being. For individuals with chronic pain conditions, stress-relieving activities have been shown to improve mood and daily function.[14] Effective strategies include the following[15,16]:

- Set personal and professional boundaries
- Maintain a healthy social support network
- Select healthy food choices
- Engage in regular physical exercise

13. Amnie, A. G. (2018). Emerging themes in coping with lifetime stress and implication for stress management education. *SAGE Open Medicine, 6*. https://doi.org/10.1177%2F2050312118782545

14. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A. L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body*. American Psychological Association. https://www.apa.org/topics/stress/body

15. Shaw, W., Labott-Smith, S., Burg, M. M., Hostinar, C., Alen, N., van Tilburg, M. A. L., Berntson, G. G., Tovian, S. M., & Spirito, M. (2018). *Stress effects on the body*. American Psychological Association. https://www.apa.org/topics/stress/body

16. Kelly, J. F., & Coons, H. L. (2019). *Stress won't go away? Maybe you are suffering from chronic stress*. American Psychological Association. https://www.apa.org/topics/stress/chronic

- Get an adequate amount of sleep each night
- Set realistic and fair expectations
- Mindfulness activities

Setting limits is essential for effectively managing stress. Individuals should list all of the projects and commitments making them feel overwhelmed, identify essential tasks, and cut back on nonessential tasks. For work-related projects, responsibilities can be discussed with supervisors to obtain input on priorities. Encourage individuals to refrain from accepting any more commitments until they feel their stress is under control.[17]

Maintaining a healthy social support network with friends and family can provide emotional support.[18] Caring relationships and healthy social connections are essential for achieving resilience.

Eating nutritiously is a valuable tool in stress management. Clients should be taught to eat at regular intervals to ensure steady blood glucose levels to ensure optimal performance. Foods high in fatty acids, such as nuts and fish oil, can help combat anxiety and depression. Foods that are high in vitamins and minerals, such as leafy greens can also work to combat stress. A diet that is high in fiber has also been shown to result in lower perceived levels of stress. Additionally, caffeine should be avoided as it can heighten anxiety. Lastly, prepare for stress inducing or hectic times by ensuring that high

17. Kelly, J. F., & Coons, H. L. (2019). *Stress won't go away? Maybe you are suffering from chronic stress*. American Psychological Association. https://www.apa.org/topics/stress/chronic

18. Kelly, J. F., & Coons, H. L. (2019). *Stress won't go away? Maybe you are suffering from chronic stress*. American Psychological Association. https://www.apa.org/topics/stress/chronic

nutrient food is readily available. Good options are hummus with carrots, yogurt with granola or fruit and cheese.[19]

Physical activity increases the body's production of endorphins that boost the mood and reduce stress. Nurses can educate clients that a brisk walk or other aerobic activity can increase energy and concentration levels and lessen feelings of anxiety.[20]

People who are chronically stressed often suffer from lack of adequate sleep and, in some cases, stress-induced insomnia. Nurses can educate individuals how to take steps to increase the quality of sleep. Experts recommend going to bed at a regular time each night, striving for at least 7-8 hours of sleep, and, if possible, eliminating distractions, such as television, cell phones, and computers from the bedroom. Begin winding down an hour or two before bedtime and engage in calming activities such as listening to relaxing music, reading an enjoyable book, taking a soothing bath, or practicing relaxation techniques like meditation. Avoid eating a heavy meal or engaging in intense exercise immediately before bedtime. If a person tends to lie in bed worrying, encourage them to write down their concerns and work on quieting their thoughts.[21] For many individuals, sleeping in a cool room facilitates sleep.

Nurses can encourage clients to set realistic expectations, look at situations more positively, see problems as opportunities, and refute negative thoughts to stay positive and minimize stress. Setting realistic expectations and

19. The University of North Carolina at Chapel Hill. (2025). *Nutrition and stress*. https://campushealth.unc.edu/health_topic/nutrition-and-stress/

20. Kelly, J. F., & Coons, H. L. (2019). *Stress won't go away? Maybe you are suffering from chronic stress*. American Psychological Association. https://www.apa.org/topics/stress/chronic

21. Kelly, J. F., & Coons, H. L. (2019). *Stress won't go away? Maybe you are suffering from chronic stress*. American Psychological Association. https://www.apa.org/topics/stress/chronic

positively reframing the way one looks at stressful situations can make life seem more manageable. Clients should be encouraged to keep challenges in perspective and do what they can reasonably do to move forward.[22]

Mindfulness is a form of meditation that uses breathing and thought techniques to create an awareness of one's body and surroundings. Research suggests that mindfulness can have a positive impact on stress, anxiety, and depression.[23] Additionally, guided imagery may be helpful for enhancing relaxation. The use of guided imagery provides a narration that the mind can focus on during the activity. For example, as the nurse encourages a client to use mindfulness and relaxation breathing, they may say, "As you breathe in, imagine waves rolling gently in. As you breathe out, imagine the waves rolling gently back out to sea." Read more about mindfulness techniques in the Coping section of this chapter.

WHO Stress Management Guide

In addition to the stress management techniques discussed in the previous section, the World Health Organization (WHO) shares additional techniques in a guide titled *Doing What Matters in Times of Stress*. This guide is consists of five categories. Each category includes techniques and skills that, based on evidence and field testing, can reduce overall stress levels even if only used for

22. Kelly, J. F., & Coons, H. L. (2019). *Stress won't go away? Maybe you are suffering from chronic stress*. American Psychological Association. https://www.apa.org/topics/stress/chronic

23. Kandola, A. (2018). *What are the health effects of chronic stress?* MedicalNewsToday. https://www.medicalnewstoday.com/articles/323324#treatment

a few minutes each day. These categories include 1) Grounding, 2) Unhooking, 3) Acting on our values, 4) Being kind, and 5) Making room.[24]

Nurses can educate clients that powerful thoughts and feelings are a natural part of stress, but problems can occur if we get "hooked" by them. For example, one minute you might be enjoying a meal with family, and the next moment you get "hooked" by angry thoughts and feelings. Stress can make someone feel as if they are being pulled away from the values of the person they want to be, such as being calm, caring, attentive, committed, persistent, and courageous.[25]

There are many kinds of difficult thoughts and feelings that can "hook us," such as, "This is too hard," "I give up," "I am never going to get this," "They shouldn't have done that," or memories about difficult events that have occurred in our lives. When we get "hooked," our behavior changes. We may do things that make our lives worse, like getting into more disagreements, withdrawing from others, or spending too much time lying in bed. These are called "away moves" because they move us away from our values. Sometimes emotions become so strong they feel like emotional storms. However, we can "unhook" ourselves by focusing and engaging in what we are doing, referred to as "grounding."[26]

GROUNDING

"Grounding" is a helpful tool when feeling distracted or having trouble focusing on a task and/or the present moment. The first step of grounding is

24. World Health Organization. (2020). *Doing what matters in times of stress: An illustrated guide*. https://www.who.int/publications/i/item/9789240003927

25. World Health Organization. (2020). *Doing what matters in times of stress: An illustrated guide*. https://www.who.int/publications/i/item/9789240003927

26. World Health Organization. (2020). *Doing what matters in times of stress: An illustrated guide*. https://www.who.int/publications/i/item/9789240003927

to notice how you are feeling and what you are thinking. Next, slow down and connect with your body by focusing on your breathing. Exhale completely and wait three seconds, and then inhale as slowly as possible. Slowly stretch your arms and legs and push your feet against the floor. The next step is to focus on the world around you. Notice where you are and what you are doing. Use your five senses. What are five things you can see? What are four things you can hear? What can you smell? Tap your leg or squeeze your thumb and count to ten. Touch your knees or another object within reach. What does it feel like? Grounding helps us engage in life, refocus on the present moment, and realign with our values.[27]

UNHOOKING

At times we may have unwanted, intrusive, negative thoughts that negatively affect us. "Unhooking" is a tool to manage and decrease the impact of these unwanted thoughts. First, NOTICE that a thought or feeling has hooked you, and then NAME it. Naming it begins by silently saying, "Here is a thought," or "Here is a feeling." By adding "I notice," it unhooks us even more. For example, "I notice there is a knot in my stomach." The next step is to REFOCUS on what you are doing, fully engage in that activity, and pay full attention to whoever is with you and whatever you are doing. For example, if you are having dinner with family and notice feelings of anger, note "I am having feelings of anger," but choose to refocus and engage with family.[28]

ACTING ON OUR VALUES

The third category of skills is called "Acting on Our Values." This means, despite challenges and struggles we are experiencing, we will act in line with

27. World Health Organization. (2020). *Doing what matters in times of stress: An illustrated guide*. https://www.who.int/publications/i/item/9789240003927

28. World Health Organization. (2020). *Doing what matters in times of stress: An illustrated guide*. https://www.who.int/publications/i/item/9789240003927

what is important to us and our beliefs. Even when facing difficult situations, we can still make the conscious choice to act in line with our values. The more we focus on our own actions, the more we can influence our immediate world and the people and situations we encounter every day. We must continually ask ourselves, "Are my actions moving me toward or away from my values?" Remember that even the smallest actions have impact, just as a giant tree grows from a small seed. Even in the most stressful of times, we can take small actions to live by our values and maintain or create a more satisfying and fulfilling life. These values should also include self-compassion and care. By caring for oneself, we ultimately have more energy and motivation to then help others.[29]

BEING KIND

"Being Kind" is a fourth tool for reducing stress. Kindness can make a significant difference to our mental health by being kind to others, as well as to ourselves. Being kind to others helps build strong relationships, which makes people happier and more resilient. Studies show that people who are kind tend to live longer and have better health. Acts of kindness benefit both the person giving and receiving them. Even just witnessing kindness can make people feel good and encourage them to be more kind themselves. It creates a positive cycle of connection and caring within communities.[30]

MAKING ROOM

"Making Room" is a fifth tool for reducing stress. Sometimes trying to push away painful thoughts and feelings does not work very well. In these

29. World Health Organization. (2020). *Doing what matters in times of stress: An illustrated guide*. https://www.who.int/publications/i/item/9789240003927

30. Fryburg, D. A. (2021). Kindness as a stress reduction-health promotion intervention: A review of the psychobiology of caring. *American Journal of Lifestyle Medicine, 16*(1):89-100. doi: 10.1177/1559827620988268.

situations, it is helpful to notice and name the feeling, and then "make room" for it. "Making room" means allowing the painful feeling or thought to come and go like the weather. Nurses can educate clients that as they breathe, they should imagine their breath flowing into and around their pain and making room for it. Instead of fighting with the thought or feeling, they should allow it to move through them, just like the weather moves through the sky. If clients are not fighting with the painful thought or feeling, they will have more time and energy to engage with the world around them and do things that are important to them.[31]

- Read *Doing What Matters in Times of Stress* by the World Health Organization (WHO).[32]
- View the following YouTube video on the WHO Stress Management Guide[33]:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingmhcc/?p=135#oembed-1

31. World Health Organization. (2020). *Doing what matters in times of stress: An illustrated guide*. https://www.who.int/publications/i/item/9789240003927

32. World Health Organization. (2020). *Doing what matters in times of stress: An illustrated guide*. https://www.who.int/publications/i/item/9789240003927

33. World Health Organization (WHO). (2020, November 4). *Doing what matters in times of stress: An illustrated guide* [Video]. YouTube. Licensed in the Public Domain. https://youtu.be/E3Cts45FNrk

Stress Related to the COVID-19 Pandemic and World Events

The COVID-19 pandemic had a major effect on many people's lives. Many health care professionals faced challenges that were stressful, overwhelming, and caused strong emotions.[34] See Figure 3.2[35] for a message from the World Health Organization regarding stress and health care workers.

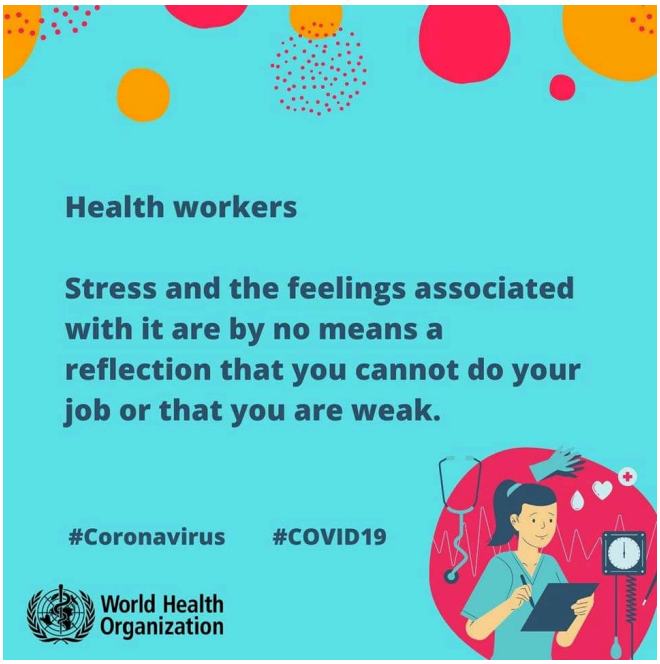

Figure 3.2 Stress and Healthcare Workers

Learning to cope with stress in a healthy way can increase feelings of

34. Centers for Disease Control and Prevention. (2021). *Healthcare personnel and first responders: How to cope with stress and build resilience during the COVID-19 pandemic.* https://stacks.cdc.gov/view/cdc/95184

35. "89118597-2933268333403014-548082632068431872-n.jpg" by unknown author for World Health Organization (WHO) is licensed in the Public Domain. Access for free at https://www.who.int/campaigns/connecting-the-world-to-combat-coronavirus/healthyathome/healthyathome—mental-health?gclid=Cj0KCQiA0MD_BRCTARIsADXoopa7YZldaIqCtKlGrxDV8YcUBtpVSD2HaOtT9NsdT8ajyCXbnPot-bsaAvlQEALw_wcB.

resiliency for health care professionals. Here are ways to help manage stress resulting from world events[36]:

- Take breaks from watching, reading, or listening to news stories and social media. It's good to be informed but consider limiting news to just a couple times a day and disconnecting from phones, TVs, and computer screens for a while.
    - It can be important to do a self check-in before reading any news. "Do I have the emotional energy to handle a difficult headline if I see one?"
- Take care of your body.
    - Take deep breaths, stretch, or meditate
    - Try to eat healthy, well-balanced meals
    - Exercise regularly
    - Get plenty of sleep
    - Avoid excessive alcohol, tobacco, and substance use
    - Continue routine preventive measures (such as vaccinations, cancer screenings, etc.) as recommended by your health care provider
- Make time to unwind. Plan activities you enjoy.
- Purposefully connect with others. It is especially important to stay connected with your friends and family. Helping others cope through phone calls or video chats can help you and your loved ones feel less lonely or isolated. Connect with your community or faith-based organizations.
- Use the techniques described in the WHO stress management guide.[37]

36. Centers for Disease Control and Prevention. (2021). *Healthcare personnel and first responders: How to cope with stress and build resilience during the COVID-19 pandemic*. https://stacks.cdc.gov/view/cdc/95184

37. World Health Organization. (2020). *Doing what matters in times of stress: An illustrated guide*. https://www.who.int/publications/i/item/9789240003927

Strategies for Self-Care

By becoming self-aware regarding signs of stress, you can implement self-care strategies to prevent compassion fatigue and burnout. Use the following "A's" to assist in building resilience, connection, and compassion[38]:

- **Attention:** Become aware of your physical, psychological, social, and spiritual health. What are you grateful for? What are your areas of improvement? This protects you from drifting through life on autopilot.
- **Acknowledgement:** Honestly look at all you have witnessed as a health care professional. What insight have you experienced? Acknowledging the pain of loss you have witnessed protects you from invalidating the experiences.
- **Affection:** Choose to look at yourself with kindness and warmth. Affection and self-compassion prevent you from becoming bitter and "being too hard" on yourself.
- **Acceptance:** Choose to be at peace and welcome all aspects of yourself. By accepting both your talents and imperfections, you can protect yourself from impatience, victim mentality, and blame.

38. Lowey, S. E. (2015). *Nursing care at the end of life*. Open SUNY Textbooks. https://ecampusontario.pressbooks.pub/nursingcare/

3.3 Coping

The health consequences of chronic stress depend on an individual's coping styles and their resilience to real or perceived stress. **Coping** refers to cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts.[1]

Coping strategies are actions, a series of actions, or thought processes used in meeting a stressful or unpleasant situation or in modifying one's reaction to such a situation. Coping strategies are classified as adaptive or maladaptive. **Adaptive coping strategies** include problem-focused coping and emotion-focused coping. **Problem-focused coping** typically focuses on seeking treatment such as counseling or cognitive behavioral therapy. **Emotion-focused coping** includes strategies such as mindfulness, meditation, and yoga; using humor and jokes; seeking spiritual or religious pursuits; engaging in physical activity or breathing exercises; and seeking social support.

Maladaptive coping responses include avoidance of the stressful condition, withdrawal from a stressful environment, disengagement from stressful relationships, and misuse of drugs and/or alcohol.[2] Nurses can educate individuals and their family members about adaptive and emotion-focused coping strategies. Additionally, nurses can make referrals to interprofessional team members for problem-focused coping and treatment options for individuals experiencing maladaptive coping responses to stress.

1. Amnie, A. G. (2018). Emerging themes in coping with lifetime stress and implication for stress management education. *SAGE Open Medicine, 6*. https://doi.org/10.1177%2F2050312118782545
2. Amnie, A. G. (2018). Emerging themes in coping with lifetime stress and implication for stress management education. *SAGE Open Medicine, 6*. https://doi.org/10.1177%2F2050312118782545

Emotion-Focused Coping Strategies

Nurses can educate clients about many emotion-focused coping strategies, such as meditating, practicing yoga, journaling, praying, spending time in nature, nurturing supportive relationships, and practicing mindfulness.

Meditation

Meditation can induce feelings of calm and clearheadedness and improve concentration and attention. Research has shown that meditation increases the brain's gray matter density, which can reduce sensitivity to pain, enhance the immune system, help regulate difficult emotions, and relieve stress. Meditation has been proven helpful for people with depression and anxiety, cancer, fibromyalgia, chronic pain, rheumatoid arthritis, type 2 diabetes, chronic fatigue syndrome, and cardiovascular disease.[3] See Figure 3.3[4] for an image of an individual participating in meditation.

3. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

4. "yoga-class-a-cross-legged-palms-up-meditation-position-850×831.jpg" by Amanda Mills, USCDCP on Pixnio is licensed under CC0

Figure 3.3 Meditation

Yoga

Yoga is a centuries-old spiritual practice that creates a sense of union within the practitioner through physical postures, ethical behaviors, and breath expansion. The systematic practice of yoga has been found to reduce inflammation and stress, decrease depression and anxiety, lower blood pressure, and increase feelings of well-being.[5] See Figure 3.4[6] for an image of an individual participating in yoga.

5. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

6. "9707554768.jpg" by Dave Rosenblum is licensed under CC BY 2.0

Figure 3.4 Yoga

Journaling

Journaling can help a person become more aware of their inner life and feel more connected to experiences. Studies show that writing during difficult times may help a person find meaning in life's challenges and become more resilient in the face of obstacles. When journaling, it can be helpful to focus on three basic questions: What experiences give me energy? What experiences drain my energy? Were there any experiences today where I felt alive and experienced "flow"? Allow yourself to write freely, without stopping to edit or worry about spelling and grammar.[7]

Prayer

Prayer can elicit the relaxation response, along with feelings of hope, gratitude, and compassion, all of which have a positive effect on overall well-being. There are several types of prayer rooted in the belief that there is a higher power. This belief can provide a sense of comfort and support in

7. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

difficult times. A recent study found that adults who were clinically depressed who believed their prayers were heard by a concerned presence responded much better to treatment than those who did not believe.[8]

Individuals can be encouraged to find a spiritual community, such as a church, synagogue, temple, mosque, meditation center, or other local group that meets to discuss spiritual issues. The benefits of social support are well-documented, and having a spiritual community to turn to for fellowship can provide a sense of belonging and support.[9]

Spending Time in Nature & Spirituality

Spending time in nature is cited by many individuals as a spiritual practice that contributes to their mental health.[10] Spirituality is defined as a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence and experience relationship to self, family, others, community, society, nature, and the significant or sacred.[11] Spiritual needs and spirituality are often mistakenly equated with religion, but

8. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality
9. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality
10. Yamada, A., Lukoff, D., Lim, C. S. F., & Mancuso, L. L. (2020). Integrating spirituality and mental health: Perspectives of adults receiving public mental health services in California. *Psychology of Religion and Spirituality, 12*(3), 276–287. https://doi.org/10.1037/rel0000260
11. Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. *Journal of Palliative Medicine, 17*(6), 642–656. https://doi.org/10.1089/jpm.2014.9427

spirituality is a broader concept. Other elements of spirituality include meaning, love, belonging, forgiveness, and connectedness.[12]

Spending time in nature is a powerful expression of spirituality for many individuals, offering a space for reflection, connection, and renewal. In the natural world, people often find a sense of awe and wonder that transcends the ordinary, fostering a deep awareness of something greater than themselves. This experience can be profoundly grounding and healing, particularly for those navigating mental health challenges or seeking greater emotional balance. Nature provides a unique setting where individuals can engage in contemplative practices such as walking, mindfulness, journaling, or simply being present. These moments often lead to a heightened sense of purpose, inner peace, and clarity. The rhythmic patterns of the natural environment—such as waves, birdsong, rustling leaves, or the rising and setting of the sun—can evoke feelings of harmony and connectedness that are essential to many people's spiritual well-being.

Supportive Relationships

Individuals should be encouraged to nurture supportive relationships with family, significant others, and friends. Relationships aren't static – they are living, dynamic aspects of our lives that require attention and care. To benefit from strong connections with others, individuals should take charge of their relationships and devote time and energy to support them. It can be helpful to create rituals together. With busy schedules and the presence of online social media that offer the façade of real contact, it's very easy to drift from friends. Research has found that people who deliberately make time for gatherings enjoy stronger relationships and more positive energy. An easy

12. Rudolfsson, G., Berggren, I., & da Silva, A. B. (2014). Experiences of spirituality and spiritual values in the context of nursing – An integrative review. *The Open Nursing Journal, 8*, 64–70. https://dx.doi.org/10.2174%2F1874434601408010064

way to do this is to create a standing ritual that you can share and that doesn't create more stress, such as talking on the telephone on Fridays or sharing a walk during lunch breaks.[13]

Mindfulness

Mindfulness has been defined as, "Awareness that arises through paying attention, on purpose, in the present moment, and nonjudgmentally." Mindfulness has also been described as, "Non-elaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises is acknowledged and accepted as it is." Mindfulness helps us be present in our lives and gives us some control over our reactions and repetitive thought patterns. It helps us pause, get a clearer picture of a situation, and respond more skillfully. Compare your default state to mindfulness when studying for an exam in a difficult course or preparing for a clinical experience. What do you do? Do you tell yourself, "I am not good at this" or "I am going to look stupid"? Does this distract you from paying attention to studying or preparing? How might it be different if you had an open attitude with no concern or judgment about your performance? What if you directly experienced the process as it unfolded, including the challenges, anxieties, insights, and accomplishments, while acknowledging each thought or feeling and accepting it without needing to figure it out or explore it further? If practiced regularly, mindfulness helps a person start to see the habitual patterns that lead to automatic negative reactions that create stress. By observing these thoughts and emotions instead of reacting to them, a person can develop a broader perspective and can choose a more effective response.[14]

13. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

14. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

- Try free mindfulness activities at the Free Mindfulness Project.

Coping with Loss and Grief

In addition to assisting individuals recognize and cope with their stress and anxiety, nurses can also use this knowledge regarding coping strategies to support clients and their family members as they cope with life changes, grief, and loss that can cause emotional problems and feelings of distress.

- Review concepts and nursing care related to coping with grief and loss in the "Grief and Loss" chapter of Open RN *Nursing Fundamentals*.

3.4 Defense Mechanisms

When providing clients with stress management techniques and effective coping strategies, nurses must be aware of common defense mechanisms. **Defense mechanisms** are reaction patterns used by individuals to protect themselves from anxiety that arises from stress and conflict.[1] Excessive use of defense mechanisms is associated with specific mental health disorders. With the exception of suppression, all other defense mechanisms are unconscious and out of the awareness of the individual. See Table 3.4 for a description of common defense mechanisms.

Table 3.4 Common Defense Mechanisms

1. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

Defense Mechanisms	Definitions	Examples
Conversion	Anxiety caused by repressed impulses and feelings are converted into a physical symptoms.[2]	An individual scheduled to see their therapist to discuss a past sexual assault experiences a severe headache and cancels the appointment.
Denial	Unpleasant thoughts, feelings, wishes, or events are ignored or excluded from conscious awareness to protect themselves from overwhelming worry or anxiety.[3,4]	A client recently diagnosed with cancer states there was an error in diagnosis and they don't have cancer. Other examples include denial of a financial problem, an addiction, or a partner's infidelity.
Dissociation	A feeling of being disconnected from a stressful or traumatic event – or feeling that the event is not really happening – to block out mental trauma and protect the mind from too much stress.[5]	A person experiencing physical abuse may feel as if they are floating above their bodies observing the situation.
Displacement	Unconscious transfer of one's emotions or reaction from an original object to a less-threatening target to discharge tension.[6]	An individual who is angry with their partner kicks the family dog. An angry child breaks a toy or yells at a sibling instead of attacking their father. A frustrated employee criticizes their spouse instead of their boss.[7]
Introjection	Unconsciously incorporating the attitudes, values, and qualities of another person's personality.[8]	A client talks and acts like one of the nurses they admire.

2. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

3. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

4. Sissons, C. (2020). *Defense mechanisms in psychology: What are they?* MedicalNewsToday. https://www.medicalnewstoday.com/articles/defense-mechanisms

5. Sissons, C. (2020). *Defense mechanisms in psychology: What are they?* MedicalNewsToday. https://www.medicalnewstoday.com/articles/defense-mechanisms

6. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

7. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

8. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

Projection	A process when one attributes their individual positive or negative characteristics, affects, and impulses to another person or group.[9]	A person conflicted over expressing anger changes "I hate him" to "He hates me."[10]
Rationalization	Logical reasons are given to justify unacceptable behavior to defend against feelings of guilt, maintain self-respect, and protect oneself from criticism.[11]	A client who is overextended on several credit cards rationalizes it is okay to buy more clothes to be in style when spending money that was set aside to pay for the monthly rent and utilities. A student caught cheating on a test rationalizes, "Everybody cheats."
Reaction Formation	Unacceptable or threatening impulses are denied and consciously replaced with an opposite, acceptable impulse.[12]	A client who hates their mother writes in their journal that their mom is a wonderful mother.
Regression	A return to a prior, lower state of cognitive, emotional, or behavioral functioning when threatened with overwhelming external problems or internal conflicts.[13]	A child who was toilet trained reverts to wetting their pants after their parents' divorce.
Repression	Painful experiences and unacceptable impulses are unconsciously excluded from consciousness as a protection against anxiety.[14]	A victim of incest indicates they have always hated their brother (the molester) but cannot remember why.
Splitting	Objects provoking anxiety and ambivalence are viewed as either all good or all bad.[15]	A client tells the nurse they are the most wonderful person in the world, but after the nurse enforces the unit rules with them, the client tells the nurse they are the worst person they have ever met.

9. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

Suppression	A conscious effort to keep disturbing thoughts and experiences out of mind or to control and inhibit the expression of unacceptable impulses and feelings. Suppression is similar to repression, but it is a conscious process.[16,17]	An individual has an impulse to tell their boss what they think about them and their unacceptable behavior, but the impulse is suppressed because of the need to keep the job.
Sublimation	Unacceptable sexual or aggressive drives are unconsciously channeled into socially acceptable modes of expression that indirectly provide some satisfaction for the original drives and protect individuals from anxiety induced by the original drive.[18]	An individual with an exhibitionistic impulse channels this impulse into creating dance choreography. A person with a voyeuristic urge completes scientific research and observes research subjects. An individual with an aggressive drive joins the football team.[19]
Symbolization	The substitution of a symbol for a repressed impulse, affect, or idea.[20]	A client unconsciously wears red clothing due a repressed impulse to physically harm someone.

10. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org
11. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org
12. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org
13. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org
14. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org
15. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

16. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

17. Sissons, C. (2020). *Defense mechanisms in psychology: What are they?* MedicalNewsToday. https://www.medicalnewstoday.com/articles/defense-mechanisms

18. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

19. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

20. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

3.5 Crisis and Crisis Intervention

If you were asked to describe someone in crisis, what would come to your mind? Many of us might draw on traditional images of someone anxiously wringing their hands, pacing the halls, having a verbal outburst, or acting erratically. Health care professionals should be aware that crisis can be reflected in these types of behaviors, but it can also be demonstrated in various verbal and nonverbal signs. There are many potential causes of crisis, and there are four phases an individual progresses through to crisis. Nurses and other health care professionals are often the frontline care providers when an individual faces a crisis, so it is important to recognize signs of crisis, know what to assess, intervene appropriately, and evaluate crisis resolution.

Definition of Crisis

A **crisis** can be broadly defined as the inability to cope or adapt to a stressor. Historically, the first examination of crisis and development of formal crisis intervention models occurred among psychologists in the 1960s and 1970s. Although definitions of crisis have evolved, there are central tenets related to an individual's stress management.

Consider the historical context of crisis as first formally defined in the literature by Gerald Caplan. Crisis was defined as a situation that produces psychological disequilibrium in an individual and constitutes an important problem in which they can't escape or solve with their customary problem-solving resources.[1] This definition emphasized the imbalance created by situation stressors.

Albert Roberts updated the concept of crisis management in more recent years to include a reflection on the level of an individual's dysfunction. He defined crisis as an acute disruption of psychological homeostasis in which one's usual coping mechanisms fail with evidence of distress and functional

1. Caplan, G. (1964). *Principles of preventive psychiatry.* Basic Books.

impairment.[2] A person's subjective reaction to a stressful life experience compromises their ability (or inability) to cope or function.

Causes of Crisis

A crisis can emerge for individuals due to a variety of events. It is also important to note that events may be managed differently by different individuals. For example, a stressful stimulus occurring for Client A may not induce the same crisis response as it does for Client B. Therefore, nurses must remain vigilant and carefully monitor each client for signs of emerging crisis.

A crisis commonly occurs when individuals experience some sort of significant life event. These events may be unanticipated, but that is not always the case. An example of anticipated life events that may cause a crisis include the birth of a baby. For example, the birth (although expected) can result in a crisis for some individuals as they struggle to cope with and adapt to this major life change. Predictable, routine schedules from before the child was born are often completely upended. Priorities shift to an unyielding focus on the needs of the new baby. Although many individuals welcome this change and cope effectively with the associated life changes, it can induce crises in those who are unprepared for such a change.

Crisis situations are more commonly associated with unexpected life events. Individuals who experience a newly diagnosed critical or life-altering illness are at risk for experiencing a crisis. For example, a client experiencing a life-threatening myocardial infarction or receiving a new diagnosis of cancer may experience a crisis. Additionally, the crisis may be experienced by family and loved ones of the client as well. Nurses should be aware that crisis

2. Roberts, A. R. (2005). Bridging the past and present to the future of crisis intervention and crisis management. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (3rd ed.). Oxford University Press. pp. 3-34.

intervention and the need for additional support may occur in these types of situations and often extend beyond the needs of the individual client.

Other events that may result in crisis development include stressors such as the loss of a job, loss of one's home, divorce, or death of a loved one. It is important to be aware that clustering of multiple events can also cause stress to build sequentially so that individuals can no longer successfully manage and adapt, resulting in crisis.

Categories of Crises

Due to a variety of stimuli that can cause the emergence of a crisis, crises can be categorized to help nurses and health care providers understand the crisis experience and the resources that may be most beneficial for assisting the client and their family members. Crises can be characterized into one of three categories: maturational, situational, or social crisis. Table 3.5a explains characteristics of the different categories of crises and provides examples of stressors associated with that category.

Table 3.5a Categories of Crises

Category	Characteristics	Examples
Maturational Crisis (also known as Developmental crisis)	• The result of normal processes of growth and development. • Commonly occurs at specific developmental periods of life. • It is predictable in nature and normally occurs as a part of life. • An individual is vulnerable based on their equilibrium.	• Birth • Adolescence • Marriage • Death
Situational Crisis	• An unexpected personal stressful event occurs with little advance warning. • It is less predictable in nature. • The event threatens an individual's equilibrium.	• Accident • Illness or serious injury of self or family member • Loss of a job • Bankruptcy • Relocation/ geographical move • Divorce
Social Crisis (also known as Adventitious crisis)	• An event that is uncommon or unanticipated. • The event often involves multiple losses or extensive losses. • It can occur due to a major natural or man-made event. • It is unpredictable in nature. • The event poses a severe threat to an individual's equilibrium.	• Flood • Fire • Tornado • Hurricane • Earthquake • War • Riot • Violent crime

Phases of Crisis

The process of crisis development can be described as four distinct phases. The phases progress from initial exposure to the stressor, to tension escalation, to an eventual breaking point. These phases reflect a sequential progression in which resource utilization and intervention are critical for assisting a client in crisis. Table 3.5b describes the various phases of crisis, their defining characteristics, and associated signs and symptoms that individuals may experience as they progress through each phase.

Table 3.5b Crisis Phases[3,4]

3. Caplan, G. (1964). *Principles of preventive psychiatry.* Basic Books.

4. Centers for Disease Control and Prevention. (2018). *The National Institute for Occupational Health and Safety*. https://www.cdc.gov/niosh/

Crisis Phase	Defining Characteristics	Signs and Symptoms
Phase 1: **Normal Stress & Anxiety**	Exposure to a precipitating stressor. Stressors may be considered minor annoyances and inconveniences of everyday life.	Anxiety levels or the stress response begin to elevate. Individuals try using previously successful problem-solving techniques to attempt resolution of the stressor. Individuals are rational and in control of their behavior and emotions.
Phase 2: **Rising Anxiety Level**	Problem-solving techniques do not relieve the stressor. Use of past coping strategies are not successful.	Anxiety levels increase and individuals experience increased discomfort. Feelings of helplessness, confusion, and disorganized thinking may occur. Individuals may complain of "feeling lost" in how to proceed. Individuals may experience elevated heart rate and respiration rate. Their voice pitch may be higher with a more rapid speech pattern. Nervous habits such as finger or foot tapping may occur.
Phase 3: **Severe Level of Stress and Anxiety**	Individuals use all possible internal and external resources. Problems are explored from different perspectives, and new problem-solving techniques are attempted.	Equilibrium may be restored if new problem-solving approaches are successful. Individuals experience decreased anxiety if resolution occurs. If new problem-solving techniques are not successful, the level of anxiety worsens, and functioning is impaired as the stressor continues to impact the individual. Capacity to reason becomes significantly diminished, and behaviors become more disruptive. Communication processes may include yelling and swearing. Individuals may become very argumentative or use threats. Individuals may pace; clench their fists; perspire heavily; or demonstrate rapid, shallow, panting breaths.

Phase 4: **Crisis**	If resolution is not achieved, tension escalates to a critical breaking point.	Individuals experience unbearable anxiety, increased feelings of panic, and disordered thinking processes. There is an urgent need to end emotional discomfort. Many cognitive functions are impaired as the crisis event becomes thought consuming. Emotions are labile, and some clients may experience psychotic thinking. *It is important to note that some individuals at this level of crisis may be a danger to themselves and others.

Crisis Assessment

Nurses must be aware of the potential impact of stressors for their clients and the ways in which they may manifest in a crisis. The first step in assessing for a crisis occurs with the basic establishment of a therapeutic nurse-client relationship. Understanding who your client is, what is occurring in their life, what resources are available to them, and their individual beliefs, supports, and general demeanor can help a nurse determine if a client is at risk for ineffective coping and possible progression to crisis.

Crisis symptoms can manifest in various ways and can vary significantly depending on the underlying condition and context. Nurses should carefully monitor for signs of the progression through the phases of crisis such as the following:

- Escalating anxiety
- Denial
- Confusion or disordered thinking
- Anger and hostility
- Helplessness and withdrawal
- Inefficiency
- Hopelessness and depression
- Steps toward resolution and reorganization
- Physiological symptoms such as headache or shortness of breath

When a nurse identifies these signs in a client or their family members, it is important to carefully explore the symptoms exhibited and the potential

stressors. Collecting information regarding the severity of the stress response, the individual's or family's resources, and the crisis phase can help guide the nurse and health care team toward appropriate intervention.

Crisis Interventions

Crisis intervention is an important role for the nurse and health care team to assist clients and families toward crisis resolution. Resources are employed, and interventions are implemented to therapeutically assist the individual in whatever phase of crisis they are experiencing. A crisis state is time-limited, usually lasting several days but no longer than four to six weeks. Depending on the stage of the crisis, various strategies and resources are used.

The goals of crisis intervention are the following:

- Ensure safety: Identify, assess, and intervene
- Provide support: Return the individual to a prior level of functioning as quickly as possible
- Lessen negative impact on future mental health, manage symptoms

During the crisis intervention process, new skills and coping strategies are acquired, resulting in change. Various factors can influence an individual's ability to resolve a crisis and return to equilibrium, such as realistic perception of an event, adequate situational support, and adequate coping strategies to respond to a problem. Nurses can implement strategies to reinforce these factors.

Strategies for Crisis Phase 1 and 2

Table 3.5c describes strategies and techniques for early phases of a crisis that can help guide the individual toward crisis resolution.

Table 3.5c Phase 1 & 2 Early Crisis Intervention Strategies[5]

5. Centers for Disease Control and Prevention. (2018). *The National Institute for Occupational Health and Safety*. https://www.cdc.gov/niosh/

Verbal	Strategies	Examples
Therapeutic use of words holds significant power to defuse the stress response.	Encourage the person to express their thoughts and concerns.	"I understand how hard this must be for you." "Can you tell me more about how you are feeling?"
Be attuned to the individual's tone of voice and body language.	Use a shared problem-solving approach. Avoid being defensive.	"I understand your feelings of frustration. How can we correct this problem?"
Be attuned to word choice.	Use empathetic inquiry.	"You seem to be upset. Tell me more about what is bothering you."
Nonverbal	**Strategies**	**Example**
Be aware of your nonverbal messages and be in control of your body positions.	Be calm and act calm. Invite the client to sit to help them calm down and demonstrate you are calm.	Maintain nonthreatening eye contact, smile, and keep hands open and visible.
	Listen.	Nod your head to demonstrate that you are engaged with the individual.
	Respect personal space.	Maintain distance and avoid touching an individual who is upset.
	Approach the client from an angle or from the side.	Avoid directly approaching an individual, as it can feel confrontational.
	Avoid threatening gestures.	Avoid finger pointing or crossing arms.

	Demonstrate respect.	Mirror the individual's nonverbal messaging. Avoid laughing or joking.

Strategies for Crisis Phase 3

If an individual continues to progress in severity to higher levels of crisis, the previously identified verbal and nonverbal interventions for Phase 1 and Phase 2 may be received with a variability of success. For example, for a receptive individual who is still in relative control of their emotions, the verbal and nonverbal interventions may still be well-received. However, if an individual has progressed to Phase 3 with emotional lability, the nurse must recognize this escalation and take additional measures to protect oneself. If an individual demonstrates loss of problem-solving ability or the loss of control, the nurse must take measures to ensure safety for themselves and others in all interactions with the client. This can be accomplished by calling security or other staff to assist when engaging with the client. It is important to always note the location of exits in the client's room and ensure the client is never between the nurse and the exit. Rapid response devices may be worn, and nurses should feel comfortable using them if a situation begins to escalate.

Verbal cues can still hold significant power even in a late phase of crisis. The

nurse should provide direct cues to an escalating client such as, “Mr. Andrews, please sit down and take a few deep breaths. I understand you are angry. You need to gain control of your emotions, or I will have to call security for assistance.” This strategy is an example of limit-setting that can be helpful for de-escalating the situation and defusing tension. Setting limits is important for providing behavioral guidance to a client who is escalating, but it is very different from making threats. Limit-setting describes the desired behavior whereas making threats is nontherapeutic. See additional examples contrasting limit-setting and making threats in the following box.[6]

Examples of Limit-Setting Versus Making Threats[7]

- **Threat:** “If you don’t stop, I’m going to call security!”
- **Limit-Setting:** “Please sit down. I will have to call for assistance if you can’t control your emotions.”

- **Threat:** “If you keep pushing the call button over and over like that, I won’t help you.”
- **Limit-Setting:** “Ms. Ferris, I will come as soon as I am able when you need assistance, but please give me a chance to get to your room.”

6. Centers for Disease Control and Prevention. (2018). *The National Institute for Occupational Health and Safety.* https://www.cdc.gov/niosh/

7. Centers for Disease Control and Prevention. (2018). *The National Institute for Occupational Health and Safety.* https://www.cdc.gov/niosh/

- **Threat:** “That type of behavior won’t be tolerated!”
- **Limit-Setting:** “Mr. Barron, please stop yelling and screaming at me. I am here to help you.”

Strategies for Crisis Phase 4

A person who is experiencing an elevated phase of crisis is not likely to be in control of their emotions, cognitive processes, or behavior. It is important to give them space so they don’t feel trapped. Many times these individuals are not responsive to verbal intervention and are solely focused on their own fear, anger, frustration, or despair. Don’t try to argue or reason with them. Individuals in Phase 4 of crisis often experience physical manifestations such as rapid heart rate, rapid breathing, and pacing.

If you can’t successfully de-escalate an individual who is becoming increasingly more agitated, seek assistance. If you don’t believe there is an immediate danger, call a psychiatrist, psychiatric-mental health nurse specialist, therapist, case manager, social worker, or family physician who is familiar with the person’s history. The professional can assess the situation and provide guidance, such as scheduling an appointment or admitting the person to the hospital. If you can’t reach someone and the situation continues to escalate, consider calling your county mental health crisis unit, crisis response team, or other similar contacts. If the situation is life-threatening or if serious property damage is occurring, call 911 and ask for immediate assistance. When you call 911, tell them someone is experiencing a mental health crisis and explain the nature of the emergency, your relationship to the person in crisis, and whether there are weapons involved. Ask the 911 operator

to send someone trained to work with people with mental illnesses such as a **Crisis Intervention Training (CIT) officer.**[8]

A nurse who assesses a client in this phase should observe the client's behaviors and take measures to ensure the client and others remain safe. A person who is out of control may require physical or chemical restraints to be safe. Nurses must be aware of organizational policies and procedures, as well as documentation required for implementing restraints, if the client's or others' safety is in jeopardy. Read more about ANA guidelines on using restraints in the "Client Rights" section of the "Legal and Ethical Considerations in Mental Health Care" chapter and information on safely implementing restraints in the "Workplace Violence" section of the "Trauma, Abuse, and Violence" chapter.

- Review guidelines for safe implementation of restraints in the "Restraints" section of Open RN *Nursing Fundamentals , 2e*.

Crisis Resources

Depending on the type of stressors and the severity of the crisis experienced, there are a variety of resources that can be offered to clients and their loved ones. Nurses should be aware of community and organizational resources that are available in their practice settings. Support groups, hotlines, shelters, counseling services, and other community resources like the Red Cross may

8. Brister, T. (2018). *Navigating a mental health crisis: A NAMI resource guide for those experiencing a mental health emergency*. National Alliance on Mental Illness. https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis/Navigating-A-Mental-Health-Crisis?utm_source=website&utm_medium=cta&utm_campaign=crisisguide

be helpful. Read more about potential national and local resources in the following box.

Mental Health Crisis Resources

- NAMI: National Alliance on Mental Health
- ADRC of Central Wisconsin
- Wisconsin County Crisis Lines
- Wisconsin Suicide & Crisis Hotlines

Mental Health Crisis

When an individual is diagnosed with a mental health disorder, the potential for crisis is always present. Risk of suicide is always a priority concern for people with mental health disorders in crisis. Any talk of suicide should always be taken seriously. Most people who attempt suicide have given some warning. If someone has attempted suicide before, the risk is even greater. Read more about assessing suicide risk in the "Establishing Safety" section of Chapter 1. Encouraging someone who is having suicidal thoughts to get help is a safety priority.

Common signs that a mental health crisis is developing are as follows:

- Inability to perform daily tasks like bathing, brushing teeth, brushing hair, or changing clothes
- Rapid mood swings, increased energy level, inability to stay still, pacing, suddenly depressed or withdrawn, or suddenly happy or calm after period of depression
- Increased agitation with verbal threats; violent, out-of-control behavior or destruction of property
- Abusive behavior to self and others, including substance misuse or self-harm (cutting)
- Isolation from school, work, family, or friends

- Loss of touch with reality (psychosis) – unable to recognize family or friends, confused, doesn't understand what people are saying, hearing voices, or seeing things that aren't there
- Paranoia

Clients with mental illness and their loved ones need information for what to do if they are experiencing a crisis. *Navigating a Mental Health Crisis: A NAMI Resource Guide for Those Experiencing a Mental Health Emergency* provides important, potentially life-saving information for people experiencing mental health crises and their loved ones. It outlines what can contribute to a crisis, warning signs that a crisis is emerging, strategies to help de-escalate a crisis, and available resources.

> Read NAMI's *Navigating a Mental Health Crisis: A NAMI Resource Guide for Those Experiencing a Mental Health Emergency*.

3.6 Applying the Nursing Process to Stress and Coping

This section will review the nursing process as it applies to stress and coping.

Assessments (Recognze Cues)

Here are several nursing assessments used to determine an individual's response to stress and their strategies for stress management and coping:

- Recognize nonverbal cues of physical or psychological stress
- Assess for environmental stressors affecting client care
- Assess for signs of abuse or neglect
- Assess client's ability to cope with life changes
- Assess family dynamics
- Assess the potential for violence
- Assess client's support systems and available resources
- Assess client's ability to adapt to temporary/permanent role changes
- Assess client's reaction to a diagnosis of acute or chronic mental illness (e.g., rationalization, hopefulness, anger)
- Assess constructive use of defense mechanisms by a client
- Assess if the client has successfully adapted to situational role changes (e.g., accept dependency on others)
- Assess client's ability to cope with end-of-life interventions
- Recognize the need for psychosocial support to the family/caregiver
- Assess clients for maladaptive coping such as substance abuse
- Identify a client in crisis

Diagnoses (Analyze Cues)

Nursing diagnoses related to stress and coping are *Stress Overload* and *Ineffective Coping*. See Table 3.6 to compare the definitions and defining characteristics for these nursing diagnoses.

Table 3.6 Stress and Coping Nursing Diagnoses

Nursing Diagnosis	Definition	Selected Defining Characteristics
Stress Overload	Excessive amounts and types of demands that require action.	• Excessive stress • Impaired decision-making • Impaired functioning • Increase in anger • Increased impatience
Ineffective Coping	A pattern of invalid appraisal of stressors, with cognitive and/or behavioral efforts, that fails to manage demands related to well-being.	• Alteration in concentration • Alteration in sleep pattern • Change in communication pattern • Fatigue • Inability to ask for help • Inability to deal with a situation • Ineffective coping strategies • Insufficient social support • Substance misuse

Outcomes Identification (Generate Solutions)

An outcome is a measurable behavior demonstrated by the client in response to nursing interventions. Outcomes should be identified before nursing interventions are planned. Outcomes identification includes setting short- and long-term goals and then creating specific expected outcome statements for each nursing diagnosis. Goals are broad, general statements, and outcomes are specific and measurable. Expected outcomes are statements of measurable action for the client within a specific time frame that are responsive to nursing interventions.

Expected outcome statements should contain five components easily remembered using the "SMART" mnemonic:

- Specific
- Measurable
- Attainable/Action oriented
- Relevant/Realistic
- Time frame

An example of a SMART outcome related to *Stress Overload* is, "The client will identify two stressors that can be modified or eliminated by the end of the week."

An example of a SMART outcome related to *Ineffective Coping* is, "The client will identify three preferred coping strategies to implement by the end of the week."

> Read more information about establishing SMART outcome statements in the "Outcome Identification" section of Chapter 4.

Planning Interventions Related to Stress and Coping (Generate Solutions)

Common nursing interventions that are implemented to facilitate effective coping in their clients include the following:

- Implement measures to reduce environmental stressors
- Teach clients about stress management techniques and coping strategies
- Provide caring interventions for a client experiencing grief or loss, as well as resources to adjust to loss/bereavement
- Identify the client in crisis and tailor crisis intervention strategies to assist them to cope
- Guide the client to resources for recovery from crisis (i.e., social supports)

Implementation (Take Action)

When implementing nursing interventions to enhance client coping, it is important to recognize signs of a crisis and maintain safety for the client, oneself, and others. Review signs of a client in crisis and crisis intervention strategies in the "Crisis and Crisis Intervention" section of this chapter.

Evaluation (Evaluate Outcome)

After implementing individualized interventions for a client, it is vital to evaluate their effectiveness. Review the specific SMART outcomes and deadlines that have been established for a client and determine if interventions were effective in meeting these outcomes or if the care plan requires modification.

3.7 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=165#h5p-26

1

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=165#h5p-12

2

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=165#h5p-13

1. “MH Stress, Coping, and Crisis Intervention Glossary Cards ” by OpenRN is licensed under CC BY-NC 4.0

2. “MH Stress, Coping, and Crisis Drag and Drop ” by OpenRN is licensed under CC BY-NC 4.0

[3]

- Test your clinical judgment with an NCLEX Next Generation-style question: Chapter 3, Assignment 1 [4]

- Test your clinical judgment with an NCLEX Next Generation-style case study: Chapter 3, Case Study 1 [5]

3. "MH Stress, Coping, and Crisis Question Set 1 " by OpenRN is licensed under CC BY-NC 4.0
4. "MH Next-Generation Style Question Stress, Coping, Crisis " by OpenRN is licensed under CC BY-NC 4.0
5. "MH Next-Generation Style Stress, Coping and Crisis Intervention " by Kellea Ewen is licensed under CC BY-NC 4.0

III Glossary

Adaptive coping strategies: Coping strategies, including problem-focused coping and emotion-focused coping.

Adverse childhood experiences: Potentially traumatic events that occur in childhood such as sexual abuse, physical abuse, emotional abuse, physical neglect, emotional neglect, parental loss, or parental separation before the child is 18 years old.

Coping: Cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts.[1]

Coping strategies: An action, series of actions, or a thought process used in meeting a stressful or unpleasant situation or in modifying one's reaction to such a situation.[2]

Crisis: The inability to cope or adapt to a stressor.

Crisis Intervention Training Officer: A law enforcement or public safety professional who is specially trained to respond to individuals experiencing a mental health crisis or other behavioral emergencies.

Defense mechanisms: Unconscious reaction patterns used by individuals to protect themselves from anxiety that arises from stress and conflict.[3]

1. Amnie, A. G. (2018). Emerging themes in coping with lifetime stress and implication for stress management education. *SAGE Open Medicine, 6*. https://doi.org/10.1177%2F2050312118782545

2. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

3. American Psychological Association. (n.d.). Stressor. *APA Dictionary of Psychology*. https://dictionary.apa.org

Emotion-focused coping: Adaptive coping strategies such as practicing mindfulness, meditation, and yoga; using humor and jokes; seeking spiritual or religious pursuits; engaging in physical activity or breathing exercises; and seeking social support.

Maladaptive coping responses: Ineffective responses to stressors such as avoidance of the stressful condition, withdrawal from a stressful environment, disengagement from stressful relationships, and misuse of drugs and/or alcohol.

Maturational crisis: A type of developmental crisis that occurs during normal life transitions or stages of growth.

Problem-focused coping: Adaptive coping strategies that typically focus on seeking treatment such as counseling or cognitive behavioral therapy.

Stress response: The body's physiological response to a real or perceived stressor. For example, the respiratory, cardiovascular, and musculoskeletal systems are activated to breathe rapidly, stimulate the heart to pump more blood, dilate the blood vessels, and increase blood pressure to deliver more oxygenated blood to the muscles.

Stressors: Any internal or external event, force, or condition that results in physical or emotional stress.

PART IV

CHAPTER 4 APPLICATION OF THE NURSING PROCESS TO MENTAL HEALTH CARE

4.1 Introduction

Learning Objectives

- Apply the nursing process to mental health care
- Apply the subcategories of the *Implementation* standard of care to mental health care
- Explain various mental health treatment approaches
- Promote a therapeutic environment
- Compare NCLEX Next Generation terminology to the nursing process

Psychiatric-mental health nursing is, "The nursing practice specialty committed to promoting mental health through the assessment, diagnosis, and treatment of behavioral problems, mental disorders, and comorbid conditions across the life span. Psychiatric-mental health nursing intervention is an art and a science, employing a purposeful use of self and a wide range of nursing, psychosocial, and neurobiological evidence to produce effective outcomes."[1]

In 2014, the American Psychiatric Nurses Association (APNA) and the International Society of Psychiatric-Mental Health Nurses (ISPN) published the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* resource in alignment with the second edition of the ANA's *Nursing: Scope*

1. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

and Standard of Practice Nursing. The *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* resource guides psychiatric-mental health nurses in the application of their professional skills and responsibilities and should be reviewed in conjunction with state Board of Nursing policies and practices that govern the practice of nursing.[2] The Standards of Practice for Psychiatric-Mental Health Nursing mirror the ANA Standards of Professional Nursing Practice of *Assessment, Diagnosis, Outcome Identification, Planning, Implementation*, and *Evaluation*, but also have additional competencies for Psychiatric-Mental Health Registered Nurse Specialists (PMH-RNs) and Advanced Practice Registered Nurse Specialists (PMH-APRNs) and additional components for the *Implementation* standard of care.

This chapter will review how nurses apply the nursing process and the ANA Standards of Professional Nursing Practice to clients experiencing a mental health condition. Assessments, nursing diagnoses, expected outcomes, and interventions pertaining to mental health will be reviewed while incorporating life span and cultural considerations. For assessments, nursing diagnoses, expected outcomes, and interventions related to specific mental health conditions, see each corresponding "disorder" chapter.

2. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

4.2 Applying the Nursing Process

The nursing process is a critical thinking model based on a systematic approach to client-centered care. Nurses use the **nursing process** to perform clinical reasoning and make clinical judgments when providing client care. The nursing process is based on the Standards of Professional Nursing Practice established by the American Nurses Association (ANA). These standards are authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform competently.[1]

The mnemonic **ADOPIE** is an easy way to remember the six ANA standards regarding the nursing process. Each letter refers to one of the six components of the nursing process: *Assessment, Diagnosis, Outcomes Identification, Planning, Implementation*, and *Evaluation*. The nursing process is a continuous, cyclic process that is constantly adapting to the client's current health status. See Figure 4.1[2] for an illustration of the nursing process.

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. "The Nursing Process" by Kim Ernstmeyer at Chippewa Valley Technical College is licensed under CC BY 4.0

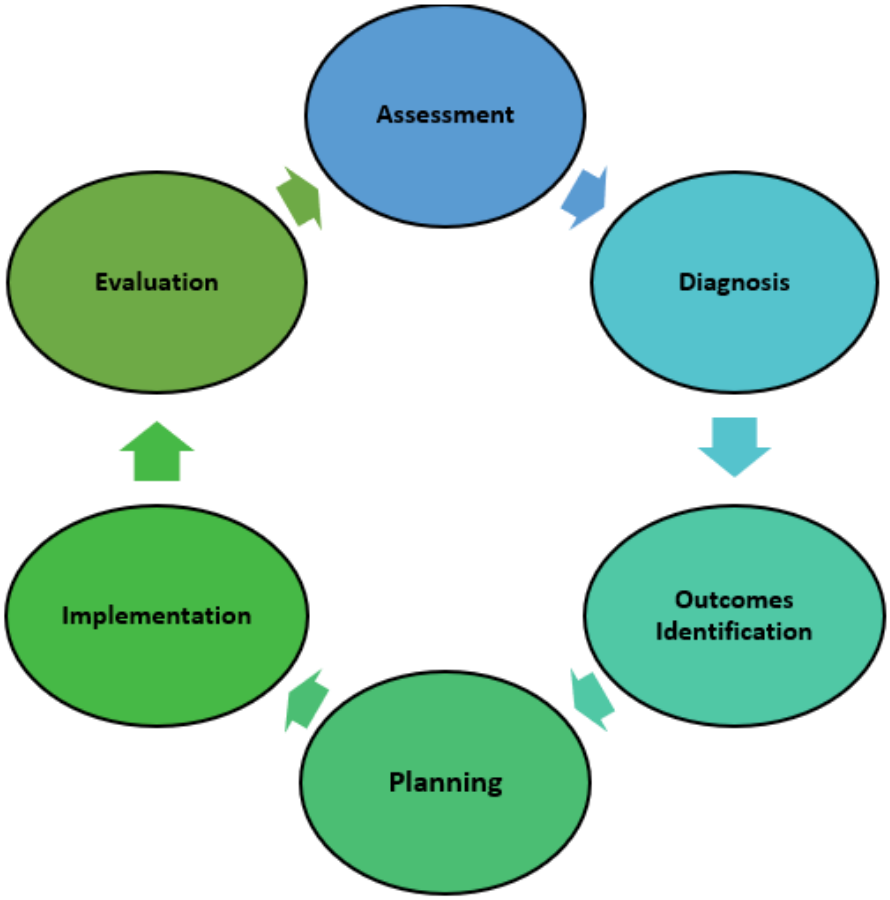

Figure 4.1 The Nursing Process

- Review using the nursing process in the "Nursing Process" chapter in Open RN *Nursing Fundamentals, 2e*.

4.3 Assessment

The *Assessment* Standard of Practice established by the American Nurses Association (ANA) states, "The registered nurse collects pertinent data to the health care and information relative to the health care consumer's health or the situation."[1] Review the competencies for the *Assessment* Standard of Practice for registered nurses in the following box.

ANA's Assessment Competencies[2]

The registered nurse:

- Creates the safest environment possible for conducting assessments.
- Collects pertinent data related to health and quality of life in a systematic, ongoing manner, with compassion and respect for the wholeness, the inherent dignity, worth, and unique attributes of every person, including, but not limited to, demographics, environmental and occupational exposures, social determinants of health, health disparities, physical, functional, psychosocial, emotional, cognitive, spiritual/transpersonal, sexual, sociocultural, age-related, environmental, and lifestyle/economic assessments.
- Utilizes a health and wellness model of assessment that incorporates integrative approaches to data collection and

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

honors the whole person.

- Recognizes the health care consumer or designated person as the decision-maker regarding their own health.
- Explores the health care consumer's culture, values, preferences, expressed and unexpressed needs, and knowledge of the heath care situation.
- Assesses the impact of family dynamics on the health care consumer's health and wellness.
- Identifies enhancements and barriers to effective communication based on personal, cognitive, physiological, psychosocial, literacy, financial, and cultural considerations.
- Engages the health care consumer, family, significant others, and interprofessional team members in holistic, culturally sensitive data collection.
- Integrates knowledge from current local, regional, national, and global health initiatives and environmental factors into the assessment process.
    - State and local departments of health
    - World Health Organization
    - World Health Organization health topics
    - Healthy People
    - Centers for Disease Control and Prevention
- Prioritizes data collection based on the health care consumer's immediate condition, the anticipated needs of the health care consumer or situation, or both.
- Uses evidence-based assessment techniques and available data and information to identify patterns and variances in the consumer's health.
- Remains knowledgeable about constantly changing technologies that impact the assessment process (e.g.,

telehealth, artificial intelligence).
- Analyzes assessment data to identify patterns, trends, and situations that impact the person's health and wellness.
- Validates the analysis with the health care consumer.
- Documents data accurately and makes accessible to the interprofessional team in a timely manner.
- Communicates changes in a person's condition to the interprofessional team.
- Applies the provisions of the ANA Code of Ethics, legal guidelines, and policies to the collection, maintenance, use, and dissemination of data and information.
- Recognizes the impact of one's own personal attitudes, values, beliefs, and biases on the assessment process.

Nursing assessments related to mental health disorders differ from physiological assessments with a greater focus on collecting subjective data. For example, prior to administering a cardiac medication to a client with a heart condition, a nurse will assess objective data such as blood pressure and an apical heart rate to determine the effectiveness of the medication treatment. However, prior to administering an antidepressant, a nurse uses therapeutic communication to ask questions and gather subjective data about how the client is feeling to determine the effectiveness of the medication. The nurse will also observe client behaviors, speech, mood, and thought processes as part of the assessment.

As a nurse, you cannot directly measure a neurotransmitter to determine the effects of the medication, but you can ask questions to determine how your client is feeling emotionally and perceiving the world, which are influenced by neurotransmitter levels. An example of a nurse using therapeutic communication to perform subjective assessment is, "Tell me more about how you are feeling today." The nurse may also use general survey techniques such as simply observing the client to assess for cues of behavior. Examples of

objective data collected by a general survey could be assessing the client's mood, hygiene, appearance, or movement.

Recall the mental health continuum introduced in the "Foundational Mental Health Concepts" chapter (see Figure 4.2[3]). Nurses in any setting holistically assess their clients' physical, emotional, and mental health, as well as any impairments impacting their functioning. They must recognize subtle cues of undiagnosed or poorly managed physical and mental disorders and follow up appropriately with other members of the interprofessional health care team.

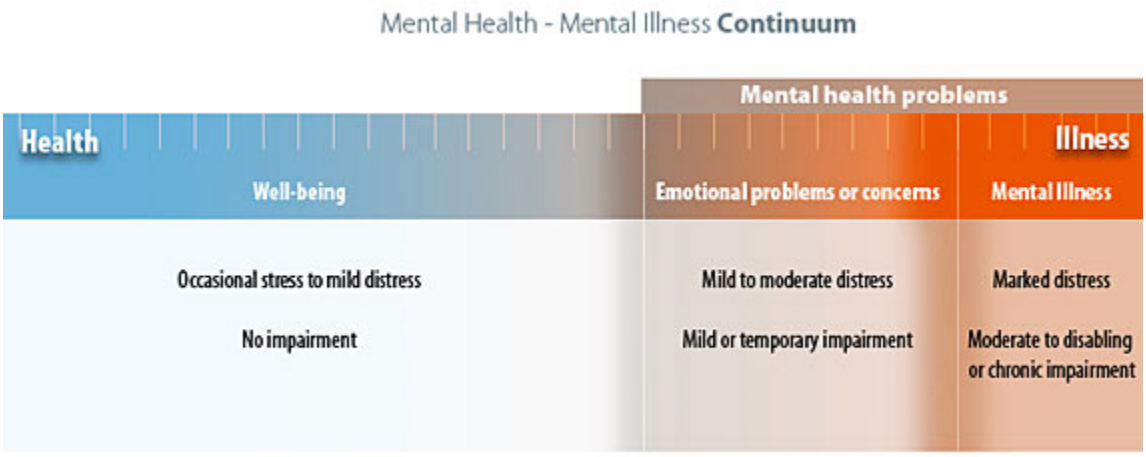

Figure 4.2 Mental Health Continuum (Used with permission.)

When assessing a client's mental health, the nurse incorporates a variety of assessments, in addition to the traditional physical examination. Assessments may include the following:

- Performing a mental status examination

3. "continuum.jpg" by University of Michigan is used with permission. Access the original at https://hr.umich.edu/benefits-wellness/health-well-being/mhealthy/faculty-staff-well-being/mental-emotional-health/mental-emotional-health-classes-training-events/online-tutorial-supervisors/section-1-what-you-need-know-about-mental-health-problems-substance-misuse.

- Completing a psychosocial assessment including:
    - Reviewing the client's reason for seeking healthcare
    - Screening the client for suicidal ideation, exposure to trauma or violence, signs of self injury, and substance misuse
    - Complete a cultural assessment, spiritual assessment, and assess client family dynamics
    - Use of psychotropic medications (drugs that treat psychiatric symptoms) and/or other medications that can cause psychiatric symptoms as side effects
    - History of mental disorders, family history of mental illness, and previous hospitalizations
    - Educational background, occupational background
    - Coping mechanisms and functional ability
- Reviewing specific laboratory results related to the client's use of psychotropic and other medications
- Incorporating life span and developmental considerations

Mental Status Examination

A **mental status examination** assesses a client's level of consciousness and orientation, appearance and general behavior, speech, motor activity, affect and mood, thought and perception, attitude and insight, and cognitive abilities. The examiner should also monitor their personal reaction to a client when performing a mental status examination. For example, the examiner should be aware of their own facial expressions in order to not influence a client's reaction or willingness to respond to questions. The structured components of a mental status examination are outlined in Table 4.3 and further described in the following subsections.

Registered nurses must use effective clinical interviewing skills while performing a mental status assessment and developing a therapeutic nurse-client relationship.[4] Read more about establishing a therapeutic nurse-client

4. American Nurses Association, American Psychiatric Nurses Association, and

relationship in the "Therapeutic Communication and the Nurse-Client Relationship" chapter. Assessing a client with a suspected or previously diagnosed mental health disorder focuses on both verbal and nonverbal assessments. New assessment findings are compared to the baseline admission findings to determine if the client's condition is improving, worsening, or remaining the same.

When conducting a focused assessment on a client's mental health, the mental status examination is a priority component of the overall assessment. A successful nurse develops a style in which the bulk of the mental status examination is performed through unstructured observations made during the routine physical examination, also referred to as the "general survey." When the nurse recognizes cues of possible mental health disorders, such as aberrant behavior or difficulties in day-to-day functioning, then a focused mental status examination should be completed.

> Read about the components of a general survey in the "General Survey" chapter of Open RN *Nursing Skills*.

Table 4.3 Mental Status Examination[5]

International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (2nd ed.). Nursebooks.org

5. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

Assessment	Expected Findings/Optimal Level of Functioning	Unexpected Findings/Impaired Functioning
Signs of Distress	• Calm and comfortable with no signs of distress	• Unresponsive • Difficulty breathing • Chest pain • New onset of confusion • Moaning • Grimacing
Level of Consciousness and Orientation	• Alert • Oriented to person, place, and time • Aware of the situation	• Unable to provide name, location, or day • Clouded consciousness • Delirium • Obtundation • Stupor • Coma
Appearance and General Behavior	• Appears stated age • Well-groomed • Dressed appropriately for the weather and situation • Erect posture • Good oral hygiene • Culturally appropriate eye contact • Socializes with others • No threatening behaviors	• Appears older than stated age • Unkempt or poor hygeine • Not dressed appropriately for the weather and/or situation • Slumped posture • Poor eye contact • Does not socialize with others • Demonstrates threatening behavior

Speech	• Exhibiting spontaneous speech • Even speech rate, rhythm, and tone • Responds to verbal questions • Speech is clear and understandable • Follows instructions appropriately for developmental level	• Does not respond to verbal questions • Does not follow instructions appropriately for development level • Speech is unclear • Rapid or pressured speech • Halting speech • Brief or reduced replies
Motor Activity	• Good balance • Moves extremities equally bilaterally • Smooth gait	• Poor balance • Uneven gait • Slow movements • Lack of spontaneous movement • Motor restlessness • Repetitive movements • Tremors • Pacing • Uncontrolled, involuntary movement

Affect and Mood	• Displays wide range of emotions that are appropriate to situation • Congruent with mood • Bright • Hopeful with goals • Positive self-worth	• Inappropriate or incongruent with the situation • Subdued • Tearful • Labile • Blunted • Flat • Feeling uneasy or unhappy • Intense excitement or happiness • Lack of motivation • Lack of interest to engage in social activities • Diminished feelings of pleasure in everyday life • Decreased interest in activities that would be interesting
Thought and Perception	• Realistic • Logical • Goal-directed • Organized • Ability to focus or concentrate • Absence of suicidal ideation • Absence of homicidal ideation • Absence of violence ideation	• Inability to focus or concentrate • Irrational fear • Exaggerated response • Delusions • Hallucinations • Illusions • Obsessions • Racing thoughts • Flight of ideas • Loose associations • Clang associations • Suicidal ideation • Homicidal ideation

Attitude and Insight	• Looks toward improvement and/or recovery • Demonstrates understanding of the situation	• Exhibits hostility, anger, helplessness, pessimism, overdramatization, self-centeredness, or passivity • Demonstrates little or no understanding of the situation • Inability to recognize one is ill
Cognitive Abilities	• Focused attention • Good immediate recall, short-term memory, and long-term storage	• Distractibility • Inability to think abstractly • Impaired reasoning • Poor immediate recall • Poor short-term memory • Poor long-term memory
Examiner's Reaction to Client	• Noticing and managing examiner's internal responses to the client such as frustration, boredom, sadness, anxiousness, or countertransference • Non-judgmental, neutral approach • Professional demeanor with control of subjective emotional and cognitive responses to ensure objectivity.	• Lack of awareness of examiner's internal responses to the client such as frustration, boredom, sadness, anxiousness, countertransference

Signs of Distress

If a client is exhibiting signs of distress during an examination, the nurse must quickly obtain focused assessment data and obtain additional assistance based on the level of emergency care required and agency policy. For example, if a client is found unresponsive, a “code” is typically called during inpatient care, or 911 is called in an outpatient setting as the nurse begins cardiopulmonary resuscitation (CPR). If a client is demonstrating difficulty breathing, new onset confusion, or other signs of a deteriorating condition, the rapid response team may be called, or other emergency assistance may be obtained per agency policy. Keep in mind that the emergency administration of naloxone may be required in cases of a suspected opioid overdose.

Level of Consciousness and Orientation

A normal level of consciousness is when the client is alert (i.e., the ability to respond to stimuli at the same level as most people) and oriented to person, place, and time while remaining aware of their situation. **Clouded consciousness** refers to a state of reduced awareness to stimuli. **Delirium** is an acute onset of an abnormal mental state, often with fluctuating levels of consciousness, disorientation, irritability, and hallucinations. Delirium is often associated with infection, metabolic disorders, or toxins in the central nervous system. **Obtundation** refers to a moderate reduction in the client’s level of awareness so that mild to moderate stimuli do not awaken the client. When arousal does occur, the client is slow to respond. **Stupor** refers to unresponsiveness unless a vigorous stimulus is applied, such as a sternal rub. The client quickly drifts back into a deep sleep-like state on cessation of the stimulation. **Coma** refers to unarousable unresponsiveness, where vigorous noxious stimuli may not elicit reflex motor responses. For example, a client in a coma may not pull their foot away from a painful prick of their toe with a needle. When documenting reduced levels of consciousness, note the type of

stimulus required to arouse the client and the degree to which the client can respond when aroused.[6]

Appearance and General Behavior

This component refers to an overall impression of the client, including their physical appearance regarding their age, grooming, dressing, posture, eye contact, ability to socialize with others, and general behaviors. There are several terms used to describe a client's appearance and behavior. For example, the appearance of one's age can be altered due to chronic illness and pain. Providers may document that a client "appears their stated age" or "appears older than their stated age." Clients may be described as well-groomed (i.e., exhibit good hygiene) or **disheveled** (i.e., their hair, clothes, or hygiene appears untidy, disordered, unkempt, or messy). Their dress may be described as "appropriate" or "inappropriate" according to the weather and situation. A client's posture may be described as "erect" or "slumped." Clients may be described as having "good eye contact" (i.e., they maintain a direct gaze into the examiner's eyes) or "poor eye contact" (i.e., they avoid direct eye contact).[7] Life span and cultural considerations must always be kept in mind when assessing a client's appearance and general behavior. For example, some cultures consider direct eye contact disrespectful.

6. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

7. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

Speech

Evaluating speech as the client answers open-ended questions provides useful information. A client demonstrates normal speech when responding to verbal questions appropriately with an even rate, rhythm, and tone. Their speech is clear and understandable, and the client follows instructions appropriately.

Characteristics of speech can be described as normal, rapid, slow (i.e., delayed rhythm of conversation), loud, or soft. Stuttering and aphasia may occur. Examples of speech difficulties include lack of appropriate responses to verbal questions, rapid and/or pressured speech of a client experiencing mania or amphetamine intoxication, or halting speech of a client experiencing word-finding difficulties due to a previous stroke.[8]

Other terms used to describe speech include **circumstantial** (i.e., speaking with many unnecessary or tedious details without getting to the point of the conversation), **poverty of content** (i.e., a conversation in which the client talks without stating anything related to the question, or their speech in general is vague and meaningless), and **alogia** (i.e. brief or reduced replies).

Motor Activity

Overall motor activity should be noted, including any tics or unusual mannerisms. Normal motor activity refers to the client having good balance, moving all extremities equally bilaterally, and walking with a smooth gait. Slow movements or lack of spontaneity in movement can occur due to depression or dementia. **Dyskinesia** (uncontrolled, involuntary movement)

8. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

and **akathisia** (i.e., motor restlessness) may occur if the client is experiencing extrapyramidal syndrome related to psychotropic medication use.[9]

Terminology used to describe motor activity includes **psychomotor agitation** (i.e., a condition of purposeless, non goal-directed activity) and **psychomotor retardation** (i.e., a condition of extremely slow physical movements, slumped posture, or slow speech patterns).

Affect and Mood

Affect refers to the client's expression of emotion, and mood refers to the predominant emotion expressed by an individual.[10] Sustained emotions influence a person's behavior, personality, and perceptions. **Mood** can be described using various terms such as neutral, elevated, or **labile** (i.e., a rapid change in emotional responses, mood, or affect that are inappropriate for the moment or the situation). It can also be described as anxious, angry, sad, irritable, **dysphoric** (i.e., exhibiting depression), or **euphoric** (i.e., a pathologically elevated sense of well-being). People may express feelings of emptiness, impaired self-esteem, indecisiveness, or crying spells.[11]

9. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/
10. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/
11. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

Normal affect and mood are described as **euthymic** (i.e., displays a wide range of emotion that is appropriate for the situation). Abnormal findings related to affect include inappropriateness for the situation (e.g., laughing at the recent death of a loved one) or incongruent. **Congruence** refers to the consistency of verbal and nonverbal communication. Affect may also be described as subdued, tearful, labile, **blunted** (i.e., diminished range and intensity), or **flat** (no emotional expression).

Other terminology related to documenting a client's mood includes **alexithymia** (i.e., the inability to describe emotions with how one is feeling), **anhedonia** (i.e, the lack of experiencing pleasure in activities normally found enjoyable), **apathy** (i.e., a lack of feelings, emotions, interests, or concerns), **avolition** (i.e. total lack of motivation) and **asociality** (i.e. a lack of motivation to engage in social activities).

Thoughts and Perceptions

The manner in which a client perceives and responds to stimuli is a critical psychiatric assessment. The inability to process information accurately is a component of the definition of psychotic thinking. For example, does the client harbor realistic concerns or are their concerns elevated to the level of irrational fear? Is the client responding in an exaggerated fashion to actual events? Is there no discernible basis in reality for the client's beliefs or behavior?[12]

Clients with mental health disorders may experience intrusive thoughts, delusions, and/or obsessions. **Delusions** are a fixed, false belief not held by cultural peers and persisting in the face of objective contradictory evidence. For example, a client may have the delusion that the CIA is listening to their

12. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

conversations via satellites. **Grandiose delusions** refer to a state of false attribution to the self of great ability, knowledge, importance or worth, identity, prestige, power, or accomplishment.[13] Clients may withdraw into an inner fantasy world that's not equivalent to reality, where they have inflated importance, powers, or a specialness that is opposite of what their actual life is like.[14] **Paranoia** is a condition characterized by delusions of persecution.[15] Clients often experience extreme suspiciousness or mistrust or express fear. For example, a resident of a long-term care facility may have delusions that the staff is trying to poison them.

Obsessions are persistent thoughts, ideas, images, or impulses that are experienced as intrusive or inappropriate and result in anxiety, distress, or discomfort. Common obsessions include repeated thoughts about contamination, a need to have things in a particular order or sequence, repeated doubts, aggressive impulses, and sexual imagery. Obsessions are distinguished from excessive worries about everyday occurrences because they are not concerned with real-life problems.[16] **Rumination** is obsessional thinking involving excessive, repetitive thoughts that interfere with other forms of mental activity.[17]

13. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/
14. Raypole, C. (2019, November 20). *10 signs of covert narcissism*. Healthline. https://www.healthline.com/health/covert-narcissist#fantasies
15. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/
16. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/
17. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/

Clients may also experience altered perceptions such as hallucinations and illusions. **Hallucinations** are false sensory perceptions not associated with real external stimuli and can include any of the five senses (auditory, visual, gustatory, olfactory, and tactile). For example, a client may see spiders climbing on the wall or hear voices telling them to do things. These are referred to as "visual hallucinations" or "auditory hallucinations."

Illusions are misperceptions of real stimuli. For example, a client may misperceive tree branches blowing in the wind at night to be the arms of monsters trying to grab them.

It is important for nurses to remember that delusions, hallucinations, and illusions feel very real to clients and cause internal emotional reactions, even when a caregiver reassures them they are not based in reality. Because clients often conceal these experiences, it is helpful to ask leading questions, such as, "Have you ever seen or heard things that other people could not see or hear? Have you ever seen or heard things that later turned out not to be there?"[18]

Other terms used to document clients' thought processes include racing thoughts, flight of ideas, loose associations, and clang associations. **Racing thoughts** are fast moving and often repetitive thought patterns that can be overwhelming. They may focus on a single topic, or they may represent multiple different lines of thought. For example, a client may have racing thoughts about a financial issue or an embarrassing moment.

Flight of ideas indicates the client frequently shifts from one topic to another with rapid speech, making it seem fragmented. The examiner may feel the client is rambling and changing topics faster than they can keep track, and

18. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

they probably can't get a word in edgewise.[19] An example of a client exhibiting a flight of ideas is, "My father sent me here. He drove me in a car. The car is yellow in color. Yellow looks good on me."[20]

Loose associations refers to jumping from one idea to an unrelated idea in the same sentence. For example, the client might state, "I like to dance, and my feet are wet."[21] The term **word salad** refers to severely disorganized and virtually incomprehensible speech or writing, marked by severe loosening of associations.[22]

Clang associations refers to stringing words together that rhyme without logical association and do not convey rational meaning. For example, a client exhibiting clang associations may state, "Here she comes with a cat catch a rat match."

Other disturbances in thought and perception may include **echolalia** (i.e. repetition of words or phrases spoken to others) and **magical thinking** (i.e. false belief that reality can be changed by one's thoughts).

Clients with altered perceptions, especially when experiencing hallucinations and delusions, may have violent thoughts regarding themselves or others. If a

19. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations*. (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

20. PsychologGenie. (n.d.). *The true meaning of flight of ideas explained with examples*. https://psychologenie.com/flight-of-ideas-meaning-examples

21. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/

22. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/

client is having auditory hallucinations, it is vital for the nurse to determine if the voices are encouraging the client to hurt themselves or others. **Homicidal ideation** refers to threats or acts of life-threatening harm toward another person. **Suicidal ideation** is used to describe an individual who has been thinking about suicide but does not necessarily have an intention to act on that idea. **Suicide attempt** is a term used to describe an individual who harms themselves with intent to end their life but does not die as a result of their actions. **Suicide plan** refers to an individual who has a plan for suicide, has the means to injure oneself, and has the intent to die.

Of all portions of the mental status examination, the evaluation of thought disorders is the most difficult and requires a thorough assessment.[23] Psychiatric-mental health nurse specialists receive additional training in assessing thought disorders. These types of thought disorders are associated with mental illnesses like bipolar disorder and schizophrenia and may precede an episode of psychosis, so it is important to obtain further assistance if you notice a client is newly exhibiting these types of behaviors.[24]

> Read more information about how to help individuals experiencing hallucinations and delusions in the "Applying the Nursing Process to Schizophrenia" section of the "Psychosis and Schizophrenia" chapter.

23. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

24. Joy, R. (2020, January 20). *Clang association: When a mental health condition disrupts speech.* Healthline. https://www.healthline.com/health/clang-association#whats-it-sound-like

Attitude and Insight

The client's attitude is the emotional tone displayed toward the examiner, other individuals, or their illness. It may convey a sense of hostility, anger, helplessness, pessimism, overdramatization, self-centeredness, or passivity. It is important to determine the client's attitude toward emotional problems or diagnosed mental health disorders. Does the client look forward to improvement and recovery or are they resigned to suffer?[25]

Insight is the client's ability to identify the existence of a problem and to have an understanding of its nature.

Nurses must also be aware of transference. **Transference** occurs when the client projects (i.e., transfers) their feelings onto the nurse. For example, a client is feeling angry at a family member related to a previous disagreement and displaces the anger onto the nurse during the interview.

Cognitive Abilities

Cognition is the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. It includes thinking, knowing, remembering, judging, and problem-solving. When performing focused assessments on cognition, the examiner assesses attention and memory.[26] A term related to assessing attention is

25. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

26. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

distractibility, referring to the client's attention being easily drawn to unimportant or irrelevant external stimuli.

Memory disturbance is a common complaint and is often a presenting symptom in the elderly. Memory can be grouped into three categories: immediate recall, short-term memory, and long-term storage. Short-term memory is the most clinically pertinent, and the most important to be tested. Short-term retention requires that the client process and store information so that they can move on to a second intellectual task and then call up the remembrance after completion of the second task. For example, short-term memory may be tested by having the client repeat the names of four unrelated objects and then asking the client to recall the information in 3 to 5 minutes after performing a second, unrelated mental task.[27]

Examiner's Reaction to the Client

Assessing a client sometimes results in the nurse developing subtle and easily overlooked feelings toward the client. For example, it can be difficult to repeatedly address a client's negative state. Examiners may experience feelings of frustration, which can be taken by clients to mean there's something wrong with them. In such cases, nurses should examine their reactions to the client and be alert to feelings of distraction, boredom, or frustration. They should also be aware that clients perceive a nurse's feelings through their nonverbal communication, such as facial expressions, posture, tone of voice, and lack of eye contact.[28]

27. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

28. DeAngelis, T. (2019). Better relationships with patients lead to better outcomes. *Monitor on Psychology, 50*(10), 38. https://www.apa.org/monitor/2019/11/ce-corner-relationships

Nurses should also be aware of countertransference. **Countertransference** refers to a tendency for the examiner to displace (transfer) their own feelings onto the client and then these feelings may influence the client. For example, a nurse finds themself providing advice about how to raise children to a client. Upon self-reflection, they realize it is a countertransference reaction related to their previous parenting experience.[29]

- Review a brief mental status examination PDF form from TherapistAid.

Psychosocial Assessment

A **psychosocial assessment** (also referred to as a health history) is a component of the nursing assessment process that obtains additional subjective data to detect risks and identify treatment opportunities and resources. Agencies have specific forms used for psychosocial assessments/health histories that typically consist of several components[30,31]:

29. DeAngelis, T. (2019). Better relationships with patients lead to better outcomes. *Monitor on Psychology, 50*(10), 38. https://www.apa.org/monitor/2019/11/ce-corner-relationships

30. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*. https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool

31. Glasner, J., Baltag, V., & Ambresin, A. E. (2021). Previsit multidomain psychosocial screening tools for adolescents and young adults: A system review. *Journal of Adolescent Health, 68*, 449-459. https://www.jahonline.org/article/S1054-139X(20)30600-5/pdf

- Reason for seeking health care (i.e., “chief complaint”)
- Cultural assessment
- Spiritual assessment
- Family dynamics
- Thoughts of self-injury or suicide
- Current and past medical history
- Current medications
- History of previously diagnosed mental health disorders
- Previous hospitalizations
- Educational background
- Occupational background
- History of exposure to psychological trauma, violence, and domestic abuse
- Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
- Family history of mental illness
- Coping mechanisms
- Functional ability/Activities of daily living

> Review specific questions used during a psychosocial assessment/health history in the “Health History” chapter in Open RN *Nursing Skills, 2e*.

Reason for Seeking Health Care

It is helpful to begin the psychosocial assessment by obtaining the reason why the client is seeking health care in their own words. During a visit to a clinic or emergency department or on admission to a health care agency, the client’s primary reasons for seeking care are referred to as the **chief complaint**. Assessing a client’s chief complaint recognizes that clients are complex beings, with potentially multiple coexisting health needs, but there

is often a pressing issue that requires most immediate care. Questions used to evaluate a client's chief complaint are as follows:

- What brought you in today?
- How long has this been going on?
- How is this affecting you?

After identifying the reason the client is seeking health care, additional focused questions are used to obtain detailed information about priority concerns, such as persistent nausea or other symptoms causing discomfort. The mnemonic PQRSTU is used to ask the client questions in an organized fashion. See Table 4.3b for examples of questions used to assess a client's report of nausea.

Table 4.3b Sample PQRSTU Questions

PQRSTU	Sample Questions
Provocation/ Palliation	What were you doing when the nausea started? Does anything make it better or worse (e.g., food, position, movement, m
Quality	Describe the feeling? (e.g., queasy, churning, lightheaded, urge to vomit?
Region	Do you feel the nausea in a specific part of your body (e.g., upper stomach
Severity	On a scale of 0 to 10, how bad is the nausea right now? Has it gotten wors
Timing/Treatment	When did the nausea start? Is it constant or does it come and go? Does it occur at specific times (e.g., after eating, in the morning)?
Understanding	What do you think is causing the nausea?

Cultural Formulation Interview Questions

While performing a psychosocial assessment, it is important to performing a cultural assessment. We all bring our own cultural beliefs, values, and expectations to the clinical encounter, which influences how we approach specific aspects of care. The American Psychiatric Association developed evidence-based Cultural Formulation Interview (CFI) questions as a way to incorporate cultural assessment into the care of all clients that enhances

clinical understanding and decision-making.[32] The CFI questions are used to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (e.g., family, friends, or others involved in the current problem). This includes the problem's meaning, potential sources of help, and expectations for health care services.

CFI questions used with all clients include the following[33]:

- What brings you here today?
- What troubles you most about this problem?
- What do you think is the cause of this problem?
- Are there any kinds of support that make this problem better, such as support from family, friends, or others?
- Are there any kinds of stresses that make this problem worse, such as difficulties with money or family problems?
- Sometimes aspects of people's background or identity can make their problem better or worse, such as the communities they belong to, the languages they speak, where they or their family are from, their race or ethnic background, their gender or sexual orientation, or their faith or religion. Are there any aspects of your background or identity that make a difference to this problem?
- Sometimes people have various ways of dealing with problems. What have you done on your own to cope with this problem?

32. DeSilva, R., Aggarwall, N. K., & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry. *Psychiatric Times, 32*(6). https://www.psychiatrictimes.com/view/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry

33. American Psychiatric Association. (2013). Cultural formulation. In *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). American Psychiatric Association. pp. 749-759.

- Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for this problem?
- Has anything prevented you from getting the help you need?
- What kinds of help do you think would be most useful to you at this time for this problem?
- Are there other kinds of help that your family, friends, or other people have suggested that would be helpful for you now?
- Sometimes health care professionals and clients misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about misaligned care expectations and is there anything that we can do to provide you with the care you need?

Findings from the cultural formulation interview are used to individualize a client's plan of care to their preferences, values, beliefs, and goals.

Spiritual Assessment

Spiritual assessment is included in a psychosocial assessment. It is common for people in the process of recovery from mental health disorders and substance use to search for spiritual support.[34] **Spirituality** includes a sense of connection to something larger than oneself and typically involves a search for meaning and purpose in life. Basic questions used to assess spirituality include the following:

- Who or what provides you with strength or hope?
- How do you express your spirituality?

34. Neto, G. L., Rodrigues, L., Rozendo da Silva, D. A., Turato, E. R., & Campos, C. J. G. (2018). Spirituality review on mental health and psychiatric nursing. *Revista Brasileira de Enfermagem, 71* (Suppl 5), 2323-2333. https://doi.org/10.1590/0034-7167-2016-0429

- What spiritual needs can we advocate for you during this health care experience?

Over the past decade, research has demonstrated the importance of spirituality in health care.[35,36] Spiritual distress is very common for clients experiencing serious illness, injury, or the dying process, and nurses are on the front lines as they assist these individuals to cope with these life events. Addressing a client's spirituality and advocating spiritual care have been shown to improve clients' health and quality of life, including how they experience pain, cope with stress and suffering associated with serious illness, and approach end of life.[37,38]

35. Pilger, C., Molzahn, A. E., de Oliveira, M. P., & Kusumota, L. (2016). The relationship of the spiritual and religious dimensions with quality of life and health of patients with chronic kidney disease: An integrative literature review. *Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association, 43*(5), 411–426. https://pubmed.ncbi.nlm.nih.gov/30550069/

36. Puchalski, C., Jafari, N., Buller, H., Haythorn, T., Jacobs, C., & Ferrell, B. (2020). Interprofessional spiritual care education curriculum: A milestone toward the provision of spiritual care. *Journal of Palliative Medicine, 23*(6), 777–784. https://doi.org/10.1089/jpm.2019.0375

37. Pilger, C., Molzahn, A. E., de Oliveira, M. P., & Kusumota, L. (2016). The relationship of the spiritual and religious dimensions with quality of life and health of patients with chronic kidney disease: An integrative literature review. *Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association, 43*(5), 411–426. https://pubmed.ncbi.nlm.nih.gov/30550069/

38. Puchalski, C., Jafari, N., Buller, H., Haythorn, T., Jacobs, C., & Ferrell, B. (2020). Interprofessional spiritual care education curriculum: A milestone toward the provision of spiritual care. *Journal of Palliative Medicine, 23*(6), 777–784. https://doi.org/10.1089/jpm.2019.0375

The FICA Spiritual History Tool© is a common tool used to gather information about a client's spiritual history and preferences.[39] FICA© is a mnemonic for Faith, Importance, Community, and Address in Care. Read more about the FICA© tool in the following box.

The FICA© Spiritual History Tool[40]

F – Faith and Belief: Determine if the client identifies with a particular belief system or spirituality.

I – Importance: Ask, "Is this belief important to you? Does it influence how you think about health and illness? Does it influence your health care decisions?"

C – Community: Determine if the client belongs to a spiritual community (e.g., a church, temple, mosque, or other group). If not, ask, "Would it be helpful to you to find a spiritual community?"

A – Address in Care: Evaluate what should be addressed during the client's care. Ask, "What should be included in your treatment plan? Are there spiritual practices you want to develop? Would you like to see a chaplain, spiritual director, or pastoral counselor while you are here?"

39. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*. https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool

40. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*. https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool

Based on the assessment findings, nurses may refer clients to agency chaplains or to the client's religious leaders for spiritual support to enhance coping.

> Read more about spiritual assessment and providing spiritual care in the "Spirituality" chapter of Open RN *Nursing Fundamentals, 2e*.

Family Dynamics

Family dynamics are included in a psychosocial assessment, especially for children, adolescents, and older adults. **Family dynamics** refers to the patterns of interactions among relatives, their roles and relationships, and the various factors that shape their interactions. Because family members rely on each other for emotional, physical, and economic support, they are primary sources of relationship security or stress. Family dynamics and the quality of family relationships can have either a positive or negative impact on an individual's health. For example, secure and supportive family relationships can provide love, advice, and care, whereas stressful family relationships can be burdened with arguments, unhealthy relationships, and a lack of support.[41]

Unhealthy family dynamics can cause children to experience trauma and stress as they grow up. This type of exposure, known as adverse childhood experiences (ACEs), is linked to an increased risk of developing physical and mental health problems such as heart, lung, and liver disease; depression; and

41. This work is a derivative of StatPearls by Jabbari & Rouster and is licensed under CC BY 4.0

anxiety. Unhealthy family dynamics also correlate with an increased risk of substance use and addiction among adolescents.[42]

> Review information about adverse childhood experiences (ACEs) in the "Mental Health and Mental Illness" section of Chapter 1.

Effectively assessing and addressing a client's family dynamic and its role in health and disease require an interprofessional team of health professionals, including nurses, physicians, social workers, and therapists. Nurses are in a unique position to observe and document interaction patterns, assess family relationships, and tend to family concerns in the clinical setting because they are in frequent contact with family members.[43]

Suicide Screening

As discussed in Chapter 1, all clients aged 12 and older presenting for acute care should be screened for suicidal ideation. Clients being evaluated or treated for mental health conditions often have suicidal ideation, and up to 10 percent of emergency department clients presenting with medical issues have a hidden risk for suicide, such as recent suicidal ideation or previous

42. This work is a derivative of StatPearls by Jabbari & Rouster and is licensed under CC BY 4.0

43. This work is a derivative of StatPearls by Jabbari & Rouster and is licensed under CC BY 4.0

suicide attempts.[44] Universal screening allows for the detection of suicide risk and implementation of early interventions before a person attempts suicide.

It is important to introduce suicide screening in a way that helps the client understand its purpose and normalize questions that might otherwise seem intrusive. A nurse might introduce the topic in the following way: "Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy, and it helps us to make sure we are not missing anything important."[45]

The Patient Safety Screener (PSS-3) is an example of a brief screening tool to detect suicide risk in all client presenting to acute care settings.[46] See Figure 4.3[47] for an image of the PSS-3.

The PSS-3 consists of assessing for three items: depression, active suicidal ideation, and lifetime suicide attempt. Each of these items explores a different aspect of suicide risk[48]:

44. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk*. https://sprc.org/micro-learning/patientsafetyscreener

45. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk*. https://sprc.org/micro-learning/patientsafetyscreener

46. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk*. https://sprc.org/micro-learning/patientsafetyscreener

47. "Patient Safety Screener (PSS-3) Pocket Card" by University of Massachusetts Medical School (UMass Medical) is used on the basis of Fair Use.

48. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief*

- Depression is a common precipitant of suicidal ideation and behavior and is the most common diagnosis among those who die by suicide.
- Suicidal ideation (i.e., thoughts about killing oneself) is a precondition for suicidal behavior.
- A previous suicide attempt is one of the most consistent risk factors for suicide.

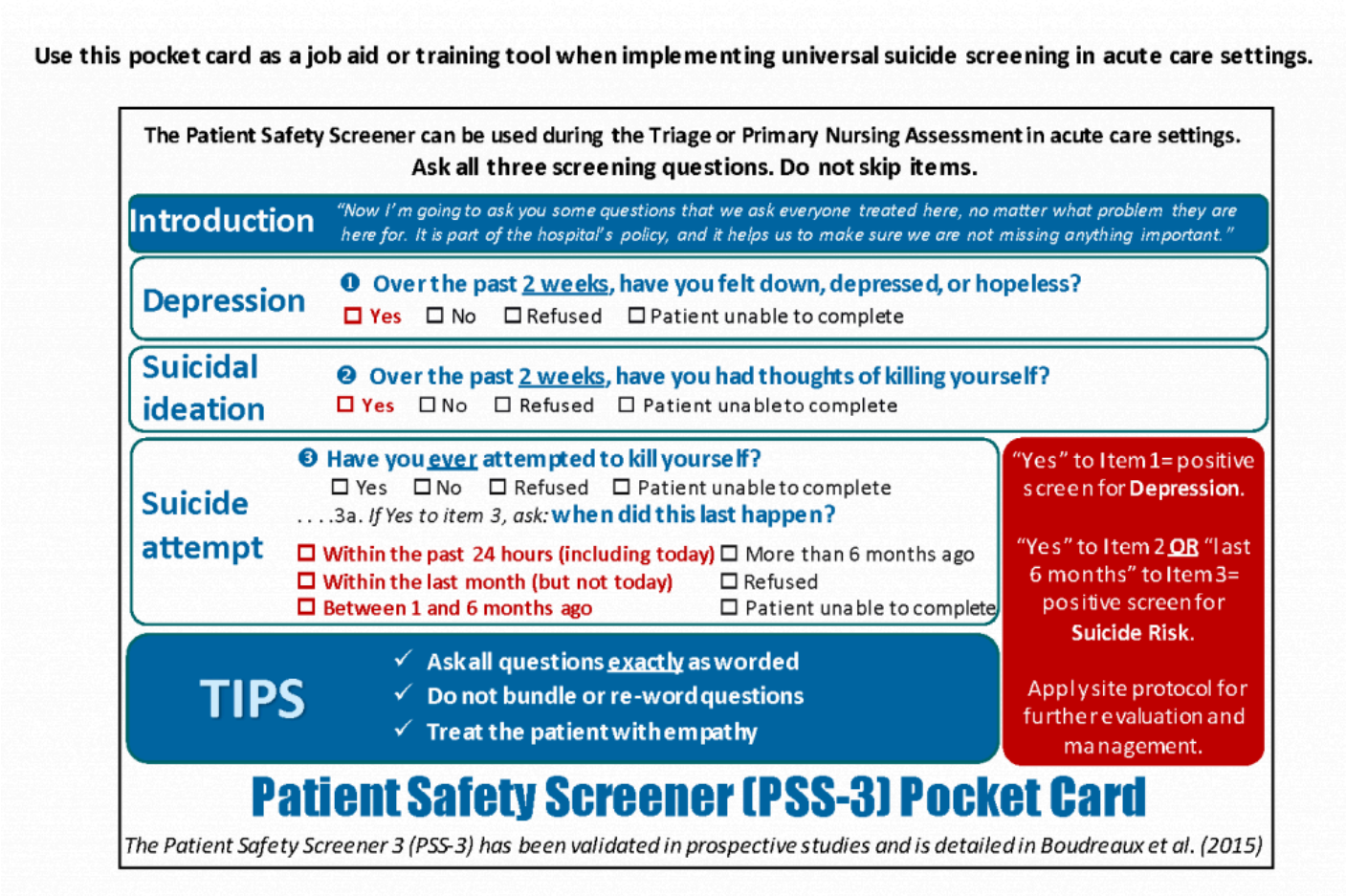

Figure 4.3 Patient Safety Screener for Suicide Risk. Used under Fair Use.

Self-Injury

Non-suicidal self-injury (NSSI) refers to intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially

tool to detect suicide risk. https://sprc.org/micro-learning/patientsafetyscreener

sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting. It is considered a maladaptive coping strategy without the desire to die. NSSI is a common finding among adolescents and young adults in psychiatric inpatient settings.[49]

Current and Past Medical History

A thorough review of a client's current and past medical conditions provides critical insight into their overall health and potential influences on mental well-being. Chronic illnesses such as diabetes, cardiovascular disease, or neurological disorders can contribute to or exacerbate psychiatric symptoms. Understanding this history helps nurses identify connections between physical and mental health.

Medication Review

When evaluating a client's mental health status, it is essential to review their current use of psychotropic medications, as well as any other prescribed or over-the-counter drugs that may contribute to psychiatric symptoms. Psychotropic medications, which are used to manage conditions such as depression, anxiety, bipolar disorder, and schizophrenia, can have complex effects and may interact with other substances in ways that influence mood, cognition, or behavior. Additionally, certain non-psychiatric medications—such as corticosteroids, antihypertensives, or stimulants—can produce side effects that mimic or exacerbate psychiatric conditions. A thorough medication review helps ensure accurate assessment, prevents misdiagnosis, and guides appropriate treatment planning.

49. Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, 8. https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full

History of Previously Diagnosed Mental Health Disorders

Documenting any formally diagnosed mental health conditions, such as depression, anxiety, schizophrenia, or bipolar disorder, offers a foundation for understanding the client's mental health journey. This history supports continuity of care and helps identify patterns or triggers related to past episodes. Documenting any formally diagnosed mental health conditions, such as depression, anxiety, schizophrenia, or bipolar disorder, offers a foundation for understanding the client's mental health journey. This history supports continuity of care and helps identify patterns or triggers related to past episodes.

Previous Hospitalizations

Exploring prior psychiatric or medical hospitalizations provides context for the severity and frequency of past health episodes. This information can help the nurse assess the progression of mental health conditions and the effectiveness of previous interventions.

Educational Background

Understanding a client's level of education assists in planning appropriate communication strategies and assessing cognitive development and health literacy. Educational attainment may also impact employment, income, and social opportunities, influencing mental wellness.

Occupational Background

A client's work history can reflect their ability to maintain structure, social roles, and economic stability. Job satisfaction or stress, unemployment, or disability due to mental health issues may reveal important psychosocial stressors or strengths.

History of Exposure to Psychological Trauma, Violence, and Domestic Abuse

Exposure to trauma—such as childhood abuse, domestic violence, or combat experiences—can profoundly impact an individual's emotional regulation, cognitive development, and overall mental health. Traumatic experiences often disrupt the brain's ability to process stress and emotions effectively, leading to heightened anxiety, depression, difficulties in forming and maintaining relationships, and in some cases, the development of post-traumatic stress disorder (PTSD). Individuals who have experienced trauma may exhibit hypervigilance, emotional numbness, mood swings, or difficulty trusting others. These long-lasting effects can persist well into adulthood, influencing personal well-being, social functioning, and physical health outcomes. Understanding the deep and complex consequences of trauma is essential for recognizing behavioral responses and addressing mental health needs with empathy and evidence-based support.

Substance Use

A comprehensive assessment of tobacco use, alcohol consumption, recreational drug use, and the misuse of prescription medications is essential in evaluating an individual's overall health, identifying risk factors, and detecting co-occurring substance use disorders. Substance use often does not occur in isolation and may be intertwined with underlying mental health conditions such as depression, anxiety, or trauma-related disorders. These substances can alter neurochemical pathways in the brain, leading to changes in mood, behavior, and cognitive function. For example, stimulant use may increase irritability or anxiety, while depressants such as alcohol or opioids can contribute to emotional blunting or memory impairment.

Accurate assessment enables healthcare providers to recognize patterns of use, understand the potential impact on physical and mental health, and tailor treatment approaches accordingly. Furthermore, substance use can interfere with the effectiveness of medical and psychiatric treatments, reduce

adherence to care plans, and increase the risk of adverse outcomes. Early identification and integrated treatment planning are critical to improving prognosis, enhancing client safety, and supporting long-term recovery and wellness.

Family History of Mental Illness

Exploring family mental health history helps identify potential genetic or environmental influences on the client's condition. It also provides insight into the support systems or stigma the client may face in their home environment.

Coping Mechanisms

Identifying the client's typical coping strategies—both adaptive and maladaptive—offers a window into their resilience and vulnerability. Understanding how individuals manage stress or adversity informs the development of effective care plans and interventions.

Functional Ability/Activities of Daily Living (ADLs)

Assessing a client's ability to perform basic self-care tasks and daily routines—such as bathing, dressing, preparing meals, maintaining personal hygiene, managing medications, or handling finances—is a critical component of evaluating overall functioning. These activities, often referred to as Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), provide important insight into a person's level of independence and the extent to which mental, emotional, or cognitive challenges may be affecting day-to-day life.

Functional impairments in these areas can serve as early warning signs of a worsening mental health condition, such as major depressive disorder, schizophrenia, or dementia, and may reflect cognitive decline, lack of motivation, or impaired judgment. Identifying deficits in daily functioning

helps clinicians determine the need for supportive services, such as occupational therapy, case management, home health care, or placement in a more structured living environment. In many cases, a multidisciplinary intervention that includes mental health professionals, medical providers, and social services is necessary to promote safety, improve quality of life, and support recovery.

In order to complete a robust mental health assessment, screening tools may be utilized to identify symptoms and standardize evaluation. Screening tools are evidence-based methods to assess specific information related to mental health disorders. These tools may be used on admission to the hospital or treatment facility, as well as at different times throughout the client's stay. Common examples include PHQ-9 for depression, GAD-7 for anxiety, and the CAGE questionnaire for alcohol use. Findings from the tool's results may be used to compare client progress during the hospital stay or from a previous admission. The registered nurse often conducts these screening tools as part of the interprofessional health care treatment team. Read more about specific screening tools in each "disorder" chapter.

Laboratory and Diagnostic Testing

Nurses review laboratory and diagnostic testing results as part of the assessment process. Laboratory and diagnostic testing are essential components of a comprehensive client assessment to exclude underlying medical causes, identify co-morbid conditions, and guide appropriate treatment. For example, nurses routinely monitor electrolytes to assess fluid and electrolyte balance, which is crucial in many clinical conditions. An example of this would be serum sodium levels, as abnormal sodium can indicate dehydration, kidney dysfunction, or other systemic issues that may impact client care and treatment decisions.

Specific laboratory and diagnostic tests will be discussed in each "disorder" chapter, as well as in the "Psychotropic Medications" chapter.

Life Span Considerations

Life span considerations influence nursing assessments, care planning, and interventions. Mental health disorders occur across the life span, from the very young to the very old, and developmental stages must be considered when identifying impairments. Assessments and interventions must be individualized to the age and developmental level of the client. **Development** encompasses physical, social, and cognitive changes that occur continuously throughout one's life. See Figure 4.4[50] for an image of the human life cycle.

Figure 4.4 Human Life Cycle

There are multiple factors that affect human development with expected milestones along the way. Cognitive development encompasses several different skills that develop at different rates. Each human has their own individual experience that influences development of intelligence and

50. "shutterstock_149010437.jpg" by Robert Adrian Hillman is used under license from Shutterstock.com

reasoning as they interact with one another. With these unique experiences, everyone has a memory of feelings and events that is exclusive to them.[51]

There are many theories regarding how infants and children grow and develop into happy, healthy adults. Three major theories that have historically impacted nursing care are Freud's Psychosexual Theory of Development, Erikson's Psychosocial Stages of Development, and Piaget's Cognitive Theory of Development.

Freud's Psychosexual Theory of Development

Sigmund Freud (1856–1939) believed that personality develops during early childhood, and childhood experiences shape our personalities and behavior as adults. Freud believed that each individual must pass through a series of stages during childhood, and if we lack proper nurturance and parenting during a stage, we may become stuck, or fixated, in that stage. According to Freud, children's pleasure-seeking urges are focused on different areas of the body, called erogenous zones, at each of the five stages of development: oral, anal, phallic, latency, and genital.[52]

While most of Freud's ideas are not supported by research and modern psychologists dispute Freud's psychosexual stages as a legitimate explanation

51. Vallotton, C. D., & Fischer, K. W. (2008). Cognitive development. *Encyclopedia of Infant and Early Childhood Development*. Academic Press. pp. 286-298. https://doi.org/10.1016/B978-012370877-9.00038-4

52. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

for how one's personality develops, Freud's original theory supported that one's personality is shaped, in some part, by childhood experiences.[53]

Erikson's Psychosocial Stages of Development

Erik Erikson (1902–1994) took Freud's theory and modified it as psychosocial theory. Erikson's psychosocial development theory emphasizes the social nature of our development rather than its sexual nature. It describes eight sequential stages of individual human development influenced by biological, psychological, and social factors throughout the life span that contribute to an individual's personality. Erikson's stages of development are trust versus mistrust, autonomy versus shame, initiative versus guilt, industry versus inferiority, identity versus identity confusion, intimacy versus isolation, generativity versus stagnation, and integrity versus despair.[54,55]

- **Trust vs. Mistrust**

  The first stage that develops is trust (or mistrust) that basic needs, such as nourishment and affection, will be met. Trust is the basis of our development during infancy (birth to 12 months). Infants are dependent upon their caregivers for their needs. Caregivers who are responsive and sensitive to their infant's needs help their baby to develop a sense of trust, and the infant will perceive the world as a safe, predictable place. Unresponsive caregivers who do not meet their baby's needs can

53. Psychology 2e by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

54. This work is a derivative of StatPearls by Orenstein & Lewis and is licensed under CC BY 4.0

55. Psychology 2e by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

engender feelings of anxiety, fear, and mistrust, and the infant will perceive the world as unpredictable.[56]

- **Autonomy vs. Shame**

  Toddlers begin to explore their world and learn that they can control their actions and act on the environment to get results. They begin to show clear preferences for certain elements of the environment, such as food, toys, and clothing. A toddler's main task is to resolve the issue of autonomy versus shame and doubt by working to establish independence. For example, we might observe a budding sense of autonomy in a two-year-old child who wishes to choose their own clothes and dress themselves. Although the outfits might not be appropriate for the situation, the input in basic decisions has an effect on the toddler's sense of independence. If denied the opportunity to act on their environment, they may begin to doubt their abilities, which could lead to low self-esteem and feelings of shame.[57]

- **Initiative vs. Guilt**

  After children reach the preschool stage (ages 3–6 years), they are capable of initiating activities and asserting control over their world through social interactions and play. By learning to plan and achieve goals while interacting with others, preschool children can master a

56. Psychology 2e by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

57. Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

feeling of initiative and develop self-confidence and a sense of purpose. Those who are unsuccessful at this stage may develop feelings of guilt.[58]

- **Industry vs. Inferiority**

  During the elementary school stage (ages 7–11), children begin to compare themselves to their peers to see how they measure up. They either develop a sense of pride and accomplishment in their schoolwork, sports, social activities, and family life, or they may feel inferior and inadequate if they feel they don't measure up to their peers.[59]

- **Identity vs. Identity Confusion**

  In adolescence (ages 12–18), children develop a sense of self. Adolescents struggle with questions such as, "Who am I?" and "What do I want to do with my life?" Along the way, adolescents try on many different selves to see which ones fit. Adolescents who are successful at this stage have a strong sense of identity and are able to remain true to their beliefs and values in the face of problems and other people's perspectives. Teens who do not make a conscious search for identity, or those who are pressured to conform to their parents' ideas for the future, may have a weak sense of self and experience role confusion as they are unsure of their identity and confused about the future.[60]

- **Intimacy vs. Isolation**

58. Psychology 2e by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

59. Psychology 2e by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

60. Psychology 2e by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

People in early adulthood (i.e., 20s through early 40s) are ready to share their lives and become intimate with others after they have developed a sense of self. Adults who do not develop a positive self-concept in adolescence may experience feelings of loneliness and emotional isolation.[61]

- **Generativity vs. Stagnation**

  When people reach their 40s, they enter a time period known as middle adulthood that extends to the mid-60s. The developmental task of middle adulthood is generativity versus stagnation. Generativity involves finding your life's work and contributing to the development of others through activities such as volunteering, mentoring, and raising children. Adults who do not master this developmental task may experience stagnation with little connection to others and little interest in productivity and self-improvement.[62]

- **Integrity vs. Despair**

  The mid-60s to the end of life is a period of development known as late adulthood. People in late adulthood reflect on their lives and feel either a sense of satisfaction or a sense of failure. People who feel proud of their accomplishments feel a sense of integrity and often look back on their lives with few regrets. However, people who are not successful at this stage may feel as if their life has been wasted. They focus on what "would

61. Psychology 2e by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

62. Psychology 2e by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

have," "should have," or "could have" been. They face the end of their lives with feelings of bitterness, depression, and despair.[63]

Piaget's Cognitive Theory of Development

Jean Piaget (1896–1980) studied childhood development by focusing on children's cognitive growth. He believed that thinking is a central aspect of development and that children are naturally inquisitive but do not think and reason like adults. Children explore the world as they attempt to make sense of their experiences. His theory explains that humans move from one stage to another as they seek cognitive equilibrium and mental balance. There are four stages in Piaget's theory of development that occur in children from all cultures[64,65]:

- **Sensorimotor period.** The first stage extends from birth to approximately two years and is a period of rapid cognitive growth. During this period, infants develop an understanding of the world by coordinating sensory experiences (seeing, hearing) with motor actions (reaching, touching). The main development during the sensorimotor stage is the understanding that objects exist, and events occur in the world independently of one's own actions. Infants develop an understanding of what they want and what they must do to have their needs met. They begin to understand language used by those around them to make needs met.

63. Psychology 2e by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

64. Vallotton, C. D., & Fischer, K. W. (2008). Cognitive development. *Encyclopedia of Infant and Early Childhood Development*. Academic Press. pp. 286-298. https://doi.org/10.1016/B978-012370877-9.00038-4

65. McLeod, S. (2025). *Piaget's theory and stages of development*. SimplyPsychology. https://www.simplypsychology.org/piaget.html

- **Preoperational period.** The second stage begins in the toddler years. This continues through early school-age years. This is the time frame when children learn to think in images and symbols. Play is an important part of cognitive development during this period.
- **Concrete Operations period.** Older school-age children (age 7 years to 11 years) learn to think in terms of processes and can understand that there is more than one perspective when discussing a concept. This stage is considered a major turning point in the child's cognitive development because it marks the beginning of logical or operational thought.
- **Formal Operations period.** Children enter this stage around age 12 as they become self-conscious and egocentric. Adolescents gain the ability to think in an abstract manner by manipulating ideas in their head. Moving toward adulthood, this further develops into the ability to critically reason.

Cognitive Impairment

Cognitive impairment is a term used to describe impairment in mental processes that drive how an individual understands and acts in the world, affecting the acquisition of information and knowledge. Cognitive impairments can range from mild impairments, such as impairments in cognitive operations, to profound intellectual impairments causing minimal independent functioning. Components of cognitive functioning include attention, decision-making, general knowledge, judgment, language, memory, perception, planning, and reasoning.[66]

Review information about cognitive impairments associated

66. Schofield, D. W. (2018, December 26). *Cognitive deficits.* Medscape. https://emedicine.medscape.com/article/917629-overview

- with dementia and Alzheimer's disease in the "Cognitive Impairments" chapter of Open RN *Nursing Fundamentals, 2e*.

Intellectual disability (formerly referred to as mental retardation) is a diagnostic term that describes intellectual and adaptive functioning deficits identified during the developmental period. In the United States, the developmental period refers to the span of time prior to the age of 18 years. Children with intellectual disabilities may demonstrate a delay in developmental milestones (e.g., sitting, speaking, walking) or demonstrate mild cognitive impairments that may not be identified until school-age. Intellectual disability is typically nonprogressive and lifelong. It is diagnosed by multidisciplinary clinical assessments and standardized testing and is treated with a multidisciplinary treatment plan that maximizes quality of life.[67]

Resilience

When assessing an individual's developmental level, it is important to consider possible effects of adverse childhood events (ACEs) on their development. Science tells us that some children develop **resilience**, the ability to overcome serious hardship or traumatic experiences, while others do not. One way to understand the development of resilience is to visualize a seesaw. Protective experiences and coping skills on one side counterbalance significant adversity on the other. Resilience is evident when a child's health

67. Schofield, D. W. (2018, December 26). *Cognitive deficits.* Medscape. https://emedicine.medscape.com/article/917629-overview

and development tip toward positive outcomes – even when a heavy load of factors is stacked on the negative outcome side.[68]

The most common factor for children who develop resilience is at least one stable and committed relationship with a supportive parent, caregiver, or other adult. These relationships provide the personalized responsiveness and protection that buffer children from developmental disruption. They also build their ability to plan, monitor, and regulate behavior that enables children to respond adaptively to adversity and thrive. This combination of supportive relationships, adaptive skill-building, and positive experiences is the foundation of resilience.[69]

The capabilities that underlie resilience can be strengthened at any age. It is never too late to build resilience. Age-appropriate, health-promoting activities can significantly improve the chances that an individual will recover from stress-inducing experiences. For example, regular physical exercise, stress management activities, and programs that actively promote self-regulation skills can improve the abilities of children and adults to cope with adversity in their lives.[70]

> Read more about promoting resilience across the life span at Harvard's Center on the Developing Child *Resilience* webpage.

68. Center on the Developing Child. (n.d.). *Resilience*. Harvard University. https://developingchild.harvard.edu/science/key-concepts/resilience/

69. Center on the Developing Child. (n.d.). *Resilience*. Harvard University. https://developingchild.harvard.edu/science/key-concepts/resilience/

70. Center on the Developing Child. (n.d.). *Resilience*. Harvard University. https://developingchild.harvard.edu/science/key-concepts/resilience/

Cultural Considerations

Cultures and communities exhibit and explain symptoms of mental illness and manifest stress in various ways. Nurses should be aware of relevant contextual information stemming from a client's culture, race, ethnicity, religion, or geographical origin. For example, uncontrollable crying and headaches are symptoms of panic attacks in some cultures, whereas difficulty breathing may be the primary symptom in another culture. Understanding such distinctions will help nurses effectively treat them.[71]

At the center of client-centered care is practicing with cultural humility and inclusiveness. In the 2021 edition of *Nursing: Scope and Standards of Practice*, the American Nurses Association (ANA) established a Standard of Professional Performance called *Respectful and Equitable Practice*. This standard is defined as, "The registered nurse practices with cultural humility and inclusiveness." **Cultural humility** is "a humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot know everything about other cultures, and approach learning about other cultures as a life-long goal and process."[72] **Inclusiveness** is defined as "the practice of providing equal access to opportunities and resources for people who might otherwise be excluded or marginalized, such as those having physical or mental disabilities or belonging to other minority groups."[73] Read the ANA competencies for the *Respectful and Equitable Practice* standard in the following box.

71. American Psychiatric Association. (n.d.). *DSM-5 fact sheets*. https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets

72. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association

73. Oxford Learner's Dictionaries. (n.d.). *Inclusion*. Oxford University Press. https://www.oxfordlearnersdictionaries.com/us/definition/english/inclusion

ANA's Respectful and Equitable Practice Competencies[74]

The registered nurse:

- Demonstrates respect, equity, and empathy in actions and interactions with all health care consumers.
- Respects consumer decisions without bias.
- Participates in life-long learning to understand cultural preferences, worldviews, choices, and decision-making processes of diverse consumers.
- Reflects upon personal and cultural values, beliefs, biases, and heritage.
- Applies knowledge of differences in health beliefs, practices, and communication patterns without assigning values to the differences.
- Addresses the effects and impact of discrimination and oppression on practice within and among diverse groups.
- Uses appropriate skills and tools for the culture, literacy, and language of the individuals and population served.
- Communicates with appropriate language and behaviors, including the use of qualified health care interpreters and translators in accordance with consumer needs and preferences.
- Serves as a role model and educator for cultural humility and the recognition and appreciation of diversity and inclusivity.
- Identifies the cultural-specific meaning of interactions,

74. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association

terms, and content.

- Advocates for policies that promote health and prevent harm among diverse health care consumers and groups.
- Promotes equity in all aspects of health and health care.
- Advances organizational policies, programs, services, and practices that reflect respect, equity, and values for diversity and inclusion.

Read more about cultural humility and advocating for the values, beliefs, and preferences of diverse clients in the "Diverse Clients" chapter of Open RN *Nursing Fundamentals, 2e*.

4.4 Diagnosis

The *Diagnosis* Standard of Practice by the American Nurses Association states, "The registered nurse analyzes assessment data to determine actual or potential diagnoses, problems, and issues."[1] Review the competencies for the *Diagnosis* Standard of Practice for registered nurses in the following box.

ANA's Diagnosis Competencies[2]

The registered nurse:

- Identifies actual or potential risks to the health care consumer's health and safety or barriers to health, which may include, but are not limited to, interpersonal, systematic, cultural, socioeconomic, or environmental circumstances.
- Uses assessment data, standardized classification systems, technology, and clinical decision support tools to articulate actual or potential diagnoses, problems, and issues.
- Identifies the health care consumer's strengths and abilities, including, but not limited to, support systems, health literacy, and engagement in self-care.
- Verifies the diagnoses, problems, and issues with the health care consumer and interprofessional colleagues.
- Prioritizes diagnoses, problems, and issues based on

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

mutually established goals to meet the needs of the health care consumer across the health-illness continuum and the care continuum.
- Documents diagnoses, problems, strengths, and issues in a manner that facilitates the development of the expected outcomes and collaborative plan.

Review how to analyze assessment data, make hypotheses, and create nursing diagnoses statements in the "Diagnosis" section of the "Nursing Process" chapter in Open RN *Nursing Fundamentals*.

Nursing Diagnoses

A nursing diagnosis is "a clinical judgment concerning a human response to health conditions/life processes, or a vulnerability to that response, by an individual, family, group, or community."[3] Nursing diagnoses are customized to each client and drive the development of the nursing care plan. The nurse should refer to an evidence-based care planning resource and review the definitions and defining characteristics of the hypothesized nursing diagnoses.

Recall that nursing diagnoses are different from medical diagnoses and

3. Herdman, T. H., & Kamitsuru, S. (Eds.). (2021). *Nursing diagnoses: Definitions and classification, 2021-2023*. Thieme Publishers.

mental health diagnoses. Medical diagnoses focus on medical problems that have been identified by the physician, physician's assistant, or advanced nurse practitioner. Mental health diagnoses are established by mental health experts, such as psychiatrists, psychologists, and advanced practice psychiatric-mental health nurses, using the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)*. See Figure 4.5[4] for an illustration of several mental health diagnoses.

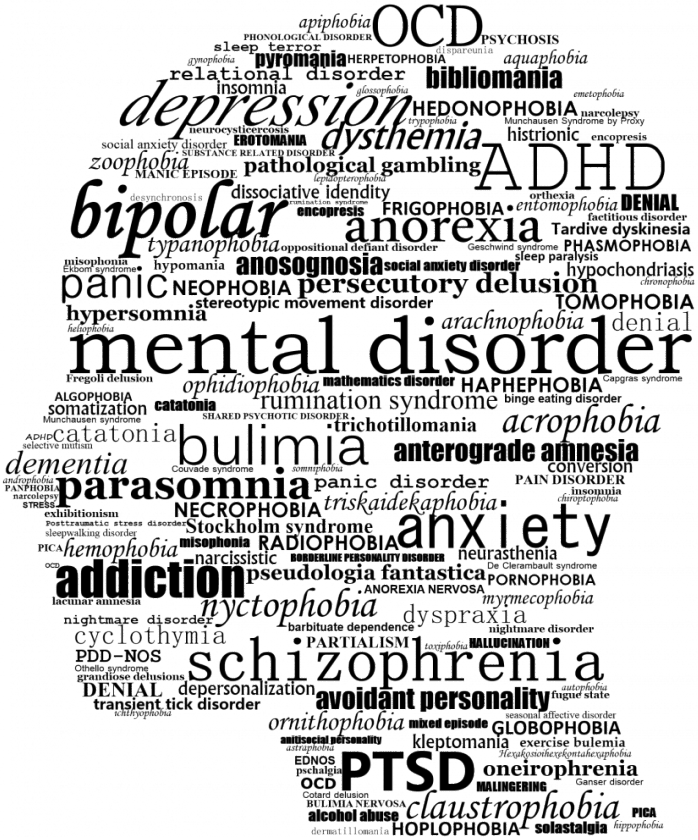

Figure 4.5 Mental Health Diagnoses

Nursing diagnoses focus on the human response to health conditions and life processes and are established by registered nurses. Clients with the same mental health diagnosis will often respond differently and thus have different nursing diagnoses. For example, two clients may have the same diagnosis of Major Depressive Disorder. However, one client may demonstrate a high risk

4. "Mental_Disorder_Silhouette.png" by Paget Michael Creelman is licensed under CC BY-SA 4.0

for suicide whereas another client may experience impaired nutrition due to lack of appetite. The nurse must consider these different responses when creating an individualized nursing care plan.

Prioritization

After identifying nursing diagnoses, the next step is prioritizing specific needs of the client. Prioritization is the process of identifying the most significant problems and the most important interventions to implement based on a client's current status.

It is essential that life-threatening concerns and crises are quickly identified and addressed immediately. Depending on the severity of a problem, the steps of the nursing process may be performed in a matter of seconds for life-threatening concerns. Nurses must recognize cues signaling a change in client condition, apply evidence-based practices in a crisis, and communicate effectively with interprofessional team members. Most client care situations fall somewhere between a crisis and routine care.

Maslow's Hierarchy of Needs is commonly used to prioritize the most urgent client needs. It is based on the theory that people are motivated by five levels of needs: physiological, safety, love, esteem, and self-actualization. The bottom levels of the pyramid represent the priority physiological needs intertwined with safety, whereas the upper levels focus on belonging, esteem, and self-actualization. Physiological needs must be met before focusing on higher level needs.[5] For example, priorities for a client experiencing mania are the need for food, fluid, and sleep, as well as controlling the agitation and impulsivity to ensure safety. These needs would need to be met before focusing on strategies to improve relationships with family and friends, build respect and acceptance for self and others, and engage in activities promoting personal growth. It is important to note that although safety is not

5. Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50(4), 370–396. https://doi.org/10.1037/h0054346

described as a top priority in this theory, nurses must always prioritize safety needs in addition to physiological needs. See Figure 4.6[6] for an image of Maslow's Hierarchy of Needs.

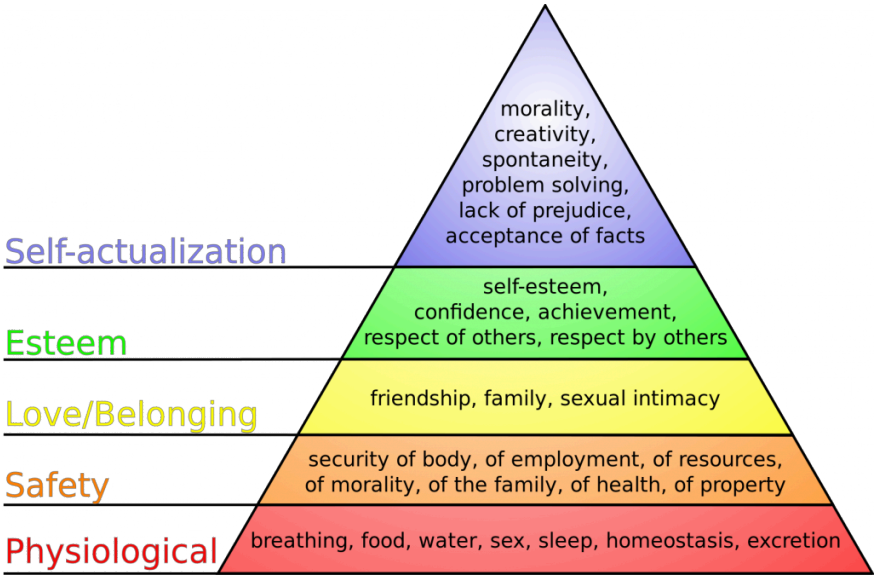

Figure 4.6 Maslow's Hierarchy of Needs

Common Nursing Diagnoses for Mental Health Conditions

Commonly used nursing diagnoses related to caring for clients with mental health conditions are included in Table 4.4. As always, when providing client care, refer to a current, evidence-based nursing care planning resource.

Table 4.4 Common Nursing Diagnoses Related to Mental Health[7]

6. "Maslow's hierarchy of needs.svg" by J. Finkelstein is licensed under CC BY-SA 3.0

7. Herdman, T. H., & Kamitsuru, S. (Eds.). (2021). *Nursing diagnoses: Definitions and classification, 2021-2023*. Thieme Publishers.

Nursing Diagnosis	Definition	Selected Defining Characteristics
Risk for Suicide	Susceptible to self-inflicted, life-threatening injury.	• Reports desire to die • Threats of killing self • Hopelessness • Social isolation • Giving away possessions • Substance misuse • Chronic pain • Sudden change in mood
Ineffective Coping	A pattern of impaired appraisal of stressors with cognitive and/or behavioral efforts that fails to manage demands related to well-being.	• Alteration in concentration • Alteration in sleep pattern • Change in communication pattern • Inability to meet basic needs • Ineffective coping strategies • Insufficient goal-directed behavior • Risk-taking behavior • Substance misuse

Readiness for Enhanced Coping	A pattern of effective appraisal of stressors with cognitive and behavioral efforts to manage demands related to well-being, which can be strengthened.	• Expresses desire to enhance: ◦ Knowledge of stress management strategies ◦ Social support ◦ Use of problem and emotion-oriented strategies ◦ Use of spiritual resources
Self-Neglect	A collection of culturally framed behaviors involving one or more self-care activities in which there is a failure to maintain a socially accepted standard of health and well-being.	• Insufficient personal hygiene • Insufficient environmental hygiene • Nonadherence to health activity

Fatigue	An overwhelming sustained sense of exhaustion and decreased capacity for physical and mental work at the usual level.	• Alteration in concentration • Alteration in libido • Apathy • Impaired ability to maintain usual routines • Ineffective role performance • Nonrestorative sleep patterns
Imbalanced Nutrition: Less than Body Requirements	Intake of nutrients insufficient to meet metabolic needs.	• Food intake less than recommended daily allowance • Insufficient interest in food • Body weight 20% or more below ideal weight range • Read more in the "Nutrition" chapter in Open RN *Nursing Fundamentals*

Constipation	Decrease in normal frequency of defecation accompanied by difficult or incomplete passage of stool and/or passage of excessively dry, hard stool.	• Read more in the "Constipation" section of the "Elimination" chapter in Open RN *Nursing Fundamentals* • Related factors: depression, emotional disturbance, medication side effects, imbalanced nutrition, and poor intake
Sleep Deprivation	Prolonged periods of time without sustained natural, periodic suspension of relative consciousness that provides rest.	• Anxiety • Agitation • Irritability • Restlessness • Alteration in concentration • Fatigue • Transient paranoia • Read more in the "Sleep and Rest" chapter of Open RN *Nursing Fundamentals*

Social Isolation	Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state.	• Absence of support system • Flat or sad affect • Feeling different from others • Values incongruent with social norms
Chronic Low Self-Esteem	Negative evaluation and/or feelings about one's own capabilities, lasting at least three months.	• Repeatedly unsuccessful in life events • Underestimates ability to deal with situation • Exaggerates negative feedback about self • Excessive seeking of reassurance • Nonassertive behavior
Hopelessness	Subjective state in which an individual sees limited or no alternatives or personal choices available and is unable to mobilize energy on own behalf.	• Decrease in: ◦ Appetite ◦ Affect ◦ Verbalization ◦ Initiative • Shrugging in response to speaker

Spiritual Distress	A state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world, or a superior being.	• Ineffective coping strategies • Perceived insufficient meaning in life • Separation from support system • Anger • Hopelessness
Readiness for Enhanced Knowledge	A pattern of cognitive information related to a specific topic or its acquisition, which can be strengthened.	• Expresses desire to enhance learning

Sample Case A

During an interview with a 32-year-old client diagnosed with Major Depressive Disorder, Mr. J. exhibited signs of a sad affect and hopelessness. He expressed desire to die and reported difficulty sleeping and a lack of appetite with weight loss. He reports he has not showered in over a week, and his clothes have a strong body odor. The nurse analyzed this data and created four nursing diagnoses using a nurse care plan reference[8]:

- *Hopelessness* related to social isolation
- *Risk for Suicide* as manifested by reported desire to die

8. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

- *Imbalanced Nutrition: Less than Body Requirements* related to insufficient dietary intake
- *Self-Neglect* related to insufficient personal hygiene

The nurse established the top priority nursing diagnosis of *Risk for Suicide* and immediately screened for suicidal ideation and a plan using the Patient Safety Screener.

4.5 Outcome Identification

The *Outcomes Identification* Standard of Practice by the American Nurses Association states, "The registered nurse identifies expected outcomes for a plan individualized to the health care consumer or the situation."[1] Review the competencies for the *Outcomes Identification* Standard of Practice for registered nurses in the following box.

ANA's Outcomes Identification Competencies[2]

The registered nurse:

- Engages with the health care consumer, interprofessional team, and others to identify expected outcomes.
- Collaborates with the health care consumer to define expected outcomes integrating the health care consumer's culture, values, and ethical considerations.
- Formulates expected outcomes derived from assessments and diagnoses.
- Integrates evidence and best practices to identify expected outcomes.
- Develops expected outcomes that facilitate coordination of care.
- Identifies a time frame for the attainment of expected outcomes.

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

- Documents expected outcomes as measurable goals.
- Identifies the actual outcomes in relation to expected outcomes, safety, and quality standards.
- Modifies expected outcomes based on the evaluation of the status of the health care consumer and situation.

An **outcome** is a "measurable behavior demonstrated by the client who is responsive to nursing interventions."[3] After nursing interventions are implemented, the nurse evaluates if the outcomes were met, partially met, or not met in the time frame indicated for that client.

Outcome identification includes setting short-term and long-term goals and then creating specific expected outcome statements for each nursing diagnosis. Outcome statements are always client-centered. They should be developed collaboratively with the client and individualized to meet the client's unique needs, values, and cultural beliefs. They should start with the phrase *"The client will..."* Outcome statements should be directed at resolving the defining characteristics for that nursing diagnosis. Additionally, the outcome must be something the client is willing to cooperate in achieving.

Read more about how to use the "Motivational Interviewing" technique in setting individualized goals and expected outcomes with a client in the "Therapeutic Communication and Nurse-Client Relationship" chapter.

3. Herdman, T. H., & Kamitsuru, S. (Eds.). (2021). *Nursing diagnoses: Definitions and classification, 2021-2023*. Thieme Publishers New York.

Outcome statements should contain five components easily remembered using the "SMART" mnemonic:

- **S**pecific
- **M**easurable
- **A**ttainable/Action-oriented
- **R**elevant/Realistic
- **T**ime frame

See Figure 4.7[4] for an image of the SMART components of outcome statements.

Figure 4.7 SMART Components

> Review how to create "SMART" expected outcomes in the "Nursing Process" chapter of Open RN *Nursing Fundamentals*.

4. "SMART-goals.png" by Dungdm93 is licensed under CC BY-SA 4.0

Unfolding Case A

Recall Sample Case A in the "Diagnosis" section regarding the 32-year-old male diagnosed with Major Depressive Disorder. The nurse created these four nursing diagnoses:

- *Hopelessness* related to social isolation
- *Risk for Suicide* as manifested by reported desire to die
- *Imbalanced Nutrition: Less than Body Requirements* related to insufficient dietary intake
- *Self-Neglect* related to insufficient personal hygiene

The nurse established the top priority nursing diagnosis of *Risk for Suicide* and immediately screened for suicidal ideation and a plan using the Patient Safety Screener.

The nurse then identified the following SMART expected outcome for the nursing diagnosis *Risk for Suicide* related to reported desire to die: *The client will remain free from self-harm self during the hospitalization stay.*

4.6 Planning

The *Planning* Standard of Practice by the American Nurses Association states, "The registered nurse develops a collaborative plan encompassing strategies to achieve expected outcomes."[1]

Review the competencies for the *Planning* Standard of Practice for registered nurses in the following box.

ANA's Planning Competencies[2]

The registered nurse:

- Develops an individualized, holistic, evidence-based plan in partnership with the health care consumer, family, significant others, and interprofessional team.
- Designs innovative nursing practices that can be incorporated into the plan.
- Prioritizes elements of the plan based on the assessment of the health care consumer's level of safety needs to include risks, benefits, and alternatives.
- Establishes the plan priorities with the health care consumer, family, significant others, and interprofessional team.
- Advocates for compassionate, responsible, and appropriate use of interventions to minimize unwarranted or unwanted

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

treatment, health care consumer suffering, or both.

- Includes strategies designed to address each of the identified diagnoses, health challenges, issues, or opportunities. These strategies may include, but are not limited to, maintaining health and wellness; promotion of comfort; promotion of wholeness, growth, and development; promotion and restoration of health and wellness; prevention of illness, injury, disease, complications, and trauma; facilitation of healing; alleviation of suffering; supportive care; and mitigation of environmental or occupational risks.
- Incorporates an implementation pathway that describes an overall timeline, steps, and milestones.
- Provides for the coordination and continuity of care.
- Identifies cost and economic implications of the plan.
- Develops a plan that reflects compliance with current statutes, rules, regulations, and standards.
- Modifies the plan according to the ongoing assessment of the health care consumer's response and other outcome indicators.
- Documents the plan using standardized language or recognized terminology.
- Actively contributes at all levels in the development and continuous improvement of systems that support the planning process.

As always, consult a current, evidence-based nursing care planning resource when planning nursing interventions individualized to each client's needs. You might be asking yourself, "How do I know what evidence-based nursing interventions to include in the nursing care plan regarding mental health care?" There are several sources that can be used to select nursing

interventions. Many agencies have care planning tools and references included in the electronic health record that are easily documented in the client chart. Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an evidence-based resource center.[3]

> Access the *Evidence-Based Resource Center* maintained by the Substance Abuse and Mental Services Administration (SAMHSA).

See sample planned nursing interventions for a client who has been diagnosed with *Risk for Suicide* in Table 4.6.

Table 4.6 Sample Nursing Interventions for Risk for Suicide[4,5]

3. Substance Abuse and Mental Health Services Administration. (n.d.). *Evidence-based practices resource center*. https://www.samhsa.gov/resource-search/ebp
4. DeAngelis, T. (2019). Better relationships with patients lead to better outcomes. *Monitor on Psychology, 50*(10), 38. https://www.apa.org/monitor/2019/11/ce-corner-relationships
5. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

Nursing Intervention The nurse will...	**Rationale**
Use an evidence-based process to conduct a suicide risk assessment.	Clients with suicidal ideation vary widely in their risk for a suicide attempt depending on whether they have a plan, intent, and past history of attempts. In-depth assessment of clients who screen positive for suicide risk must be completed to determine how to appropriately treat them.
Document and communicate the client's overall level of risk for suicide with the treatment team and the plan for mitigating their risk for suicide.	All interprofessional health care team members who might come in contact with a client at risk for suicide must be aware of the level of risk and the mitigation plans to reduce that risk. This information should be explicitly documented in the client's record.
Perform an environmental risk assessment and remove features that could be used to attempt suicide.	The Veteran's Health Administration showed that use of a Mental Health Environment of Care Checklist to facilitate a thorough, systematic environmental assessment reduced the rate of suicide from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions.
Administer prescribed treatment and collaboratively manage psychiatric symptoms that may be contributing to the client's suicidal ideation or behavior.	Symptoms of the disorder may require treatment with antidepressant, antipsychotic, or antianxiety medications. A systematic review has shown a significant effect for cognitive behavioral therapy in reducing suicidal behavior.
Express desire to help the client and validate the client's experience of psychological pain while maintaining a safe environment for the client.	The nurse must reconcile their goal of preventing suicide with recognition of the client's goal to alleviate their psychological pain.

Develop a positive therapeutic relationship with the client; do not make promises that may not be kept.	Nurses connect suicidal clients with humanity by guiding the client, encouraging effective coping strategies, and helping them connect appropriately with others.
Determine the client's need for supervision and assign a room near the nursing station as necessary.	Close assignment increases ease of observation and availability for a rapid response in the event of a suicide attempt.
Search the newly hospitalized client and the client's personal belongings for weapons or potential weapons and hoarded medications during the admission process and remove dangerous items.	Clients with suicidal ideation may bring the means with them. This action is necessary to maintain a hazard-free environment and client safety.
Limit access to windows and exits unless locked and shatterproof, as appropriate. Ensure exits are secure.	Suicidal behavior may include attempts to jump out of windows or escape to find other means of suicide.
Place the client in the least restrictive, safe, and monitored environment that allows for the necessary level of observation. Assess suicidal risk at least daily and more frequently as warranted.	Close observation of the client is necessary for safety as long as the intent remains high. Suicide risk should be assessed at frequent intervals to adjust suicide precautions and ensure restrictions continue to be appropriate.
Consider strategies to decrease isolation and opportunity to act on harmful thoughts (e.g., use of a sitter).	Clients have reported feeling safe and having their hope restored in response to close observation.
Create a safety plan that includes a no-suicide contract. Contract verbally or in writing with the client for no self-harm and recontract at appropriate intervals.	Discussing thoughts of suicide and self-harm with a trusted person can provide relief for the client. A safety plan gets the subject out in the open and places some of the responsibility for safety with the client. However, research has suggested that self-harm is not prevented by contracts, and ongoing assessment of suicide risk is necessary.

Explain suicide precautions and relevant safety issues to the client and family (purpose, duration, behavioral expectations, and behavioral consequences).	Suicide precautions may be viewed as restrictive. Clients have reported the loss of privacy as distressing. Explaining the reasoning for safety precautions helps the client understand why they are being used even though they may feel restrictive and distressing. When clients and family members understand the reasoning for the precautions, they are more likely to comply.
Verify the client has taken medications as ordered (e.g., conduct mouth checks after medication administration).	The client may attempt to hoard medications for a later suicide attempt.
Maintain increased surveillance of the client whenever the use of an antidepressant has been initiated or the dose increased.	Antidepressant medications take anywhere from 2 to 6 weeks to achieve full efficacy. During that period, the client's energy level may increase although the depression has not yet lifted, which increases the potential for suicide.
Involve the client in treatment planning and self-care management of psychiatric disorders.	Self-care management promotes feelings of self-efficacy. The more clients participate in their own care, the less powerless and hopeless they feel.
Assist the client in identifying a network of supportive persons and resources (e.g., family, clergy, care providers).	Social support and positive events were found to have a protective effect against suicidal ideation.
Document client behavior in detail to support involuntary admission if actively suicidal.	Read more about involuntary admissions in the "Patient Rights" section of the "Legal and Ethical Considerations" chapter. Involuntary inpatient admissions serve to keep the client safe from harm. Involuntary outpatient commitment is also available in many states and can improve treatment, reduce the likelihood of hospital readmission, and reduce episodes of violent behavior in persons with severe psychiatric illnesses.

Involve the family in discharge planning (e.g., illness/medication teaching, recognition of increasing suicidal risk, client's plan for dealing with recurring suicidal thoughts, and community resources).	Family members must learn how to respond to cues early, support the treatment regimen, and encourage the client to initiate an emergency plan. When family members are aware of cues, treatments, and emergency plans, clients are less likely to act on thoughts of suicide or self-harm.
Before discharge from the hospital, ensure the client has a safety plan to use after discharge, including a supply of prescribed medications and a plan for outpatient follow-up. Ensure they understand the plan or have a caregiver able and willing to follow the plan, as well as the ability to access outpatient treatment.	Clients may have difficulty concentrating on the plan for follow-up. They may need assistance from others to ensure prescriptions are filled, appointments are attended, and transportation is available to appointments.
In the event of a client's suicide, refer the family to a support group for survivors of suicide.	Psychoeducational support group participants found relief in sharing their bereavement with others.

Review the "Establishing Safety" section for clients at risk for suicide in Chapter 1.

4.7 Implementation

The *Implementation* Standard of Practice by the American Nurses Association (ANA) states, "The registered nurse implements the identified plan."[1] Review the competencies for the *Implementation* Standard of Practice for registered nurses in the following box.

ANA's Implementation Competencies[2]

The registered nurse:

- Demonstrates caring behaviors to develop therapeutic relationships.
- Provides care that focuses on the health care consumer.
- Advocates for the needs of diverse populations across the life span.
- Uses critical thinking and technology solutions to implement the nursing process to collect, measure, record, retrieve, trend, and analyze data and information to enhance health care consumer outcomes and nursing practice.
- Partners with the health care consumer to implement the plan in a safe, effective, efficient, timely, and equitable manner.
- Engages interprofessional team partners with

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

implementation of the plan through collaboration and communication across the continuum of care.
- Uses evidence-based interventions and strategies to achieve mutually identified goals and outcomes specific to the problem or needs.
- Delegates according to the health, safety, and welfare of the health care consumer.
- Delegates after considering the circumstance, person, task, direction or communication, supervision, and evaluation.
- Considers the state's Nurse Practice Act regulations, institution, and regulatory entities while maintaining accountability for the care.
- Documents implementation and any modifications, including changes or omissions, of the identified nursing care plan.

In addition to these competencies, the American Nurses Association established two additional subcategories for the *Implementation* standard: *Coordination of Care* and *Health Teaching and Health Promotion*. In addition to these basic subcategories, the American Psychiatric Association established additional subcategories for registered nurses working in psychiatric/mental health settings: *Pharmacological, Biological, and Integrative Therapies; Milieu Therapy;* and *Therapeutic Relationship and Counseling*. Each of these additional subcategories of *Implementation* is discussed in the following subsections.

Coordination of Care

Review the competencies for the *Coordination of Care* Standard of Care in the following box.

ANA's Coordination of Care Competencies[3]

The registered nurse:

- Collaborates with the health care consumer and the interprofessional team to help manage health care based on mutually agreed-upon outcomes.
- Organizes the components of the plan with input from the health care consumer and other stakeholders.
- Manages the health care consumer's care to reach mutually agreed-upon outcomes.
- Engages health care consumers in self-care to achieve preferred goals for quality of life.
- Assists the health care consumer to identify options for care and navigate the health care system and its services.
- Communicates with the health care consumer, interprofessional team, and community-based resources to effect safe transitions in continuity of care.
- Advocates for the delivery of dignified and person-centered care by the interprofessional team.
- Documents the coordination of care.

Health Teaching and Health Promotion

Review the competencies for *Health Teaching and Health Promotio*n in the following box.

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

ANA's Health Teaching and Health Promotion Competencies[4]

The registered nurse:

- Provides opportunities for the health care consumer to identify needed health promotion, disease prevention, and self-management topics such as:
    - Healthy lifestyles
    - Self-care and risk management
    - Coping, adaptability, and resiliency
- Uses health promotion and health teaching methods in collaboration with the health care consumer's values, beliefs, health practices, developmental level, learning needs, readiness and ability to learn, language preference, spirituality, culture, and socioeconomic status.
- Uses feedback from the health care consumer and other assessments to determine the effectiveness of the employed strategies.
- Uses technologies to communicate health promotion and disease prevention information to the health care consumer.
- Provides health care consumers with information and education about intended effects and potential adverse effects of the plan of care.
- Engages consumer alliance and advocacy groups in health teaching and health promotion activities for health care

4. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

consumers.
- Provides anticipatory guidance to health care consumers to promote health and prevent or reduce risk.

Pharmacological, Biological, and Integrative Therapies

Biological therapies are "any form of treatment for mental disorders that attempts to alter physiological functioning, including drug therapies, electroconvulsive therapy, and psychosurgery."[5] **Integrative therapies** are defined by the American Psychiatric Association (APA) as "psychotherapy that selects theoretical models or techniques from various therapeutic schools to suit the client's particular problems."[6] **Psychotherapy interventions** include "all generally accepted and evidence-based methods of brief or long-term therapy, including individual therapy, group therapy, marital or couple therapy, and family therapy. These interventions use a range of therapy models, including, but not limited to, psychodynamic, cognitive, behavioral, and supportive interpersonal therapies to promote insight, produce behavioral change, maintain function, and promote recovery."[7] Review the competencies for this Standard of Care in the following box.

5. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/
6. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/
7. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

APNA's Pharmacological, Biological, and Integrative Therapies Competencies[8]

"The psychiatric-mental health registered nurse (PMH-RN) incorporates knowledge of pharmacological, biological, and complementary interventions with applied clinical skills to restore the health care consumer's health and prevent future disability."[9]

The PMH-RN:

- Applies current research findings to guide nursing actions related to pharmacology, other biological therapies, and integrative therapies.
- Assesses the health care consumer's response to biological interventions based on current knowledge of pharmacological agent's intended actions, interactive effects, potential untoward effects, and therapeutic doses.
- Includes health teaching for medication management to support health care consumers in managing their own medications and adhering to a prescribed regimen.

8. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

9. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

- Provides health teaching about mechanism of action, intended effects, potential adverse effects of the proposed prescription, ways to cope with transitional side effects, and other treatment options, including the selection of a no-treatment option.
- Directs interventions toward alleviating untoward effects of biological interventions.
- Communicates observations about the health care consumer's response to biological interventions to other health clinicians.

- Read more details about different types of psychotherapy treatments in Psychology2e by OpenStax and on the National Alliance of Mental Illness (NAMI) website.
- Read more about medications in the "Psychotropic Medications" chapter.

Milieu Therapy

A **therapeutic milieu** is defined by the American Psychiatric Nursing Association as, "A safe, welcoming, supportive, and functional physical treatment environment." **Milieu therapy** includes nursing interventions used to assist health care consumers to make positive change and promote recovery in a therapeutic milieu. Nursing interventions include providing empathy, assisting in problem-solving, acting as a role model, demonstrating leadership, confronting discrepancies, encouraging self-efficacy, decreasing stimuli when necessary, and manipulating the environment so that the above

interventions can be effective."[10] Review the APNA competencies for this Standard of Care in the following box.

APNA's Milieu Therapy Competencies[11]

"The psychiatric-mental health registered nurse (PMH-RN) provides, structures, and maintains a safe, therapeutic, recovery-oriented environment in collaboration with health care consumers, families, and other health care clinicians."[12]

The PMH-RN:

- Orients the health care consumer and family to the care environment, including the physical environment, the roles of the different health care providers, self-involvement in the treatment and care delivery processes, schedules of events pertinent to their care and treatment, and

10. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

11. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

12. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

expectations regarding safe and therapeutic behaviors.

- Orients health care consumers to their rights and responsibilities particular to the treatment or care environment.
- Establishes a welcome, trauma-sensitive environment using therapeutic interventions, including, but not limited to, sensory or relaxation rooms.
- Conducts ongoing assessments of the health care consumer in relation to the environment to guide nursing interventions in maintaining a safe environment.
- Selects specific activities (both individual and group) that meet the health care consumer's physical and mental health needs for meaningful participation in the milieu and promotion of personal growth.
- Advocates that the health care consumer is treated in the least restrictive environment necessary to maintain the safety of the individual and others.
- Informs the health care consumer in a culturally sensitive manner about the need for limits related to safety and the conditions necessary to remove the restrictions.
- Provides support and validation to health care consumers when discussing their illness experience and seeks to prevent complications of illness.

Therapeutic Relationship and Counseling

The American Nurses Association states, "Nursing integrates the art and science of caring... It facilitates healing and alleviates suffering through compassionate presence... The act of caring is the first step in the power to

heal."[13] Jean Watson's Human Caring Science Theory emphasizes the therapeutic relationship between the client and nurse and highlights the role of the nurse in defining the client as a unique human being to be valued, respected, nurtured, understood, and assisted. In a caring, therapeutic relationship, the nurse implements interventions to promote interpersonal connection, such as listening attentively, making eye contact, using verbal reassurances, and using professional touch with permission.[14] Nurses use several therapeutic techniques during a nurse-client relationship. Read more information in the "Therapeutic Communication and the Nurse-Client Relationship" chapter.

Read the APNA competencies regarding therapeutic relationship and counseling in the following box.

APNA's Therapeutic Relationship and Counseling Competencies[15]

"The psychiatric-mental health registered nurse (PMH-RN) uses the therapeutic relationship and counseling interventions to assist health care consumers in their individual recovery journeys by improving and regaining their previous coping abilities,

13. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

14. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

15. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

fostering mental health, and preventing mental disorder and disability."[16]

The PMH-RN:

- Uses therapeutic relationship and counseling techniques to promote the health care consumer's stabilization of symptoms and personal recovery goals.
- Uses the therapeutic relationship and counseling techniques, both in the individual and group setting, to reinforce healthy behaviors and interaction patterns and helps the health care consumer discover individualized health care behaviors to replace unhealthy ones.
- Documents counseling interventions, including, but not limited to, communication and interviewing techniques, problem-solving activities, crisis intervention, stress management, supportive skill building and educational groups, relaxation techniques, assertiveness training, and conflict resolution.

Read more information about stress management, relaxation techniques, and crisis intervention in the "Stress, Coping, and Crisis Management" chapter.

16. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

Categories of Interventions

Nurses implement several interventions related to each subcategory of the *Implementation* Standard of Care for clients in mental health settings. See Table 4.7 for common nursing interventions in mental health settings for each subcategory.

Table 4.7 Categories of Nursing Mental Health Interventions

Subcategories: Implementation Standard of Care	Sample Nursing Interventions
Coordination of Care	• Refer to community support groups for optimal recovery. • Advocate for dignified care with the interprofessional team. • Communicate client trends with interprofessional team members such as cheeking (i.e., not swallowing medications), increased agitation, or propensity toward violence.
Health Teaching and Health Promotion	• Deliver health teaching to clients about self-care and stress management techniques. • Promote health by teaching about adaptive coping strategies such as journaling and daily exercise.
Pharmacological, Biological, and Integrative Therapies	• Provide health teaching about medications' mechanisms of action, intended effects, potential adverse effects, and ways to cope with transitional side effects.

Milieu Therapy	• Encourage client participation within the therapeutic milieu by attending support groups and exercise groups. • Perform intentional rounding at varying times between every 15-60 minutes and document. • Advocate for the least restrictive environment necessary to maintain the safety of the individual and others. • Perform environmental safety scans and eliminate any devices or objects that can cause injury. Remove strings, cords, and drawstrings.
Therapeutic Relationship and Counseling	• Observe for, document, and communicate changes in behavior. • Demonstrate caring behaviors. • Utilize therapeutic communication techniques.

Implementing Interventions

Implementation of interventions requires the RN to use critical thinking and clinical judgment. After the initial plan of care is developed, continual reassessment of the client is necessary to detect any changes in the client's condition requiring modification of the plan. The need for continual client reassessment underscores the dynamic nature of the nursing process and is crucial to providing safe care.

During the *Implementation* phase of the nursing process, the nurse prioritizes planned interventions, assesses client safety while implementing interventions, delegates interventions as appropriate, and documents interventions performed.

Prioritizing implementation of interventions follows a similar method as to prioritizing nursing diagnoses. Maslow's Hierarchy of Needs and the ABCs of

airway, breathing, and circulation are used to establish top priority interventions. When possible, least restrictive interventions are preferred. Read more about methods for prioritization under the "Diagnosis" section of this chapter.

It is essential to consider client safety when implementing interventions. At times, clients may experience a change in condition that makes a planned nursing intervention or provider prescription no longer safe to implement. For example, an established nursing care plan for a client states, "The nurse will ambulate the client 100 feet three times daily." However, during assessment this morning, the client reports feeling dizzy today, and their blood pressure is 90/60. Using critical thinking and clinical judgment, the nurse decides to not implement the planned intervention of ambulating the client and notifies the provider of suspected side effects of the client's antidepressant medication. This decision, supporting assessment findings, and notification of the provider should be documented in the client's chart and also communicated during the shift handoff report.

> Read more about delegating interventions in the "Delegation and Supervision" chapter of Open RN *Nursing Management and Professional Concepts, 2e*.

4.8 Evaluation

The *Evaluation* Standard of Practice by the American Nurses Association states, "The registered nurse evaluates progress toward attainment of goals and outcomes."[1] Review the competencies for the *Evaluation* Standard of Practice for registered nurses in the following box.

ANA's Evaluation Competencies[2]

The registered nurse:

- Uses applicable standards and defined criteria (e.g., Quality and Safety Education for Nurses [QSEN], Quadruple Aim, Institute for Healthcare Improvement [IHI]).
- Conducts a systematic, ongoing, and criterion-based evaluation of the goals and outcomes in relation to the structure, processes, and timelines prescribed in the plan.
- Collaborates with the health care consumer, stakeholders, interprofessional team, and others involved in the care or situation in the evaluation process.
- Determines, in partnership with the health care consumer and other stakeholders, the person-centeredness, effectiveness, efficiency, safety, timeliness, and equitability of the strategies in relation to the responses to the plan and attainment of outcomes.

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

- Uses ongoing assessment data, other data and information resources and benchmarks, research, and meta-analyses for the analytic activities to revise the diagnoses, outcomes, plan, implementation, and evaluation strategies as needed.
- Documents the results of the evaluation.
- Reports evaluation data in a timely fashion.
- Shares evaluation data and conclusions with the health care consumer and other stakeholders to promote clarity and transparency in accordance with state, federal, organizational, and professional requirements.

Evaluation focuses on the effectiveness of the nursing interventions by reviewing the expected outcomes to determine if they were met, partially met, or not met by the time frames indicated. Evaluation includes analysis of data from assessments, screening tools, laboratory results, and pharmacologic interventions, as well as the effectiveness of nursing interventions related to thought process and content. During the *Evaluation* phase, nurses use critical thinking to analyze reassessment data and determine if a client's expected outcomes have been met, partially met, or not met by the time frames established. If outcomes are not met or only partially met by the time frame indicated, the care plan should be revised. If revision is necessary, the nurse should consider which step of the nursing process requires modification. Have additional assessment data been obtained, or have assessment data changed? Has a different nursing diagnosis become a priority? Were the identified goals or expected outcomes unrealistic? Were any interventions not effective?

Reassessment should occur every time the nurse interacts with a client, discusses the care plan with others on the interprofessional team, or reviews updated laboratory or diagnostic test results. Nursing care plans should be updated as higher priority goals emerge. The results of the evaluation must be documented in the client medical record.

Ideally, when the planned interventions are implemented, the client will respond positively, and the expected outcomes are achieved. However, when interventions do not assist in progressing the client toward the expected outcomes, the nursing care plan must be revised to more effectively address the needs of the client. These questions can be used as a guide when revising the nursing care plan:

- Did anything unanticipated occur?
- Has the client's condition changed?
- Have the client's goals and priorities shifted?
- Were the expected outcomes and their time frames realistic?
- Are the nursing diagnoses accurate for this client at this time?
- Are the planned interventions appropriately focused on supporting outcome attainment?
- What barriers were experienced as interventions were implemented?
- Do ongoing assessment data indicate the need to revise diagnoses, outcome criteria, planned interventions, or implementation strategies?
- Are different interventions required?

4.9 NCLEX Next Generation

The National Council Licensure Examination for Registered Nurses (NCLEX-RN) is the exam that all nursing graduates must successfully pass to obtain their nursing license and become a registered nurse. The purpose of the NCLEX is to evaluate if a nursing graduate (i.e., candidate) is competent to provide safe, competent, entry-level nursing care. The NCLEX-RN is developed by the National Council of State Board of Nursing (NCSBN), an independent, nonprofit organization composed of the 50 state boards of nursing and other regulatory agencies.[1]

A new edition of the NCLEX called the "Next Generation NCLEX" was released in April 2023 that uses the Clinical Judgment Measurement Model (CJMM) to asses how well the candidate can think critically and use clinical judgment when providing safe nursing care.[2]

The CJMM complements the nursing process but uses different terminology in exam questions to assess the candidate's clinical judgment. This terminology includes recognize cues, analyze cues, prioritize hypotheses,

1. NCLEX. (n.d.). NCSBN. https://www.nclex.com/
2. NCLEX. (n.d.). NCSBN. https://www.nclex.com/

generate solutions, take actions, and evaluate outcomes. See Table 4.9 for a comparison of these terms and actions to the nursing process.[3, 4, 5]

Table 4.9 Comparison of the NCSBN Clinical Judgment Measurement Model to the Nursing Process

3. NCLEX. (n.d.). *Clinical judgment measurement model. NCSBN*. https://www.nclex.com/clinical-judgment-measurement-model.page

4. Ignativicius, V. & Silvestri, L. (2022). *Preparing for the Next-Generation NCLEX (NGN): A "how-to" step-by-step faculty resource manual* [PDF]. Elsevier. https://evolve.elsevier.com/education/wp-content/uploads/sites/2/NGN_FacultyGuide_Final.pdf

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

NCSBN Clinical Judgment Skill	Description	Corresponding Step of the Nursing Process
Recognize Cues	*What data is clinically significant?* Determining what client findings are significant, most important, and of immediate concern to the nurse (i.e., identifying "relevant cues").	Assessment
Analyze Cues	*What does the data mean?* Analyzing data to determine if it is "expected" or "unexpected" or "normal" or "abnormal" for this client at this time according to their age, development, and clinical status. Making a clinical judgment concerning the clients' "human response to health conditions/life processes, or a vulnerability for that response," also referred to as "forming a hypothesis."	Diagnosis (Analysis of Data)
Prioritize Hypotheses	*What hypotheses should receive priority attention?* Ranking client conditions and problems according to urgency, complexity, and time.	Planning
Generate Solutions	*What should be done?* Planning individualized interventions that meet the desired outcomes for the client; may include gathering additional assessment data.	Planning
Take Action	*What will I do now?* Implementing interventions that are safe and most appropriate for the client's current priority conditions and problems.	Implementation

Evaluate Outcomes	*Did the interventions work?* Comparing actual client outcomes with desired client outcomes to determine effectiveness of care and making appropriate revisions to the nursing care plan.	Evaluation

It is important to note that NANDA Nursing Diagnoses are not specifically assessed on the NCLEX. However, the ability of a candidate to cluster client data, make hypotheses, prioritize hypotheses, and plan nursing interventions is based on a nursing knowledge base of potential human responses to health problems and life processes (otherwise known as nursing diagnoses).

There are also new "Next Generation" test questions called extended multiple response, extended drag and drop, cloze (drop-down), extended hot spot (highlighting), and matrix-grid[6]:

- **Extended Multiple Response:** Extended Multiple Response items allow candidates to select one or more answer options at a time and uses partial credit scoring.
- **Extended Drag and Drop:** Extended Drag and Drop items allow candidates to move or place response options into answer spaces.
- **Cloze (Drop – Down):** Cloze (Drop – Down) items allow candidates to select one option from a drop-down list. There can be more than one drop-down list in a cloze item. These drop-down lists can be used as words or phrases within a sentence or within tables and charts.
- **Enhanced Hot Spot (Highlighting):** Enhanced Hot Spot items allow candidates to select their answer by highlighting predefined words or phrases. Candidates can select and deselect the highlighted parts by clicking on the words or phrases. These types of items allow an individual to read a portion of a client medical record (e.g., a nursing note, medical

6. NCLEX. (n.d.). NCSBN. https://www.nclex.com/

history, lab values, medication record, etc.), and then select the words or phrases that answer the item.

- **Matrix/Grid:** Matrix/Grid items allow the candidate to select one or more answer options for each row and/or column. This item type can be useful in measuring multiple aspects of the clinical scenario with a single item.

View the following YouTube video[7] from NCSBN on Next Generation test items: *The Right Decisions Come from the Right Questions*

Learning activities are incorporated throughout this book to assist students in learning how to use clinical judgment to client-based scenarios and respond to NCLEX Next Generation-style test questions.

7. NCSBN. (2019, December 17). *The Right Decisions Come from the Right Questions*. [Video]. YouTube. All rights reserved. https://youtu.be/ZBXfkINIRF0

4.10 Spotlight Application

Let's review how the nursing process can be applied to Sample Case A introduced in the "Diagnosis" section of this chapter regarding caring for a suicidal client:

Assessment

During an interview with a 32-year-old male client diagnosed with Major Depressive Disorder, the client exhibited signs of a sad affect and hopelessness. He expressed desire to die and reported difficulty sleeping and a lack of appetite. He reports he has not showered in over a week and his clothes have a strong body odor.

Diagnosis

The nurse analyzed this data and created four nursing diagnoses:

- *Hopelessness* related to social isolation
- *Risk for Suicide* as manifested by the reported desire to die
- *Imbalanced Nutrition: Less than Body Requirements* related to insufficient dietary intake
- *Self-Neglect* related to insufficient personal hygiene

The nurse established the top priority nursing diagnosis of *Risk for Suicide* and immediately screened for suicidal ideation and a plan using the Columbia Suicide Severity Rating Scale (C-SSRS).

Outcome Identification

The nurse identified the following SMART expected outcomes:

- The client will verbalize feelings by the end of the shift.
- The client will remain free from injury during the hospitalization stay.

- The client will progressively gain at least one pound per week toward his ideal body weight (180 pounds).
- The client will participate in daily bathing.

Planning and Implementation

The nurse implemented planned nursing interventions for *Risk for Suicide* as previously discussed in Table 4.6.

Evaluation

Day 1: Outcomes partially met. By the end of the shift, the client verbalized feelings related to hopelessness and did not harm himself. He did not agree to participate in taking a bath and only ate 25% of his meal tray. Interventions will be re-attempted on Day 2 and reassessed for effectiveness.

Sample Documentation

0900: 32-year-old male client diagnosed with Major Depressive Disorder admitted for active suicidal ideation with a plan to do so with a gun. He has the means to accomplish this plan at home. He has expressed the desire to die and reports difficulty sleeping and a lack of appetite for the past two weeks. He reports he has not showered in over a week, and his clothes have a strong body odor. Client was placed in a room near the nursing station and assigned a 1:1 sitter. His personal belongings were removed and placed in a secure area. An environmental scan was completed, and all hazards were removed from the room. He agreed to complete a no-harm contract. Dr. Delgado was notified at 0930. She assessed the client at 0945, and new orders for medications were received and administered. —— Zerimiah Alimi, Nursing Student

4.11 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=296#h5p-16

[1]

Complete this learning activity to learn about typical clinical decisions a mental health nurse makes every day.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=296#h5p-61

[2]

Test your clinical judgment with a NCLEX Next Generation-style question: Chapter 4, Assignment 1 [3]

1. "MH Nursing Process Glossary Cards " by OpenRN is licensed under CC BY-NC 4.0
2. "MH A Day in the Life " by Sue Dzubay s licensed under CC BY-NC 4.0
3. "MH Next Gen Nursing Process Question by OpenRN is licensed under CC BY-NC 4.0

Test your clinical judgment with a NCLEX Next Generation-style case study: Chapter 4, Case Study 1 [4]

4. "MH Next Gen Nursing Process Case Study " by Kellea Ewen is licensed under CC BY-NC 4.0

IV Glossary

ADOPIE: A mnemonic for the components of the nursing process: Assessment, Diagnosis, Outcomes Identification, Planning, Implementation, and Evaluation.

Affect: A client's expression of emotion.

Akathisia: Motor restlessness.

Alexithymia: The inability to describe emotions with how one is feeling.

Alogia: Brief or reduced replies.

Anhedonia: The lack of experiencing pleasure in activities normally found enjoyable.

Apathy: A lack of feelings, emotions, interests, or concerns.

Asociality: A lack of interest in or withdrawal from social interactions and relationships.

Avolition: A lack of motivation or inability to initiate and persist in goal-directed activities.

Biological therapies: Any form of treatment for mental health disorders that attempts to alter physiological functioning, including drug therapies, electroconvulsive therapy, and psychosurgery.[1]

Blunted: A diminished range and intensity of affect or mood.

Chief complaint: The client's primary reasons for seeking care.

1. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/

Circumstantial: Speaking with many unnecessary or tedious details without getting to the point of the conversation.

Clang associations: Stringing words together that rhyme without logical association and do not convey rational meaning. For example, a client exhibiting clang associations may state, "Here she comes with a cat catch a rat match."

Clouded consciousness: A state of reduced awareness to stimuli.

Cognition: The mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. It includes thinking, knowing, remembering, judging, and problem-solving.

Cognitive impairment: Impaired mental processes that drive how an individual understands and acts in the world, affecting the acquisition of information and knowledge. Components of cognitive functioning include attention, decision-making, general knowledge, judgment, language, memory, perception, planning, and reasoning.[2]

Coma: A state of unarousable unresponsiveness, where vigorous noxious stimuli may not elicit reflex motor responses.

Congruence: Consistency of verbal and nonverbal communication.

Countertransference: A tendency for the examiner to displace (transfer) their own feelings onto the client, and these feelings may influence the client.

Cultural humility: A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize

2. Schofield, D. W. (2018). *Cognitive deficits.* Medscape. https://emedicine.medscape.com/article/917629-overview

they cannot know everything about other cultures, and approach learning about other cultures as a life-long goal and process.[3]

Delirium: An onset of an abnormal mental state, often with fluctuating levels of consciousness, disorientation, irritability, and hallucinations. Delirium is often associated with infection, metabolic disorders, or toxins in the central nervous system.

Delusions: A fixed, false belief not held by cultural peers and persisting in the face of objective contradictory evidence. For example, a client may have the delusion that the CIA is listening to their conversations via satellites.

Development: Physical, social, and cognitive changes that occur continuously throughout one's life.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5): The manual used to make mental health diagnoses established by mental health experts.

Disheveled: A client's hair, clothes, or hygiene appears untidy, disordered, unkempt, or messy.

Distractibility: A state when the client's attention is easily drawn to unimportant or irrelevant external stimuli.

Dyskinesia: Uncontrolled, involuntary movements.

Dysphoric: A client's mood or affect exhibiting persistent sadness or depression.

Echolalia: Repetitive imitation or echoing of words or phrases spoken by others.

Euphoric: A pathologically elevated sense of well-being.

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Euthymic: Normal affect and mood with a wide range of emotion appropriate for the situation.

Family dynamics: Patterns of interactions among relatives, their roles and relationships, and the various factors that shape their interactions. Because family members rely on each other for emotional, physical, and economic support, they are primary sources of relationship security or stress. Family dynamics and the quality of family relationships can have either a positive or negative impact on an individual's health.

Flat: No emotional expression.

Flight of ideas: A state where the client frequently shifts from one topic to another with rapid speech, making it seem fragmented. The examiner may feel the client is rambling and changing topics faster than they can keep track, and they probably can't get a word in edgewise.[4] An example of a client exhibiting a flight of ideas is, "My father sent me here. He drove me in a car. The car is yellow in color. Yellow looks good on me."[5]

Grandiose delusions: A state of false attribution to the self of great ability, knowledge, importance or worth, identity, prestige, power, accomplishment.[6] Clients may withdraw into an inner fantasy world that's not equivalent to reality, where they have inflated importance, powers, or a specialness that is opposite of what their actual life is like.

4. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), *Clinical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

5. PsycholoGenie. (n.d.). *The true meaning of flight of ideas explained with examples.* https://psychologenie.com/flight-of-ideas-meaning-examples

6. American Psychological Association. (n.d.). *APA Dictionary of Psychology.* https://dictionary.apa.org/

Hallucinations: False sensory perceptions not associated with real external stimuli that can include any of the five senses (auditory, visual, gustatory, olfactory and tactile). For example, a client may see spiders climbing on the wall or hear voices telling them to do things. These are referred to as "visual hallucinations" or "auditory hallucinations."

Homicidal ideation: Threats or acts of life-threatening harm towards another person.

Illusions: Misperceptions of real stimuli. For example, a client may misperceive tree branches blowing in the wind at night to be the arms of monsters trying to grab them.

Inclusiveness: The practice of providing equal access to opportunities and resources for people who might otherwise be excluded or marginalized, such as those having physical or mental disabilities or belonging to other minority groups.[7]

Insight: The client demonstrates awareness of their situation.

Integrative therapies: Psychotherapy that selects theoretical models or techniques from various therapeutic schools to suit the client's particular problems.[8]

Intellectual disability: A diagnostic term that describes intellectual and adaptive functioning deficits identified during the developmental period prior to the age 18.

Labile: Rapid changes in emotional responses, mood, or affect that are inappropriate for the moment or the situation.

7. Oxford Learner's Dictionaries. (n.d.). *Inclusion.* Oxford University Press. https://www.oxfordlearnersdictionaries.com/us/definition/english/inclusion

8. American Psychological Association. (n.d.). *APA Dictionary of Psychology.* https://dictionary.apa.org/

Loose associations: Jumping from one idea to an unrelated idea in the same sentence. For example, the client might state, "I like to dance; my feet are wet."[9] The term "word salad" refers to severely disorganized and virtually incomprehensible speech or writing, marked by severe loosening of associations.[10]

Magical thinking: A cognitive process in which an individual believes that their thoughts, words, or actions can directly influence events in the physical world in a way that defies the laws of cause and effect.

Maslow's Hierarchy of Needs: A theory commonly used to prioritize the most urgent client needs.

Mental status examination: An assessment of a client's level of consciousness and orientation, appearance and general behavior, speech, motor activity, affect and mood, thought and perception, attitude and insight, and cognitive abilities.

Milieu therapy: Nursing interventions used to assist health care consumers to make positive change and promote recovery by creating a therapeutic milieu. Milieu therapy includes interventions such as providing empathy, assisting in problem-solving, acting as a role model, demonstrating leadership, confronting discrepancies, encouraging self-efficacy, decreasing stimuli when necessary, and manipulating the environment so that the above interventions can be effective.[11]

9. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/

10. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/

11. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-*

Mood: The predominant emotion expressed by an individual.[12]

Non-suicidal self-injury (NSSI): Intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting.

Nursing diagnosis: A clinical judgment concerning a human response to health conditions/life processes or a vulnerability for that response, by an individual, family, group, or community.

Nursing process: A critical thinking model based on a systematic approach to client-centered care. Nurses use the nursing process to perform clinical reasoning and make clinical judgments when providing patient care.

Obsessions: Persistent thoughts, ideas, images, or impulses that are experienced as intrusive or inappropriate and result in anxiety, distress, or discomfort. Common obsessions include repeated thoughts about contamination, a need to have things in a particular order or sequence, repeated doubts, aggressive impulses, and sexual imagery. Obsessions are distinguished from excessive worries about everyday occurrences because they are not concerned with real-life problems.[13]

Obtundation: A moderate reduction in the client's level of awareness so that

mental health nursing: Scope and standards of practice (2nd ed.) Nursebooks.org.

12. Martin, D. C. (1990). The mental status examination. In Walker, H. K., Hall, W. D., Hurst, J. W., (Eds.), C*linical methods: The history, physical, and laboratory examinations.* (3rd ed.). Butterworths. https://www.ncbi.nlm.nih.gov/books/NBK320/

13. American Psychological Association. (n.d.). *APA Dictionary of Psychology.* https://dictionary.apa.org/

mild to moderate stimuli do not awaken the client. When arousal does occur, the client is slow to respond.

Outcome: A measurable behavior demonstrated by the client who is responsive to nursing interventions.

Paranoia: A condition characterized by delusions of persecution.[14] Clients often experience extreme suspiciousness, mistrust, or expression of fear. For example, a resident of a long-term care facility may have delusions that the staff is trying to poison him.

Poverty of content: A conversation in which the client talks without stating anything related to the question, or their speech in general is vague and meaningless.

Prioritization: The process of identifying the most significant problems and the most important interventions to implement based on a client's current status.

Psychiatric-mental health nursing: The nursing practice specialty committed to promoting mental health through the assessment, diagnosis, and treatment of behavioral problems, mental disorders, and comorbid conditions across the life span. Psychiatric-mental health nursing intervention is an art and a science, employing a purposeful use of self and a wide range of nursing, psychosocial, and neurobiological evidence to produce effective outcomes.[15]

14. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/

15. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

Psychomotor agitation: A condition of purposeless, non-goal-directed activity.

Psychomotor retardation: A condition of extremely slow physical movements, slumped posture, or slow speech patterns.

Psychosocial assessment: A component of the nursing assessment process that obtains additional subjective data to detect risks and identify treatment opportunities and resources.

Psychotherapy interventions: Generally accepted and evidence-based methods of brief or long-term therapy, including individual therapy, group therapy, marital or couple therapy, and family therapy. These interventions use a range of therapy models including, but not limited to, psychodynamic, cognitive, behavioral, and supportive interpersonal therapies to promote insight, produce behavioral change, maintain function, and promote recovery.[16]

Racing thoughts: Fast-moving and often repetitive thought patterns that can be overwhelming. They may focus on a single topic, or they may represent multiple different lines of thought. For example, a client may have racing thoughts about a financial issue or an embarrassing moment.

Resilience: The ability to overcome serious hardship or traumatic experiences.

Rumination: Obsessional thinking involving excessive, repetitive thoughts that interfere with other forms of mental activity.[17]

16. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

17. American Psychological Association. (n.d.). *APA Dictionary of Psychology*. https://dictionary.apa.org/

Safety plan: A prioritized written list of coping strategies and sources of support that clients can use before or during a suicidal crisis. The plan should be brief, in the client's own words, and easy to read. After the plan is developed, the nurse should problem solve with the client to identify barriers or obstacles to using the plan. It should be discussed where the client will keep the safety plan and how it will be located during a crisis.

SMART outcomes: Outcome statements should contain five components easily remembered using the "SMART" mnemonic: Specific, Measurable, Attainable/Action-oriented, Relevant/Realistic, with a Time frame.

Spirituality: A sense of connection to something larger than oneself that typically involves a search for meaning and purpose in life.

Stupor: A state of unresponsiveness unless a vigorous stimulus is applied, such as a sternal rub. The client quickly drifts back into a deep sleep-like state on cessation of the stimulation.

Suicide attempt: An action in which there is intent to end one's life but the individual does not die as a result of their actions.

Suicidal ideation: When an individual has been thinking about suicide but does not necessarily have an intention to act on that idea.

Suicide plan: An individual who has a plan for suicide, has the means to injury oneself, and has the intent to die.

Therapeutic milieu: A safe, welcoming, supportive, and functional physical treatment environment.

Transference: When the client projects (i.e., transfers) their feelings to the nurse. For example, a client is feeling angry at a family member related to a previous disagreement and displaces the anger to the nurse during the interview.

PART V

CHAPTER 5 LEGAL AND ETHICAL CONSIDERATIONS IN MENTAL HEALTH CARE

5.1 Introduction

Learning Objectives

- Identify safety/protective interventions for the client and others
- Identify safety/protective concerns for the nurse
- Explain the nurse role as a collaborative advocate for the health needs of the community
- Support diversity across the lifespan in client-centered care
- Explore the nurse's role and legal and ethical responsibilities when providing care to clients with mental health disorders

Mental health nursing requires a deep understanding of the legal and ethical principles that guide safe, compassionate, and equitable care. This chapter explores the foundational concepts that shape ethical decision-making based on the American Nurses Association publication, *Code of Ethics for Nurses*.[1] It also reviews legal considerations specific to psychiatric settings, such as involuntary commitment, competency, mandatory reporting, duty to warn, and the use of seclusion and restraints during mental health treatment. By understanding these guidelines, nurses are prepared to advocate for their clients, uphold professional standards, and navigate the delicate balance between respecting individual freedoms and ensuring safety.

1. American Nurses Association. (2025). Code of ethics for nurses. American Nurses Association. https://codeofethics.ana.org/provisions

5.2 Ethical Principles

The American Nurses Association (ANA) designates "*Ethics*" as the first Standard of Professional Performance in the publication *Nursing: Scope and Standards of Practice*, stating, "The registered nurse integrates ethics in all aspects of practice."[1] See the following box for nursing actions associated with the *Ethics* Standard of Professional Performance.

Ethics Standard of Professional Performance[2]

The registered nurse:

- Uses the *Code of Ethics for Nurses* as a moral foundation to guide nursing practice and decision-making.
- Demonstrates that every person is worthy of nursing care through the provision of respectful, person-centered, compassionate care, regardless of personal history or characteristics (Beneficence).
- Advocates for health care consumer perspectives, preferences, and rights to informed decision-making and self-determination (Respect for autonomy).
- Demonstrates a primary commitment to the recipients of nursing and health care services in all settings and situations (Fidelity).
- Maintains therapeutic relationships and professional

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

boundaries.

- Safeguards sensitive information within ethical, legal, and regulatory parameters (Nonmaleficence).
- Identifies ethics resources within the practice setting to assist and collaborate in addressing ethical issues.
- Integrates principles of social justice in all aspects of nursing practice (Justice).
- Refines ethical competence through continued professional education and personal self-development activities.
- Depicts one's professional nursing identity through demonstrated values and ethics, knowledge, leadership, and professional comportment.
- Engages in self-care and self-reflection practices to support and preserve personal health, well-being, and integrity.
- Contributes to the establishment and maintenance of an ethical environment that is conducive to safe, quality health care.
- Collaborates with other health professionals and the public to protect human rights, promote health diplomacy, enhance cultural sensitivity and congruence, and reduce health disparities.
- Represents the nursing perspective in clinic, institutional, community, or professional association ethics discussions.

American Nurse Association Code of Ethics

The ANA *Code of Ethics* establishes the ethical standard for the nursing profession. It contains ten provisions that provide a guide for nurses to use in ethical practice and decision-making in all practice settings. The *Code of Ethics for Nurses* states that it stands as both a normative framework and an

aspirational guide, with the 2025 edition containing updated provisions based on the current health care environment and a new tenth provision that envisions the role of nursing in creating a healthier society and a healthier world. Read a summary of the ten provisions in the following box.[3]

Ten Provisions of the ANA's Code of Ethics for Nurses[4]

Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

Provision 2: The nurse's primary commitment is to the recipient(s) of nursing care, whether an individual, family, group, community, or population.

Provision 3: The nurse establishes a trusting relationship and advocates for the rights, health, and safety of the recipient(s) of nursing care.

Provision 4: Nurses have authority over nursing practice and are responsible and accountable for their practice consistent with their obligations to promote health, prevent illness, and to provide optimal care.

Provision 5: The nurse has moral duties to self as person of inherent dignity and worth including an expectation of a safe place to work that fosters flourishing, authenticity of self at work, and self-respect through integrity and professional competency.

3. American Nurses Association. (2025). *Code of ethics for nurses*. American Nurses Association. https://codeofethics.ana.org/provisions

4. American Nurses Association. (2025). *Code of ethics for nurses*. American Nurses Association. https://codeofethics.ana.org/provisions

Provision 6: Nurses through individual and collective effort, establish, maintain, and improve the ethical environment of the work setting that affects nursing care and the well-being of nurses.

Provision 7: Nurses advance the profession through multiple approaches to knowledge development, professional standards, and the generation of policies for nursing, health, and social concerns.

Provision 8: Nurses build collaborative relationships and networks with nurses, other healthcare and non-health care disciplines, and the public to achieve greater ends.

Provision 9: Nurses and their professional organizations work to enact and resource practices, policies, and legislation to promote social justice, eliminate health inequities, and facilitate human flourishing.

Provision 10: Nursing, through organizations and associations, participates in the global nursing and health community to promote human and environmental health, well-being, and flourishing.

Read the full descriptions of the ten provisions in the online 2025 ANA Code of Ethics for Nurses.

Ethical Principles

Ethical principles are used to define right from wrong actions. They are used to help define nurses' moral duties and aid in ethical analysis and decision

making. Although there are many ethical principles that guide nursing practice, foundational ethical principles include respect for autonomy and self-determination, beneficence (do good), nonmaleficence (do no harm), justice (fairness), fidelity (keep promises), and veracity (tell the truth).

Autonomy and Self Determination

The ANA *Ethics* Standard of Professional Performance states that nurses respect a client's **autonomy** by advocating for their perspectives, preferences, and rights to informed decision-making and self determination.[5]

Provision 1, Section 1.4 of the ANA *Code of Ethics for Nurses* states, "Respect for human dignity requires the recognition of specific patient rights, in particular, the right to self-determination. Recipients of care have the moral and legal right to determine what will be done with and to their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed decision; and to be assisted with weighing the benefits, burdens, and available options in their treatment, including the choice of no treatment. They also have the right to accept, refuse, or terminate treatment without undue influence, duress, deception, manipulation, coercion, or prejudice, and to be given necessary support throughout the decision-making and treatment process. Such support includes the opportunity to make decisions with family and persons of their choosing, and to partner with nurses and other healthcare professionals."[6] See examples of nurses implementing interventions based on the ethical principles of autonomy and self-determination in the following box.

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
6. American Nurses Association. (2025). *Code of ethics for nurses.* American Nurses Association. https://codeofethics.ana.org/provisions

Case Applications of Autonomy and Self Determination

Medical Example: Sarah, an experienced registered nurse, is caring for Mr. Thompson, a 68-year-old man recently diagnosed with early-stage lung cancer. His oncologist has recommended surgery followed by chemotherapy, explaining that this approach offers the best chance of remission. However, after discussing the options with Sarah and his family, Mr. Thompson decides to decline aggressive treatment in favor of palliative care, prioritizing his quality of life over prolonged treatment. Although Sarah personally believes that pursuing treatment might extend his life, she respects Mr. Thompson's decision. She ensures that he fully understands the risks and benefits of his choice, answers his questions, and advocates for his wishes with the healthcare team. She arranges for a palliative care consultation and works to provide comfort-focused care, demonstrating her commitment to the ethical principle of autonomy.

Mental Health Care Example: A nurse is providing care for a client diagnosed with severe, treatment-resistant depression whose health care provider has recommended electroconvulsive therapy (ECT). The client tells the nurse they feel unsure about proceeding with ECT. The nurse provides health teaching about the ECT procedure and the potential side effects in a clear, compassionate manner and provides time for the client to ask questions and voice concerns. This action upholds the client's rights to self determination and autonomy and by respecting their right to make informed choices about their mental health treatment.

Beneficence and Respect for Human Dignity

The ethical principle of **beneficence** is described in the ANA *Ethics* Standard of Professional Performance as the nurse "demonstrates that every person is worthy of nursing care through the provision of respectful, person-centered, compassionate care, regardless of personal history or characteristics.[7]

Provision 1, Section 1.1 of the ANA *Code of Ethics for Nurses* states, "A fundamental principle that underlies all nursing practice is respect for the inherent dignity, worth, unique attributes, and human rights of all individuals; therefore, ethical nursing practice requires compassion for all humans as deserving of dignity and respect. Nurses maintain caring relationships and are committed to fair treatment, transparency, integrity-preserving compromise, building trust, and the best resolution of conflicts. The nurse is additionally committed to creating and sustaining an ethical environment where the nurse-patient relationship can flourish."[8]

Section 1.3 of Provision 1 of the ANA *Code of Ethics for Nurses* further described beneficence as, "Optimal nursing care enables recipients to live with as much physical, emotional, social, religious, and/or spiritual well-being as possible, aligning with their preferences, values, and determination of quality of life. Nurses lead the implementation of responsible and appropriate evidence-based interventions across the lifespan to optimize the health and well-being of those in their care. When a recipient of care no longer sees a proportional benefit from the burdens of interventions, nurses are attentive and practice shared decision-making to arrive at medically achievable goals that reflect patient values. All human beings should have access to what they recognize as a good quality of life, which is subjective. Nurses appreciate that

7. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

8. American Nurses Association. (2025). *Code of ethics for nurses.* American Nurses Association. https://codeofethics.ana.org/provisions

what is right for one person may not be right for another. The nurse balances respect for values with harm mitigation and recognizes that every decision for each person is unique and situational."[9]

When caring for clients with mental health disorders, nurses implement beneficence by actively advocating for evidence-based treatments that promote the best possible outcomes. For instance, if a client with schizophrenia is not responding well to their current medication regimen and is experiencing distressing side effects, the nurse collaborate with the healthcare team to recommend a more effective and better-tolerated alternative. By staying informed about current research and clinical guidelines, the nurse ensures the client receives the most appropriate care, demonstrating a commitment to the client's well-being and overall mental health recovery. See an example of nurse implementing interventions based on the ethical principles of beneficence respect for human dignity in the following box.

Beneficence Case Application

A nurse is caring for Jake, a 25-year-old client admitted for severe depression and suicidal ideation. After assessing Jake's condition, the nurse notices that he is hesitant to engage in psychotherapy and has refused to take his prescribed antidepressant medication due to side effects he experienced in the past. The nurse provides health teaching to Jake about the prescribed antidepressants, psychotherapy, and lifestyle modifications to help treat depression, and also contacts his psychiatrist to share Jake's concerns and sets up an appointment to discuss adjusting

9. American Nurses Association. (2025). *Code of ethics for nurses*. American Nurses Association. https://codeofethics.ana.org/provisions

his treatment plan to better suit his preferences. The nurse also continues to encourage Jake to participate in his scheduled cognitive behavioral therapy sessions, recognizing its proven effectiveness in treating depression. By proactively seeking the best care for Jake and ensuring he receives appropriate, individualized treatment, the nurse exemplifies the ethical principle of beneficence.

Nonmaleficence

The ethical principle of **nonmaleficence** is commonly defined as a duty to do no harm and balancing avoidable harm with benefits of good achieved. Non-maleficence is further described in the ANA *Ethics* Standard of Professional Performance as the nurse "safeguards sensitive information within ethical, legal, and regulatory parameters."[10]

Provision 1, Section 1.3 of the ANA *Code of Ethics for Nurses* further describes nonmaleficence related to health as, "Nurses promote health and wellness, address problems, and respect patient decisions. Respect for a patient's decisions does not require that the nurse agrees with or supports all choices made by a recipient of care. When patient choices are assessed to be dangerous, risky, or self-destructive, nurses have a moral obligation to take appropriate actions to address the behavior, and provide accurate, evidence-based education and resources. In immediately dangerous situations, the

10. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

nurse focuses on modifying the harmful behavior to either mitigate or eliminate the risk."[11]

A classic example of doing no harm in nursing practice is reflected by nurses checking medication rights three times before administering medications. In this manner, medication errors can be avoided, and the duty to do no harm is met. Furthermore, nurses continually assess for side effects of medications and promptly report them to the health care provider. See an additional example of nursing implementing interventions based on the nonmaleficence ethical principle in the following box.

Nonmaleficence Case Application

A nurse is caring for Lisa, a client diagnosed with bipolar disorder who has been taking lithium for mood stabilization. During the routine nursing assessment, the nurses notices that Lisa is experiencing potential signs of lithium toxicity, including symptoms of nausea, hand tremors, and mild confusion. Recognizing these cues, the nurse immediately reviews Lisa's most recent lab results and finds that her lithium level is approaching a toxic range. Acting quickly, the nurse notifies the prescribing provider and advocates for dosage adjustment to prevent further harm. The nurse educates Lisa about the importance of staying hydrated and recognizing and reporting early signs of lithium toxicity. By proactively identifying and addressing a potential medication-related harm, the nurse demonstrate the ethical principle of nonmaleficence, ensuring that Lisa's treatment remains both safe and effective.

11. American Nurses Association. (2025). *Code of ethics for nurses*. American Nurses Association. https://codeofethics.ana.org/provisions

Justice

Justice is described in the ANA *Ethics* Standard of Professional Performance as the nurse "integrates principles of social justice in all aspects of nursing practice."[12]

Provision 1, Section 1.2 of the ANA Code of Ethics for Nurses further describes justice as, "Nurses establish relationships of trust and provide nursing services according to need. Nurses engage in self-reflection to identify and mitigate bias or prejudice that interferes with or harms the nurse-patient relationship. The nurse recognizes that biases can exist both explicitly and unconsciously. Attributes such as the patient's culture, value systems, religious and/or spiritual beliefs, lifestyle, social support system, preferred language, and sexual identity are to be considered when planning individual, family, and population-centered care. Nurses promote health and wellness, address problems, and respect patient decisions. Respect for a patient's decisions does not require that the nurse agrees with or supports all choices made by a recipient of care."[13]

Nurses have a social contract to "provide compassionate care that addresses the individual's needs for protection, advocacy, empowerment, optimization of health, prevention of illness and injury, alleviation of suffering, comfort, and well-being."[14] An example of a nurse upholding the principle of justice in all settings is ensuring that quality care is provided to all clients, even for those who do not have the cognitive ability to communicate their needs. See an

12. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

13. American Nurses Association. (2025). *Code of ethics for nurses.* American Nurses Association. https://codeofethics.ana.org/provisions

14. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

additional example of nursing implementing interventions based on the justice ethical principle in the following box.

Justice Case Application

A nurse working in a busy emergency department is caring for two clients who arrived at the same time. One client is a well-dressed business professional with private insurance who is experiencing a panic attack, and the other is an unhoused individual with no health insurance who is experiencing a mental health crisis. Despite their differing backgrounds, the nurse treats both clients with the same level of care, professionalism, and respect.

The business professional can clearly articulate his concerns and symptoms. The unhoused client is disoriented and unable to clearly communicate his needs. The nurse takes time to thoroughly assess both clients, advocating for psychiatric evaluations and appropriate mental health care. For the unhoused individual, the nurse also implements interventions based on the client's physiological needs by making a referral to social work support services to advocate for food and housing resources. The nurse provides individualized health teaching to both clients and ensures they have follow-up care in place before discharge.

By providing equitable and compassionate care to both clients—regardless of their socioeconomic status— the nurse upholds the ethical principle of justice, ensuring that healthcare is delivered fairly and without bias.

Fidelity

Fidelity is described in the ANA *Ethics* Standard of Professional Performance as the nurse "demonstrates a primary commitment to the recipients of nursing and healthcare services in all settings and services."[15]

Provision 2, Section 2.1 of the ANA Code of Ethics for Nurses further describes fidelity as, "Within the context of nursing practice, the nurse prioritizes recipients of nursing care, placing them over institutions. Every clinical encounter and plan of care reflects the fundamental commitment of nursing to the inherent dignity, worth, unique attributes, and human rights of the patient. Nurses provide patients with opportunities to participate in …planning and implementing their plan of care, and deciding what supportive services are acceptable to them."[16]

Fidelity also means nurses must remain up-to-date with evidence-based practice in order to plan and implement effective nursing interventions. For example, a nurse is upholding the ethical standard of fidelity by staying informed about current cognitive-behavioral therapy (CBT) techniques and appropriately integrating them into nursing care plans for clients with mental health disorders.

Fidelity Case Application

A nurse on a medical-surgical unit is caring for Mr. Thompson, a 70 year-old postoperative client recovering from orthopedic

15. American Nurses Association. (2021). Nursing: Scope and standards of practice (4th ed.). American Nurses Association.

16. American Nurses Association. (2025). *Code of ethics for nurses*. American Nurses Association. https://codeofethics.ana.org/provisions

surgery. During the assessment, the nurse notices non-verbal cues of pain, including wincing and guarding of the affected area, even though Mr. Thompson reports his pain level as a "1." The nurses states this observation and incongruency in verbal and nonverbal pain indicators. Mr. Thompson confides in the nurse that he is in more pain than he has been reporting to the health care provider and nurses, but asks the nurse to not document it because he's afraid it might delay his planned discharge to go home today.

The nurse listens carefully and empathetically to Mr. Thompson's concerns. The nurse asks Mr. Thompson about his desire for discharge today and discovers he is mostly concerned about his cat, who is alone at home and needs to be fed. The nurse explains the importance of appropriate pain management for his recovery process and offers to contact the health care provider regarding the pain management plan offers. The nurse also offers to assist Mr. Thompson to use the phone in the room to call a trusted neighbor to feed the cat. The nurse documents the client's verbal and nonverbal indicators of pain as well as his preferences for discharge today in the electronic medical record.

The nurse upholds the ethical principle of fidelity by maintaining honest, empathetic communication, honoring professional responsibilities, and maintaining trust in the nurse-client relationship.

Veracity

Veracity means telling the truth. An example of veracity in health care is informed consent. Nurses ensure that clients have a good understanding of the benefits and risks of a prescribed procedure or psychotropic medication. By providing honest, clear, and complete information, nurses support clients

in making informed decisions about their mental health treatment, fostering trust and ethical care.

Veracity Case Application

A nurse is providing preoperative care while preparing Mr. Jackson for an elective colonoscopy. The nurse reviews the client's chart and notices that he has not yet signed the informed consent form. When asking Mr. Jackson if he has any questions about the procedure or post-operative care, he admits he doesn't understand the risks and benefits of the procedure. The nurse waits to administer preoperative sedative medications and notifies the health care provider about Mr. Jackson's concerns. After the health care provider visits the client, answers his questions, and addresses his concerns, Mr. Jackson signs the informed consent form. The nurses witnesses the signature then administers the prescribed sedative medication. By ensuring that the client receives complete information before signing the informed consent form and ensuring the form is signed before preoperative medications are administered, the nurse upholds the ethical principle of veracity.

Role of Caring

Nurses use a client-centered, care-based, ethical approach to nursing care that focuses on the specific circumstances of each situation. This approach aligns with the foundational nursing concepts of holism and caring in a nurse-client relationship rooted in dignity, respect, kindness, and

compassion.[17] It is grounded in dignity, respect, kindness, and compassion, ensuring that care is both ethically sound and deeply humanistic.

Role of Caring Case Application

Elena, a nurse on an oncology unit, is caring for Mrs. Rivera, a client undergoing chemotherapy who is experiencing significant fatigue, hair loss, and emotional distress. During morning rounds, Elena notices that Mrs. Rivera is unusually quiet and tearful.

Instead of simply focusing on clinical tasks, Elena pulls up a chair, holds Mrs. Rivera's hand, and asks how she's truly feeling. Mrs. Rivera opens up about her fears, body image concerns, and feelings of isolation. Elena listens with empathy, validates her emotions, and offers support by involving the hospital counselor and arranging a visit from a volunteer who also underwent cancer treatment.

Later that day, Elena brings in a soft headscarf gifted by a local support group and helps Mrs. Rivera feel more comfortable and cared for. She checks in regularly—not just to assess physical symptoms, but to ensure emotional and spiritual needs are met.

By going beyond physical care to foster connection, compassion, and comfort, Elena exemplifies the role of caring in nursing, nurturing a healing environment that supports the whole person, not just the illness.

17. Legal Information Institute. (n.d.). *Welcome to LII.* Cornell Law School. https://www.law.cornell.edu

5.3 Standards of Care

Standards of care in nursing are guidelines that provide a foundation as to how a nurse should act and what they should and should not do in their professional capacity. These guidelines establish a baseline of quality client care and provide an objective standard of accountability within the profession. Standards of care are enforced by courts of law and state Boards of Nursing, who evaluate a nurse's practice against these standards. If a nurse's actions (or lack of actions) do not meet the accepted standard of care, their conduct may be found to be negligent.[1]

Standards for nursing care are set by several organizations, including the American Nurses Association (ANA), states' Nurse Practice Acts, agency policies and procedures, federal regulators, and professional nursing organizations.

American Nursing Association's Scope and Standards of Practice

In the United States, the American Nurses Association (ANA) publishes two resources that set standards and guide professional nursing practice: *Code of Ethics for Nurses* and *Nursing: Scope and Standards of Practice*.

The *Code of Ethics for Nurses* establishes an ethical framework for nursing practice across all roles, levels, and settings.[2] It is discussed in greater detail in the "Ethical Principles" section of this chapter.

1. Law Office of Nicole Irmer. (2019). *Nursing standards of care issues*. https://www.californialicensingdefense.com/practice-areas/professionals/nursing-license/standards-of-care-issues/#:~:text=Standards%20of%20care%20in%20nursing,that%20all%20nurses%20must%20follow.
2. American Nurses Association. (2025). *Code of ethics for nurses*. American Nurses Association. https://codeofethics.ana.org/provisions

Nursing: Scope and Standards of Practice describes a professional nurse's scope of practice and defines the who, what, where, when, why, and how of nursing. This resource includes Standards of Professional Nursing Practice and Standards of Professional Performance. The **Standards of Professional Nursing Practice** are "authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform competently." These standards define a competent level of nursing practice based on the critical thinking model known as the nursing process and include the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation.[3] Each of these standards is further discussed in the "Application of the Nursing Process in Mental Health Care" chapter of this book. The **Standards of Professional Performance** are 12 additional standards that describe a nurse's professional behavior, including activities related to ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health. All registered nurses are expected to engage in these professional role activities based on their level of education, position, and role. Registered nurses are accountable for their professional behaviors to themselves, health care consumers, peers, and ultimately to society.[4]

The ANA Standards of Professional Performance are as follows[5]:

- **Ethics.** The registered nurse integrates ethics in all aspects of practice.

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association
4. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association
5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association

- **Advocacy.** The registered nurse demonstrates advocacy in all roles and settings.
- **Respectful and Equitable Practice.** The registered nurse practices with cultural humility and inclusiveness.
- **Communication.** The registered nurse communicates effectively in all areas of professional practice.
- **Collaboration.** The registered nurse collaborates with the health care consumer and other key stakeholders.
- **Leadership.** The registered nurse leads within the profession and practice setting.
- **Education.** The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking.
- **Scholarly Inquiry.** The registered nurse integrates scholarship, evidence, and research findings into practice.
- **Quality of Practice.** The registered nurse contributes to quality nursing practice.
- **Professional Practice Evaluation.** The registered nurse evaluates one's own and others' nursing practice.
- **Resource Stewardship.** The registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, financially responsible, and judiciously used.
- **Environmental Health.** The registered nurse practices in a manner that advances environmental safety and health.

American Psychiatric Nurses Association Standards of Practice

In addition to the ANA Standards of Professional Nursing Practice, the American Psychiatric Nurses Association establishes standards of practice for psychiatric-mental health nurse specialists in *Psychiatric-Mental Health Nursing: Scope and Standards of Practice*.[6] These standards are built on the

6. American Nurses Association, American Psychiatric Nurses Association, and

ANA's Standards of Professional Nursing Practice, with additional activities included under the *Intervention* standard of care. These interventions are further discussed in the "Application of the Nursing Process in Mental Health Care" chapter.

> Read more about the American Psychiatric Nurses Association.

Nurse Practice Act

In addition to the professional standards of practice, nurses must legally follow regulations set by the Nurse Practice Act and enforced by the Board of Nursing in the state where they are employed. The Board of Nursing is the state-specific licensing and regulatory body that sets standards for safe nursing care and issues nursing licenses to qualified candidates, based on the Nurse Practice Act enacted by that state's legislature. The Nurse Practice Act establishes regulations for nursing practice within that state and defines the scope of nursing practice. If nurses do not follow the standards and scope of practice set forth by the Nurse Practice Act, they can have their nursing license revoked by the Board of Nursing.

Nursing students are legally accountable for the quality of care they provide to clients just as nurses are accountable. Students are expected to recognize the limits of their knowledge and experience and appropriately alert individuals in authority regarding situations that are beyond their competency. A violation of the standards of practice constitutes unprofessional conduct and can result in the Board of Nursing denying a license to a nursing graduate.

International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-mental health nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org

Employer Policies, Procedures, and Protocols

In addition to following professional nursing standards and the state Nurse Practice Act, nurses and nursing students must also practice according to agency policies, procedures, and protocols. For example, each agency has specific policies regarding the use of restraints. If a nurse did not follow this policy and a client was injured or died, the nurse could be held liable in a court of law.

Agencies also have their own sets of procedures and protocols. For example, each agency has specific procedural steps for performing nursing skills, such as inserting urinary catheters. Agencies also have protocols that are precisely written plans for a regimen of therapy. For example, agencies typically have a hypoglycemia protocol that nurses automatically implement when a client's blood sugar falls below a specific number and includes actions such as providing orange juice and rechecking the blood sugar. These agency-specific policies, procedures, and protocols supersede the information taught in nursing school, and nurses and nursing students can be held legally liable if they don't follow them. Therefore, it is vital for nurses and nursing students to review and follow current agency-specific procedures, policies, and protocols when providing client care.

Federal Regulations

In addition to professional standards, state Nurse Practice Acts, and employer policies, procedures, and protocols, nursing practice is also influenced by federal regulations enacted by government agencies such as The Joint Commission and the Centers for Medicare and Medicaid.

The Joint Commission (TJC) is a national organization that accredits and certifies over 20,000 health care organizations in the United States. The mission of TJC is to continuously improve health care by setting standards for providing safe, high-quality health care. The Centers for Medicare & Medicaid Services (CMS) enforces quality standards in health care organizations that receive Medicare and Medicaid funding. Nurses must follow standards set by these agencies and implemented by their employers. For example, the

expectation that a nurse perform medication rights three times before administering medication to a client is based on a federal regulation.

Read more information at the The Joint Commission website and the Centers for Medicare & Medicaid Services website

5.4 Laws, Torts, Malpractice, and Disciplinary Actions

In addition to following standards of care, nurses must also follow related federal and state laws. **Criminal law** is a system of laws that punishes individuals who commit crimes. Crimes are classified as felonies, misdemeanors, and infractions. Conviction for a crime requires evidence to show the defendant is guilty beyond a shadow of doubt. This means the prosecution must convince a jury there is no reasonable explanation other than guilty that can come from the evidence presented at trial. See Figure 5.1[1] for an illustration of a criminal case being tried in front of a jury. **Civil law** focuses on the rights, responsibilities, and legal relationships between private citizens, and involves compensation to the injured party. A person bringing the lawsuit is called the **plaintiff**, and the parties named in the lawsuit are called **defendants**.[2]

Figure 5.1 Criminal Trial by Jury

1. "Courtroom Trial with Judge, Jury – Vector Image" designed by WannaPik is licensed under CC0
2. Brous, E. (2019). The elements of a nursing malpractice case, part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

Civil law includes torts. A **tort** is an act of commission or omission that gives rise to injury or harm to another and amounts to a civil wrong for which courts impose liability. Tort law exists to compensate clients injured by negligent practice, provide corrective judgment, and deter negligence with consequences of action or inaction.[3]

Two categories of torts affecting nursing practice are intentional torts and unintentional torts. **Intentional torts** are wrongs that the defendant knew (or should have known) would be caused by their actions. Examples of intentional torts include assault, battery, false imprisonment, slander, libel, and breach of privacy or client confidentiality. **Unintentional torts** occur when the defendant's actions or inactions were unreasonably unsafe. Unintentional torts can result from acts of commission (i.e., doing something a reasonable nurse would not have done) or omission (i.e., failing to do something a reasonable nurse would do). Examples of torts affecting nursing practice are discussed in further detail in the following subsections.[4]

Assault and Battery

Assault and battery are intentional torts. **Assault** is defined as intentionally putting another person in reasonable apprehension of an imminent harmful or offensive contact. For example, assault would occur by threatening to forcibly administering a medication. **Battery** is defined as intentional causation of harmful or offensive contact with another person without that person's consent For example, battery would occur with the administration of a medication forcibly. Physical harm does not need to occur in order to be

3. Wis. JI—Civil 1005. (2016). https://wilawlibrary.gov/jury/civil/instruction.php?n=1005

4. Brous, E. (2019). The elements of a nursing malpractice case, part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

charged with assault or battery. Battery convictions are typically misdemeanors but can be felonies if serious bodily harm occurs.[5]

An example related to assault and battery in health care is the client's right to refuse treatment. For example, a hospitalized client can refuse to take prescribed medication. If a nurse forcibly administers medication without a client's consent, it could be ruled assault or battery in a court of law. However, forcible administration of a medication based on a provider's order may be justified in an emergency situation to prevent imminent harm to oneself or others.[6]

False Imprisonment

False imprisonment is an intentional tort. **False imprisonment** is defined as an act of restraining another person and causing that person to be confined in a bounded area. An example of possible false imprisonment in health care is the use of restraints. See Figure 5.2[7] for an image of a simulated client in full physical medical restraints. Restraints can be physical, chemical, or verbal. Nurses must vigilantly follow agency policies related to the use of physical and chemical restraints and monitor clients who are restrained. Chemical restraints include administration of PRN medications such as benzodiazepines and require clear documentation supporting their use. Verbal restraints consist of using speech to restrict the movement or actions of a client. Verbal threats to keep an individual in an inpatient environment is an example of a verbal restraint. This can also qualify as false imprisonment

5. Brous, E. (2019). The elements of a nursing malpractice case, part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

6. Fry, S. T. (1989). The role of caring in a theory of nursing ethics. *Hypatia, 4*(2), 87-103. https://doi.org/10.1111/j.1527-2001.1989.tb00575.x

7. "PinelRestaint.jpg" by James Heilman, MD is licensed under CC BY-SA 4.0

and should be avoided. Additional information regarding the use of restraints is discussed in the "Patient Rights" section.

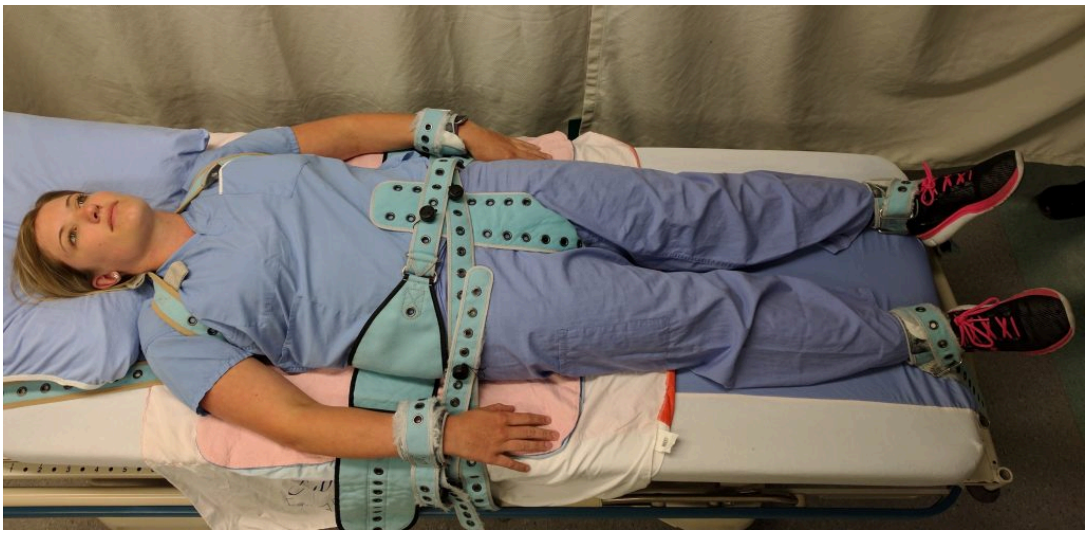

Figure 5.2 Full Physical Medical Restraints

Privacy and Confidentiality

Breaching privacy and confidentiality are intentional torts. **Confidentiality**is the right of an individual to have personal, identifiable medical information, referred to as protected health information, kept private. **Protected Health Information (PHI)** is defined as individually identifiable health information, including demographic data, that relates to the individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; and the past, present, or future payment for the provision of health care to the individual.[8]

Confidentiality is a right protected by the **Health Insurance Portability and Accountability Act (HIPAA)**. HIPAA was enacted in 1996 and was prompted by the need to ensure privacy and protection of personal health records in an environment of electronic medical records and third-party insurance payers. There are two main sections of HIPAA law: the Privacy Rule and the Security

8. Wis. JI—Civil 1005. (2016). https://wilawlibrary.gov/jury/civil/instruction.php?n=1005

Rule. The Privacy Rule addresses the use and disclosure of individuals' health information. The Security Rule sets national standards for protecting the confidentiality, integrity, and availability of electronically protected health information. HIPAA regulations extend beyond medical records and apply to client information shared with others. Therefore, all types of client information and data should be shared only with health care team members who are actively providing care to them. For example, when applying HIPAA to mental health inpatient settings, nurses may not answer in the affirmative if someone calls and asks if an individual has been admitted to the unit.[9] See Figure 5.3[10] for a depiction of confidentiality.

Figure 5.3 Confidentiality

There are specific circumstances in which HIPAA does not apply. For example, nurses have a duty to warn and protect, are mandated reporters of suspected abuse or neglect, and are required to share specific information reported by minors with authorities or their parents.

Duty to Warn and Protect

Most states have laws regarding the duty to protect third parties from

9. Wis. JI—Civil 1005. (2016). https://wilawlibrary.gov/jury/civil/instruction.php?n=1005

10. "Concept of Data Privacy And Policy Illustration" by Delesign Graphics at Iconscout is licensed under CC BY 4.0

potential life threats. Nurses and other mental health professionals have a duty to warn and protect third parties when they may be in danger from a client. This duty falls outside of HIPAA regulations. This includes assessing and predicting the client's threat of violence towards another person or groups of people and taking action to protect the identified victims.[11] An example of duty to warn and protect would be a hospitalized patient disclosing a plan to harm their coworkers upon discharge. The nurse would be obligated to report this realistic threat.

Mandatory Reporting of Suspected Abuse or Neglect

HIPAA does not apply to reporting the suspected neglect or abuse of children, adults at risk, or older adults. Many states require health professionals to report suspected neglect or abuse. State laws vary, but they generally include a definition of abuse, a list of people required to report abuse, and the government agency designated to receive and investigate the reports. Nurses and other health professionals are referred to as **mandated reporters** because they are required by state law to report suspected neglect or abuse of children, adults at risk, and the elderly. **Adults at risk** are adults who have a physical or mental condition that impairs their ability to care for their own needs.

For example, in Wisconsin, suspected neglect or abuse is reported to Child Protective Services (CPS), Adult Protective Services, or law enforcement. Nurses should be aware of the county or state agencies to whom they should report suspected abuse. See the following box for additional information.

11. Fry, S. T. (1989). The role of caring in a theory of nursing ethics. *Hypatia, 4*(2), 87-103. https://doi.org/10.1111/j.1527-2001.1989.tb00575.x

- Read additional information about signs of child and elder abuse in the "Trauma, Abuse, and Violence" chapter.
- Read more about protective services in your state. Here are links to Wisconsin's Child Protective Services and Adult Protective Services.
- Find resources in your area for reporting suspected child abuse at ChildHelp National Child Abuse Hotline or elder abuse at the National Adult Protective Services Association website.

Conditional Confidentiality for Minors

"Conditional confidentiality" applies to minors under the age of 18. State laws determine what information is considered confidential and what requires reporting to law enforcement or Child Protective Services, such as child abuse, gunshot or stabbing wounds, sexually transmitted infections, abortions, suicidal ideation, and homicidal ideation. Some state laws make it optional for clinicians to inform parents/guardians if their child is seeking services related to sexual health care, substance use, or mental health care. Nurses should be aware of the state laws affecting the confidentiality of child and adolescent care in the state in which they are practicing.[12]

12. Nurses Service Organization and CNA Financial. (2020). *Nurse professional liability exposure claim report* (4th ed.). https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

View the Wisconsin Department of Health Services' Client Rights for Minors.

Slander and Libel

Slander and libel are intentional torts. **Defamation of character** occurs when an individual makes negative, malicious, and false remarks about another person to damage their reputation. **Slander** is spoken defamation and **libel** is written defamation. Nurses must take care in their oral communication and documentation to avoid defaming clients or coworkers.[13]

Fraud

Fraud is an intentional tort that occurs when an individual is deceived for personal gain. A nurse may be charged with fraud for documenting interventions not performed or for altering documentation to cover up an error. Fraud can result in civil and criminal charges, as well as suspension or revocation of a nurse's license.[14]

Negligence and Malpractice

Negligence and malpractice are unintentional torts. **Negligence** is the failure to exercise the ordinary care a reasonable person would use in similar circumstances. Wisconsin civil jury instruction states, "A person is not using ordinary care and is negligent, if the person, without intending to do harm, does something (or fails to do something) that a reasonable person would

13. Wis. JI—Civil 1005. (2016). https://wilawlibrary.gov/jury/civil/instruction.php?n=1005

14. Wis. JI—Civil 1005. (2016). https://wilawlibrary.gov/jury/civil/instruction.php?n=1005

recognize as creating an unreasonable risk of injury or damage to a person or property." **Malpractice** is a specific term used for negligence committed by a health professional with a license.

Elements of Malpractice

Clients bringing a malpractice lawsuit must be able to demonstrate to the court that their interests were harmed. Most malpractice lawsuits name physicians or hospitals as defendants, although nurses can be individually named. Employers can be held liable for the actions of their employees.

Malpractice lawsuits are concerned with the legal obligations nurses have to their clients to adhere to current standards of practice. These legal obligations are referred to as the duty of reasonable care. Nurses are required to adhere to standards of practice when providing care to clients they have been assigned. This includes following organizational policies and procedures, maintaining clinical competency, and confining their activities to the authorized scope of practice as defined by their state's Nurse Practice Act. Nurses also have a legal duty to be physically, mentally, and morally fit for practice. When nurses do not meet these professional obligations, they are said to have breached their duties to clients.[15]

All of the following elements must be established in a court of law to prove malpractice[16]:

- **Duty:** A nurse-client relationship exists.
- **Breach:** The standard of care was not met and harm was a foreseeable consequence of the action or inaction.

15. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

16. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

- **Cause:** Injury was caused by the nurse's breach.
- **Harm:** Injury resulted in damages.

Duty

In the work environment, a duty is created when the nurse accepts responsibility for a client and establishes a nurse-client relationship. This generally occurs during inpatient care upon acceptance of a handoff report from another nurse. Outside the work environment, a nurse-client relationship is created when the nurse volunteers services. Mandatory reporting and duty to warn and protect are additional examples of a nurse's duty.[17]

Breach of Duty

The second element of malpractice is breach of duty. After a plaintiff has established the first element in a malpractice suit (i.e., the nurse owed a duty to the plaintiff), the plaintiff must demonstrate that the nurse breached that duty by failing to comply with the duty of reasonable care. To demonstrate that a nurse breached their duty to a client, the plaintiff must prove the nurse deviated from acceptable standards of practice. The plaintiff must establish how a reasonably prudent nurse in the same or similar circumstances would act and then show how the defendant nurse departed from that standard of practice. The plaintiff must claim the nurse did something a reasonably prudent nurse would not have done (an act of commission) or failed to do something a reasonable nurse would have done (an act of omission).[18]

17. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

18. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

Experts are needed during court hearings to explain things outside the knowledge of non-nurse jurors. In reaching their opinions, experts review many materials, including the state's Nurse Practice Act and organizational policies, to determine whether the nurse adhered to them. To qualify as a nurse expert, the person testifying must have relevant experience, education, skill, and knowledge. Medical malpractice trials take place primarily in state courts, so experts are deemed qualified based on state requirements.[19]

Cause

The third element of malpractice is cause. After the plaintiff has established that the nurse owed a duty to a client and then breached that duty, they must then demonstrate that damages or harm were caused by that breach. Plaintiffs cannot prevail by only demonstrating the nurse departed from acceptable standards of practice, but also must prove that such departures were the cause of any injuries. Additionally, nurses are held accountable for foreseeability, meaning a nurse of ordinary skill, care, and diligence could anticipate the risk of harm of departing from standards of practice in similar circumstances.[20]

Plaintiffs must be able to link the defendant's acts or omissions to the harm for which they are seeking compensation. This requires expert testimony from a physician because it requires a medical diagnosis. Unlike criminal cases, where the standard of proof is "beyond reasonable doubt," the elements of a malpractice lawsuit must be proven by a "preponderance of

19. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

20. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

evidence." Expert testimony is required to demonstrate "medical certainty" that the nurse's breach was the cause of an actual injury.[21]

Harm

The fourth element of malpractice is harm. In a civil lawsuit, after a plaintiff has established the nurse owed a duty to the client, breached that duty, and injury was caused by the nurse's breach, they must prove the injury resulted in damages. They request compensation for what they have lost.[22]

There are several types of injuries for which clients or their representatives seek compensation. Injuries can be physical, emotional, financial, professional, marital, or any combination of these. Physical injuries include loss of function, disfigurement, physical or mental impairment, exacerbation of prior medical problems, the need for additional medical care, and death. Economic injuries can include lost wages, additional medical expenses, rehabilitation, durable medical expenses, the need for architectural changes to one's home, the loss of earning capacity, the need to hire people to perform tasks the plaintiff can no longer do, and the loss of financial support. Emotional injuries can include psychological damage, emotional distress, or other forms of mental suffering.[23]

Determining the specific amount a plaintiff needs can require expert witness testimony from a person known as a life care planner who is trained in analyzing and evaluating medical costs, as well as the subjective

21. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

22. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

23. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

determination of a jury. **Damages** are what the plaintiff requests from the court in order to remedy the injured party's situation. Damages fall into several categories, including compensatory (economic) damages, noneconomic damages, and punitive damages.[24] Compensatory or economic damages consist of monetary compensation for financial loss. Non economic damages consist of things like pain and suffering, but can be hard to quantify monetarily. Punitive damages are awarded to provide further punishment to the defendant in order to deter similar actions in the future.[25]

Implications for Nurses

Nurses defending themselves against allegations of professional malpractice must demonstrate that their actions conformed with accepted standards of practice. They must convince a jury they acted as a reasonably prudent nurse would have in the same or similar circumstances. Nurses should follow these practices to avoid allegations of malpractice[26]:

- Practice according to current standards of practice.
- Carry their own professional liability insurance.
- Adhere to organizational policies and procedures. The standard of practice is to adhere to agency policy. Failing to do so creates an assumption of departure from standards.
- Document in a manner that permits accurate reconstruction of client assessments and the sequence of events, especially when notifying providers regarding clinical concerns.

24. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

25. Cornell Law School. (n.d.). *Legal information institute*. https://www.law.cornell.edu/wex/damages

26. Teoli, D., & Ghassemzadeh, S. (2023). Patient self-determination act. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

- Maintain competence through continuing education, participation in professional conferences, membership in professional organizations, and subscriptions to professional journals.
- When using an interpreter, ensure that properly trained interpreters are used and document the name of the interpreter. The use of family, friends, or other untrained interpreters is unsafe practice and is not consistent with acceptable standards of practice.
- Maintain professional boundaries. Personal relationships with clients or their families can be red flags for juries and can be viewed as evidence of departure from professional standards.
- Engage the chain of command with client concerns and pursuing concerns to resolution.

> Read more about actual nursing malpractice cases in the "Frequent Allegations and SBON Investigations" section of the "Legal Implications" chapter in Open RN *Nursing Management and Professional Concepts*.

Disciplinary Action by the Board of Nursing

In addition to being held liable in a court of law, nurses can have their licenses suspended or revoked by the State Board of Nursing (SBON) for unsafe nursing practice. The SBON governs nursing practice according to that state's Nurse Practice Act to protect the public through licensure, education, legislation, and discipline. A nursing license is a contract between the state and the nurse in which the licensee agrees to provide nursing care according to that state's Nurse Practice Act. Deviation from the Nurse Practice Act is a breach of contract that can lead to limited or revoked licensure. Nurses must

practice according to the Nurse Practice Act of the state in which they are providing client care.[27]

A nurse may be named in a board licensing complaint called an allegation. Allegations can be directly related to a nurse's clinical responsibilities, or they can be nonclinical (such as operating a vehicle under the influence of a substance, exhibiting unprofessional behavior, or committing billing fraud). A complaint can be filed against a nurse by anyone, such as a client, a client's family member, a colleague, or an employer. It can also be filed anonymously. After a complaint is filed, the SBON follows a disciplinary process that includes investigation, proceedings, board actions, and enforcement. The process can take months or years to resolve, and it can be costly to hire legal representation.[28]

Disciplinary actions by the SBON may include the following[29]:

- **Reprimand:** The licensee receives a public warning for a violation.
- **Limitation of License:** The licensee has conditions or requirements imposed upon their license, their scope of practice, or both.

27. American Nurses Association. (2012). *Position statement: Reduction of patient restraint and seclusion in health care settings*. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/reduction-of-patient-restraint-and-seclusion-in-health-care-settings/

28. American Nurses Association. (2012). *Position statement: Reduction of patient restraint and seclusion in health care settings*. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/reduction-of-patient-restraint-and-seclusion-in-health-care-settings/

29. American Nurses Association. (2012). *Position statement: Reduction of patient restraint and seclusion in health care settings*. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/reduction-of-patient-restraint-and-seclusion-in-health-care-settings/

- **Suspension:** The license is completely and absolutely withdrawn and withheld for a period of time, including all rights, privileges, and authority previously conferred by the credential.
- **Revocation:** The license is completely and absolutely terminated, as well as all rights, privileges, and authority previously conferred by the credential.
- **Administrative Warning:** A warning is issued if the violation is of a minor nature, or a first occurrence and the warning will adequately protect the public. The issuance of an administrative warning is public information but the reason for issuance is not.
- **Remedial Education Order:** A remedial education order is issued when there is reason to believe that the deficiency can be corrected with remedial education, while sufficiently protecting the public.

> Find and review your state's Nurse Practice Act.

5.5 Client Rights

When individuals with mental health disorders are admitted to a hospital, they may lose a number of abilities that we take for granted, such as the ability to come and go, schedule their time, and choose and control their activities of daily living. In many states, client's rights associated with inpatient admission to a mental health unit are spelled out in state law. Clients must be specifically informed of their rights as described in the Patient Bill of Rights document.

Clients who are determined to be legally incompetent also lose the ability to manage their financial and legal affairs and make important decisions. The Patient Self-Determination Act was passed to protect client rights.[1]

The Patient Self-Determination Act was passed in 1990 and is considered a landmark law for client rights. This law requires hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance organizations to provide clear written information for clients concerning their legal rights to make health care decisions, including the right to accept or refuse treatment. It also requires agencies to ask clients about advanced directives and to document any wishes the client has in regard to the care they do or do not want.[2] Interprofessional team members, including nurses, have an ethical duty to ensure that clients know and understand their health care-related rights.[3] See the following box for a list of client rights included in this law. These rights are further discussed in the following subsections.

1. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

2. Ernstmeyer, K., & Christman, E. (Eds.). (2024). *Nursing fundamentals 2e*. Open RN | WisTech Open. https://wtcs.pressbooks.pub/nursingfundamentals/

3. Middleman, A. B., & Olson, K. A. (2021). Confidentiality in adolescent health care. *UpToDate*. https://www.uptodate.com/

Patient Self-Determination Act[4]

1. The right to appropriate treatment and related services in a setting and under conditions that are the most supportive of a person's personal liberty and restrict such liberty only to the extent necessary consistent with the person's treatment needs, applicable requirements of law, and applicable judicial orders.
2. The right to an individualized, written treatment or service plan (developed promptly after admission), the right to treatment based on the plan, the right to periodic review and reassessment of treatment and related service needs, and the right to appropriate revision of the plan, including revisions necessary to provide a description of mental health services that may be needed after the person is discharged from the program or facility.
3. The right to ongoing participation, in a manner appropriate to the person's capabilities, in the planning of mental health services to be provided (including the right to participate in the development and periodic revision of the plan).
4. The right to be provided with a reasonable explanation, in terms and language appropriate to the person's mental and physical condition, the objectives of treatment, the nature and significance of possible adverse effects of recommended treatment, the reasons why the

4. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

recommended treatment is considered appropriate, the reasons why access to certain visitors may not be appropriate, and any appropriate and available alternative treatments, services, and types of providers of mental health services.

5. The right not to receive a course of treatment in the absence of informed, voluntary, written consent to treatments except during an emergency situation or as permitted by law when the person is being treated as a result of a court order.
6. The right to not participate in experimentation in the absence of informed, voluntary, written consent.
7. The right to freedom from restraint or seclusion, other than as a course of treatment during an emergency situation with a written order by a mental health professional.
8. The right to a humane treatment environment that affords reasonable protection from harm and appropriate privacy with regard to personal needs.
9. The right to access, on request, one's mental health care records.
10. The right of a person admitted to residential or inpatient care to converse with others privately, to have convenient and reasonable access to the telephone and mail, and to see visitors during regularly scheduled hours.
11. The right to be informed promptly at the time of admission and in writing of these rights.
12. The right to assert grievances with respect to infringement of these rights.
13. The right to exercise these rights without reprisal.
14. The right of referral to other providers upon discharge.

Informed Consent

Informed consent is the fundamental right of an individual to accept or reject health care. Based on the Patient Self-Determination Act, clients have the right to give informed consent before receiving medical assessment or treatment (except in emergency situations when imminent harm may occur to themselves or others). Most states allow a client to sue for battery if consent is not obtained before medical treatment is given.[5] However, a client must be competent and have the legal capacity to give informed consent.

Competency is a legal term related to the degree of cognitive ability an individual has to make decisions or carry out specific acts. Individuals are considered competent until they have been declared incompetent in a formal legal proceeding. If found incompetent, the individual is appointed a legal guardian or representative who is responsible for providing or refusing consent (while considering the individual's wishes). Guardians are typically family members such as spouses, adult children, or parents. If family members are unavailable or unwilling to serve in this role, the court may appoint a court-trained guardian.[6]

Capacity is a functional determination that an individual is or is not capable of making a medical decision within a given situation. It is outside the scope of practice for nurses to formally assess capacity, but nurses may initiate the evaluation of client capacity and contribute assessment information. Capacity

5. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

6. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

may be a temporary or permanent state. The following box outlines situations where the nurse may question a client's decision-making capacity.[7,8]

Triggers for Questioning a Client's Decision-Making Capacity

- Unawareness of surroundings
- Absence of questions about the treatment being offered or provided
- New inability to perform activities of daily living
- Disruptive behavior or agitation
- Labile emotions
- Hallucinations
- Intoxication

When a client does not have the capacity to provide informed consent, health care providers must obtain substituted consent for treatments. Substituted consent is authorization that another person gives on behalf of the client. For example, the activation of a client's health care power of attorney is an example of substituted consent. Substituted consent may also come from a court-appointed guardian or if state law permits, from next of kin.[9]

7. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

8. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

9. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

> Read more about informed consent and capacity in the "Other Legal Issues" section of Open RN *Nursing Management and Professional Concepts*.

Protective Placement

Guardianships and protective orders are legal methods in states for appointing an alternative decision-maker and identifying required services for individuals who are legally incompetent. Legally incompetent individuals may have developmental disabilities, chronic and serious mental illness, severe substance use disorders, or other conditions that limit their decision-making ability. A court can issue orders for a person who has a guardian to be protectively placed. The legal standard basically states that without the protective placement, the individual is incapable of providing for their own care and well-being that it creates a substantial risk of serious harm to themselves or others. Protective services may include case management, in-home care, nursing services, adult day care, or inpatient treatment. Protective placements must be the least restrictive setting necessary to meet the individual's needs and must be reviewed annually by the court.

Psychiatric Advance Directive

A **Psychiatric Advance Directive (PAD)** is a legal document that describes a person's preferences for future mental health treatment or names an individual to make treatment decisions for them if they are in a crisis and unable to make decisions. Many people with mental illness, their family members, and health professionals are not familiar with PADs.[10]

10. The Joint Commission. (n.d.) https://www.jointcommission.org/

For states that do not have laws regarding PADs, an individual can still draft a PAD under the more general statutes connected to advance health care directives and living wills. However, a PAD is more beneficial because of the unique issues of mental health care and treatment, such as medication preferences and inpatient treatment considerations and the fact that a person with mental health disorders can experience recovery and wellness over time.[11]

> Read more about Psychiatric Advance Directives on the National Alliance on Mental Illness website.

Restraints and Seclusion

Restraints are devices used in health care settings to prevent clients from causing harm to themselves or others when alternative interventions are not effective. A restraint is a device, method, or process that is used for the specific purpose of restricting a client's freedom of movement without the permission of the person. Restraints include mechanical devices such as a tie wrist device, chemical restraints, or seclusion. The Joint Commission defines a chemical restraint as a drug used to manage a client's behavior, restrict the client's freedom of movement, or impair the client's ability to appropriately interact with their surroundings that is not standard treatment or dosage for the client's condition.[12] It is important to note that the definition states the medication "is not standard treatment or dosage for the client's condition." For example, administering prescribed benzodiazepines as standard treatment to manage the symptoms of a diagnosed mental health disorder is

11. The Joint Commission. (n.d.) https://www.jointcommission.org/

12. The Joint Commission. (n.d.) https://www.jointcommission.org

not considered a chemical restraint, but administering benzodiazepines to limit a client's movement is considered a chemical restraint.

Seclusion is defined as the confinement of a client in a locked room or an area from which they cannot exit on their own. Seclusion should only be used for the management of violent or self-destructive behavior. Seclusion limits freedom of movement because, although the client is not mechanically restrained, they cannot leave the area.[13,14]

Although restraints are used with the intention to keep a client safe, they impact a client's psychological safety and dignity and can cause additional safety issues and death. A restrained person has a natural tendency to struggle and try to remove the restraint and can fall or become fatally entangled in the restraint. Furthermore, immobility that results from the use of restraints can cause pressure injuries, contractures, and muscle loss. Restraints take a large emotional toll on the client's self-esteem and may cause humiliation, fear, and anger.

Restraint Guidelines

The American Nurses Association (ANA) has established evidence-based guidelines that a restraint-free environment is the standard of care. The ANA encourages the participation of nurses to reduce client restraints and seclusion in all health care settings. Restraining or secluding clients is viewed

13. Wood County, Wisconsin. (n.d.). *Guardianship and protective placements*. https://www.co.wood.wi.us/Departments/HumanServices/GuardianshipAndProtectivePlacement.aspx

14. Knox, D. K., & Holloman, G. H. (2012). Use and avoidance of seclusion and restraint: Consensus statement of the American Association for Emergency Psychiatry Project Beta Seclusion and Restraint Workgroup. *The Western Journal of Emergency Medicine 13*(1), 35-40. https://doi.org/10.5811/westjem.2011.9.6867

as contrary to the goals and ethical traditions of nursing because it violates the fundamental client rights of autonomy and dignity. However, the ANA also recognizes there are times when there is no viable option other than restraints to keep a client safe, such as during an acute psychotic episode when client and staff safety are in jeopardy due to aggression or assault. The ANA also states that restraints may be justified in some clients with severe dementia or delirium when they are at risk for serious injuries such as a hip fracture due to falling.[15]

The ANA provides the following guidelines: "When restraint is necessary, documentation should be done by more than one witness. Once restrained, the client should be treated with humane care that preserves human dignity. In those instances where restraint, seclusion, or therapeutic holding is determined to be clinically appropriate and adequately justified, registered nurses who possess the necessary knowledge and skills to effectively manage the situation must be actively involved in the assessment, implementation, and evaluation of the selected emergency measure, adhering to federal regulations and the standards of the The Joint Commission (2009) regarding appropriate use of restraints and seclusion." Nursing documentation typically includes information such as client behavior necessitating the restraint, alternatives to restraints that were attempted, the type of restraint used, the time it was applied, the location of the restraint, and client education regarding the restraint.[16]

Any health care facility that accepts Medicare and Medicaid reimbursement

15. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. https://www.uptodate.com/

16. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. https://www.uptodate.com/

must follow federal guidelines for the use of behavioral restraints. These guidelines include the following[17]:

- When a restraint is the only viable option, it must be discontinued at the earliest possible time.
- Orders for the use of seclusion or restraint can never be written as a standing order or PRN (as needed).
- The treating physician must be consulted as soon as possible if the restraint or seclusion is not ordered by the client's treating physician.
- A physician or licensed independent practitioner must see and evaluate the need for the restraint or seclusion within one hour after the initiation.
- After restraints have been applied, the nurse should follow agency policy for frequent monitoring and regularly changing the client's position to prevent complications. Nurses must also ensure the client's basic needs (e.g., hydration, nutrition, and toileting) are met. Range of motion exercises and circulatory checks are typically provided hourly. Some agencies require a 1:1 client sitter or continuous monitoring when restraints are applied or seclusion is implemented.
- Each written order for a physical restraint or seclusion is limited to 4 hours for adults, 2 hours for children and adolescents ages 9 to 17, or 1 hour for clients under 9. The original order may only be renewed in accordance with these limits for up to a total of 24 hours. After the original order expires, a physician or licensed independent practitioner (if allowed under state law) must see and assess the client before issuing a new order.

Review safe use of restraints and alternatives to restraints in the

17. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. https://www.uptodate.com/

- "Restraints" section of the "Safety" chapter in Open RN *Nursing Fundamentals*.

Admission for Care

When clients with mental health disorders are admitted for inpatient care, the type of admission dictates certain rights and aspects of their treatment plan. Admissions may be voluntary, emergency, or involuntary.

Voluntary Admission

Individuals over age 16 who present to a psychiatric facility and request hospitalization are considered **voluntary admissions**. Clients admitted under voluntary admission have certain rights that differ from emergency and involuntary admissions. For example, they are considered competent with the capacity to make health care decisions (unless determined otherwise). Therefore, they have the right to refuse treatment, including psychotropic medications, unless they become a danger to themselves or others.[18]

Clients with voluntary admission do not necessarily have an absolute right to discharge at any time but may be required to request discharge. This gives the health care team an opportunity to initiate a procedure to change the client's admission status to involuntary if needed and associated legal requirements are met.[19]

18. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

19. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S*

Emergency Admissions

Many states allow individuals to be admitted to psychiatric facilities under **emergency admission** status when they are deemed likely to harm themselves or others. State laws define the exact procedure for the initial evaluation, possible length of detainment, and treatment provided. All clients who are admitted as emergency admissions require diagnosis, evaluation, and emergency treatment according to state law. At the end of the admission period, the facility must either discharge the client, change their status to voluntary admission, or initiate a civil court hearing to determine the need for continuing treatment on an involuntary basis.[20]

During an emergency admission, the client's right to come and go is restricted, but they have a right to consult with an attorney and prepare for a hearing. Clients may be forced to receive psychotropic medications if they continue to be a danger to themselves or others. However, invasive procedures like electroconvulsive therapy (ECT) are not permitted unless they are ordered by the court or consented to by the client or their legal guardian.[21]

Involuntary Admissions

There may be circumstances when a person becomes so mentally ill they are at risk of hurting themselves or others, and involuntary admission for care

Healthcare Law, Ethics and Regulation, 12(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

20. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

21. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

becomes necessary even though the individual does not desire care. An individual can have an **involuntary admission** to a psychiatric facility if they are diagnosed with a mental illness, pose a danger to themselves or others, are gravely disabled (e.g., unable to provide themselves basic necessities like food, clothing, and shelter), or are in need of treatment but their mental illness prevents voluntary help-seeking behaviors. The legal procedures are different in each state, but standards for involuntary admission are similar.[22,23]

Because involuntary commitment is a serious matter, there are strict legal protections established by the U.S. Supreme Court. The standard of proof of "mentally ill and dangerous to self or others" must be based on "clear and convincing evidence." Therefore, two physicians must certify the individual's mental health status. Additionally, the client has the right to legal counsel and can take the case to a judge who can order release. If not released, the client can be involuntarily committed to a state-specified number of days with interim court appearances. Most states permit a 72-hour admission followed by a formal hearing. If the client feels they are being held without just cause, they can file a writ of habeas corpus (i.e., a formal written order to free the person). The court makes a decision based on the "least restrictive alternative"

22. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

23. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

doctrine, meaning the least drastic action is taken to achieve the purpose of care.[24,25] Review your state's laws regarding involuntary admissions.

- For example, Wisconsin state law, referred to as "Chapter 51," dictates the requirements for involuntary admissions and is further explained by NAMI Kenosha County. View the PDF Document: CHAPTER 51 State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act

INVOLUNTARY ADMISSION OF MINORS

Special considerations apply to minors receiving psychiatric care. Many states grant minors aged 12-18 the right to provide consent for mental health treatment and to protest involuntary admission unless they are a risk to themselves or others. In many cases, a neutral mental health review officer is assigned to the case to ensure rights are upheld.[26] State laws are complex; therefore, nurses must be aware of legal protections of minors in the state in which they work.

24. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

25. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

26. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

Read additional information about Clients' Rights for Minors in Wisconsin.

CRIMINAL CASES AND PLEAS OF INSANITY

If a defendant pleads an insanity defense in a criminal case, they are involuntarily admitted to a mental health facility for an evaluation period determined by state law. During this time an interprofessional team of mental health professionals (including nurses) evaluates the individual's need for hospitalization and notifies the court of their treatment recommendations. This specialized mental health care is referred to as forensic psychiatry.[27]

Discharge

When clients with mental health disorders are hospitalized, their admission status may impact their rights related to discharge. There are four main types of discharge[28]:

- **Unconditional Discharge:** Unconditional discharge refers to unconditional termination of the legal client and institution relationship. Discharge may be ordered by a psychiatrist, advanced practice provider, or the court.
- **Release Against Medical Advice (AMA):** Clients who were admitted voluntarily may elect to leave an institution against the advice of the

27. Cady, R. F. (2010). A review of basic patient rights in psychiatric care. *JONA'S Healthcare Law, Ethics and Regulation, 12*(4), 117–127. https://doi.org/10.1097/NHL.0b013e3181f4d357

28. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

health care provider.

- **Conditional Release:** Conditional release means the client is discharged from inpatient care but requires outpatient treatment for a specified period of time. If the client was involuntarily admitted, they can be readmitted based on the original commitment order if they don't participate in outpatient treatment.
- **Assisted Outpatient Treatment:** Assisted outpatient treatment means the conditional release is court-ordered. This treatment is tied to services and goods provided by social welfare agencies, such as disability benefits and housing.

Reporting Unsafe or Impaired Professionals

Clients have the right to humane treatment and reasonable protection from harm. For example, if a suicidal client is admitted and left alone with the means of self-harm, the nurse has a duty to protect the client and can be held liable for injuries or death that occurs.

Nurses also have a duty to protect clients from suspected negligence by a colleague. In many states, nurses have a legal duty to intervene and report risks of harm to clients. This may include reporting concerns to a supervisor, the institution, and/or the state Board of Nursing. For example, nurses must report suspected drug diversion by colleagues because it can impact safe and humane treatment of clients. Read more about drug diversion and substance use disorder in nursing in the "Substance Use Disorders" chapter.

> View the NCSBN webpage on *Substance Use Disorder in Nursing*.

5.6 Learning Activities

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https://wtcs.pressbooks.pub/nursingmhcc/?p=944#h5p-29

1

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https://wtcs.pressbooks.pub/nursingmhcc/?p=944#h5p-30

2

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=944#h5p-31

1. “MH Legal/Ethical Glossary Cards ” by OpenRN is licensed under CC BY-NC 4.0
2. “MH Legal Ethical Question Set 1 ” by OpenRN is licensed under CC BY-NC 4.0

[3]

- Test your clinical judgment with a NCLEX Next Generation-style question: Chapter 5, Assignment 1 [4]

- Test your clinical judgment with a NCLEX Next Generation-style question: Chapter 5, Assignment 2 [5]

- Test your clinical judgment with a NCLEX Next Generation-style case study: Chapter 5, Case Study 1 [6]

3. "MH Legal Ethical Question Set 2" by OpenRN is licensed under CC BY-NC 4.0
4. "MH Legal Ethical Next Gen Question 1" by OpenRN is licensed under CC BY-NC 4.0
5. "MH Legal Ethical Next Gen Question 2" by OpenRN is licensed under CC BY-NC 4.0
6. "MH Legal Ethical Case Study" by Kellea Ewen is licensed under CC BY-NC 4.0

V Glossary

Adults at risk: Adults who have a physical or mental condition that impairs their ability to care for their own needs and are at risk for neglect and/or abuse.

Assault: Intentionally putting another person in reasonable apprehension of an imminent harmful or offensive contact.

Autonomy: The capacity to determine one's own actions through independent choice, including demonstration of competence. The nurse's primary ethical obligation is client autonomy.

Battery: Intentional causation of harmful or offensive contact with another person without that person's consent.

Beneficence: Benefiting others by preventing harm, removing harmful conditions, or affirmatively acting to benefit another or others, often going beyond what is required by law.

Board of Nursing: The state-specific licensing and regulatory body that sets standards for safe nursing care and issues nursing licenses to qualified candidates based on the Nurse Practice Act enacted by that state's legislature.

Capacity: A functional determination that an individual is or is not capable of making a medical decision within a given situation.

Competency: A legal term related to the degree of cognitive ability an individual has to make decisions or carry out specific acts.

Confidentiality: The right of an individual to have personal, identifiable medical information kept private.

Civil law: The rights, responsibilities, and legal relationships between private citizens and involves compensation to the injured party.

Criminal law: A system of laws that punishes individuals who commit crimes.

Damages: What the plaintiff requests from the court in order to remedy the injured party's situation.

Defamation of character: Actions when an individual makes negative, malicious, and false remarks about another person to damage their reputation.

Defendants: The parties named in the lawsuit.

Emergency admission: Individuals are admitted to psychiatric facilities under emergency admission status when they are deemed likely to harm themselves or others.

False imprisonment: An act of restraining another person and causing that person to be confined in a bounded area.

Fraud: An intentional tort that occurs when an individual is deceived for personal gain.

Health Insurance Portability and Accountability Act (HIPAA): Federal regulations to ensure the privacy and protection of personal records and information.

Informed consent: The fundamental right of an individual to receive information about the risks, benefits, and alternatives in order to make a healthcare decision.

Intentional tort: A wrong that the defendant knew (or should have known) would be caused by their actions.

Involuntary admission: Circumstances when a person becomes so mentally ill they are at risk of hurting themselves or others, and inpatient care becomes necessary even though the individual does not desire inpatient care.

Justice: A moral obligation to act on the basis of equality and equity and a standard linked to fairness for all in society.

Libel: Written defamation.

Malpractice: A specific term used for negligence committed by a health professional with a license.

Mandated reporters: Nurses and other professionals required by state law to report suspected neglect and/or abuse of children, adults at risk, and the elderly.

Negligence: The failure to exercise the ordinary care a reasonable person would use in similar circumstances.

Nonmaleficence: The bioethical principle that specifies a duty to do no harm and balances avoidable harm with benefits of good achieved.

Nurse Practice Act: Law enacted by that state's legislature that establishes regulations for nursing practice within that state and defines the scope of nursing practice.

Plaintiff: A person bringing a lawsuit.

Protected Health Information (PHI): Individually identifiable health information including demographic data that relates to the individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; and the past, present, or future payment for the provision of health care to the individual.

Psychiatric Advance Directive (PAD): A legal document that describes a person's preferences for future mental health treatment or names an individual to make treatment decisions for them if they are in a crisis and unable to make decisions.

Restraints: Devices used in health care settings to prevent clients from causing harm to themselves or others when alternative interventions are not effective.

Role fidelity: Being responsible for providing competent nursing care.

Seclusion: The confinement of a client in a locked room from which they

cannot exit on their own. It is generally used as a method of discipline, convenience, or coercion.

Slander: Spoken defamation.

Standards of Professional Nursing Practice: Authoritative statements from the American Nurses Association regarding the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform competently.

Standards of Professional Performance: Twelve standards set by the American Nurses Association that describe a nurse's professional behavior, including activities related to ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health.

Tort: An act of commission or omission that gives rise to injury or harm to another and amounts to a civil wrong for which courts impose liability.

Unintentional tort: A wrong that occurs when the defendant's actions or inactions were unreasonably unsafe. Unintentional torts can result from acts of commission (i.e., doing something a reasonable nurse would not have done) or omission (i.e., failing to do something a reasonable nurse would do).

Veracity: Telling the truth.

Voluntary admission: An individual over age 16 who presents to a psychiatric facility and requests hospitalization. They are considered competent with the capacity to make health care decisions (unless determined otherwise).

PART VI

CHAPTER 6 PSYCHOTROPIC MEDICATIONS

6.1 Introduction

Learning Objectives

- Relate the anatomy and physiology of the central nervous system to mental health disorders and psychotropic medications
- Describe classes of psychotropic medications, their mechanism of action, side effects, and health teaching topics

Psychotropic medications are medications that affect the mind, emotions, and behavior. This chapter reviews the anatomy and physiology of the central nervous system (CNS) as it relates to mental health disorders and medications followed by an overview of several classes of psychotropic medications.

Medication guidelines change frequently so it is vital for nurses to consult evidence-based resources for the latest drug information, warnings, and client education guidelines when administering medications. Free reference information is provided by the National Library of Medicine (NLM) on DailyMed and the MedlinePlus websites.

- DailyMed is a database containing current information from the Food and Drug Administration on prescription and over-the-counter medications. It provides essential information to health professionals for the safe and effective use of medications, including indications, dosage

and administration, contraindications, boxed warnings and precautions, adverse reactions, drug interactions, information about use in specific populations, and other important information for health care practitioners.[1]

- MedlinePlus is an online health information resource for clients and their loved ones with easy-to-understand medication information.[2]

- Additional information regarding psychotropic medications can be found on the National Alliance on Mental Illness' Mental Health Medications webpage.[3]

1. DailyMed. (n.d.). *About us*. https://dailymed.nlm.nih.gov/dailymed/about-dailymed.cfm

2. MedlinePlus. (n.d.). *About us*. https://medlineplus.gov/

3. National Alliance on Mental Illness. (n.d.). *Mental health medications*. https://nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications

6.2 Review of the Nervous System

Understanding the anatomy and physiology of the nervous system is essential to understanding how psychotropic medications work. The nervous system regulates both conscious and unconscious processes in the body, including thought, movement, sensation, and automatic functions like heart rate and digestion. It is divided into two main parts: the central nervous system (CNS) and the peripheral nervous system (PNS). See Figure 6.1[1] for an illustration of the central and peripheral nervous systems.

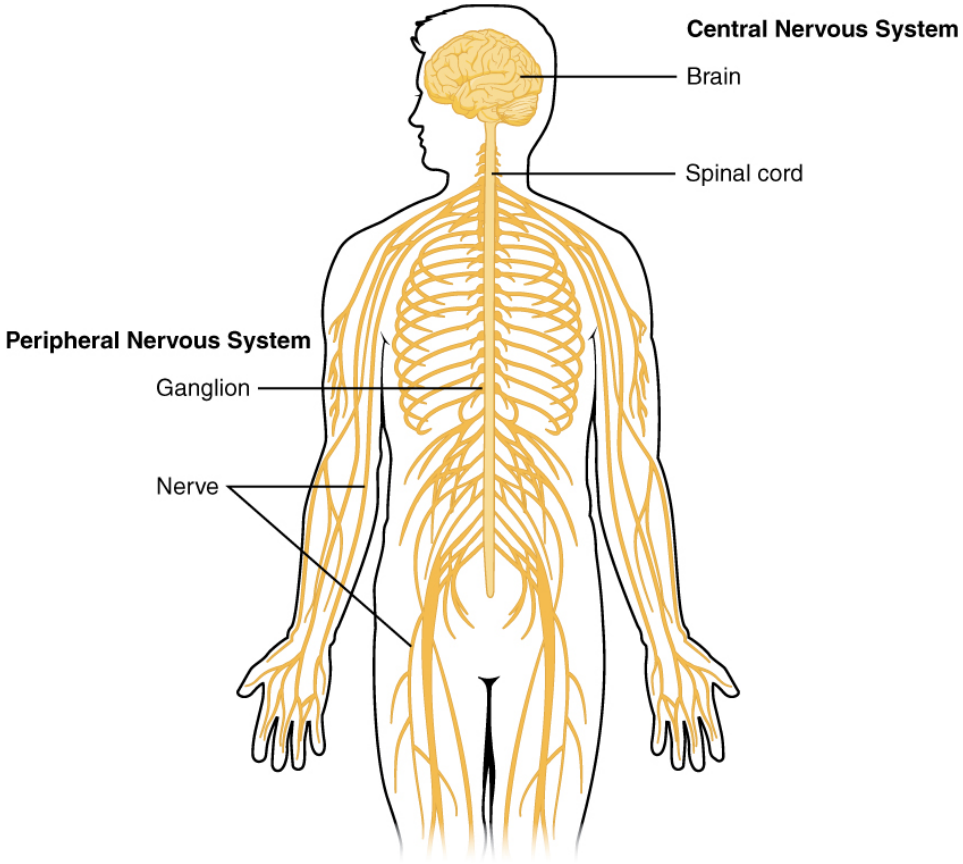

Figure 6.1 The Central and Peripheral Nervous Systems

1. "1201 Overview of Nervous System.jpg" by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/anatomy-and-physiology/pages/12-1-basic-structure-and-function-of-the-nervous-system

The Central Nervous System (CNS)

The CNS consists of the brain and spinal cord, serving as the primary control center for processing and integrating information. The brain regulates cognition, emotions, and autonomic functions, while the spinal cord transmits signals between the brain and the rest of the body.

The brain's complex systems also regulate key functions such as pain perception, reward processing, and emotional regulation. For example, the opioid system in the brain plays a crucial role in pain and reward, and is integral to understanding addiction and the effects of psychoactive substances. This system, along with other neurotransmitter systems, such as dopamine and serotonin, is central to many mental health disorders. These neurotransmitters act as messengers, influencing mood, behavior, and thought processes, and are frequently targeted by psychotropic medications.

(We'll explore these systems and their role in mental health disorders and medication therapy in more detail later.)

The Peripheral Nervous System (PNS)

The PNS consists of sensory and motor neurons that connect the CNS to the rest of the body, playing a vital role in both voluntary and involuntary processes. It functions as a bridge, relaying information between the CNS and various organs, muscles, and sensory receptors.

- Sensory neurons detect stimuli from the environment (such as light, sound, and temperature) and send signals to the brain, creating conscious perception of these stimuli.
- Motor neurons transmit signals from the brain to muscles and glands, initiating voluntary movements and autonomic responses.

Motor neurons are further divided into:

- The somatic nervous system, which controls voluntary muscle movements, such as those required for walking, talking, and writing.

- The autonomic nervous system (ANS), which regulates involuntary functions such as heart rate, digestion, and respiratory rate, maintaining homeostasis in the body.

The peripheral nervous system consists of sensory neurons and motor neurons. Sensory neurons sense the environment and conduct signals to the brain that become a person's conscious perception of that stimulus. This conscious perception may lead to a motor response that is conducted from the brain to the peripheral nervous system via motor neurons. Motor neurons are part of the somatic nervous system that stimulates voluntary movement of muscles and the autonomic nervous system that controls involuntary responses.

Sympathetic and Parasympathetic Nervous System

The autonomic nervous system is further subdivided into the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS), each with distinct and complementary functions:

- Sympathetic Nervous System (SNS): The SNS is often associated with the "fight-or-flight" response. When activated, it prepares the body for stress or emergency situations by increasing heart rate, constricting blood vessels to raise blood pressure, and causing bronchodilation (widening of the airways) to increase oxygen intake.
- Parasympathetic Nervous System (PNS): In contrast, the PNS supports "rest-and-digest" functions, helping the body conserve energy and maintain a state of relaxation. PNS activation slows the heart rate, dilates blood vessels to reduce blood pressure, and promotes bronchoconstriction (narrowing of the airways).

The body maintains homeostasis by balancing the stimulation of the SNS and PNS. For example, during physical activity, the SNS dominates to help the body respond to the increased demand for energy, while during rest, the PNS takes over to return the body to a state of calm and relaxation.

See Figure 6.2[2] to compare the effects of PNS and SNS stimulation on target organs.

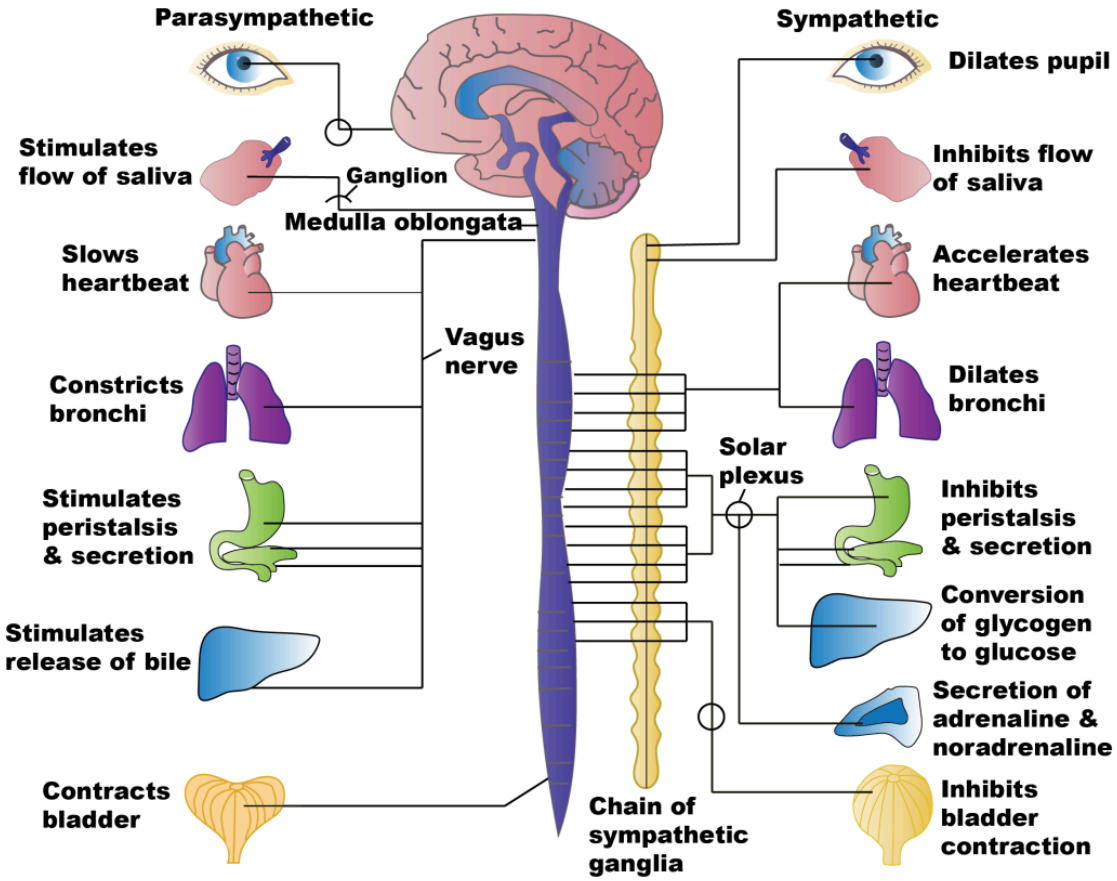

Figure 6.2 Effects of SNS and PNS Stimulation

SNS Receptors

SNS receptors include Alpha-1, Alpha-2, Beta-1, and Beta-2 receptors which are stimulated by epinephrine and norepinephrine. Medications that activate these receptors are referred to as **adrenergic agonists** because they mimic the effects of the body's natural SNS response. For example, stimulants like methylphenidate are adrenergic agonists used to treat attention deficit hyperactivity disorder (ADHD). Conversely, **adrenergic antagonists** block SNS

2. "Updated SNS-PNS image.png" by Meredith Pomietlo for Open RN is licensed under CC BY 4.0

receptors. For example, propranolol is a Beta-2 antagonist used to manage the physical symptoms of severe anxiety (e.g., trembling, rapid heartbeat, and sweating).

PNS Receptors

PNS receptors include nicotinic and muscarinic receptors that are stimulated by acetylcholine (ACh). Drugs that stimulate nicotinic and muscarinic receptors are called **cholinergics**. For example, nicotine in tobacco products stimulates nicotinic receptors. Stimulation of muscarinic receptors primarily causes smooth muscle contraction. An example of a muscarinic agonist is bethanechol used to treat urinary retention by increasing the tone of the detrusor muscle to increase bladder emptying.[3] Drugs that block the effects of PNS receptors are called **anticholinergics.** For example, benztropine is an anticholinergic used to treat muscle spasms associated with extrapyramidal symptoms from antipsychotic medications.[4] Many psychotropic medications cause anticholinergic adverse effects that can be especially hazardous for older adults. **SLUDGE** is a mnemonic for anticholinergic side effects: Salivation decreased, Lacrimation decreased, Urinary retention, Drowsiness/dizziness, GI upset, and Eyes (blurred vision/dry eyes). See Figure 6.3[5] for an illustration of the "SLUDGE" effects caused by anticholinergics.

3. Padda, I. S., & Derian, A. (2024). *Bethanechol*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK560587/

4. Ahuja, A., Patel, P., & Abdijadid, S. (2024). *Benztropine*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK560633/

5. "SLUDGE effects of Anticholinergics" by Dominic Slausen at Chippewa Valley Technical College is licensed under CC BY 4.0

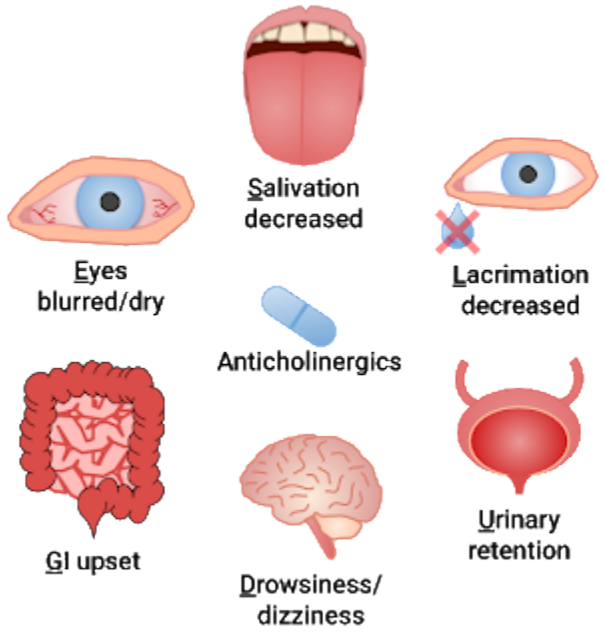

Figure 6.3 SLUDGE Effects of Anticholinergics

Opioid System

The opioid system in the brain controls pain, reward, and addictive behaviors. There are three types of **opioid receptors** called mu, delta, and kappa receptors. Opioid receptors are stimulated by endogenous peptides released by neurons (such as endorphins) and exogenous opiates. **Opiates** include powerful analgesics (such as morphine and oxycodone) prescribed to treat moderate to severe pain. Opiates also include illicit drugs (such as heroin). Chronic use of prescribed and illicit opiates can be highly addictive because of their actions on the reward system of the brain.[6] Read more about the addictive cycle in the "Substance Use Disorders" chapter.

Neurotransmitters

Neurons are responsible for the communication that the nervous system

6. Dhaliwal, A., & Gupta, M. (2023). *Physiology, opioid receptor*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK546642/

provides. **Neurotransmitters** are chemical substances released at the end of a neuron by the arrival of an electrical impulse. They diffuse across the synapse and cause the transfer of the impulse to another nerve fiber, a muscle fiber, or other structure. Neurotransmitters interact with specific receptors like a key and a lock. See Figure 6.4[7] for an illustration of neuron communication with neurotransmitters and receptors.

7. "Chemical synapse schema cropped.jpg" by Looie496 is licensed under Public Domain. Access for free at https://med.libretexts.org/Bookshelves/Anatomy_and_Physiology/Book%3A_Anatomy_and_Physiology_(Boundless)/10%3A_Overview_of_the_Nervous_System/10.1%3A_Introduction_to_the_Nervous_System/10.1A%3A_Organization_of_the_Nervous_System

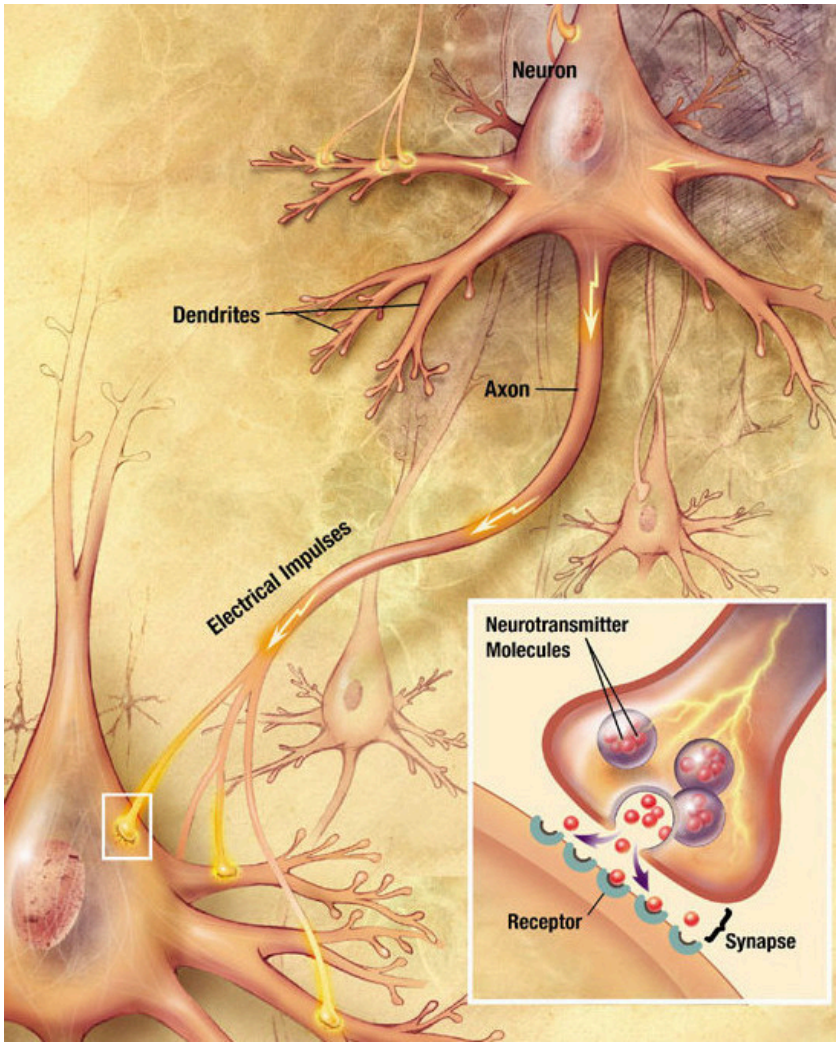

Figure 6.4 Neuron Communication With Neurotransmitters

There are several types of neurotransmitters associated with mental health disorders and psychoactive medications, including acetylcholine, glutamate, GABA, glycine, dopamine, serotonin, epinephrine, norepinephrine, and histamine[8,9]:

8. Betts, J. G., Young, K. A., Wise, J. A., Johnson, E., Poe, B., Kruse, D. H., Korol, O., Johnson, J. E., Womble, M., & DeSaix, P. (2022). *Anatomy and physiology 2e*. OpenStax. https://openstax.org/books/anatomy-and-physiology-2e/pages/1-introduction

9. Sheffler, Z. M., Reddy, V., & Pillarisetty, L. S. (2023). *Physiology,*

- **Acetylcholine:** Acetylcholine stimulates nicotinic and muscarinic receptors in the parasympathetic nervous system. Other substances also bind to these receptors. For instance, nicotine (in tobacco products) binds to nicotinic receptors, and muscarine (products of specific mushrooms used as a hallucinogenic) binds to muscarinic receptors.
- **Glutamate:** Glutamate is an excitatory neurotransmitter. Elevated levels of glutamate are associated with psychosis symptoms that can occur with schizophrenia, as well as with illicit drug use such as methamphetamines. Conversely, lamotrigine, a medication used to treat bipolar disorder, inhibits glutamate.
- **Gamma-Aminobutyric Acid and Glycine:** Gamma-aminobutyric acid (GABA) and glycine are inhibitory neurotransmitters that act like brakes in a car by slowing down overexcited nerve cells. Low levels of GABA are associated with seizures, anxiety, mania, and impulse control.
- **Dopamine:** Dopamine plays an essential role in several brain functions, including learning, motor control, reward, emotion, and executive functions. It is associated with several mental health disorders and is targeted by many psychotropic medications. For example, bupropion is an antidepressant that inhibits dopamine reuptake, leading to increased dopamine levels in the synapse and relieving the symptoms of depression. Conversely, chlorpromazine blocks dopamine receptors and is used to treat psychosis, but this blockade can cause extrapyramidal side effects (involuntary and uncontrolled muscle movements).
- **Serotonin:** Serotonin modulates multiple neuropsychological processes such as mood, sleep, libido, and temperature regulation. Abnormal levels of serotonin have been linked to many mental health disorders such as depression, bipolar disorder, and anxiety. Many psychotropic medications target serotonin. For example, fluoxetine belongs to a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). SSRIs prevent the reuptake of serotonin at the synapse, making more of

neurotransmitters. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK539894/

the chemical available in the brain and relieving depression.

- **Norepinephrine and Epinephrine:** Norepinephrine and epinephrine stimulate alpha- and beta-receptors in the sympathetic nervous system. Their release exerts effects on a variety of body processes, including stress, sleep, attention, and focus. Many psychotropic medications target these neurotransmitters. For example, venlafaxine belongs to a class of antidepressants called norepinephrine reuptake inhibitors (NRIs). NRIs are prescribed to treat depression by preventing the reuptake of norepinephrine at the synapse and boosting levels of norepinephrine in the brain.
- **Histamine:** Histamine mediates homeostatic functions in the body, promotes wakefulness, modulates feeding behavior, and controls motivational behavior. For example, diphenhydramine, a histamine antagonist, causes drowsiness and is also used to treat extrapyramidal symptoms.

View a YouTube[10] video called the Neurotransmitter Anatomy that compares the effects of neurotransmitters.

10. Khan Academy. (2014). Neurotransmitter Anatomy. [Video]. YouTube. All rights reserved. https://youtu.be/fYUpLvM5X7A

6.3 Antidepressants

Antidepressants are commonly used to treat depression and are also used to treat other conditions, such as anxiety, chronic pain, and insomnia. According to a research review by the Agency for Healthcare Research and Quality, antidepressant medications work relatively well in improving symptoms of depression and to keep depression symptoms from coming back.[1] For reasons not yet well understood, some people respond better to certain antidepressant medications than to others, so an individual may have to try different types of antidepressants before finding one that effectively treats their symptoms.[2] Additionally, it may take antidepressants two or more weeks to achieve peak effect.

There are several classes and types of antidepressants, including selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), norepinephrine and dopamine reuptake inhibitors (NDRIs), serotonin antagonist and reuptake inhibitors, tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs). TCAs and MAOIs are often referred to as first-generation antidepressants because they were first marketed in the 1950s. They have many side effects and are not prescribed as frequently to treat depression as are SSRIs, SNRIs, and NDRI that have fewer side effects.

Selective Serotonin Reuptake Inhibitors

Selective serotonin reuptake inhibitors (SSRIs) prevent the uptake of serotonin at the synapse, causing the serotonin neurotransmitter to stay in

1. Volpi-Abadie, J., Kaye, A. M., & Kaye, A. D. (2013). Serotonin syndrome. *The Ochsner Journal, 13*(4), 533–540. https://dx.doi.org/10.1177%2F2045125311400779

2. National Institute of Mental Health. (2023). *Mental health medications.* U.S. Department of Health & Human Services. *https://www.nimh.nih.gov/health/topics/mental-health-medications*

the synapse longer and overall raise the level of serotonin in the brain. SSRIs are primarily used to treat depression but are also used to treat bipolar disorder, obsessive-compulsive disorder, bulimia, panic disorder, post-traumatic stress disorder, anxiety, premenstrual syndrome, and migraines. Examples of common SSRIs include fluoxetine, citalopram, sertraline, paroxetine, and escitalopram.[3]

Serotonin Norepinephrine Reuptake Inhibitor (SNRI)

Serotonin norepinephrine reuptake inhibitors (SNRI) prevent the reuptake of serotonin and norepinephrine, with weak inhibition of dopamine reuptake. Examples of SNRIs are venlafaxine and duloxetine.[4]

Norepinephrine and Dopamine Reuptake Inhibitor (NDRI)

Bupropion is an example of a norepinephrine and dopamine reuptake inhibitor. It therefore leads to increased levels of norepinephrine and dopamine. It is used to treat depressive disorders, seasonal affective disorder, attention deficit disorder and to help people stop smoking. It is also important to note that this medication does decrease seizure threshold.[5]

3. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

4. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

5. MedlinePlus [Internet]. (2022). *Bupropion*. https://medlineplus.gov/druginfo/meds/a695033.html

Serotonin Antagonist and Reuptake Inhibitor

Trazodone is an example of a serotonin antagonist and reuptake inhibitor. It is an antidepressant but most commonly prescribed off-label for anxiety or as a hypnotic. Trazodone reduces levels of the neurotransmitters associated with arousal effects, such as serotonin, noradrenaline, dopamine, acetylcholine, and histamine. Low-dose trazodone use exerts a sedative effect for sleep, so is typically administered in the evening.[6]

Tricyclic Antidepressants

Tricyclic antidepressants (TCAs) are older first-generation antidepressants that block the reuptake of serotonin and norepinephrine in the synapse, which leads to increased concentration of these neurotransmitters in the brain. They are now more commonly used to treat neuropathic pain and insomnia. An example of a TCA is amitriptyline.[7]

TCAs are often administered at bedtime due to sedating effects. Older adults are particularly sensitive to the anticholinergic side effects of tricyclic antidepressants (e.g., tachycardia, urinary retention, constipation, dry mouth, blurred vision, confusion, psychomotor slowing, sedation, and delirium). Elderly clients should be started on low doses of amitriptyline and observed closely because they are at increased risk for falls. Blockage of adrenergic receptors can cause cardiac conduction disturbances and hypotension.[8]

Death may occur from overdosage with this class of drugs. Multiple drug

6. Shin, J. J., & Saadabadi, A. (2024). *Trazodone*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK470560/

7. National Institutes of Health. (n.d.). *Tricyclic antidepressants*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/

8. National Institutes of Health. (n.d.). *Tricyclic antidepressants*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/

ingestion (including alcohol) is common in deliberate tricyclic antidepressant overdose. If overdose occurs, call 911 in an outpatient setting or rapid response in an inpatient setting. Responders can consult with a Certified Poison Control Center (1-800-222-1222) or go to https://www.poisonhelp.org/help for the latest treatment recommendations.[9]

Monoamine Oxidase Inhibitors (MAOI)

Monoamine oxidase inhibitors (MAOIs) are an older first-generation antidepressant. MAOIs are contraindicated with all other classes of antidepressants. Monoamine oxidase is an enzyme that removes the neurotransmitters norepinephrine, serotonin, and dopamine from the brain. By inhibiting this enzyme, MAOIs cause the levels of these transmitters to increase. Tranylcypromine is an example of an MAOI.[10]

A significant disadvantage to MAOIs is their potential to cause a hypertensive crisis when taken with stimulant medications or foods or beverages containing tyramine. Examples of foods containing tyramine are aged cheese, cured or smoked meats, alcoholic beverages, and soy sauce. Older adults are at increased risk for postural hypotension and serious adverse effects.[11]

Classes of antidepressant medications and their mechanisms of action are outlined in Table 6.3a.

Table 6.3. Antidepressants

9. National Institutes of Health. (n.d.). *Tricyclic antidepressants*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/
10. National Institutes of Health. (n.d.). *Monoamine oxidase inhibitors*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/
11. National Institutes of Health. (n.d.). *Monoamine oxidase inhibitors*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/

Medication Class	Mechanism of Action
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) Common examples: Venlafaxine Duloxetine	Block the uptake of both serotonin SSRIs but with two neurotransmitte
Selective Serotonin Reuptake Inhibitors (SSRIs) Common examples: Fluoxetine Sertraline Citalopram	Impact the receptors of the cell syn the neurotransmitter serotonin stay
Tricyclic Antidepressants (TCAs) Common examples: Amitriptyline Nortriptyline	Block the presynaptic receptor for n neurotransmitter norepinephrine le
Monoamine Oxidase Inhibitors (MAOIs) Common examples: Phenelzine Tranylcypromine	Block the enzyme that breaks down neurotransmitters serotonin and no
Norepinephrine and Dopamine Reuptake Inhibitor (NDRI) Example: Bupropion	Block the uptake of both norepinep
Serotonin Antagonist and Reuptake Inhibitor Example: Trazodone	Reduces levels of the neurotransmit noradrenaline, dopamine, acetylcho

Antidepressants commonly take four to eight weeks for noticeable effects on mood symptoms. Clients should also be counseled that if they do not feel better with the first antidepressant prescribed, the provider may need to try several different classes of medications to find one that works best for them. If a person's symptoms do not improve after trying at least two antidepressants, esketamine may be prescribed for treatment-resistant depression. Esketamine is delivered as a nasal spray in a health care provider's office, clinic, or hospital and acts rapidly within a few hours, to relieve depression symptoms. People usually continue to take an oral antidepressant(s) to manage their symptoms.[12]

Clients should be instructed to never suddenly stop taking antidepressant medications or they may experience withdrawal symptoms.

Withdrawal Symptoms

To safely stop or change antidepressants, clients must have prescribed dosage reductions with 2-6 weeks between dose reductions. Withdrawal syndrome may occur if antidepressants are stopped abruptly due to the rapid changes in levels of neurotransmitters in the brain. Withdrawal symptoms can include the following[13]:

- Flu-like symptoms, such as fatigue, headache, muscle aches, and sweating
- Fatigue
- Flushing
- Heart racing

12. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health & Human Services. *https://www.nimh.nih.gov/health/topics/mental-health-medications*

13. Miller, K. & King, L. (2024). *Antidepressant withdrawal*. https://www.webmd.com/depression/withdrawal-from-antidepressants

- Trouble sleeping
- Vivid dreams or nightmares
- Nausea, diarrhea, and possibly vomiting
- Loss of appetite
- Dizziness, lightheadedness, or feeling unsteady on your feet
- Burning, tingling, or shock-like sensations
- Mood changes, such as anxiety, irritability, agitation, and aggression
- Brief shock-like feelings in the brain, short periods of blacking out, or a shock-like feeling with a buzzing sound

Side Effects

Nurses monitor clients receiving antidepressants for side effects and report concerns to the prescribing provider. Common side effects of SSRIs and SNRIs are as follows:

- Nausea
- Diarrhea
- Weight gain
- Insomnia
- Feeling agitated, shaky or anxious
- Sexual dysfunction (reduced sex drive, difficulties achieving orgasm, or difficulties obtaining or maintaining an erection)

Side effects generally improve within a few weeks, although some can occasionally persist and require tapering or switching to a different class of antidepressant.

Black Box Warning

A **Black Box Warning** is a significant warning from the Food and Drug Administration (FDA) that alerts the public and health care providers to serious side effects, such as injury or death. Black Box Warnings are in place for all classes of antidepressants used with children, adolescents, and young adults under age 25 due to a higher risk of suicide. All clients receiving

antidepressants should be monitored for signs of worsening depression or changing behavior, especially when the medication is started or dosages changed. Clients should be instructed to immediately call their provider if they have any of the following symptoms:

- Thoughts about suicide or dying or attempts to commit suicide
- Worsening symptoms of depression
- Anxiety or feelings of mania
- Aggression, anger, or violence

Serotonin Syndrome

Serotonin Syndrome is a potentially life-threatening condition resulting from excessive serotonergic activity in the central nervous system, often triggered by the use or interaction of certain psychiatric medications. It most commonly occurs when two or more drugs that increase serotonin levels—such as selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs), or certain over-the-counter supplements—are combined. Symptoms typically include altered mental status (e.g., agitation, confusion), autonomic instability (e.g., hyperthermia, tachycardia), and neuromuscular abnormalities (e.g., tremors, hyperreflexia, clonus). Nurses play an important role in early recognition and prompt intervention, including immediate discontinuation of serotonergic agents and supportive care.

A mnemonic commonly used to remember the symptoms of serotonin syndrome is **SHIVERS**:

- **S: Shivering:** A neuromuscular symptom similar to tremors specific to serotonin syndrome
- **H: Hyperreflexia (and myoclonus):** Hyperactive reflexes most prominent in the lower extremities.
- **I: Increased Temperature**
- **V: Vital Sign Abnormalities:** Tachycardia, tachypnea, and labile blood pressure

- **E: Encephalopathy:** Mental status changes such as agitation, delirium, and confusion
- **R: Restlessness**
- **S: Sweating**

People may get slowly worse and can become severely ill if not quickly treated. Untreated, serotonin syndrome can be deadly. With treatment, symptoms usually go away within 24 hours, but permanent kidney damage may result even with treatment. Uncontrolled muscle spasms can cause severe muscle breakdown called **rhabdomyolysis**. Myoglobin is released into the blood with muscle breakdown and clogs renal tubules, which can cause severe kidney damage if serotonin syndrome isn't recognized promptly and treated.

Treatment of serotonin syndrome may include the following[14,15]:

- Stopping all serotonergic medications.
- Providing supportive care to normalize vital signs such as IV fluids, cooling measures, and medications to control heart rate and blood pressure.
- Sedating with benzodiazepines, such as diazepam or lorazepam, to decrease agitation, seizure-like movements, and muscle stiffness.
- If symptoms persist, administering cyproheptadine to block serotonin production.
- For clients with severe symptoms such as hyperthermia and muscle rigidity, more aggressive measures are required. These include sedation, intubation, neuromuscular paralysis, and active cooling techniques.[16]

14. Boyer, E. W. (2021). Serotonin syndrome (serotonin toxicity). *UpToDate*. https://www.uptodate.com/

15. Tanen, D. (2021). *Serotonin syndrome*. Merck Manual Professional Version. https://www.merckmanuals.com/professional/injuries-poisoning/heat-illness/serotonin-syndrome

Clients with moderate to severe serotonin syndrome should be hospitalized for close monitoring and management. Serotonin syndrome, in its most severe form, can resemble neuroleptic malignant syndrome (NMS) caused by antipsychotic medications. However, NMS develops over a period of days to weeks. Neuroleptic malignant syndrome (NMS) will be discussed further in Chapter 11.

Hypertensive Crisis

Hypertensive crisis can occur when clients taking monoamine oxidase inhibitors (MAOIs) also take medications containing pseudoephedrine or eat foods containing tyramine (aged foods; fermented foods; cured meats; alcoholic beverages such as beer or red wine; or overripe fruits such as raisins, prunes, or bananas). MAOIs inhibit the breakdown of tyramine, causing elevated tyramine levels in the body that can lead to hypertensive crisis. **Hypertensive crisis** is a medical emergency defined as severe hypertension (blood pressure over 180/120 mm Hg) with acute end-organ damage such as stroke, myocardial infarction, or acute kidney damage. Symptoms may include a severe headache accompanied with confusion and blurred vision. Tachycardia or bradycardia may be present and associated with constricting chest pain. Other symptoms include neck stiffness or soreness, nausea or vomiting, sweating, dilated pupils, photophobia, shortness of breath, severe anxiety, and unresponsiveness. Seizures may occur, as well as intracranial bleeding in association with the increased blood pressure. Hypertensive crisis treatment involves discontinuation of the offending agent, administration of appropriate intravenous antihypertensive medications such as phentolamine

16. Spadaro, A., Scott, K. R., Koyfman, A., & Long, B. (2022). High risk and low prevalence diseases: Serotonin syndrome. *The American Journal of Emergency Medicine, 61*, 90-97. doi: 10.1016/j.ajem.2022.08.030.

or labetalol, and supportive care.. In severe cases, treatment in the intensive care unit may be required.[17][/footnote],[18]

Client Education

Clients should be instructed it may take 4 to 8 weeks for antidepressants to achieve their full effectiveness. They should not suddenly stop taking antidepressants or they may experience withdrawal symptoms. When it is time to stop the medication, the provider will slowly and safely decrease the dose. If clients stop taking the medication before the provider advises, the depression may return. They may not feel better with the first antidepressant they try, and they may need to try several different classes of medications to find one that works best for them. Education related to potential side effects and when to contact the provider, clinical worsening, avoiding alcohol, interference with cognitive or motor functioning, and potential drug interactions should also be provided.

- Review additional information in the "Antidepressants" section of the "Central Nervous System" chapter of Open RN *Nursing Pharmacology, 2e*.

17. National Institutes of Health. (n.d.). *Monoamine oxidase inhibitors*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/

18. Sheps, S. G. (2021). *Hypertensive crisis: What are the symptoms?* Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/hypertensive-crisis/faq-20058491#:~:text=A%20hypertensive%20crisis%20is%20a,higher%20%E2%80%94%20can%20damage%20blood%20vessels.

6.4 Mood Stabilizer - Lithium

Mood stabilizers are used primarily to treat bipolar disorder. They are also used to treat depression (usually in combination with an antidepressant), schizoaffective disorder, and disorders of impulse control. Lithium is an example of a medication historically used as a mood stabilizer. Other medications prescribed for mood stabilizers include anticonvulsants, antipsychotic, antianxiety, and antidepressant medications.[1] Read more about medications used to treat bipolar disorder in the "Treatments for Bipolar Disorder" section of the "Bipolar Disorders" chapter.

Lithium

The most commonly prescribed mood stabilizer is lithium. Lithium is primarily used to treat mania in bipolar disorder. Lithium reduces excitatory neurotransmission (dopamine and glutamate) and increases inhibitory neurotransmission (GABA). It also alters sodium transport in nerve and muscle cells and causes a shift in metabolism of catecholamines. When administered to a client experiencing a manic episode, lithium may reduce symptoms within 1 to 3 weeks. It also possesses unique antisuicidal properties that sets it apart from antidepressants. However, lithium toxicity can occur at doses close to therapeutic levels so lithium levels must be monitored regularly.[2,3]

1. National Institute of Mental Health. (2016). *Mental health medications.* U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

2. This work is a derivative of DailyMed by U.S. National Library of Medicine and is available in the Public Domain

3. Malhi, G. S., Tanious, M., Das, P., Coulston, C. M., & Berk, M. (2013). Potential mechanisms of action of lithium in bipolar disorder. Current understanding. *CNS Drugs, 27*(2), 135–153. https://doi.org/10.1007/s40263-013-0039-0

Side Effects

Lithium toxicity can occur at doses close to therapeutic levels, so lithium levels must be routinely monitored regularly. Signs of lithium toxicity must be promptly reported to the health care provider for dosage adjustment and treatment. Lithium blocks ADH, so symptoms of diabetes insipidus (i.e., excessive thirst and urination) should be monitored and promptly reported. Lithium's mechanism of action, nursing considerations, and side effects are summarized in Table 6.4.

Table 6.4 Lithium

Medication Class	Nursing Considerations	Common Side (*Indicates me
Lithium	• Used as a first-line mood stabilizing agent to treat mania when symptoms are acute or as maintenance therapy • Improved tolerance with food and better drug absorption • Recommended water intake is 1.5 – 3 liters/day • Given in divided doses if gastrointestinal distress occurs • NSAIDs are not recommended because they increase lithium levels • Therapeutic blood levels are required. Blood levels are drawn 10-12 hours after the last dose taken. The therapeutic lithium serum level is 0.6-1.2 mEq/L • Treatments for toxicity: ◦ Notify the health care provider regarding elevated lithium levels ◦ Withhold the lithium ◦ Encourage fluids; IV fluids may be required ◦ Gastric lavage ◦ May require urea, mannitol, aminophylline, or dialysis to hasten the excretion of the drug in severe cases	Lithium blocks and urination) • Long-term kidney fur ***Lithium toxic** • Early signs muscle we • Moderate complaint • Severe sig hypotensi death sec ***Lithium level** **asymptomatic**

Client Education

Nurses teach clients that lithium must be taken as prescribed or serious side effects can occur. They reinforce the importance of adhering to regular blood tests to measure lithium levels and reporting symptoms of elevated levels of lithium, including diarrhea, vomiting, drowsiness, muscular weakness, lack of coordination, ringing in the ears (tinnitus), or large amounts of dilute urine. Driving or operating heavy machinery should be avoided when first starting lithium because it can impair mental alertness. Lithium should not be taken during pregnancy or while breastfeeding unless it is determined that the benefits to the mother outweigh the potential risks to the baby.

- Read additional information about lithium in the "Antimanias" section of the "Central Nervous System" chapter of Open RN *Nursing Pharmacology, 2e*.

6.5 Antianxiety Medications

Antianxiety medications help reduce the symptoms of anxiety, panic attacks, or extreme fear and worry. The most common class of antianxiety medications is benzodiazepines. Benzodiazepines are used to treat generalized anxiety disorder, although SSRIs or other antidepressants are typically used to treat panic disorder or social phobia (i.e., social anxiety disorder). Beta-blockers and buspirone may also be prescribed for anxiety.[1]

Benzodiazepines

Benzodiazepines are used to treat anxiety and are also used for their sedation and anticonvulsant effects because they bind to GABA receptors and stimulate the effects of GABA (an inhibitory neurotransmitter). Benzodiazepines include clonazepam, alprazolam, and lorazepam. Benzodiazepines are a Schedule IV controlled substance because they have a potential for misuse and can cause dependence. Short-acting benzodiazepines (such as lorazepam) and beta-blockers are used to treat the short-term symptoms of anxiety. Lorazepam is available for oral, intramuscular, or intravenous routes of administration.[2][/footnote]

If people suddenly stop taking benzodiazepines after taking them for a long period of time, they may have withdrawal symptoms, or their anxiety may return. Withdrawal symptoms include sleep disturbances, irritability, increased tension and anxiety, hand tremors, sweating, difficulty concentrating, nausea and vomiting, weight loss, palpitations, headache,

1. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

2. National Institutes of Health. (n.d.). *Benzodiazepines*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/

muscular pain, and perceptual changes.[3] Therefore, benzodiazepines should be tapered off slowly.[4]

Overdosage of Benzodiazepines

Overdosage of benzodiazepines is manifested by varying degrees of central nervous system depression, ranging from drowsiness to coma. If overdose occurs, call 911 or the rapid response team during inpatient care. Treatment of overdosage is mainly supportive until the drug is eliminated from the body. Vital signs and fluid balance should be carefully monitored in conjunction with close observation of the client. An adequate airway should be maintained; intubation and mechanical ventilation may be required. The benzodiazepine antagonist flumazenil may be used to manage benzodiazepine overdose. There is a risk of seizure in association with flumazenil treatment, particularly in chronic users of benzodiazepines.

Side Effects

Overdosage of benzodiazepines causes central nervous system depression, ranging from drowsiness to coma. Children and older adults are more susceptible to the sedative and respiratory depressive effects of lorazepam and may experience paradoxical reactions such as tremors, agitation, or visual hallucinations. Benzodiazepines may cause fetal harm when administered to pregnant women. There is a boxed warning that concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory

3. Pétursson, H. (1994). The benzodiazepine withdrawal syndrome. *Addiction*, 89(11), 1455-9. doi:10.1111/j.1360-0443.1994.tb03743.x.

4. National Institute of Mental Health. (2018). *Anxiety disorders*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders

depression, coma, and death. See Table 6.5 for summarized information about benzodiazepines.

Table 6.5. Benzodiazepines

Generic	Nursing Considerations	Side/Adverse Effects
• **Lorazepam** • **Alprazolam** • **Clonazepam**	May cause fetal harm in pregnant women and may cause paradoxical effect in children	Boxed Warning: Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death Increased risk for falls

BLACK BOX WARNING

A Black Box Warning states that concurrent use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. The use of benzodiazepines exposes users to risks of misuse, substance use disorder, and addiction. Misuse of benzodiazepines commonly involves concomitant use of other medications, alcohol, and/or illicit substances, which is associated with an increased frequency of serious adverse outcomes. Additionally, the continued use of benzodiazepines may lead to clinically significant physical dependence. The risks of dependence and withdrawal increase with longer treatment duration and higher daily doses, and abrupt discontinuation or rapid dosage reduction may precipitate life-threatening withdrawal reactions. To reduce the risk of withdrawal reactions, a gradual taper should be used to stop or reduce the dosage.[5]

Client Education

Clients should be cautioned that driving a motor vehicle, operating machinery, or engaging in hazardous or other activities requiring attention

5. National Institutes of Health. (n.d.). *Benzodiazepines*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/

and coordination should be delayed for 24 to 48 hours following administration of benzodiazepines or until the effects of the drug, such as drowsiness, have subsided. Alcoholic beverages should not be consumed for at least 24 to 48 hours after receiving lorazepam due to the additive effects on central nervous system depression. Hospitalized clients should be advised that benzodiazepines increase fall risk, and getting out of bed unassisted may result in falling and potential injury.

> Read more information about benzodiazepines in the "CNS Depressants" chapter of Open RN *Nursing Pharmacology, 2e*.

Beta-Blockers

Beta-blockers, such as propranolol, are medications that block the effects of the sympathetic nervous system by acting on Beta-1 receptors in the heart and other areas of the body. While they are most commonly prescribed to treat high blood pressure, heart rhythm disorders, and other cardiac conditions, beta-blockers may also be used off-label to help manage the physical symptoms of anxiety—such as trembling, rapid heartbeat, and sweating—especially in short-term or situational anxiety, such as public speaking or test anxiety. In these cases, they are often prescribed "as needed" rather than for continuous daily use. They may be prescribed to manage the physical symptoms of anxiety (such as trembling, rapid heartbeat, and sweating) for a short period of time or used "as needed" to reduce acute physical symptoms.[6]

Common side effects of beta-blockers are fatigue, hypotension, dizziness,

6. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

weakness, and cold hands. Beta-blockers are typically avoided in clients with asthma or diabetes.[7]

> Read more information about propranolol in the "Beta-2 Antagonists" section of the "Autonomic Nervous System" chapter of Open RN *Nursing Pharmacology, 2e*.

Buspirone

Buspirone is a non-benzodiazepine medication indicated for the treatment of chronic anxiety. It is included in the class of medications called anxiolytics, but it is not chemically related to benzodiazepines, barbiturates, or other sedatives. Buspirone should not be taken concurrently with a monoamine oxidase inhibitor (MAOI) due to the risk of fatal side effects. It can also cause serotonin syndrome if used in combination with MAOIs, SSRIs, or SNRIs.[8][/footnote]

Buspirone increases serotonin and dopamine levels in the brain. In contrast to benzodiazepines, buspirone must be taken every day for a few weeks to reach its full effect; it is not useful on an "as-needed" basis. A common side effect of buspirone is dizziness.[9] Buspirone is non-addictive and safer for long-term use than benzodiazepines.

7. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications
8. National Institutes of Health. (n.d.). *Buspirone*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/
9. National Institutes of Health. (n.d.). *Buspirone*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/

Hydroxyzine

Hydroxyzine is type of antihistamine which may be prescribed to alleviate anxiety for individuals for whom benzodiazepines are not appropriate. It causes sedation, so it must be used cautiously if used in combination with opioids or barbiturates. Hydroxyzine is recommended for short-term use in the treatment of anxiety and tension. The effectiveness of hydroxyzine for long-term use, defined as more than 4 months, has not been systematically assessed in clinical studies. Therefore, it is advised that physicians periodically reassess the usefulness of the drug for each individual client.[10]

> Read additional information about "Treatments for Anxiety" in the "Anxiety Disorders" chapter.

10. National Institutes of Health. (n.d.). *Hydroxyzine*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/

6.6 Antipsychotics

Antipsychotic medicines are primarily used to treat psychosis (i.e., a loss of contact with reality that may include delusions or hallucinations). Psychosis can be a symptom of a physical condition (such as a high fever, head injury, or substance intoxication) or a mental disorder (such as schizophrenia, bipolar disorder, or severe depression).[1]

Antipsychotic medications reduce the intensity and frequency of psychotic symptoms by inhibiting dopamine receptors. Certain symptoms of psychosis, such as feeling agitated and having hallucinations, resolve within days of starting an antipsychotic medication. Symptoms like delusions usually resolve within a few weeks, but the full effects of the medication may not be seen for up to six weeks.[2]

First-Generation (Typical) Antipsychotics

Common first-generation antipsychotic medications (also called "typical" antipsychotics) treat positive symptoms of schizophrenia. Examples include chlorpromazine, haloperidol, perphenazine, and fluphenazine.[3]

First-generation antipsychotics work by blocking dopamine receptors in certain areas of the CNS, such as the limbic system and the basal ganglia.

1. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications
2. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362
3. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362

These areas are associated with emotions, cognitive function, and motor function. As a result, blockage produces a tranquilizing effect in psychotic clients. However, several adverse effects are caused by this dopamine blockade, such **extrapyramidal side effects** (e.g., involuntary or uncontrollable movements, tremors, and muscle contractions) and **tardive dyskinesia** (a syndrome of movement disorders that persists for at least one month and can last up to several years despite discontinuation of the medications).[4]

Second-Generation (Atypical) Antipsychotics

Newer, second-generation antipsychotics (also called atypical antipsychotics) work by blocking specific D2 dopamine receptors and serotonin receptors. Examples of second-generation medications include risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, paliperidone, and lurasidone. Second generation antipsychotics treat both positive and negative symptoms of schizophrenia, and several are also used for treating bipolar depression or depression that has not responded to an antidepressant medication alone. Second generation antipsychotics have a significantly decreased risk of extrapyramidal side effects but are associated with weight gain and the development of metabolic syndrome.[5] **Metabolic syndrome** increases the risk of heart disease, stroke, and type 2 diabetes. Clinical symptoms of metabolic syndrome include high blood glucose, symptoms of diabetes (i.e., increased thirst and urination, fatigue, and blurred vision), obesity with a large abdominal girth, hypertension, elevated triglyceride, and lower levels of HDL.

See Table 6.6 for a list of common antipsychotic medications. Some are taken daily in pill or liquid form. Others can be administered as injections twice a

4. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362

5. Chokhawala, K., & Stevens, L. (2023). *Antipsychotic medications*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK519503/

month, monthly, every three months, or every six months, which can be more convenient and improve medication adherence.

Table 6.6 Common Antipsychotic Medications[6,7,8]

6. National Institute of Mental Health. (2023). *Mental health medications.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362

7. Vasan, S., & Padhy, R. K. (2023). *Tardive dyskinesia*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK448207/

8. Jibson, M. D. (2021). Second-generation antipsychotic medications: Pharmacology, administration, and side effects. *UpToDate*. www.uptodate.com

Medication Class	Mechanism of Action	Adverse Effects
First-Generation (Typical) Examples: Chlorpromazine Haloperidol Perphenazine Fluphenazine	Postsynaptic blockade of dopamine receptors in the brain	• Extrapyramidal side effects (EPS) • Tardive dyskinesia (TD) • Neuroleptic Malignant Syndrome (NMS)
Second-Generation (Atypical) Examples: Risperidone Olanzapine Quetiapine Ziprasidone Aripiprazole Paliperidone Lurasidone Clozapine	Postsynaptic blockade of dopamine receptors in the brain	• Metabolic syndrome • Akathisia • Decreased risk for EPS, TD, and NMS

Clients respond differently to antipsychotic medications, so it may take several trials of different medications to find the one that works best for their symptoms.[9]

9. National Institute of Mental Health. (2023). *Mental health medications.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362

Clozapine

Clients with treatment-resistant schizophrenia may be prescribed clozapine, a specific atypical antipsychotic medication that binds to both serotonin and dopamine receptors. Clozapine is often effective when other antipsychotics have failed, but it carries a complex side effect profile, including strong anticholinergic, sedative, cardiac, and hypotensive properties, as well as frequent drug-drug interactions. One of the most important risks to note is **agranulocytosis**, a rare but potentially life-threatening drop in white blood cells that significantly increases infection risk. For this reason, clients must be enrolled in a REMS (Risk Evaluation and Mitigation Strategy) program, with regular monitoring of their absolute neutrophil count (ANC)—typically weekly during the initial months of treatment. Nurses play a critical role in educating clients about the importance of lab work and recognizing early signs of infection such as fever or sore throat, which must be reported immediately.[10]

Side Effects

Common side effects of both first- and second-generation antipsychotics include the following:

- Anticholinergic symptoms: dry mouth, constipation, blurred vision, or urinary retention
- Drowsiness
- Dizziness
- Restlessness
- Weight gain
- Nausea or vomiting
- Low blood pressure
- Falls related to sedation, motor instability, and postural hypotension

10. Jibson, M. D. (2021). Second-generation antipsychotic medications: Pharmacology, administration, and side effects. *UpToDate*. https://www.uptodate.com/

Neuroleptic malignant syndrome (NMS) is a rare but fatal adverse effect that can occur at any time during treatment with antipsychotics. It typically develops over a period of days to weeks and resolves in approximately nine days with treatment. Signs include increased temperature, severe muscular rigidity, confusion, agitation, hyperreflexia, elevation in white blood cell count, elevated creatinine phosphokinase, elevated liver enzymes, myoglobinuria, and acute renal failure. The antipsychotic should be immediately discontinued when signs occur. Dantrolene and bromocriptine are typically prescribed for treatment. Nursing interventions include adequate hydration, cooling, and close monitoring of vital signs and serum electrolytes.[11]

Black Box Warning

A Black Box Warning states that elderly clients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.[12]

Side Effects of First-Generation Antipsychotics

First-generation antipsychotics have significant potential to cause extrapyramidal side effects and tardive dyskinesia due to their tight binding to dopamine receptors.[13]

Extrapyramidal (EPS) side effects refer to **akathisia** (psychomotor

11. Chokhawala, K., & Stevens, L. (2023). *Antipsychotic medications*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK519503/

12. National Institutes of Health. (2019). *Antipsychotic drugs*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=165d01d4-a9f7-2293-e054-00144ff8d46c

13. Jibson, M. D. (2021). Second-generation antipsychotic medications: Pharmacology, administration, and side effects. *UpToDate*. www.uptodate.com

restlessness), rigidity, **bradykinesia** (slowed movement), tremor, and **dystonia** (involuntary contractions of muscles of the extremities, face, neck, abdomen, pelvis, or larynx in either sustained or intermittent patterns that lead to abnormal movements or postures). Acute dystonic reactions affecting the larynx can be a medical emergency requiring intubation and mechanical ventilation. EPS symptoms usually resolve dramatically within 10 to 30 minutes of administration of parenteral anticholinergics such as diphenhydramine and benztropine.[14]

Tardive dyskinesia (TD) is a syndrome of movement disorders that can occur in clients taking first-generation antipsychotics. Hallmark symptoms are smacking and puckering lips, eye blinking, grimacing, and twitching. TD persists for at least one month and can last up to several years despite discontinuation of the medications. Primary treatment of TD includes discontinuation of first-generation antipsychotics and may include the addition of another medication. Second-generation VMAT2 inhibitors such as deutetrabenazine and valbenazine are considered first-line treatment for TD. Clonazepam and ginkgo biloba have also shown good effectiveness for improving symptoms of TD.[15,16]

14. Lewis, K., O'Day, C. S. (2025). *Dystonic reactions*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK531466/

15. Vasan, S., & Padhy, R. K. (2023). *Tardive dyskinesia*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK448207/

16. Pontone, G. (2020). Treating tardive dyskinesia: A clinical conundrum and new approaches. *Drug Induced Disorders: The Clinical Essentials.* Psychopharmacology Institute. https://psychopharmacologyinstitute.com/section/treating-tardive-dyskinesia-a-clinical-conundrum-and-new-approaches-2557-4810#:~:text=Clonazepam%20probably%20improves%20tardiv

Side Effects of Second-Generation Antipsychotics

Second-generation antipsychotics have a significantly decreased risk of extrapyramidal side effects but are associated with weight gain and the development of metabolic syndrome.[17] Metabolic syndrome is a cluster of conditions that occur together, increasing the risk of heart disease, stroke, and type 2 diabetes. Symptoms include increased blood pressure; high blood sugar; excess body fat around the waist (also referred to as having an "apple waistline"); and abnormal cholesterol, triglyceride levels, and high-density lipoprotein (HDL) levels. Weight, glucose levels, and lipid levels should be monitored before treatment is initiated then annually.

View a YouTube video[18] on metabolic syndrome: What is Metabolic Syndrome?

View this PDF: Adverse Effects of Antipsychotic Medications.

Client Education

Clients should be advised to contact their provider if and side effects occur. This includes the development of any involuntary or uncontrollable movements. They should be warned to not suddenly stop taking the

17. Chokhawala, K., & Stevens, L. (2023). *Second-generation antipsychotics*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK519503/

18. Health Link. (2019, December 31). What is metabolic Syndrome? [Video]. YouTube. All rights reserved. https://youtu.be/fVMvY_Lsqzw

medication because abrupt withdrawal can cause dizziness; nausea and vomiting; and uncontrolled movements of the mouth, tongue, or jaw. Clients should be warned to not consume alcohol or other CNS depressants because their ability to operate machinery or drive may be impaired.

Some people may experience relapse, meaning their psychosis symptoms come back or get worse. Relapses typically occur when people stop taking their prescribed antipsychotic medication or when they take it sporadically. Some people stop taking prescribed medications because they feel better or they feel that they don't need it anymore, but medication should never be stopped suddenly. After talking with a prescriber, clients can gradually taper their medications in some situations. However, most people with schizophrenia must stay on an antipsychotic continuously for mental wellness.[19]

View a supplementary YouTube video[20] explaining how clozapine binds to additional neuroreceptors compared to other antipsychotic medications: The Pines, the Dones, Two Pips and a Rip

19. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362

20. NEI Psychopharm. (2014, March 18). *The pines, the dones, two pips, and a rip* [Video]. YouTube. All rights reserved. https://youtu.be/kuYGJOcloH8

View a supplementary YouTube video[21] exploring antipsychotics: Pharmacology-Antipsychotics.

Read additional information about the mechanism of action, adverse side effects, and client education regarding antipsychotic medications in the "Schizophrenia" section of the "Psychosis and Schizophrenia" chapter.

21. Speed Pharmacology. (2018, July 18). *Pharmacology-Antipsychotics (Made Easy)*[Video]. YouTube. All rights reserved. https://youtu.be/nKkIh1B2Js8?si=4s1ecekHq9v3UDWA

6.7 Stimulants

Stimulant medications are prescribed to treat children, adolescents, or adults diagnosed with attention deficit hyperactivity disorder (ADHD). Stimulants block the reuptake of norepinephrine and dopamine in the synapse and increase the overall level of these substances in the brain, but they have a paradoxical calming effect and improve the ability to focus and concentrate for individuals diagnosed with ADHD. Common stimulants used to treat ADHD include methylphenidate, amphetamine, dextroamphetamine, and lisdexamfetamine dimesylate. Stimulant medications are safe when prescribed with close supervision, but they are a Schedule II controlled substance because they have a high potential for misuse and dependence. Stimulants are available in short-, intermediate-, and long-acting formulations. See Table 6.7 for an overview of information about stimulants.

Table 6.7. Stimulants

Generic	Nursing Considerations	Side/Adverse Effects
• **Methylphenidate** • **Amphetamine** • **Dextroamphetamine**	• High potential for misuse and drug diversion; promptly report concerns to the health care provider • Clients should avoid alcohol • Monitor BP and HR • Monitor growth and weight in children	• Immediately report signs and symptoms of mania, psychosis, cardiac or peripheral vascular complications, and priapism • Common side effects: headache, insomnia, upper abdominal pain, and decreased appetite

Side Effects

Stimulants may cause minor side effects that resolve when dosage levels are

lowered, or a different stimulant is prescribed. The most common side effects include the following[1,2]:

- Difficulty falling asleep or staying asleep
- Loss of appetite and weight loss
- Stomach pain
- Headache

Less common side effects include motor or verbal tics (sudden, repetitive movements or sounds) or personality changes (such as appearing "flat" or without emotion).[3] Sudden death, stroke, and myocardial infarction have been reported in adults with CNS-stimulant treatment at recommended doses. Sudden death has been reported in pediatric clients with structural cardiac abnormalities and other serious heart problems taking CNS stimulants at recommended doses. If paradoxical worsening of symptoms or other adverse reactions occur, the provider should be contacted, and the dosage reduced or discontinued. Stimulants are contraindicated in clients using a monoamine oxidase inhibitor (MAOI) or using an MAOI within the preceding 14 days.[4]

1. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

2. National Institutes of Health. (n.d.). *Stimulants*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/index.cfm

3. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

4. National Institutes of Health. (n.d.). *Monoamine oxidase inhibitor*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/index.cfm

Black Box Warning

CNS stimulants, including methylphenidate and amphetamine-like substances, have a high potential for abuse and dependence. The risk of abuse by the client or their family members should be assessed prior to prescribing stimulants, and signs of abuse and dependence should be evaluated while the client is receiving therapy.[5]

Client Education

There are several important client education topics to provide to clients and/or the parents of minor children[6]:

- **Medication information:** Discussing the purpose, potential side effects, and the importance of adherence to prescribed treatments.
- **Controlled Substance Status/High Potential for Abuse and Dependence:** Stimulants are a controlled substance by the FDA that can be abused and lead to dependence. Stimulants should be stored in a safe (preferably locked) place to prevent misuse and should not be shared with anyone. Unused or expired stimulants should be disposed of based on state law and regulations or returned to a medicine take-back program if it is available in the community.
- **Cardiovascular Risks:** Stimulants can increase blood pressure and pulse rate. Potential serious cardiovascular risks include sudden death, cardiomyopathy, myocardial infarction, stroke, and hypertension. Instruct clients to contact a health care provider immediately if they develop symptoms, such as exertional chest pain, dizziness, or passing out.
- **Suppression of Growth:** Stimulants may cause slowing of growth in

5. National Institutes of Health. (n.d.). *CNS stimulants*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/index.cfm

6. National Institutes of Health. (n.d.). *CNS stimulants*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/index.cfm

children and weight loss.
- **Psychiatric Risks:** Stimulants can cause psychosis or manic symptoms, even in clients who have no prior history of these symptoms.
- **Priapism:** Painful or prolonged penile erections can occur; seek immediate medical attention.
- **Alcohol:** Alcohol should be avoided.

Nurses should reinforce with the client and their family members that the reason for the prescribed medication for ADHD is to help with self-control and the ability to focus. Possible side effects should be reviewed, and clients and their family members should be reminded it may take one to three months to determine the best pharmacological treatment, dose, and frequency of medication administration. During this time, the child's symptoms and adverse effects will be monitored weekly and the medication dose adjusted accordingly.[7]

> Read more information about other medications used to treat ADHD in the "Common Disorders and Disabilities in Children and Adolescents" section of the "Childhood and Adolescent Disorders" chapter.

7. Krull, K. R. (2022). Attention deficit hyperactivity disorder in children and adolescents: Treatment with medications. *UpToDate*. www.uptodate.com

6.8 Psychoactive Substances and Medications to Treat Substance Use and Withdrawal

Information about the effects of substances such alcohol, cannabis, and illicit drugs is discussed in the "Substances: Use, Intoxication, and Overdose" section of the "Substance Use Disorders" chapter.

Medications to treat alcohol use disorder and opioid disorder include buprenorphine-naloxone, methadone, naltrexone, acamprosate, and disulfiram. These medications are further discussed in the "Treatment and Recovery Services" subsection of the "Substance Use Disorders" chapter.

See Table 6.8 for a list of medications commonly used to treat alcohol and opioid use disorders.

Table 6.8 Common Medications Used to Treat Alcohol and Opioid Use Disorders[1]

1. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. https://www.ncbi.nlm.nih.gov/books/NBK424857/

Medication	Use	DEA Schedule	Application
Buprenorphine-naloxone	Opioid use disorder	CIII	Used for detoxification or maintenance of abstinence.
Methadone	Opioid use disorder	CII	Used for withdrawal and long-term maintenance of abstinence of opioid addiction. Dispersed only at opioid treatment centers certified by SAMHSA and approved by state authority.
Naltrexone	Opioid use disorder and alcohol use disorder	Not scheduled under the Controlled Substances Act	Block opioid receptors, reduce cravings, and diminish rewarding effects of opioids and alcohol. Extended-release injections are recommended to prevent relapse.
Acamprosate	Alcohol use disorder	Not scheduled under the Controlled Substances Act	Used for maintenance of alcohol abstinence.
Disulfiram	Alcohol use disorder	Not scheduled under the Controlled Substances Act	Causes severe physical reactions when alcohol is ingested, such as nausea, flushing, and heart palpitations. The knowledge that the reaction will occur acts as a deterrent to drinking alcohol.

Medications used to manage symptoms of substance withdrawal/detoxification include buprenorphine, methadone, and Alpha-2 adrenergic agonists (such as clonidine and lofexidine). In the case of alcohol withdrawal, benzodiazepines (such as lorazepam or diazepam) remain the first-line treatment, particularly for preventing seizures and delirium tremens. In certain cases—especially in ICU-level care—dexmedetomidine (Precedex) may be used as an adjunct for sympathetic overactivity, though it does not treat seizures and must be used with close monitoring. Read more about these medications in the "Withdrawal Management/Detoxification" section of the "Substance Use Disorders" chapter.

6.9 Learning Activities

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1

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https://wtcs.pressbooks.pub/nursingmhcc/?p=996#h5p-33

2

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=996#h5p-34

1. “MH Psychotropic Medications Glossary Cards” by OpenRN is licensed under CC BY-NC 4.0

2. “MH Psychotropic Medication Question Set 1” by OpenRN is licensed under CC BY-NC 4.0

3

- Test your clinical judgment with a NCLEX Next Generation-style question: Chapter 6, Assignment 1[4]

- Test your clinical judgment with a NCLEX Next Generation-style case study: Chapter 6, Case Study 1[5]

3. "MH Psychotropic Medication Drag and Drop" by OpenRN is licensed under CC BY-NC 4.0
4. "MH Psychotropic Medication Next Gen Question 1" by OpenRN is licensed under CC BY-NC 4.0
5. "MH Psychotropic Medication Case Study" by Kellea Ewen is licensed under CC BY-NC 4.0

VI Glossary

Acetylcholine: A neurotransmitter that stimulates nicotinic and muscarinic receptors in the parasympathetic nervous system.

Adrenergic agonists: Substances that stimulate SNS receptors and cause effects similar to epinephrine and norepinephrine.

Adrenergic antagonists: Substances that block SNS receptors.

Agranulocytosis: Extremely low white blood cell count and an adverse effect of clozapine and antipsychotic medication.

Anticholinergics: Substances that block the effects of PNS receptors.

Black Box Warning: A significant warning from the Food and Drug Administration (FDA) that alerts the public and health care providers to serious side effects, such as injury or death.

Catecholamines: Substances that include epinephrine, norepinephrine, and dopamine and are responsible for the body's "fight-or-flight" response.

Central nervous system (CNS): The brain and spinal cord.

Cholinergics: Substances that stimulate nicotinic and muscarinic receptors and cause effects similar to acetylcholine (ACh).

Controlled substance: Drugs regulated by federal law that can cause dependence and abuse.

Dopamine: A neurotransmitter that plays an essential role in several brain functions, including learning, motor control, reward, emotion, and executive functions.

Extrapyramidal side effects: Involuntary or uncontrollable movements, tremors, and muscle contractions that can occur with antipsychotic medications.

Gamma-aminobutyric acid and Glycine: Inhibitory neurotransmitters that

act like brakes in a car by slowing down overexcited nerve cells. Low levels of GABA are associated with seizures, anxiety, mania, and impulse control. Pregabalin is an anticonvulsant that mimics the effects of GABA and is used to treat generalized anxiety disorder.

Glutamate: An excitatory neurotransmitter. Elevated levels of glutamate are associated with psychosis that can occur with schizophrenia, as well as with illicit drug use such as methamphetamines. Conversely, lamotrigine, a medication used to treat bipolar disorder, inhibits glutamate.

Histamine: A substance that mediates homeostatic functions in the body, promotes wakefulness, modulates feeding behavior, and controls motivational behavior. For example, diphenhydramine, a histamine antagonist, causes drowsiness.

Hypertensive crisis: A condition that can be caused by MAOIs with severe hypertension (blood pressure greater than 180/120 mm Hg) and evidence of organ dysfunction. Symptoms may include occipital headache (which may radiate frontally), palpitations, neck stiffness or soreness, nausea or vomiting, sweating, dilated pupils, photophobia, shortness of breath, or confusion.

Lithium toxicity: Lithium has a narrow therapeutic range of 0.8 to 1.2 mEq/L. Levels above this range cause lithium toxicity. Signs of early lithium toxicity include diarrhea, vomiting, drowsiness, muscular weakness, and lack of coordination. At higher levels, giddiness, ataxia, blurred vision, tinnitus, and a large output of dilute urine may occur.

Neuroleptic malignant syndrome (NMS): A rare but fatal adverse effect that can occur at any time during treatment with antipsychotics. It typically develops over a period of days to weeks and resolves in approximately nine days with treatment. Signs include increased temperature, severe muscular rigidity, confusion, agitation, hyperreflexia, elevation in white blood cell count, elevated creatinine phosphokinase, elevated liver enzymes, myoglobinuria, and acute renal failure.

Neurotransmitters: Chemical substances released at the end of a neuron by

the arrival of an electrical impulse. They diffuse across the synapse and cause the transfer of the impulse to another nerve fiber, a muscle fiber, or other structure. Neurotransmitters interact with specific receptors like a key and a lock.

Norepinephrine and Epinephrine: Substances that stimulate alpha- and beta-receptors in the sympathetic nervous system.

Opiates: Powerful analgesics prescribed to treat moderate to severe pain (such as morphine and oxycodone). Opiates also include illicit drugs (such as heroin).

Opioid receptors: Mu, delta, and kappa receptors that are stimulated by endogenous peptides released by neurons (such as endorphins) and exogenous opiates.

Opioid system: A system in the brain that controls pain and reward and addictive behaviors.

Parasympathetic Nervous System (PNS) receptors: Nicotinic and muscarinic receptors that are stimulated by acetylcholine (ACh).

Serotonin: A neurotransmitter that modulates multiple neuropsychological processes such as mood, sleep, libido, and temperature regulation. Abnormal levels of serotonin have been linked to many mental health disorders such as depression, bipolar disorder, and anxiety. Many psychotropic medications target serotonin.

Serotonin syndrome: A syndrome caused by the combination of multiple medications that affect serotonin. It typically develops within 24 hours from the combination of medication and can range from mild to a life-threatening syndrome. Signs of serotonin syndrome include mental status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), incoordination, or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). Serotonin syndrome, in its most severe form, can resemble neuroleptic malignant syndrome (NMS).

SLUDGE: A mnemonic for anticholinergic side effects: Salivation decreased, Lacrimation decreased, Urinary retention, Drowsiness/dizziness, GI upset, Eyes (blurred vision/dry eyes).

Sympathetic Nervous System (SNS) receptors: Alpha-1, Alpha-2, Beta-1, and Beta-2 receptors that are stimulated by epinephrine and norepinephrine.

Tardive dyskinesia: A syndrome of movement disorders associated with antipsychotic medications that persists for at least one month and can last up to several years despite discontinuation of the medications.

PART VII

CHAPTER 7 DEPRESSIVE DISORDERS

7.1 Introduction

Learning Objectives

- Identify assessment cues of depressive disorders
- Identify nursing priorities for clients with depressive disorders
- Plan outcomes for clients with depressive disorders
- Describe safety/protective interventions for clients with depressive disorders
- Apply evidence-based practice when planning care and interventions for clients with depressive disorders
- Analyze treatments for clients with depressive disorders
- Apply the nursing process to clients with depressive disorders at risk for suicide

Depression is a common illness affecting an estimated 8% of adults in the United States annually.[1] Approximately 280 million people in the world have depression.[2]

Depressive disorders represent a group of conditions that share a core set of symptoms such as a persistent and pervasive low mood, loss of interest or pleasure in most activities, and a range of cognitive and physical symptoms

1. National Alliance on Mental Illness. (2017). *Depression*. https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Depression
2. World Health Organization. (n.d.). *Depression*. https://www.who.int/health-topics/depression#tab=tab_1

that significantly impair daily functioning.[3] This chapter will discuss causes and types of depression, treatments for depression, and steps for applying the nursing process when caring for clients with depressive disorders.

3. World Health Organization. (2023). *Depressive disorder*. https://www.who.int/news-room/fact-sheets/detail/depression

7.2 Causes of Depression

There are several possible causes of depression, including faulty mood regulation by the brain, genetic vulnerability, stressful life events, medications, and medical problems. Based on current research, it is believed that several of these forces interact to bring on depression.[1]

The Brain

Certain areas of the brain help regulate mood, including the hippocampus, amygdala, and hypothalamus. See Figure 7.1[2] for an image of these areas of the brain. Researchers believe that nerve cell connections, nerve cell growth, the functioning of nerve circuits, and levels of specific brain chemicals (called neurotransmitters) have a major impact on depression.[3]

1. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression
2. "1511_The_Limbic_Lobe.jpg" by OpenStax College is licensed under CC BY 3.0. Access for free at http://cnx.org/content/col11496/1.6/
3. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

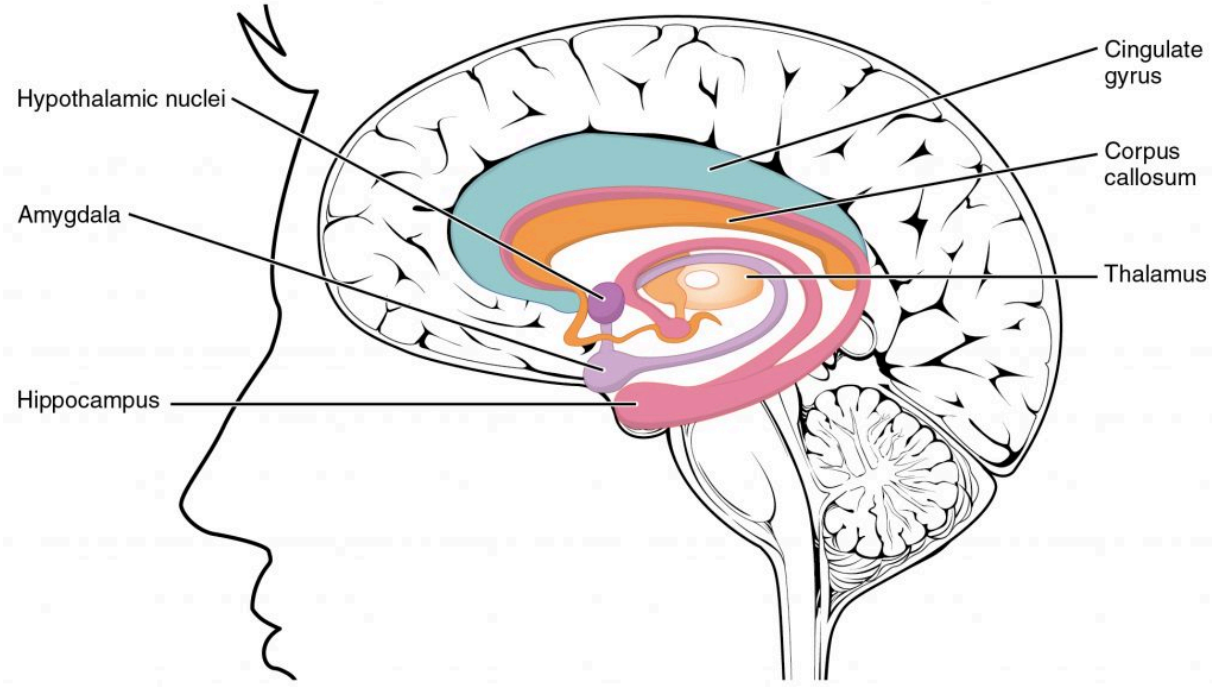


Figure 7.1 Areas of the Brain Regulating Mood

The hippocampus is part of the limbic system in the brain that has a central role in processing long-term memory and recollection. For example, this part of the brain registers fear when you are confronted by a frightening situation, like an aggressive dog, and the memory of such an experience may make you wary of dogs you come across later in life. The hippocampus is smaller in some depressed people, and research suggests that ongoing exposure to stress hormones impairs the growth of nerve cells in this part of the brain.[4]

The amygdala is also part of the limbic system and is a group of structures deep in the brain that are associated with emotions such as anger, pleasure, sorrow, fear, and sexual arousal. The amygdala is activated when a person experiences or recalls emotionally charged memories, such as a frightening situation, and sends signals to the hypothalamus to stimulate the sympathetic fight-or-flight response. Activity in the amygdala is higher when

4. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

a person is sad or clinically depressed. This increased activity continues even after recovery from depression.[5]

The hypothalamus is involved in the stress response. The stress response starts with a signal from the hypothalamus. The hypothalamus, pituitary gland, and adrenal glands form the hypothalamic-pituitary-adrenal (HPA) axis, which governs a multitude of hormonal activities in the body and also plays a role in depression. When a physical or emotional threat looms, the hypothalamus secretes corticotropin-releasing hormone (CRH) that rouses the body. CRH follows a pathway to the pituitary gland, where it stimulates the secretion of adrenocorticotropic hormone (ACTH) into the bloodstream. When ACTH reaches the adrenal glands, it prompts the release of cortisol. The boost in cortisol readies the body to fight or flee by causing the heart to beat faster, the blood pressure to rise, and the respiratory rate to increase. CRH also affects the cerebral cortex, part of the amygdala, and the brain stem. It is thought to play a major role in coordinating one's thoughts and behaviors, emotional reactions, and involuntary responses. Working along a variety of neural pathways, it influences the concentration of neurotransmitters throughout the brain. Disturbances in hormonal systems affect neurotransmitters and vice versa.[6]

Neurotransmitters

There are many types of neurotransmitters that play a role in depression[7]:

5. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression
6. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression
7. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical

- **Acetylcholine** enhances memory and is involved in learning and recall.[8] Research has also shown that increased levels have been linked to depression.[9]
- **Serotonin** helps regulate sleep, appetite, and mood and inhibits pain. Research supports the idea that some depressed people have reduced serotonin transmission. Low levels of a serotonin by-product have been linked to a higher risk for suicide.[10]
- **Norepinephrine** constricts blood vessels, raising blood pressure. It may trigger anxiety and be involved in some types of depression. It also seems to help determine motivation and reward.[11]
- **Dopamine** is essential to movement. It also influences motivation and plays a role in how a person perceives reality. Problems in dopamine transmission have been associated with psychosis, a severe form of distorted thinking characterized by hallucinations or delusions. It's also involved in the brain's reward system, so it is thought to play a role in

School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

8. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

9. Dulawa, S. C., & Janowsky, D. S. (2018). Cholinergic regulation of mood: From basic and clinical studies to emerging therapeutics, *Molecular Psychiatry, 24*(5), 694-709. doi: 10.1038/s41380-018-0219-x

10. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

11. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

substance abuse.[12] Dysregulation of dopamine pathways is also thought to contribute to anhedonia, the inability to experience pleasure, which is a common symptom in major depressive disorder.[13]

- **Glutamate** is a small molecule believed to act as an excitatory neurotransmitter and to play a role in bipolar disorder and schizophrenia. Animal research suggests that lithium stabilizes glutamate reuptake and smooths out the highs of mania and the lows of depression in the long-term.[14]
- **Gamma-aminobutyric acid (GABA)** is an amino acid that researchers believe acts as an inhibitory neurotransmitter. It is thought to help subdue anxiety.[15] Low levels of GABA have been associated with major depressive disorders.[16]

12. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

13. Belujon, P. & Grace, A. A. (2017). Dopamine system dysregulation in major depressive disorders. *International Journal of Neuropsychopharmacology, 20*(12), 1036-1046. doi: 10.1093/ijnp/pyx056.

14. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

15. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

16. Luscher, B., Shen, Q., & Sahir, N. (2011). The GABAergic deficit hypothesis of major depressive disorder. *Molecular Psychiatry, 16*(4), 383-406. doi: 10.1038/mp.2010.120.

See Figure 7.2[17] for an illustration of neurotransmitter communication between neurons at the synapse. Antidepressants immediately boost the concentration of chemical messengers in the brain (neurotransmitters), but people typically don't begin to feel better for several weeks or longer. Experts have long wondered why people don't improve as soon as the level of neurotransmitters increases. New theories explain that antidepressants spur the growth and enhanced branching of nerve cells in the hippocampus (a process called neurogenesis), and mood improves over several weeks as nerves grow and form new connections.[18]

17. "1225_Chemical_Synapse.jpg" by Young, K. A., Wise, J. A., DeSaix, P., Kruse, D. H., Poe, B., Johnson, E., Johnson, J. E., Korol, O., Betts, J. G., & Womble, M. is licensed under CC BY 4.0

18. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

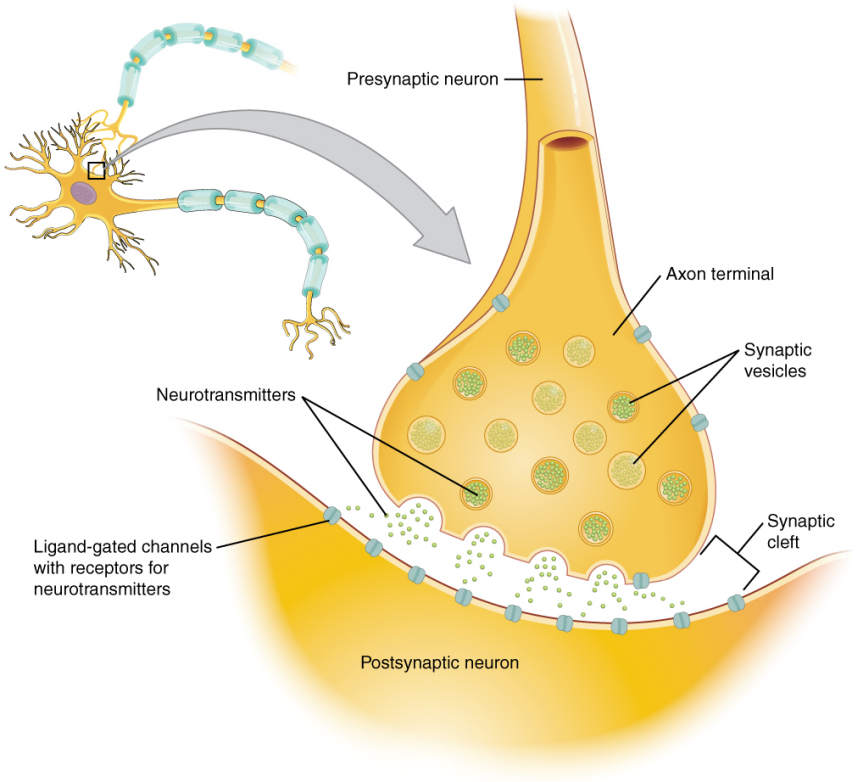


Figure 7.2 Neurotransmitters at the Synapse Level

Genes

Every part of our body, including our brain, is controlled by our genes. Humans have almost 22,000 genes in their DNA within 46 chromosomes inside the nucleus of each cell. The sequence of nitrogen-containing bases within a strand of DNA forms the genes that act as a molecular code instructing cells in the assembly of amino acids into proteins. See Figure 7.3[19] for an image of sequences of bases within a DNA strand that forms genes. Genes make proteins that are involved in biological processes. Throughout life, different genes turn on and off and make the right proteins at the right time. However, genes can alter biology in a way that results in a person's mood becoming unstable. In a person who is genetically vulnerable to

19. "229_Nucleotides-01.jpg" by OpenStax College is licensed under CC BY 3.0. Access for free at http://cnx.org/content/col11496/1.6/.

depression, any stress (such as a missed deadline at work or a medical illness) can then push this system off balance.[20]

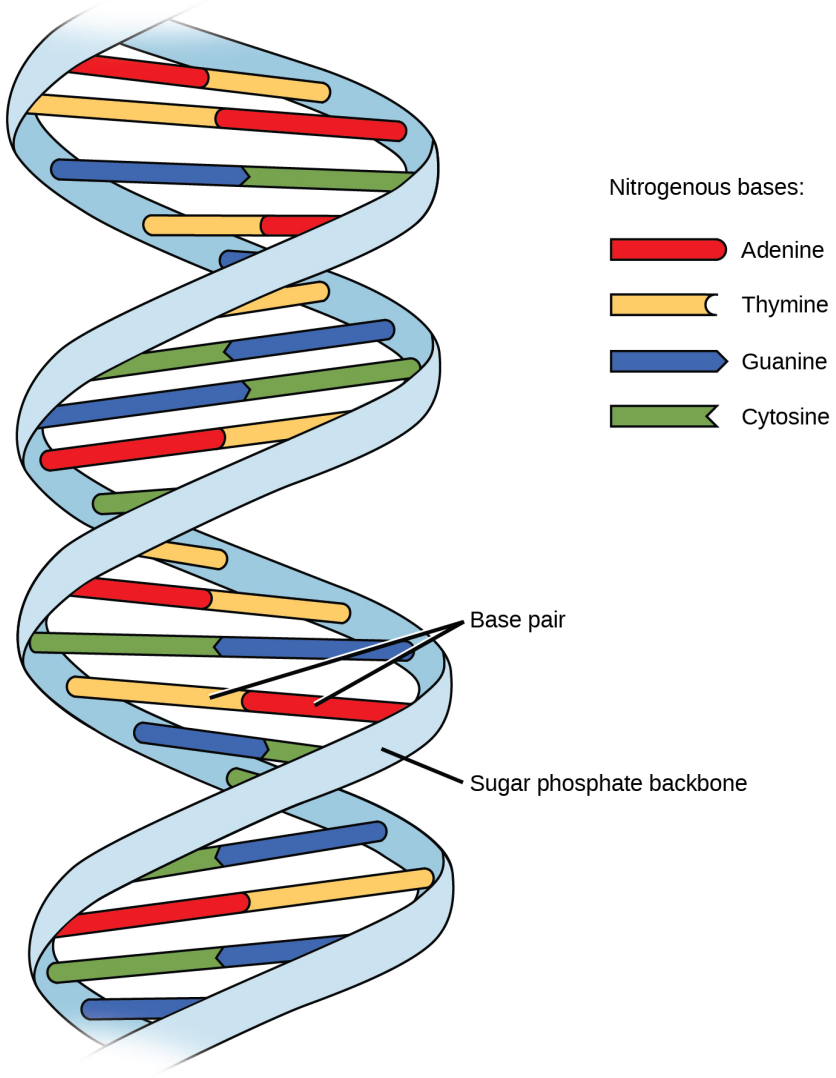


Figure 7.3 Sequence of Bases Within DNA That Form Genes

It is well-known that depressive and bipolar disorders run in families. Mood is affected by dozens of genes, and as our genes differ, so does depression. As researchers pinpoint specific genes involved in mood disorders and better

20. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

understand their functions, it is hoped that treatment for depressive disorders can become more individualized and more successful as clients receive targeted medication for their specific type of depression.[21]

Genetics provides one perspective on how resilient an individual is in the face of difficult life events. Temperament is determined by a person's genetic inheritance and the experiences they have had in life. For example, one person may have the temperament of an introvert and tend to withdraw from social situations, whereas another person may have the temperament of an extrovert who seeks out social situations and feels energized by them. Cognitive psychologists believe that one's view of the world and assumptions about how the world works influence how a person feels. Individuals develop their assumptions about life early and automatically fall back on them when loss, disappointment, or rejection occurs. For example, a person who was continually criticized as a child may have the genetic inheritance and temperament where they become so self-critical they can't bear the slightest criticism from others, which can slow or block their career progress and make intimate relationships more difficult. Therapy and medications can shift thoughts and attitudes that have developed over time.[22]

Sociocultural Influencing Factors

Many sociocultural factors play a role in depression. These factors may be related to social norms, cultural expectations, and social environments. Stressful life events—such as the death of a loved one, the loss of a job, the diagnosis of a severe illness, or the end of a significant relationship—can

21. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

22. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

affect anyone. In addition, family and relationship stress, including marital conflicts or domestic abuse, can contribute significantly to depressive symptoms. Cultural and societal expectations may also create psychological strain. For example, women are often expected to excel both in the workplace and as primary caregivers at home, creating conflicting demands that can lead to chronic stress and feelings of inadequacy. Socioeconomic factors such as unemployment, financial instability, and low income are strongly linked to an increased risk of depression. Gender inequality further compounds these risks, as women disproportionately experience burdens like domestic violence, caregiving responsibilities, and economic insecurity—all of which are deeply rooted in societal norms and expectations. Beyond current life stressors, many individuals have experienced traumatic childhood events that continue to affect their coping and functioning into adulthood. It is estimated that 61% of adults have experienced early adverse childhood experiences (ACEs) such as abuse, neglect, or growing up in a household with violence, mental illness, substance use, incarceration, or divorce. See Figure 7.4[23] for an illustration of adverse childhood experiences. Toxic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood.[24]

23. "ACEs.png" by unknown author for Centers for Disease Control and Prevention is licensed in the Public Domain. Access for free at https://www.cdc.gov/injury/pdfs/priority/ACEs-Strategic-Plan_Final_508.pdf.

24. Centers for Disease Control and Prevention. (2021). *Adverse childhood experiences (ACEs)*. https://www.cdc.gov/violenceprevention/aces/index.html

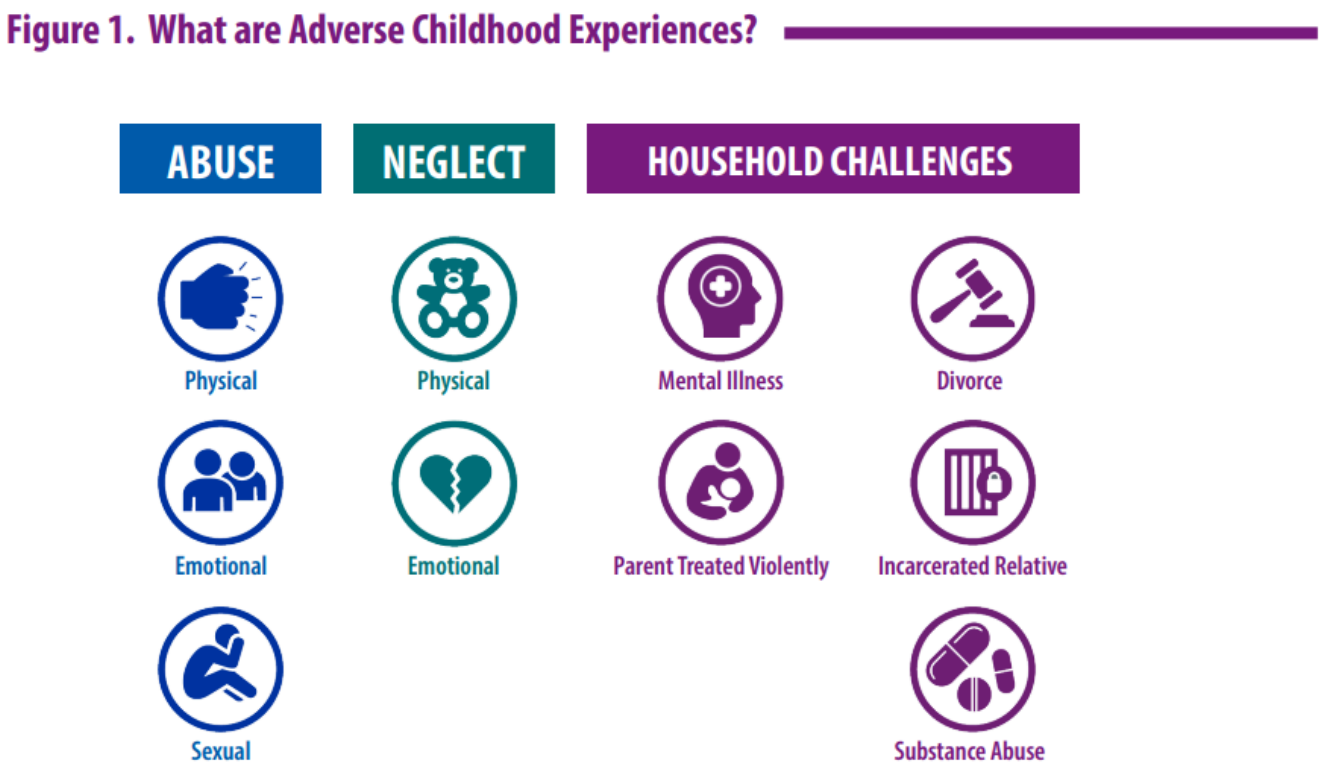


Figure 7.4 Adverse Childhood Experiences (ACEs)

Stress triggers a chain of chemical reactions and responses in the body. If the stress is short-lived, the body usually returns to normal. But when stress is chronic or the system gets stuck in overdrive, changes in the body and brain can be long-lasting. Every real or perceived threat to one's body triggers a cascade of stress hormones that produces physiological changes called the stress response. Normally, a feedback loop allows the body to turn off "fight-or-flight" defenses when the threat passes. In some cases, though, the floodgates never close properly, and cortisol levels rise too often or simply stay high. These elevated cortisol levels can contribute to problems such as high blood pressure, immune suppression, asthma, and depression. Studies have also shown that people who have depressive disorders typically have increased levels of CRH. Antidepressants and electroconvulsive therapy are both known to reduce these high CRH levels. As CRH levels return to normal, depressive symptoms recede. Research also suggests that trauma during

childhood can negatively affect the functioning of CRH and the HPA axis throughout life.[25]

> Read the Adverse Childhood Experiences Prevention Strategy.

Medical Problems/Medication

Certain medical problems are linked to up to 10% to 15% of all depressions. For example, hypothyroidism, a condition where the body produces too little thyroid hormone, often leads to exhaustion and depression, whereas hyperthyroidism (excess thyroid hormone) can trigger manic symptoms. Heart disease has also been linked to depression, with up to half of heart attack survivors reporting feeling blue and many having significant depression. Another example of depression linked to a medical condition is postpartum depression that occurs after pregnancy.[26]

The following medical conditions have also been associated with depression and other mood disorders[27]:

- Degenerative neurological conditions, such as multiple sclerosis,

25. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

26. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

27. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

Parkinson's disease, Alzheimer's disease, and Huntington's disease
- Cerebrovascular accidents (i.e., strokes)
- Some nutritional deficiencies, such as a lack of vitamin B12
- Endocrine disorders involving the parathyroid or adrenal glands
- Immune system diseases, such as lupus
- Some viruses, such as mononucleosis, hepatitis, and HIV
- Cancer
- Erectile dysfunction in men
- Chronic pain

When considering the connection between health problems and depression, an important question to address is which came first, the medical condition or the mood changes. Stress of having certain illnesses can trigger depression, whereas in other cases, depression precedes the medical illness and may even contribute to it. If depression is caused by an underlying medical problem, the mood changes should disappear after the medical condition is treated. For example, after hypothyroidism is treated, lethargy and depression often lift. In many cases, however, depression is an independent problem, which means that in order to be successful, treatment must address depression directly.[28]

Symptoms of depression can be a side effect of certain drugs, such as steroids or some types of blood pressure medication. Other medications associated with depressive symptoms include corticosteroids, antiepileptic drugs, oral contraceptives, and barbiturates. In addition, substances such as alcohol and cannabis can contribute to or worsen depressive symptoms, particularly with long-term or heavy use. A health care provider can help determine whether a

28. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

new medication, a change in dosage, or interactions with other drugs or substances might be affecting an individual's mood.[29]

29. Harvard Health Publishing. (2019). *What causes depression?* Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/what-causes-depression

7.3 Types of Depression

Depression is different from the usual mood fluctuations and short-lived emotional responses to everyday life stressors. When it is recurrent with moderate or severe intensity, depression can become a serious health condition that causes the affected person to suffer greatly and function poorly at work and school and can affect relationships with family and friends. At its worst, depression can lead to suicide. Over 700,000 people die every year due to suicide. Barriers to effective care for depression include a lack of resources, lack of trained health care providers, and social stigma associated with mental health disorders.[1] Depressive disorders represent a group of conditions that share a core set of symptoms but differ in important ways such as duration, timing, triggers, and presumed causes (etiology). The common feature across all depressive disorders is the presence of a sad, empty, or irritable mood that is accompanied by physical (somatic) and mental (cognitive) changes. These changes significantly impair a person's ability to function in daily life—impacting work, relationships, self-care, and overall quality of life. See Figure 7.5[2] for an artistic depiction of an individual experiencing depression.

1. World Health Organization. (2021). *Depression*. https://www.who.int/news-room/fact-sheets/detail/depression

2. "320531.png" by j4p4n at openclipart.org is licensed in the Public Domain.

Figure 7.5 Depression

Major Depressive Disorder

A **major depressive episode** is a period of at least two weeks during which a person experiences a persistently depressed mood or a loss of interest or pleasure in nearly all activities, most of the day, nearly every day. This emotional state is accompanied by additional symptoms such as changes in appetite or weight, sleep disturbances (insomnia or sleeping too much), fatigue or loss of energy, feelings of worthlessness or excessive guilt, difficulty concentrating or making decisions, and recurrent thoughts of death or suicide. During a **depressive episode**, the person experiences a depressed mood (feeling sad, irritable, empty) or a loss of pleasure or interest in activities (anhedonia) for most of the day, nearly every day, for at least two weeks. Several other symptoms may also be present, which may include poor concentration, feelings of excessive guilt or low self-worth, hopelessness about the future, thoughts about dying or suicide, disrupted sleep, changes in appetite or weight, and feeling especially tired or low in energy. In some cultural contexts, some people may express their mood changes more readily in the form of bodily symptoms (such as pain, fatigue, or weakness) that are not due to another medical condition. During a depressive episode, the person experiences significant difficulty and/or impairment in important areas of personal, family, social, educational, and work functioning.[3]

3. World Health Organization. (2021). *Depression*. https://www.who.int/news-room/fact-sheets/detail/depression

A depressive episode is categorized by a provider as mild, moderate, or severe depending on the number and severity of symptoms, as well as the impact on the individual's functioning.[4] Mild severity indicates the symptoms to make the diagnosis are present but result in minor impairment in social or occupational functioning. Moderate severity indicates symptoms and impairment are between mild and severe. Severe indicates the intensity is seriously distressing, unmanageable, and markedly interferes with social and occupational functioning. Read the full list of criteria for Major Depressive Disorder from the *DSM-5-TR* in the following box.

DSM-5-TR Criteria for Major Depressive Disorder[5]

1. Five or more of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
    - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
    - Markedly diminished interest or pleasure in all,

4. World Health Organization. (2021). *Depression*. https://www.who.int/news-room/fact-sheets/detail/depression

5. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

or almost all, activities most of the day, nearly every day.
    - Significant weight loss when not dieting or weight gain (i.e., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
    - Insomnia or hypersomnia nearly every day.
    - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
    - Fatigue or loss of energy nearly every day.
    - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
    - Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
    - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

2. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
3. The episode is not attributable to the physiological effects of a substance or another medical condition.

4. The client has never had a manic or hypomanic episode.

Seasonal Pattern

Seasonal affective disorder (SAD) is a type of major depressive disorder that affects about 5% of adults in the United States. People with SAD experience mood changes and symptoms similar to depression. The symptoms usually occur during the fall and winter months when there is less sunlight and usually improve with the arrival of spring. SAD is more than just "winter blues." The symptoms can be distressing and overwhelming and can interfere with daily functioning.[6]

SAD has been linked to a biochemical imbalance in the brain prompted by shorter daylight hours and less sunlight in winter. As seasons change, people experience a shift in their biological internal clock or circadian rhythm that can cause them to be out of step with their daily schedule. SAD is more common in people living far from the equator where there are fewer daylight hours in the winter.[7]

SAD can be effectively treated with light therapy, antidepressant medications, cognitive behavioral therapy, or some combination of these. While symptoms will generally improve on their own with the change of season, symptoms can

6. American Psychiatric Association. (2020). *Seasonal affective disorder (SAD)*. https://www.psychiatry.org/patients-families/depression/seasonal-affective-disorder

7. American Psychiatric Association. (2020). *Seasonal affective disorder (SAD)*. https://www.psychiatry.org/patients-families/depression/seasonal-affective-disorder

improve more quickly with treatment. **Light therapy** involves sitting in front of a light therapy box that emits a very bright light (and filters out harmful ultraviolet [UV] rays). Bright light therapy typically involves exposure to a light box emitting 2,500 to 10,000 lx of light[8] It usually requires 20 minutes or more per day, typically first thing in the morning during the winter months. Most people see some improvements from light therapy within one or two weeks of beginning treatment. For some people, increased exposure to natural sunlight can help improve symptoms of SAD by spending time outside or arranging their home or office space to increase exposure to windows during daylight hours. General wellness activities such as performing regular exercise, eating healthfully, getting enough sleep, and staying active and connected (such as volunteering, participating in group activities and getting together with friends and family) can also help.[9]

Peripartum Onset

Pregnancy and the time following childbirth represent a uniquely vulnerable period for women. This phase of life often involves intense biological changes, emotional adjustments, financial pressures, and shifting social roles. These stressors can have a profound impact on a woman's mental health, potentially resulting in a spectrum of mood disturbances—from mild and temporary feelings of sadness to more severe depressive disorders that may require clinical intervention.

8. Pjrek, E., Friedrich, M.E., Cambioli, L., Dold, M., Jäger, F., Komorowski, A., Lanzenberger, R., Kasper, S, Winkler, D. (2020). The efficacy of light therapy in the treatment of seasonal affective disorder: A meta-analysis of randomized controlled trials. *Psychotherapy Psychosomatics, 89*(1):17-24. doi: 10.1159/000502891.

9. American Psychiatric Association. (2020). *Seasonal affective disorder (SAD)*. https://www.psychiatry.org/patients-families/depression/seasonal-affective-disorder

BABY BLUES

It is common for new mothers to experience what is known as the "baby blues," which affects up to 70% of women after childbirth. The baby blues typically begin within a few days of delivery and include emotional lability, tearfulness without an obvious cause, mild irritability, restlessness, and a general sense of anxiety or being overwhelmed. These symptoms are usually mild, self-limited, and do not interfere significantly with a mother's ability to care for herself or her baby. Most cases resolve spontaneously within about two weeks, and medical treatment is generally not necessary.

PERINATAL DEPRESSION

Perinatal depression represents a more serious mental health condition. **Perinatal depression** is a broad term that refers to depressive symptoms that occur any time during pregnancy and up to one year after childbirth. This includes both antenatal (or prenatal) depression, which develops while the person is still pregnant, and postpartum depression, which occurs after the baby is born. Perinatal depression can affect emotional well-being, physical health, bonding with the baby, and overall family functioning. It is more than just occasional sadness or stress. Symptoms of perinatal depression often include persistent feelings of sadness, anxiety, fatigue, irritability, changes in sleep and appetite, and difficulty concentrating or feeling connected to the baby.[10]

Postpartum Depression

Postpartum depression is a subset of perinatal depression and refers to to a major depressive episode that begins after childbirth. It is much more serious mental health condition than the "baby blues". **Postpartum depression** is characterized by persistent feelings of sadness, hopelessness, anxiety, and

10. National Institute of Mental Health (2023). *Perinatal Depression*. https://www.nimh.nih.gov/health/publications/perinatal-depression

exhaustion that interfere with a mother's ability to function and care for her infant. These symptoms go beyond the scope of the baby blues in both intensity and duration, often requiring professional treatment such as psychotherapy, medication, or a combination of both. If left untreated, postpartum depression can significantly impair the mother–infant bond, contribute to difficulties with infant feeding and sleeping, and may have long-term consequences for the child's emotional, cognitive, and social development. Symptoms of postpartum depression usually start between one to three weeks after birth[11] These symptoms reflect the same characteristics as those in the perinatal depression group, yet the time of onset is different. Many healthcare providers recognize that postpartum depression can emerge at any point within the first year following childbirth, even though this extended timeframe is not explicitly captured in DSM-5-TR criteria.

In rare and severe cases, postpartum depression may escalate into a condition called postpartum psychosis. This is a psychiatric emergency that requires immediate medical intervention. Postpartum psychosis can involve hallucinations, delusions, disorganized thinking, mania, severe agitation, and confusion. Because of the potential risk for self-harm or harm to the infant, individuals experiencing symptoms of postpartum psychosis should be brought to the nearest emergency room or emergency services should be contacted immediately.

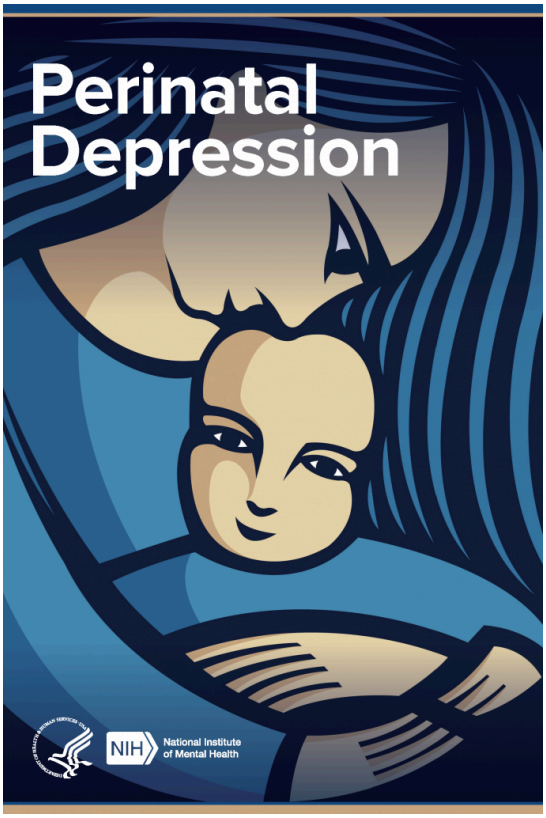
Understanding the range and severity of mood disorders related to pregnancy and childbirth is essential for early identification and intervention. Prompt recognition and appropriate care can significantly improve outcomes for both the mother and her child.

Pregnancy and the period after delivery can be a vulnerable time for women. Mothers can experience significant biological, emotional, financial, and social

11. National Library of Medicine. (2022). Postpartum depression screening. https://medlineplus.gov/lab-tests/postpartum-depression-screening/

changes during this time. Up to 70 percent of new mothers experience the "baby blues," a short-term condition that does not interfere with their daily activities and does not require medical attention. Symptoms include crying for no reason, irritability, restlessness, and anxiety. These symptoms generally last up to two weeks and resolve on their own.[12]

See Figure 7.6[13] for an illustration of perinatal depression from the National Institutes of Health.



12. American Psychiatric Association (2020). *What is peripartum depression (formerly postpartum)?* https://www.psychiatry.org/patients-families/postpartum-depression/what-is-postpartum-depression

13. This image is a derivative of "20-mh-8116-perinataldepression.pdf" by National Institute of Mental Health and is licensed in the Public Domain. Access for free at https://www.nimh.nih.gov/health/publications/perinatal-depression.

Figure 7.6 Perinatal Depression

Untreated peripartum depression is not only a problem for the mother's health and quality of life but can also affect the well-being of the baby. Postpartum depression can cause bonding issues with the baby and also contribute to sleeping and feeding problems for the baby. In the long-term, children of mothers with peripartum depression are at greater risk for cognitive, emotional, developmental and verbal deficits, and impaired social skills.[14]

> Read more information about perinatal depression on the National Institute of Mental Health's Perinatal Depression webpage.

Persistent Depressive Disorder

Persistent Depressive Disorder, previously known as dysthymia, is a chronic form of depression that is typically less severe in intensity than Major Depressive Disorder but lasts much longer. In adults, symptoms must be present for most of the day, more days than not, for at least two years. In children and adolescents, the required duration is at least one year, and the mood may be irritable rather than depressed. Individuals with this disorder often describe themselves as feeling "down in the dumps," "low," or "just not themselves." Because the symptoms are milder and may develop gradually, they can become part of a person's normal daily experience, leading many to

14. American Psychiatric Association (2020). *What is peripartum depression (formerly postpartum)?* https://www.psychiatry.org/patients-families/postpartum-depression/what-is-postpartum-depression

believe their persistent low mood is simply part of their personality rather than a treatable mental health condition.[15]

Common features of Persistent Depressive Disorder include poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. While these symptoms may not be as intense as those seen in a major depressive episode, they can still significantly affect a person's functioning and quality of life over time.[16]

Because the condition is long-lasting, it can interfere with relationships, work or school responsibilities, and the ability to enjoy life. Treatment often includes a combination of psychotherapy, such as cognitive behavioral therapy, and antidepressant medications like SSRIs or SNRIs. Ongoing support and follow-up care are important, as the chronic nature of the disorder requires long-term management to help individuals regain and maintain emotional well-being.[17]

Premenstrual Dysphoric Disorder

Premenstrual Dysphoric Disorder (PMDD) is a severe and disabling form of premenstrual syndrome (PMS) that involves significant mood disturbances and physical symptoms occurring in the final week before menstruation. While many individuals experience some degree of emotional or physical discomfort during their menstrual cycle, PMDD is much more intense and

15. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

16. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

17. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

can seriously interfere with daily life, relationships, and functioning. The symptoms become minimal or absent in the week post-menses.[18]

Individuals with PMDD must have one or more of the following symptoms[19]:

- Extreme affective lability (mood swings, feeling suddenly sad or tearful, or increased sensitivity to rejection)
- Significant irritability or anger or increased interpersonal conflicts
- Significant depressed mood, feelings of hopelessness, or self-deprecating thoughts
- Significant anxiety, tension, or feelings of being keyed up or on edge.

One or more of the following symptoms must be additionally present to reach a total of five symptoms when combined with the symptoms in the preceding paragraph[20]:

- Decreased interest in usual activities (e.g., work, school, friends, hobbies)
- Difficulty concentrating
- Lethargy, easy fatigability, or significant lack of energy
- Significant change in appetite, overeating, or specific food cravings
- Hypersomnia or insomnia
- A sense of being overwhelmed or out of control
- Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sense of bloating, or weight gain.

18. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

19. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

20. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

A key feature of PMDD is that these symptoms are not merely uncomfortable—they are severe enough to disrupt work, school, and personal relationships, and they go beyond what is typically expected in PMS.[21]

The exact cause of PMDD is not fully understood, but it is believed to be related to sensitivity to normal hormonal fluctuations during the menstrual cycle, particularly in individuals with an underlying vulnerability to mood disorders. Treatment may involve a combination of antidepressant medications, birth control hormonal medications, psychotherapy (especially cognitive behavioral therapy), and lifestyle modifications such as regular exercise, vitamin supplementation with B-6 and magnesium, and adaptive coping strategies such as yoga and meditation.[22]

Substance/Medication-Induced Depressive Disorder

Substance/Medication-Induced Depressive Disorder is a type of depression that occurs as a direct result of using, misusing, or withdrawing from certain substances or medications. This disorder is diagnosed when depressive symptoms such as a persistently low mood, lack of interest or pleasure, fatigue, difficulty concentrating, and feelings of worthlessness are closely linked to the use of a particular drug or substance and not better explained by another mental health condition. The depressive symptoms typically develop during or soon after substance use or withdrawal and must cause significant distress or impairment in daily functioning.[23]

21. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

22. Cleveland Clinic. (2023). *Premenstrual dysphoric disorder.* https://my.clevelandclinic.org/health/diseases/9132-premenstrual-dysphoric-disorder-pmdd

23. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

A wide range of substances can trigger this disorder. Common examples include alcohol, cannabis, opioids, sedatives, stimulants, and hallucinogens, as well as prescription medications such as corticosteroids, antihypertensives, hormonal contraceptives, barbiturates, and certain antiepileptic drugs. The effects may occur in people who are taking the substance as prescribed or in those who are misusing it. In some cases, individuals may not realize that their depressive symptoms are linked to a medication or drug, especially if the symptoms have developed gradually.[24]

An important part of diagnosing this condition is establishing the temporal relationship between substance use and the onset of depression. Once the substance is discontinued or the medication is adjusted, symptoms may improve—though in some cases, clinical treatment is still necessary to help manage mood changes. Treatment involves identifying and stopping the responsible substance, providing emotional support, and in some cases, using antidepressant medications or therapy to help stabilize mood during recovery.[25]

Depressive Disorder Due to Another Medical Condition

Depressive Disorder Due to Another Medical Condition is diagnosed when a person experiences a persistent depressed mood or a significant loss of interest or pleasure in activities, and these symptoms are directly caused by a medical illness or condition. Unlike other types of depression, this disorder is not primarily psychological in origin—it results from the physiological effects

24. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

25. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

of a medical issue. The depressive symptoms must cause significant distress or impair the person's ability to function in daily life.[26]

Common medical conditions associated with this type of depression include neurological disorders (such as stroke, Parkinson's disease, multiple sclerosis), endocrine disorders (like hypothyroidism or Cushing's disease), and chronic illnesses (such as cancer, diabetes, or heart disease). The timing of symptom onset is important for diagnosis, as the depressive symptoms must clearly follow the development of the medical condition and not be better explained by another mental health disorder.[27]

Treatment involves addressing both the underlying medical condition and the depressive symptoms, which may include psychotherapy, medication, or supportive care depending on the individual's needs.[28]

Mixed Features

Depressive episodes can also be classified as "mixed," meaning symptoms are present but do not predominate.[29] Mixed features associated with a major depressive episode have been found to be a significant risk factor for the development of bipolar I or bipolar II disorder. Characteristics and treatment of bipolar disorder are further discussed in the "Bipolar Disorders" chapter.

26. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
27. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
28. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
29. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

See Figure 7.7[30] for a comparison of the features of different types of mood disorders.

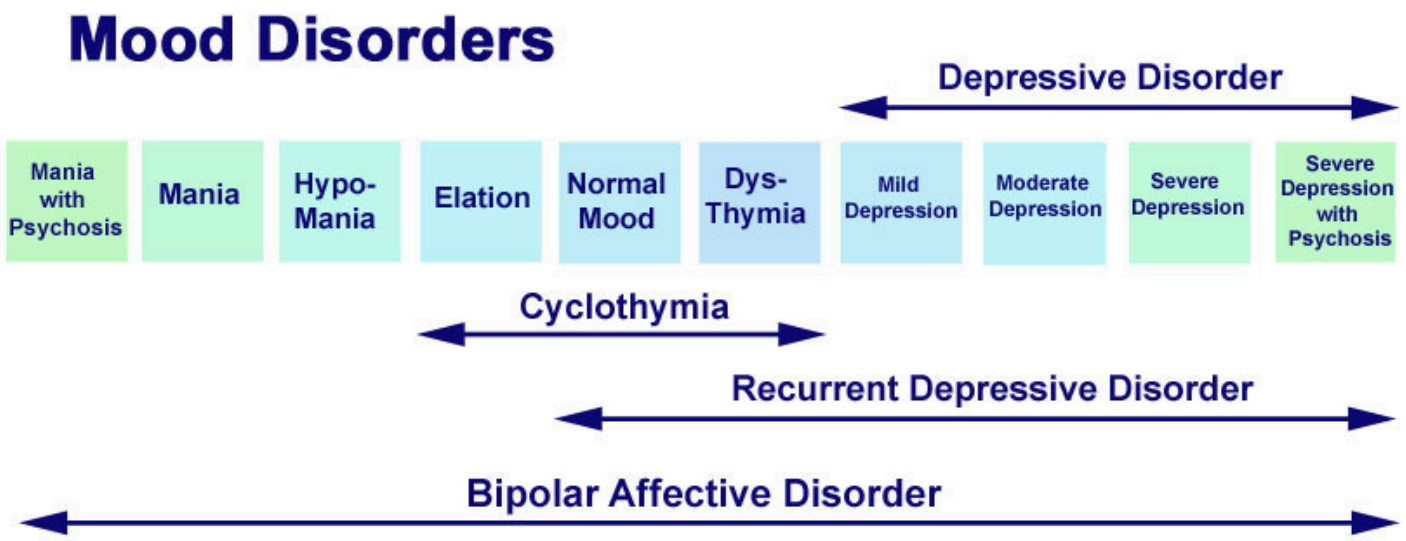


Figure 7.7 Mood Disorders. Used under Fair Use.

- Read more information at the American Psychiatric Association's What is Depression? webpage.
- Listen to The Dark Place podcast on the Podbean website to hear personal perspectives on depression and other mental health topics.

30. "mood-disorders.jpg" by Dr. Vipul Rastogi, MBBS; DCP (Ireland); MRCPsych (UK) Speciality Registrar, Hampshire Partnership Trust, UK for www.clinicaljunior.com. Image used under Fair Use. Access for free at http://www.clinicaljunior.com/psychmoodvipul.html

View the following YouTube video of an advocate explaining her experiences with depression and her journey to recovery[31]:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingmhcc/?p=326#oembed-1

Grief

Individuals often have difficulty coping with the death or loss of a loved one, job, or relationship. It is normal for feelings of sadness or grief to develop in response to such situations, but these symptoms are not the same as having a major depressive disorder. The grieving process is natural and unique to each individual and shares some of the same features of depression. Both grief and depression can involve intense sadness and withdrawal from usual activities with increased risk for suicide.

According to the American Psychiatric Association, grief and depression are different in these ways[32]:

- In grief, painful feelings come in waves, often intermixed with positive

31. World Health Organization (WHO). (2018, September 19). *Youth voices: Kylie Verzosa on depression* [Video]. YouTube. Licensed in the Public Domain. https://youtu.be/tRc4XZXYTgY

32. American Psychiatric Association. (2020). *What is depression?* https://www.psychiatry.org/patients-families/depression/what-is-depression

memories of the deceased. In major depression, mood and/or interest (pleasure) are decreased for most of two weeks.
- In grief, one's self-esteem is usually maintained. In major depression, feelings of worthlessness and self-loathing are common.
- In grief, thoughts of death may surface when thinking of or fantasizing about "joining" the deceased loved one. In major depression, thoughts are focused on ending one's life due to feeling worthless or undeserving of living or being unable to cope with the pain of depression.

Prolonged Grief Disorder

The DSM-5-TR introduced a new diagnosis called **Prolonged Grief Disorder** that is characterized by intense longing and preoccupation with the deceased person that persists beyond 12 months and causes significant impairment. Additionally, since the death, at least three of the following symptoms are present[33]:

- Identity disruption (e.g., feeling as though part of oneself has died) since the death
- Significant sense of disbelief about the death
- Avoidance of reminders that the person is dead
- Intense emotional pain related to the death
- Difficulty reintegrating into one's relationships and activities after the death
- Emotional numbness as a result of the death
- Feeling that life is meaningless as a result of the death
- Intense loneliness as a result of the death

33. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

Read more information about grief in the "Grief and Loss" chapter in Open RN *Nursing Fundamentals*, *2e*.

7.4 Treatments for Depression

Depression is one of the most treatable mental disorders. Between 80% and 90% percent of people with depression eventually respond well to treatment. Almost all patients gain some relief from their symptoms with effective treatment. Before a diagnosis is made or treatment planned, a mental health care provider should conduct a thorough diagnostic evaluation, including an interview, mental status examination, psychosocial assessment, and a physical examination performed by a primary care provider. In some cases, a blood test might be done to make sure the depression is not due to a medical condition like a thyroid problem or a vitamin deficiency. The evaluation also explores medical and family histories, cultural beliefs, and environmental factors as part of the psychosocial assessment with the goal of arriving at a diagnosis and planning a course of action. Treatments for depression include medications, psychotherapy, electroconvulsive therapy, transcranial magnetic stimulation, and encouraging self-care and effective coping strategies. Nurses should keep patient-centered care and client preferences in mind when implementing a client's treatment plan. For example, the client should be educated about the possible adverse effects associated with antidepressant medication, and their ability to pay for and obtain transportation to treatments like psychotherapy should be considered.[1]

Antidepressant Medications

Brain chemistry may contribute to an individual's depression and may factor into their treatment. Read more about the causes of depression in the "Causes of Depression" section of this chapter. For this reason, providers may prescribe antidepressants to help modify an individual's brain chemistry.

Antidepressants are used to regulate and increase neurotransmitters in the brain to improve mood. There are several classes of antidepressants with

1. American Psychiatric Association. (2020). *What is depression?* https://www.psychiatry.org/patients-families/depression/what-is-depression

different mechanisms of action and potential adverse side effects. Classes of antidepressants, their mechanism of action, and common side effects are outlined in Table 7.4.[2] Common side effects are listed in this table by frequency of their occurrence. Some medications can cause QTc prolongation, which refers to delayed cardiac electrical conduction that can lead to dysrhythmias. Tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) often cause anticholingeric side effects (e.g., tachycardia, urinary retention, constipation, dry mouth, blurred vision, confusion, psychomotor slowing, sedation, and delirium). A specific medication class is typically initiated by the provider based on the individual's symptoms, potential side effects, cost, and family history of success with certain medications.

Review neurotransmitter actions and related central nervous system physiology in the "Psychotropics Medications" chapter.

Table 7.4 Antidepressants

2. Rush, J. A. (2025). Side effects of antidepressant medication. UpToDate. https://www.uptodate.com/

Medication Class	Mechanism of Action	Common Side Effects (*Indicates medical emergency)
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) Common examples: Venlafaxine Duloxetine	Block the uptake of both serotonin and norepinephrine from the cell synapse. Similar to SSRIs but with two neurotransmitters.	• Gastrointestinal upset • Sexual dysfunction • Drowsiness • Insomnia • Agitation • Weight gain
Selective Serotonin Reuptake Inhibitors (SSRIs) Common examples: Fluoxetine Sertraline Citalopram	Impact the receptors of the cell synapse to inhibit or prevent the uptake of serotonin, making the neurotransmitter serotonin stay in the synapse longer.	• Sexual dysfunction • Gastrointestinal upset • QTc prolongation • Weight gain • Insomnia • Agitation • Drowsiness • Dizziness • Headache • Dry mouth • Constipation • Tremor ***Serotonin syndrome**

Tricyclic Antidepressants (TCAs) Common examples: Amitriptyline Nortriptyline	Block the presynaptic receptor for norepinephrine and partially serotonin. This makes the neurotransmitter norepinephrine level increase in the synapse.	• Anticholinergic side effects • Orthostatic hypotension • Drowsiness • QTc prolongation • Insomnia • Agitation • Weight gain • Sexual dysfunction
Monoamine Oxidase Inhibitors (MAOIs) Common examples: Phenelzine Tranylcypromine	Block the enzyme that breaks down monoamine, which causes an increase in the level of neurotransmitters serotonin and norepinephrine.	• Sexual dysfunction • Orthostatic hypotension • Insomnia • Agitation • Anticholinergic side effects • Drowsiness • Gastrointestinal upset • Weight gain ***Hypertensive crisis**

Norepinephrine and Dopamine Reuptake Inhibitor (NDRI) Bupropion	Blocks the uptake of both norepinephrine and dopamine from the cell synapse.	• Tachycardia • Diaphoresis • Weight loss • Gastrointestinal upset • Agitation • Dizziness, • Headache • Insomnia • Tremor • Blurred vision

Antidepressants may produce some improvement within the first week or two, but full benefits may not be seen for two to three months. If a patient feels little or no improvement after several weeks, the mental health care provider can alter the dose of the medication, add another medication, or substitute another antidepressant. In a similar manner, if a client develops ongoing bothersome side effects, the provider can switch them to a different medication. Nurses should encourage clients to contact their mental health care prescriber if a medication is not working within the expected time frame or if they are experiencing ongoing bothersome side effects. It is typically recommended that clients continue to take medication(s) for six or more months after the symptoms have improved. Long-term maintenance therapy may be suggested to decrease the risk of future episodes for people at high risk for recurrence.[3]

Black Box Warning

A **Black Box Warning** is a significant warning from the Food and Drug

3. American Psychiatric Association. (2020). *What is depression?* https://www.psychiatry.org/patients-families/depression/what-is-depression

Administration (FDA) that alerts the public and health care providers to serious side effects, such as injury or death. Black Box Warnings are in place for all classes of antidepressants used with children, adolescents, and young adults due to a higher risk of suicide. All clients receiving antidepressants should be monitored for signs of worsening depression or changing behavior, especially when the medication is started or dosages changed.

Adverse/Side Effects

Nurses must monitor clients receiving antidepressants for side effects and report concerns to the prescribing provider. Clients should be instructed to immediately call their provider if they have any of the following symptoms, especially if they are new or worsening[4]:

- Thoughts about suicide or dying
- Attempts to commit suicide
- Worsening depression
- Anxiety
- Agitation or restlessness
- Panic attacks
- Trouble sleeping (insomnia)
- Irritability
- Aggression, anger, or violence
- Dangerous impulses
- Increased activity and talking (i.e., signs of mania)
- Other unusual changes in behavior or mood

4. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

SEROTONIN SYNDROME

High doses of antidepressants or a combination of medications that affect serotonin, such as antidepressants or triptans (used to treat migraine headaches) can cause a medical emergency called serotonin syndrome. The presentation of **serotonin syndrome** is extremely variable, ranging from mild symptoms to a life-threatening syndrome. It typically develops within 24 hours from the increased dosage or combination of medications and can be fatal.

Symptoms of serotonin syndrome can be classified into three categories[5,6,7]:

- Mental status changes: Agitation, restlessness, or delirium
- Autonomic hyperactivity: Tachycardia, hypertension, hyperthermia, diaphoresis, shivering, vomiting, or diarrhea
- Neuromuscular hyperactivity: Tremor, muscle hypertonia or rigidity, myoclonus, hyperreflexia, or clonus (including rapid, horizontal eye movements)

A mnemonic commonly used to remember the symptoms of serotonin syndrome is **SHIVERS**:

- **S:** Shivering: A neuromuscular symptom similar to tremors specific to serotonin syndrome
- **H:** Hyperreflexia (and myoclonus): Hyperactive reflexes most prominent in

5. A.D.A.M. Medical Encyclopedia [Internet]. (2021). *Serotonin syndrome*. https://medlineplus.gov/ency/article/007272.htm

6. Boyer, E. W. (2021). Serotonin syndrome (serotonin toxicity). *UpToDate*. https://www.uptodate.com/

7. Tanen, D. (2021). *Serotonin syndrome*. Merck Manual Professional Version. https://www.merckmanuals.com/professional/injuries-poisoning/heat-illness/serotonin-syndrome

the lower extremities.
- **I:** Increased Temperature
- **V:** Vital Sign Abnormalities: Tachycardia, tachypnea, and labile blood pressure
- **E:** Encephalopathy: Mental status changes such as agitation, delirium, and confusion
- **R:** Restlessness
- **S:** Sweating

People may get slowly worse and can become severely ill if not quickly treated. Untreated, serotonin syndrome can be deadly. With treatment, symptoms usually go away within 24 hours, but permanent kidney damage may result even with treatment. Uncontrolled muscle spasms can cause severe muscle breakdown called **rhabdomyolysis**. Myoglobin is released into the blood with muscle breakdown and clogs renal tubules, which can cause severe kidney damage if serotonin syndrome isn't recognized promptly and treated.

Treatment of serotonin syndrome may include the following[8,9]:

- Stopping all serotonergic medications.
- Providing supportive care to normalize vital signs such as IV fluids, cooling measures, and medications to control heart rate and blood pressure.
- Sedating with benzodiazepines, such as diazepam or lorazepam, to decrease agitation, seizure-like movements, and muscle stiffness.
- If symptoms persist, administering cyproheptadine to block serotonin production.

8. Boyer, E. W. (2021). Serotonin syndrome (serotonin toxicity). *UpToDate*. https://www.uptodate.com/

9. Tanen, D. (2021). *Serotonin syndrome*. Merck Manual Professional Version. https://www.merckmanuals.com/professional/injuries-poisoning/heat-illness/serotonin-syndrome

- For patients with severe symptoms such as hyperthermia and muscle rigidity, more aggressive measures are required. These include sedation, intubation, neuromuscular paralysis, and active cooling techniques.[10]

Clients with moderate to severe serotonin syndrome should be hospitalized for close monitoring and management. Serotonin syndrome, in its most severe form, can resemble neuroleptic malignant syndrome (NMS) caused by antipsychotic medications. However, NMS develops over a period of days to weeks. Neuroleptic malignant syndrome (NMS) will be discussed further in Chapter 11.

HYPERTENSIVE CRISIS

Hypertensive crisis can occur when clients taking monoamine oxidase inhibitors (MAOIs) also take medications containing pseudoephedrine or eat foods containing tyramine (aged foods; fermented foods; cured meats; alcoholic beverages such as beer or red wine; or overripe fruits such as raisins, prunes, or bananas). MAOIs inhibit the breakdown of tyramine, causing elevated tyramine levels in the body that can lead to hypertensive crisis. **Hypertensive crisis** is a medical emergency defined as severe hypertension (blood pressure over 180/120 mm Hg) with acute end-organ damage such as stroke, myocardial infarction, or acute kidney damage. Symptoms may include a severe headache accompanied with confusion and blurred vision. Tachycardia or bradycardia may be present and associated with constricting chest pain. Other symptoms include neck stiffness or soreness, nausea or vomiting, sweating, dilated pupils, photophobia, shortness of breath, severe anxiety, and unresponsiveness. Seizures may occur, as well as intracranial bleeding in association with the increased blood pressure. Hypertensive crisis treatment involves discontinuation of the offending agent, administration of

10. Spadaro, A., Scott, K. R., Koyfman, A., & Long, B. (2022). High risk and low prevalence diseases: Serotonin syndrome. *The American Journal of Emergency Medicine, 61*, 90-97. doi: 10.1016/j.ajem.2022.08.030.

appropriate intravenous antihypertensive medications such as phentolamine or labetalol, and supportive care.. In severe cases, treatment in the intensive care unit may be required.[11,12]

Client Education

Clients should be instructed it may take 4 to 6 weeks for antidepressants to achieve their full effectiveness. They should not suddenly stop taking antidepressants or they may experience withdrawal symptoms. When it is time to stop the medication, the provider will slowly and safely decrease the dose. If clients stop taking the medication before the provider advises, the depression may return. They may not feel better with the first antidepressant they try, and they may need to try several different classes of medications to find one that works best for them. Education related to potential side effects and when to contact the provider, clinical worsening, avoiding alcohol, interference with cognitive or motor functioning, and potential drug interactions should also be provided.

Nurses also teach clients about coping strategies to reduce symptoms of depression. For example, regular exercise helps create positive feelings and improves mood. Getting enough quality sleep on a regular basis, eating a healthy diet, and avoiding alcohol (a depressant) can also reduce symptoms

11. U.S. National Library of Medicine. (2024). *Hypertensive crisis*. MedlinePlus. https://medlineplus.gov/

12. Sheps, S. G. (2021). *Hypertensive crisis: What are the symptoms?* Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/hypertensive-crisis/faq-20058491#:~:text=A%20hypertensive%20crisis%20is%20a,higher%20%E2%80%94%20can%20damage%20blood%20vessels.

of depression.[13] Read more about coping strategies in the "Stress, Coping, and Crisis Intervention" chapter.

Psychotherapy

Psychotherapy may be used alone for treatment of mild depression or in combination with antidepressant medications for moderate to severe depression. Psychotherapy may involve only the individual, but it can include others such as family members or couples therapy to help address issues within these close relationships. Depending on the severity of the depression, significant improvement can be made in 10 to 15 sessions. **Group therapy** brings people with similar disorders together in a supportive environment to learn how others cope in similar situations.[14]

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a form of psychotherapy that is effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital conflict, eating disorders, and severe mental illness. CBT helps a person to recognize distorted/negative thinking with the goal of changing thoughts and behaviors to respond to changes in a more positive manner.[15] Numerous research studies suggest that CBT leads to significant improvement in functioning and quality of life. Studies show that

13. American Psychiatric Association. (2020). *What is depression?* https://www.psychiatry.org/patients-families/depression/what-is-depression
14. American Psychiatric Association. (2020). *What is depression?* https://www.psychiatry.org/patients-families/depression/what-is-depression
15. American Psychiatric Association. (2020). *What is depression?* https://www.psychiatry.org/patients-families/depression/what-is-depression

CBT has been demonstrated to be as effective as, or more effective than, other forms of psychological therapy or psychiatric medications.[16]

CBT is based on these core principles[17]:

- Psychological problems are based, in part, on faulty or unhelpful ways of thinking.
- Psychological problems are based, in part, on learned patterns of unhelpful behavior.
- People suffering from psychological problems can learn better ways of coping with them, thereby relieving their symptoms and increasing quality of life.

CBT treatment involves efforts to change thinking patterns. These strategies might include the following[18]:

- Learning to recognize one's distortions in thinking that are creating problems, and then reevaluating them in light of reality.
- Gaining a better understanding of the behavior and motivation of others.

16. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. (2017). *What is cognitive behavioral treatment?* American Psychological Association. https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

17. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. (2017). *What is cognitive behavioral treatment?* American Psychological Association. https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

18. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. (2017). *What is cognitive behavioral treatment?* American Psychological Association. https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

- Using problem-solving skills to cope with difficult situations.
- Learning to develop a greater sense of confidence in one's own abilities.

CBT treatment also usually involves efforts to change behavioral patterns. These strategies might include facing one's fears instead of avoiding them, using role-playing to prepare for potentially problematic interactions with others, and learning to calm one's mind and relax one's body.[19]

CBT aims to help clients develop skills to manage their feelings in healthy ways. Through in-session exercises and "homework" between sessions, clients develop coping skills, whereby they learn ways to change their own thinking and behavior, ultimately changing how they feel. CBT therapists focus on current situations, thought patterns, and behaviors rather than past events. A certain amount of information about one's history is needed, but the focus is primarily on developing more effective ways of coping with life moving forward.[20]

DIALECTICAL BEHAVIOR THERAPY

Dialectical behavior therapy (DBT) is a type of cognitive behavioral therapy that provides clients with new skills to manage painful emotions and decrease conflict in relationships. It has been used successfully to treat people experiencing depression, bulimia, binge-eating, bipolar disorder, post-

19. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. (2017). *What is cognitive behavioral treatment?* American Psychological Association. https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

20. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. (2017). *What is cognitive behavioral treatment?* American Psychological Association. https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

traumatic stress disorder, borderline personality disorder, and substance abuse. DBT focuses on providing therapeutic skills in four key areas[21]:

- Mindfulness focuses on improving an individual's ability to accept and be present in the current moment.
- Distress tolerance is geared toward increasing a person's tolerance of negative emotion, rather than trying to escape from it.
- Emotion regulation strategies are used to manage and change intense emotions that are causing problems in a person's life.
- Interpersonal effectiveness techniques allow a person to communicate with others in a way that is assertive, maintains self-respect, and strengthens relationships.

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is a medical treatment reserved for clients with severe major depression who have not responded to medications, psychotherapy, or other treatments. It involves a brief electrical stimulation of the brain while the client is under anesthesia. A client typically receives ECT two to three times a week for a total of 6 to 12 treatments. It is usually managed by a team of trained medical professionals, including a psychiatrist, an anesthesiologist, and a nurse.[22] See Figure 7.8[23] for an image showing ECT electrode placement.

21. Psychology Today. (n.d.). *Dialectical behavior therapy.* https://www.psychologytoday.com/us/therapy-types/dialectical-behavior-therapy

22. American Psychiatric Association. (2020). *What is depression?* https://www.psychiatry.org/patients-families/depression/what-is-depression

23. "Electroconvulsive_Therapy.png" by BruceBlaus is licensed under CC BY-SA 4.0

Figure 7.8 Electroconvulsive Therapy

Nursing considerations regarding ECT include the following:

- Pre-procedure education
- Securement of informed consent
- Pre-procedure preparation
- Screening tools used pre- and post-ECT to evaluate side effects, including memory loss
- Medication administration
- Post-ECT care, such as monitoring vital signs and for changes in airway, breathing, and circulation, and implementing fall risk precautions post-anesthesia

A client must provide written informed consent before ECT is administered. In situations where a client is too ill to make decisions for themselves, the consent process is governed by state law (for example, a court-appointed guardian).[24]

Clients and their families should discuss all options for treatment with the psychiatrist before making a specific treatment decision. They should be provided with sufficient information to fully understand the procedure and

24. American Psychiatric Association. (2019). *What is electroconvulsive therapy (ECT)?* https://www.psychiatry.org/patients-families/ect

the potential benefits, risks, and side effects of each treatment option before providing written consent.[25]

General anesthesia is provided during ECT, so presurgical preparation is provided with typical dietary restrictions before the procedure. Typically, this means no food or water after midnight and only a sip of water with morning medications. An intravenous line is inserted, and electrode pads are placed on the head.

A client typically receives ECT two or three times a week for a total of 6 to 12 treatments, depending on the severity of symptoms and the response to treatment. At the time of each treatment, a client is given general anesthesia and a muscle relaxant, and electrodes are attached to the scalp at precise locations. The client's brain is stimulated with a brief controlled series of electrical pulses. This causes a seizure within the brain that lasts for approximately one minute. The patient is asleep for the procedure and awakens after 5-10 minutes, much as from minor surgery.[26]

ECT treatment has been associated with some risks such as short-term memory loss and difficulty learning. Some people have trouble remembering events that occurred in the weeks before the treatment or earlier. In most cases, memory problems improve within a couple of months. Some clients may experience longer-lasting problems, including permanent gaps in memory.[27]

25. American Psychiatric Association. (2019). *What is electroconvulsive therapy (ECT)?* https://www.psychiatry.org/patients-families/ect

26. American Psychiatric Association. (2019). *What is electroconvulsive therapy (ECT)?* https://www.psychiatry.org/patients-families/ect

27. American Psychiatric Association. (2019). *What is electroconvulsive therapy (ECT)?* https://www.psychiatry.org/patients-families/ect

View the following YouTube video of ECT therapy[28]

Transcranial Magnetic Stimulation

Transcranial Magnetic Stimulation (TMS) is a noninvasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression. TMS is typically used when other depression treatments haven't been effective. It uses a magnet to activate the brain. Unlike electroconvulsive therapy (ECT), in which electrical stimulation is more generalized, TMS can be targeted to a specific site in the brain. A typical TMS session lasts 30 to 60 minutes and does not require anesthesia. During the procedure, an electromagnetic coil is held against the forehead near an area of the brain that is thought to be involved in mood regulation. Short electromagnetic pulses are administered through the coil. The magnetic pulses easily pass through the skull and cause small electrical currents that stimulate nerve cells in the targeted brain region. The magnetic field is about the same strength as that of a magnetic resonance imaging (MRI) scan. The person generally feels a slight knocking or tapping on the head as the pulses are administered. The muscles of the scalp, jaw, or face may contract or tingle during the procedure, and mild headaches or brief light-headedness may result after the procedure. It is also possible that the procedure could cause a seizure, although this adverse effect is uncommon. Because the treatment is relatively new, long-term side effects are unknown.[29]

28. Michigan Medicine. (2022). *ECT: Disrupting the Stigma Around an Essential Treatment Option* [Video]. YouTube. https://youtu.be/qk_FjhitKDI?si=hwi32ffhJGvOGM-a

29. National Institute of Mental Health. (2016). Brain stimulation therapies. U.S.

Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies

7.5 Applying the Nursing Process to Depressive Disorders

The following subsections will describe how a nurse applies the nursing process and the National Council of State Board of Nursing Clinical Judgment Measurement Model (NCJMM) to caring for clients with depression. The stages of the NCJMM are listed in parentheses next to each stage of the nursing process.

Assessment (Recognize Cues)

The initial assessment should determine if clinical depression exists, consider other conditions that might account for the client's symptoms, and assess for risk of harm to self or others.[1] Assessing a client with a depressive disorder focuses on both verbal and nonverbal assessments. As the nurse conducts follow-up assessments, findings are compared to baseline admission assessments. Assessment includes several components, such as a mental status examination, psychosocial assessment, cultural assessment, spiritual assessment, screening with validated tools, and review of laboratory testing results while also considering lifespan considerations.

The role of the nurse in caring for clients with depression is related to primary nursing care, as well as collaboration with interprofessional team members. As a team member, the nurse may collaborate with psychiatrists, psychologists, licensed social workers, and other health care providers. The scope and practice of each team member is clearly defined within their professional licensure.

1. Gaynes, B.N. (2024). Depression in adults: Clinical features and diagnosis. *UpToDate*. https://www.uptodate.com/

Mental Status Examination

A psychiatric interview aims to collect information from the client as well as create a therapeutic relationship between the nurse and the client. The registered nurse uses specific questions during the client's admission process based on agency policy. See Table 7.5a for common findings when assessing a client with a depressive disorder. See expected findings for these components of a mental status examination in the "Assessment" section in Chapter 4. Critical findings that require immediate notification of the provider are bolded with an asterisk.

Table 7.5a Common Findings During A Mental Status Examination Of A Client With A Depressive Disorder

Mental Status Examination Component	Common Findings in Depressive Disorders (*Indicates immediately notify provider)
Level of Consciousness and Orientation	• Disoriented/confused. The client may be very self-focused and may appear disoriented when others initiate conversation or talk about current events because they are unaware of what is occurring around them due to their depression.
Appearance and General Behavior	• Disheveled. The client's hair may not be combed, and they may be unwashed with poor dental care. They may be wearing dirty clothing with food stains and have body odor with little or no attention to self-care. • Sleep disturbances. The client may exhibit too much sleep (i.e., 14-18 hours daily) or have insomnia (i.e., less than 4 hours of sleep or in intervals of sleep). • Psychomotor retardation. The client may have a slow response with walking, talking, and reacting; may tend to stay put on the couch or in bed. • Vegetative signs. The client may exhibit weight loss, insomnia, constipation, and self-care deficits. • Avolition (reduced motivation or goal-directed behavior). For example, the client states, "I just don't want to shower today." • Anergia (low energy). For example, the client states, "I have no energy; I cannot get out of bed." • Social isolation. • Aggressiveness and agitation. • ***Verbal and nonverbal threats of harm**. • ***Self-harming behaviors** such as cutting, picking at skin, knocking head against the wall, tightening string or items on wrists, or stabbing self with anything fashioned into a weapon. • ***"Cheeking pills"** (i.e., holding pills in mouth and not swallowing them). Clients may save medications for use in a later suicide attempt.)

Speech	• May speak slowly in a monotone. • May exhibit **latency** (i.e., a delayed response to a question or comment). However, be aware of the client's baseline because this may be their normal if they have a history of traumatic brain injuries, dementia, or are English language learners.
Motor Activity	• Psychomotor retardation. • Motor restlessness and anxiety. • Inactive or not initiating self-activity or care.

Mood and Affect	• **Apathy** (a lack of interest in events that one previously found enjoyable). For example, the client is no longer interested in participating in pleasurable activities. This may be verbalized or observed. • Anxious, irritable, angry, euphoric, tearful, or depressed. • **Labile mood** (rapid, exaggerated changes in mood). For example, a client is crying uncontrollably but when asked about the reason for crying, they state, "I don't know, I have no reason but can't stop crying." • **Dysphoria** (a state of unease or dissatisfaction). For example, the client states, "I don't like it here." • Sadness. • Crying episodes. • Flat or blunted affect. • Constricted/restricted affect. For example, a client usually laughs at jokes and giggles at funny comments but now does neither. • **Incongruency** (a lack of alignment between response and actions). For example, a client responds that they are fine, yet their body language is curled in a fetal position with no eye contact, and they are mumbling. • Mood is inappropriate for the current situation. • ***Hopelessness**. For example, a client may feel there is no longer any hope for them getting better or for life improving. • ***Worthlessness**. For example, a client may have feelings of guilt regarding themselves and their depression. They may feel like a burden to others and are unable to recognize their own value. • ***Helplessness**. For example, a client does not feel in control of life events. ***Note: Hopelessness, worthlessness, and helplessness are related to an increased risk of self-injury behavior and suicide and must be reported to provider. Do not leave clients alone if statements such as these are being made.**

Thought and Perception	• **Poverty of content** (responds without saying anything substantive or says much more than is necessary to convey a message). For example, if a client is asked, "How did you sleep last night?," the client answers with a long response about different brands of bedsheets without answering the question. • Decreased attention span. • Obsessions/preoccupations/ruminations. For example, a client may dwell on negative aspects of self-concept or faults and failures because they are unable to focus on anything else and thus repeat these thoughts often. • ***Suicidal ideation.** • ***Homicidal ideation.** • ***Violence ideation.** ***Note: Suicidal, homicidal, and violence ideations are characteristics of depression with recurring thoughts of death. These types of comments indicate increased risk for self-injury, suicide, or injury to others and must be reported to provider. Do not leave clients alone if statements such as these are being made.**
Attitude and Insight	• Unaware of the current situation. • Unable to relate to current trends or settings. • Lack of perception. • Low awareness outside of self. • Irritability.
Cognitive Abilities and Level of Judgment	• The inability to make decisions, think clearly, or solve problems is common in clients with depression.

Psychosocial Assessment

As previously discussed in the "Application of the Nursing Process in Mental

Health Care" chapter, a psychosocial assessment obtains additional subjective data that detects risks and identifies treatment opportunities and resources.[2,3]:

- Reason for seeking health care (i.e., "chief complaint")
- Thoughts of self-harm or suicide (both current and historical)
- Cultural assessment
- Spiritual assessment
- Family dynamics
- Current and past medical history
- Current medications
- History of previously diagnosed mental health disorders
- Previous hospitalizations
- Educational background
- Occupational background
- History of exposure to psychological trauma, violence, and domestic abuse
- Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
- Family history of mental illness
- Coping mechanisms
- Functional ability/Activities of daily living

After identifying the reason the client is seeking health care, additional focused questions are used to obtain detailed information used to plan care. The mnemonic PQRSTU can be used to ask questions in an organized

2. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. (2017). *What is cognitive behavioral treatment?* American Psychological Association. https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

3. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

fashion. See Table 7.5b for a sample PQRST assessment for depression and sample responses by a client.

Table 7.5b Sample PQRSTU Questions for Assessing Depression

PQRSTU	Sample Questions	Sample Client Response
Provocation/ Palliation	"What makes your low mood or sadness better or worse?"	"It gets worse when I'm alone or when I think about things I haven't done right. Sometimes walking outside or talking to a friend helps, but I rarely have the energy to try."
Quality	"Can you describe what your low mood or sadness feels like?"	"I feel numb, tired, and like I'm just going through the motions. Nothing feels enjoyable anymore."
Region	"Do you feel any physical symptoms associated with your low mood?"	"Sometimes it feels like a heavy weight on my chest and shoulders. I get a lot of body aches, especially in my back and shoulders. My legs feel tired and my head feels cloudy."
Severity	"On a scale of 0 to 10, how would you rate how bad your sadness or low mood feels right now?"	"It's about a 7 on most days. On bad days it's a 9 and I feel like I can't pull myself out of bed."
Timing/ Treatment	"When did this sadness or low mood start? How often do you feel this way? Does it come and go or stay constant?"	"It started about six months ago after I lost my job. I feel like this nearly every day. Mornings are the worst, but some days it never really lifts."
Understanding	"What do you think is causing your sadness or low mood? How do you make sense of these feelings?"	"I think it's because I lost my job and haven't felt useful since. I feel like a failure at everything I do."

SUICIDE AND SELF INJURY SCREENING

Clients being evaluated or treated for depression often have suicidal ideation. It is important for the nurse to introduce suicide screening in a way that helps the client understand its purpose and normalize questions that might otherwise seem intrusive. The Patient Safety Screener (PSS-3) is an example of a brief screening tool to detect suicide risk in all client presenting to acute care settings.[4]

Non-suicidal self-injury (NSSI) refers to intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting. It is considered a maladaptive coping strategy without the desire to die. NSSI is a common finding among adolescents and young adults in psychiatric inpatient settings.[5]

Review information about suicide screening, the Patient Safety Screener, and screening for non-suicidal self-injury (NSSI) in the "Assessment" section of the Applying the Nursing Process to Mental Health Care" chapter.

CULTURAL ASSESSMENT

Cultural Formulation Interview (CFI) questions help nurses understand a client's cultural background and how it influences their experience of mental health symptoms, including depression.[6] Sample CFI questions focused

4. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk*. https://sprc.org/micro-learning/patientsafetyscreener

5. Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, 8. https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full

6. DeSilva, R., Aggarwall, N. K., & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry.

specifically on understanding depression within a cultural context include the following:

- Cultural Definition of the Problem
  - “Can you describe what you’re experiencing emotionally? How would you name or label this problem?”
  - “What do people in your family or community call these kinds of feelings or mood?”
  - “How does your culture or family view feeling sad or losing interest in life?”
- Cultural Perceptions of Cause, Context, and Support
  - “What do you think caused your sadness or low mood?”
  - “Are there events in your life, such as stress or loss, that you think may have contributed to these feelings of sadness or low mood?”
  - “Do you have any cultural or spiritual beliefs that help explain what you’re going through?”
- Cultural Factors Affecting Coping and Help-Seeking
  - “What kinds of things have you done to cope with these feelings so far?”
  - “Are there any traditional remedies, rituals, or religious practices you use to feel better?”
  - “Have you tried to talk to anyone about these feelings, like family members, friends, religious leaders, or traditional healers?”
- Cultural Features of the Nurse–Client Relationship
  - ““Is there anything I should know about your background or beliefs that would help me better understand you?”
  - “Do you have any concerns or hesitations you have about seeing a mental health professional?”

Psychiatric Times, 32(6). https://www.psychiatrictimes.com/view/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry

- “What kind of help do you think would work best for you?”

Findings from the cultural formulation interview are used to individualize a client’s plan of care to their preferences, values, beliefs, and goals.

Reflective Questions

Reflect on how a client’s cultural values, beliefs, or preferences impact presenting symptoms, the nursing care plan, or treatment modalities. Consider the following components:

- Religious/Spiritual beliefs
- Language/Communication
- Nutritional preferences
- Fasting
- Potential drug-food interactions
- Rituals/Customs/Practices
- Gender dysphoria

SPIRITUAL ASSESSMENT

The FICA Spiritual History Tool is a widely used assessment model for evaluating a client’s spiritual beliefs and how they may influence health, illness, and coping. FICA© is a mnemonic for the domains of Faith, Importance, Community, and Address in Care.[7] The data obtained from a FICA assessment can be helpful in understanding how clients with depression draw on spirituality or religion for support—or how spiritual distress may be contributing to feelings of depression. Spiritual distress is very common for

7. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*. https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool

clients experiencing serious illness, injury, loss, or the dying process, and nurses assist clients to adopt healthy coping strategies to deal with these life events. Addressing a client's spirituality and advocating spiritual care have been shown to improve clients' health and quality of life.[8,9]

Table 7.5c summarizes a sample spiritual assessment questions and sample responses from a client experiencing depression.

Table 7.5c Sample FICA Spiritual Assessment Questions for Clients with Depression

8. Pilger, C., Molzahn, A. E., de Oliveira, M. P., & Kusumota, L. (2016). The relationship of the spiritual and religious dimensions with quality of life and health of patients with chronic kidney disease: An integrative literature review. *Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association, 43*(5), 411–426. https://pubmed.ncbi.nlm.nih.gov/30550069/

9. Puchalski, C., Jafari, N., Buller, H., Haythorn, T., Jacobs, C., & Ferrell, B. (2020). Interprofessional spiritual care education curriculum: A milestone toward the provision of spiritual care. *Journal of Palliative Medicine, 23*(6), 777–784. https://doi.org/10.1089/jpm.2019.0375

Domain	Sample Assessment Question	Sample Client Response
Faith	"Do you consider yourself spiritual or religious? What gives your life meaning?"	"I was raised in a religious family that went to church every Sunday, but lately I've felt disconnected. I used to find comfort in prayer, but now I don't even feel like trying."
Importance	"What importance does your faith or belief have in your life? Has it influenced how you cope with sadness or low mood?"	"My faith used to mean a lot to me, but lately it's been hard to feel hopeful that things will get better."
Community	"Are you part of a spiritual or religious community? Does participation in this community provide support when you're feeling sad or in a low mood?"	"I used to go to church regularly and event went to a prayer group, but I've stopped attending. I don't want people to see me like this."
Address in Care	"How would you like me (or the health care team) to address spiritual issues during your care? Would you like to speak with a chaplain?"	"I would talk with a chaplain if they will just listen and not impose their faith on me."

Feelings of guilt, abandonment, and spiritual distress are common in individuals experiencing depression and may compound their symptoms. Nurses may recognize cues of spiritual distress and offer to connect the client with a chaplain or spiritual care services. Spiritual goals may be included in the nursing care plan if the client finds them valuable.

FAMILY DYNAMICS

Family dynamics are included in a psychosocial assessment, especially for children, adolescents, and older adults. **Family dynamics** refers to the patterns of interactions among relatives, their roles and relationships, and the various factors that shape their interactions. Because family members rely on each other for emotional, physical, and economic support, they are primary sources of relationship security or stress. Family dynamics and the quality of family relationships can have either a positive or negative impact on an individual's health. For example, secure and supportive family relationships

can provide love, advice, and care, whereas stressful family relationships can be burdened with arguments, unhealthy relationships, and a lack of support.[10]

Unhealthy family dynamics can cause children to experience trauma and stress as they grow up. This type of exposure, known as adverse childhood experiences (ACEs), is linked to an increased risk of developing physical and mental health problems such as heart, lung, and liver disease, depression, and anxiety. Unhealthy family dynamics also correlate with an increased risk of substance use and addiction among adolescents.[11] Review information about adverse childhood experiences (ACEs) in the "Mental Health and Mental Illness" section of Chapter 1.

Screening Tools

Screening tools assess characteristics of specific mental health disorders. The screening tools listed below are examples of screenings, assessments, and question/answer prompts designed to address depressive disorders. These screening tools may be used on admission and at different times throughout the hospital or treatment stay. The findings may be used to compare and contrast client progress within the hospital stay, from a previous admission, or periodically on an outpatient basis. The registered nurse often conducts these tools as a collaborative member of the health care team.

Links to Common Screening Tools for Depressive Disorders

10. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK560487/

11. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK560487/

- **Columbia-Suicide Severity Rating Scale (C-SSRS) PDF:** A rating scale for suicidal ideation and behaviors that rates the degree of risk or intent of harm. It can be a self-assessment or administered by the health care professional.
- **Patient Health Questionnaire-9 (PHQ-9):** A quick screening tool with nine criteria for assessing a client's risk of depression.
- **Beck Depression Inventory (BDI):** A 21-item self-assessment questionnaire that determines the severity of depression from none to severe.
- **Hamilton Depression Scale (HDRS) PDF:** A 17-item questionnaire used to rate the severity of one's depression.
- **Geriatric Depression Scale (GDS) PDF:** A self-report of depressive symptoms for older adults; the new version is 15 questions.
- **Edinburgh Postnatal Depression Scale (EPDS):** A self-report of ten statements by mothers to screen for postpartum depression.

Laboratory Testing

There is no specific blood test to diagnose depression, but health care providers often order laboratory tests to rule out other conditions that can mimic depression symptoms, like anemia or thyroid disease. Testing may also be performed to assess overall health and kidney/liver function, especially if medication will be prescribed. Common laboratory tests for new onset depression include complete blood count, chemistry panels, kidney and liver function tests, Vitamin B12 levels, urinalysis, thyroid stimulating hormone,

rapid plasma reagin (RPR) for syphilis, human chorionic gonadotropin (HCG) for pregnancy, and toxicology screening for drug use.[12]

Life Span Considerations

Life span considerations influence how the client is assessed, as well as the selection of appropriate nursing interventions. Depressive disorders can be found across the life span from the very young to the very old. It is important to individualize all interventions to the age and developmental level of the client. Review developmental stages in the "Application of the Nursing Process in Mental Health Care" chapter.

CHILDREN AND ADOLESCENTS

Children may not verbalize sadness. Instead, depression often presents as irritability, frequent temper tantrums, somatic complaints (e.g., stomachaches, headaches), withdrawal from school, friends, or family, or behavioral changes like clinginess, acting out, or poor academic performance. It is important to ask children and adolescents who are withdrawn or sad about thoughts of suicide or self-harm. Adolescents may perceive a single disappointment (such as a relationship break-up) as so catastrophic they feel suicidal or begin to hurt themselves. Nurses can use play-based or art-based therapeutic techniques to facilitate a therapeutic nurse-client relationship. If a school-aged child or adolescent is suspected to have undiagnosed depression, a nurse or school counselor can refer them to a mental health professional to conduct a comprehensive assessment and plan effective treatments.

12. Chand, S. P., & Arif, H. (2023). *Depression*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK430847/

OLDER ADULTS

Depression in older adults may manifest differently as somatic symptoms (e.g., fatigue, pain, GI issues), anxiety, irritability, reduced verbal expression of sadness, or cognitive changes that may be mistaken for dementia. Furthermore, individuals with dementia are at higher risk for depression.

Depression Associated With Dementia

Dementia refers to a group of symptoms that lead to a progressive, irreversible decline in mental function severe enough to disrupt daily life caused by a group of conditions including Alzheimer's disease, vascular dementia, frontal-temporal dementia, and Lewy body disease. Alzheimer's disease is one of the most common forms of dementia. Alzheimer's disease causes impaired memory and the ability to learn, reason, make judgments, communicate, and carry out daily activities. An early symptom of Alzheimer's disease can be subtle memory loss and personality changes that differ from normal age-related memory problems. They seem to tire or become upset or anxious more easily. They do not cope well with change. For example, they can follow familiar routes, but traveling to a new place confuses them, and they can easily become lost. In the early stages of the illness, people with Alzheimer's disease are particularly susceptible to depression.[13]

While changes in the brain that cause dementia are permanent and worsen over time, thinking and memory problems can be

13. American Psychiatric Association. (2019). *What is Alzheimer's disease?* https://www.psychiatry.org/patients-families/alzheimers/what-is-alzheimers-disease

aggravated by untreated depression.[14] Nurses should report new symptoms of depression in clients who have been diagnosed with dementia.

- Read more about dementia at the Alzheimer's Association's webpage.

Reflective Questions

How does a nurse differentiate between symptoms that could indicate depression, delirium, dementia, or psychosis?

1. What are some common underlying medical conditions that could potentially mimic the symptoms of depression or mania in those who are elderly?
2. What other symptoms might a client who is a child/adolescent display that would indicate the need to assess for disorders other than depression?

Diagnosis (Analyze Cues)

Mental health disorders are diagnosed by health providers using the *DSM-5-TR*, similar to how medical conditions are diagnosed by trained medical professionals. Nurses create individualized nursing care plans based

14. Alzheimer's Association. (n.d.) *What is dementia?* https://www.alz.org/alzheimers-dementia/what-is-dementia

on the client's response to mental health disorders. See common nursing diagnoses related to mental health disorders in the "Diagnosis" section of the "Application of the Nursing Process in Mental Health Care" chapter.

Risk for suicide is always evaluated for clients with depressive disorders because suicidal ideation is a symptom of depression. Other common nursing diagnoses with sample expected outcomes for clients with depressive disorders are discussed in the following section in Table 7.5d.

Outcome Identification (Generate Solutions)

SMART outcomes are identified in relation to the established nursing diagnoses for each client. SMART is an acronym for Specific, Measurable, Attainable/Actionable, Relevant, and Timely. Read more about outcomes identification in the "Application of the Nursing Process in Mental Health Care" chapter. Table 7.5d provides common nursing diagnoses and sample expected outcomes for each nursing diagnosis.

Table 7.5d. Common Expected Outcomes for Nursing Diagnoses Related to Depressive Disorders[15]

15. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Nursing Diagnosis[16,17]	Sample Expected Outcomes
Risk for Suicide	The client will communicate feelings and thoughts of suicide to the health care team, prior to acting on thoughts, during their inpatient stay. ***Note: Clients with depression are at higher risk of suicide when experiencing sudden euphoric recovery from major depression**.[18]
Ineffective Coping/Readiness for Enhanced Coping	The client will identify effective coping strategies within 24 hours of admission. The client will engage in preferred stress management techniques by Day 3 of admission.
Self-Neglect	The client will increase participation in baseline personal care each day during their stay.
Fatigue/Sleep Deprivation	The client will, within one week, report feeling rested upon awakening.
Imbalanced Nutrition: Less than Body Requirements	The client will eat 50% or more of their meal tray at each meal.
Constipation	The client will have a soft, formed stool at least every three days during their inpatient stay.
Social Isolation	The client will communicate with others during their inpatient stay by participating in daily group offerings within the milieu.
Chronic Low Self-Esteem	The client will verbalize at least three personal strengths within three days of admission.
Hopelessness	The client will describe plans for a positive future by discharge.
Spiritual Distress	The client will identify a meaning and purpose in life within two weeks.
Readiness for Enhanced Knowledge	The client will verbalize three common side effects of their medications by the end of the shift.

16. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

Planning (Generate Solutions)

Safety

Safety receives top priority when planning and implementing interventions for clients with depression. Clients with depressive disorders are monitored closely for risk of suicide, and interventions are planned according to their level of risk. Review interventions for clients at risk of suicide in the "Application of the Nursing Process in Mental Health Care" chapter.

Phases of Treatment and Recovery

As discussed earlier in this chapter, a combination of pharmacological treatments and psychotherapies are often an effective approach to treating depressive disorders. There are three phases in treatment and recovery from major depression[19]:

- The active phase (6 to 12 weeks) is directed at reduction of depressive symptoms and restoration of psychosocial and work function. Hospitalization may be required, and medication and other biological treatments may be initiated.
- The continuation phase (4 to 9 months) is directed at prevention of relapse through pharmacotherapy, education, and depression-specific psychotherapy. This phase focuses on maintaining the client as a functional and contributing member of the community after recovery

17. Herdman, T. H., & Kamitsuru, S. (Eds.). (2018). *Nursing diagnoses: Definitions and classification, 2018-2020.* Thieme Publishers New York.

18. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

19. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

from the acute phase.
- The maintenance phase (1 year or more) is directed at preventing future episodes of depression. Medication may be phased out or continued.

Nurses target interventions based on the client's current phase of treatment and recovery, their current nursing diagnoses, and established expected outcomes.

Implementation (Take Action)

Nursing Interventions for Depression Based on Categories of the APNA Implementation Standard

Nursing interventions for clients with depressive disorders can be categorized based on the American Psychiatric Nurses Association (APNA) standard for *Implementation* that includes the *Coordination of Care; Health Teaching and Health Promotion; Pharmacological, Biological, and Integrative Therapies; Milieu Therapy;* and *Therapeutic Relationship and Counseling*. Read more about these subcategories in the "Application of the Nursing Process in Mental Health Care" chapter. See examples of interventions for each of these categories for clients with depressive disorders in Table 7.5e.

Table 7.5e Examples of Nursing Interventions for Clients with Depressive Disorders Based on Subcategories of APNA Implementation Standard

Subcategory of the APNA Standard of Implementation	The nurse will …	Rationale
Coordination of Care	– Collaborate with mental health professionals (e.g., therapists, psychiatrists) to ensure continuity of care. – Communicate client assessment data, such suicidal ideation or cheeking of medications, with interprofessional team members. – Facilitate referrals to community support resources such as support groups or home health. – Assist with care transitions (e.g., hospital discharge to long-term care or other community-based facilities).	Interdisciplinary collaboration ensures a comprehensive treatment plan and helps reduce relapse risk through continued support. All team members providing care must be aware of the client's suicide risk to maintain a safe environment.
Health Teaching and Health Promotion	-Educate the client and family members about depression, symptoms, and treatment options. – Promote lifestyle modifications such as regular sleep, exercise, and healthy nutrition. – Address stigma and normalize help-seeking.	Empowering clients with knowledge improves self-management and treatment adherence. Health promotion activities can help alleviate mild to moderate depression symptoms and reduce recurrence.

Pharmacological, Biological, and Integrative Therapies	-Administer prescribed antidepressants and monitor for side effects (e.g., GI distress, suicidality, serotonin syndrome). Open all medications in front of the client. – Provide health teaching on medication purpose, effects, adherence, and expected timeframes for improved symptoms. -Promote positive coping strategies such as journaling, meditation, and yoga. – Encourage adherence to treatment (therapy, medications).	Client understanding of their medications and potential side effects can increase medication compliance. Opening all medications in front of the client may decrease paranoia, if present. Nurses encourage resilience by adopting positive coping strategies.
Milieu Therapy	-Provide a structured, safe, and supportive environment. – Encourage participation in group therapy or therapeutic recreation. – Use daily routines and posted schedules to increase stability and reduce decision fatigue. -Perform and document intentional rounding every 15 to 60 minutes on a varied schedule.	A therapeutic milieu fosters a sense of safety, belonging, and predictability, which helps stabilize mood and reduce isolation. Visually rounding on every client in the milieu creates a strong safety plan for all clients and staff. Following a varied schedule prevents the client from anticipating when staff will check on them, which can reduce the ability to plan for suicide/risky behaviors.

Therapeutic Relationship and Counseling	– Use active listening, empathy, and validation to build trust and a supportive nurse-client relationship. – Explore cognitive distortions through supportive dialogue. – Facilitate goal-setting and positive affirmations. – Encourage verbalization of feelings, especially guilt, hopelessness, or suicidal thoughts. -Refer to spiritual supports such as chaplains, based on client preferences. -Review additional communication interventions in the "Communication Tips" subsection below.	Providing effective therapeutic techniques for clients with depression can promote hope and positive self-esteem.

Nursing Interventions for Physiological Signs of Depression

Nursing interventions are also planned that target common physiological signs of depression and associated self-care deficits. See common interventions for these conditions in Table 7.5f.

Table 7.5f Nursing Interventions Targeting Physiological Signs of Depression and Self-Care Deficit[20]

20. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Problem/Intervention	Rationale
Nutrition • **Offer small, high-calorie, and high-protein snacks and fluids frequently.** • **When possible, encourage family or friends to join the client during meals.** • **Encourage the client to participate in selecting food and drinks.** • **Teach about nutrient-dense foods that support mood (e.g., omega-3s, B vitamins).** • **Refer the client to a dietician if necessary.** • **Weight the client weekly and monitor trends.** • **Observe the client's eating patterns, maintain safety. (*In the hospital setting, client's that are suicidal are given their food on a tray with plastic silverware, food in Styrofoam containers, etc. to reduce the risk of injury to self/ others).*** 	Poor nutrition increases the risk for physical illness and improving nutrition can help stabilize energy and mood. Small, frequent snacks are more easily tolerated than large portions of food if the client has a loss of appetite. Fluids prevent dehydration and minimize constipation. Eating is a social event. Eating with loved ones reinforces the idea that someone cares about them and can serve as an incentive to eat. The client is more likely to eat foods they prefer. A dietician can help create an individualized diet plan. Monitoring the client's status provides data for evaluating effectiveness.

Sleep • **Assess sleep patterns and disturbances.** • **Encourage consistent sleep-wake cycles and limit daytime naps. Provide periods of rest after activities, if needed.** • **Encourage the client to get up and dress and stay out of bed during the day.** • **Encourage relaxation measures in the evening, such as a warm bath, warm milk, or soothing music.** • **Avoid caffeinated beverages.**	Sleep disruption is a hallmark of depression and worsens emotional regulation. Promoting good sleep hygiene helps restore circadian rhythm and reduce fatigue Minimizing sleep during the day and establishing routines increase the likelihood of restful sleep at night. Relaxation techniques induce sleep. Decreasing caffeine intake increases the possibility of sleep.
Elimination (Constipation) • **Monitor frequency of bowel movements.** • **Encourage fluids and foods high in fiber.** • **Provide periods of exercise.** • **Evaluate medications for side effects affecting elimination (e.g., TCAs, SSRIs).** • **Support toileting routines and privacy.** • **Evaluate the need for a bowel management program with stool softeners and laxatives.**	Many depressed clients are constipated, so frequency of bowel movements should be monitored. Fluids, fiber, and exercise stimulate peristalsis and soften stools. Bowel management programs may be needed to avoid constipation or fecal impaction. Addressing elimination improves physical comfort and self-esteem.

Fatigue/Energy Deficit • **Schedule activities during periods of higher energy (usually morning).** • **Promote light physical activity, such as walking or stretching.** • **Provide rest periods without encouraging excessive sleeping.** • **Use motivational interviewing to support gradual engagement according to the treatment plan.**	Depression often causes feelings of extreme fatigue. Light exercise improves endorphin levels and sleep quality. Motivational interviewing helps encourage clients to set personal goals and participate in the treatment plan.
Self-Care Deficits • **Assess ability to perform ADLs (e.g., bathing, grooming, dressing).** • **Offer verbal prompts, encouragement, and step-by-step support. When appropriate, give step-by-step reminders, such as "Wash the right side of your face and now your left."** • **Establish a simple daily hygiene routine.** • **Reinforce successes positively.**	Depression impairs motivation and concentration, leading to neglect of self-care. Slowed thinking and difficulty concentrating make organizing simple tasks difficult. Supporting ADLs restores self-worth and promotes dignity. Being clean and well-groomed can improve self-esteem.

Communication Tips for Clients with Depressive Disorders

Some clients with depression may be so withdrawn they are unwilling or unable to speak. Sitting with them in silence may feel like a waste of time, but nurses should be aware that providing therapeutic presence can be meaningful in supporting the client with depression. Helpful communication techniques for clients with depression and their rationale are described in the following box.

Communication Tips for Clients with Depressive Disorders[21]

- Use a calm, soft, and patient tone.
    - **Rationale:** Depressed individuals may feel overwhelmed or hopeless; a soft tone reduces pressure and invites connection.
- Allow extra time for responses.
    - **Rationale:** Psychomotor retardation (slowed thinking or movement) is common in depression. Waiting without rushing encourages the client to participate without feeling inadequate.
- Use simple, concrete words and allow the client time to respond.
    - **Rationale:** Depression can impair concentration and processing. Short, straightforward phrases are easier to understand and less cognitively demanding.
- Acknowledge and validate feelings.
    - **Rationale:** Statements like “It sounds like things have been really difficult for you” show empathy and help the client feel seen and understood,

21. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

rather than judged.

- Be alert for signs of suicidal ideation and ask directly.
    - **Rationale:** Use nonjudgmental phrasing like, “Sometimes people with depression have thoughts of not wanting to live. Have you felt that way?” Asking does not increase risk for suicide and opens a vital safety dialogue. People often experience relief and decreased feelings of isolation when they share thoughts of suicide.
- Avoid platitudes such as, “Just think positive,” “Everyone feels down once in a while,” or “Just snap out of it.”
    - **Rationale:** Platitudes invalidate the individual’s feelings and can increase feelings of guilt or worthlessness because they cannot “snap out of it.”
- Normalize their experience.
    - **Rationale:** Letting clients know that “many people with depression feel this way” helps reduce shame and stigma, and reassures them they are not alone.
- When a client is silent, use the technique of making observations, such as “There are new pictures on the wall,” or “You are wearing new shoes.”
    - **Rationale:** When an individual is not ready to talk, direct questions can raise their anxiety

levels. Respect the client's silence or limited responses. Pointing out objects in the environment can draw the person into reality. Being present without pressuring them to talk builds trust and shows unconditional support.

- Offer hope in small, realistic ways.
    - **Rationale:** Gently reinforce that treatment is available and recovery is possible, e.g., "There are things we can try that have helped others feel better."

Nurses counsel individuals with depression to help them explore positive coping strategies[22]:

- Encourage stress management techniques such as exercise, good sleep, and healthy food choices.
- Promote the formation of supportive relationships such as peer support and support groups to reduce social isolation and enable the individual to work on personal goals and relationship needs.
- Provide information about spiritual support as the individual defines it, such as chaplain or pastoral visits or spending time in nature; many people find strength and comfort in spiritual and/or religious activities.
- Help the client reconstruct a healthier and more hopeful attitude about the future (without providing false reassurance).

22. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Collaborative Mental Health Treatments

Nurses assist in implementing collaborative interventions based on the client's treatment plan. Review collaborative mental health treatments and common medications used to treat depression in the "Treatments for Depression" section of this chapter.

Client Education Regarding Antidepressant Medications

Nurses educate clients about their medications, including the manner in which they work, common side effects, and issues to report to their provider. Clients taking antidepressants should also be educated regarding the following considerations[23]:

- When taking antidepressants, it is important to follow the instructions on how much to take. Some people start to feel better a few days after starting the medication, but it can take four to eight weeks to feel the most benefit. Antidepressants work well and are safe for most people, but it is still important to talk with your mental health care provider if you have side effects such as sexual dysfunction, weight gain, dizziness, nausea, palpitations, drowsiness, insomnia, or anxiety. Side effects may go away as your body adjusts to the medication, but in some cases, switching to a different medication may be required.
- Don't stop taking an antidepressant without first talking to your health care provider. Stopping your medicine suddenly can cause symptoms or worsen depression.
- Antidepressants cannot solve all of your problems. Antidepressants work best when combined with psychotherapy and healthy coping strategies. If you notice that your mood is getting worse or if you have thoughts

23. Centers for Disease Control and Prevention. (2021). *Mental health conditions: Depression and anxiety.* https://www.cdc.gov/tobacco/campaign/tips/diseases/depression-anxiety.html

about hurting yourself, it is important to call your provider right away.
- Some people who are depressed may think about hurting themselves or committing suicide (taking their own life). If you are having thoughts about committing suicide, please seek immediate help by calling your provider, 911, or 1–800–273–TALK to reach a 24–hour crisis center that provides free, confidential help to people in crisis.
- Some antidepressants may cause risks to the baby during pregnancy. Talk with your provider if you are pregnant or might be pregnant or if you are planning to become pregnant.
- For individuals who are very depressed or suicidal, it is important to provide close monitoring when the individual first starts taking an antidepressant medication. Often an individual may have increased energy to make a suicidal attempt when they first begin a medication, whereas previously they may have had suicidal thoughts but lacked the energy to make an attempt.

Supporting Family Members

It is important to support the family members and significant others who are living with an individual with a depressive disorder. Read tips on living with someone with depression in Figure 7.9.[24]

24. "2_living_with_someone_with_depression.png" by unknown author for World Health Organization is in the Public Domain. Access for free at https://www.who.int/campaigns/world-mental-health-day/2021/campaign-materials.

Figure 7.9 Supporting Family Members and Significant Others

Evaluation (Evaluate Outcomes)

Evaluation of the client's progress towards meeting expected outcomes occurs continuously throughout the treatment phase. Evaluation includes comparing results from screening tools, reviewing laboratory results, and monitoring the effectiveness of prescribed medications, treatments, and nursing interventions. Based on the evaluation findings, the nursing care plan may be modified, or new interventions or outcomes may be added.

7.6 Spotlight Application

Postpartum Depression[1]

Maya is a healthy 32-year-old woman who has been married for over two years and is expecting her first child, a baby boy. She had a history of depression and generalized anxiety disorder.

She has been doing well with a combination of medication and cognitive behavioral therapy (CBT) for many years. Maya had decided in the months leading up to getting pregnant that she wanted to be off medication and worked with her psychiatrist to carefully accomplish this. She continued weekly therapy. She was mostly active, upbeat, and cheerful during her pregnancy. She gave birth to a healthy 7.3-pound baby boy. After the delivery, she started to feel sad, overwhelmed, and consistently tearful. She frequently felt irritable and on edge. This feeling persisted for the first ten weeks after the baby was born. She had limited support—her parents were divorced, and her mother was living in another state. Her in-laws were much older with numerous health complications and couldn't help regularly.

Maya and her husband went to see her psychiatrist. She was quite tearful and felt she was a "failure as a mom." Her baby cried incessantly, and she could barely get any sleep. Maya felt utterly incapable of soothing her baby and would get frustrated and tearful. She was so afraid of what she had learned about sudden infant death syndrome (SIDS) that she would barely allow herself to sleep. She felt that it was a constant race against the clock—with nursing, pumping, and changing. She was always cleaning bottles and diapers. She felt horrified with how she looked. She had expected to wear pre-pregnancy clothes immediately after childbirth. She hadn't had a meal in peace or gotten her hair or nails done and couldn't even think about having

1. American Psychiatric Association. (n.d.). *Patient story: Postpartum depression*. https://www.psychiatry.org/patients-families/postpartum-depression/patient-story

sex with her husband. He tried to be supportive, but also felt overwhelmed by it all. He felt she was inconsolable, and they both felt at a loss.

The psychiatrist talked about a variety of tools, including participating in cognitive behavioral therapy, incorporating 15-20 minutes of daily relaxation, practicing mindfulness skills, hiring help, getting her mom to stay with her for a few weeks, and seeking other support. Her husband understood the urgency of the situation and offered to take time off work and to do some of the overnight feedings. Maya decided to restart on her previous antidepressant and also joined a new moms' support group and continued CBT weekly therapy.

Over the next few months, she was exercising more and getting more sleep and support and had significant improvement in mood and energy. She received some sleep training tips from her pediatrician as well. Maya and her husband shared with her psychiatrist that they were feeling significantly better. They were excited to share that they found a series of self-help parenting books to be particularly helpful and had gotten some helpful tips from others in the moms' group.

"Wow, it really does take a village to raise a child, doesn't it?" Maya commented to her psychiatrist. They spoke about how in previous generations new couples could rely on extended family support and how that support often doesn't exist now. Also, inaccurate beliefs, such as babies are easy and infancy should be a happy time for parents, add to stress, conflict, and guilt. Being able to normalize the stress of adjusting to parenthood was extremely helpful for Maya and her husband.

Reflective Questions:

1. What educational tips and strategies may have been of benefit to Maya as part of her prenatal care?
2. How have cultural and societal norms impacted families in relation to child rearing?

3. What support strategies and education might be offered to birth partners to help them anticipate challenges and recognize early signs of post-partum depression?

7.7 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=313#h5p-17

1

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=313#h5p-18

2

An interactive H5P element has been excluded from this version of the text. You can view it

1. "MH Depression Glossary Cards" by OpenRN is licensed under CC BY-NC 4.0

2. "MH Depression Drag and Drop" by OpenRN is licensed under CC BY-NC 4.0

online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=313#h5p-19

3

Case Study

Kinsey Valdez, age 26 years, is brought into the urgent care clinic today by her roommate, Sara, who reports a recent change in Kinsey's behavior and difficulty concentrating. Kinsey states she let her roommate bring her to the outpatient clinic because she was not feeling well, and "I just do not know what's wrong." During the initial visit with Kinsey, the nurse notes that Kinsey turns away, does not make eye contact, and speaks quietly.

Sarah reports that Kinsey has had a lack of energy for several weeks. She says that Kinsey frequently talks about her life being "hopeless," doesn't get out of bed in the morning, and has no interest in sleeping or eating.

Sarah further explains that when Kinsey was 16, her best friend died in a car accident and she experienced severe depression at that time. She received family support but did not take any medication and was not involved in traditional counseling services. Additionally, Kinsey recently discovered that she is HIV

3. "MH Depression Select All" by OpenRN is licensed under CC BY-NC 4.0

positive and this occurred roughly on the anniversary of her best friend's passing.

Kinsey has been living with Sarah for 3 years in an apartment and they also work together as nurses on the night shift in the Med-Tele unit at a local hospital. Kinsey's closest family member, her younger brother, lives 3 hours away and they rarely speak. Kinsey admits that she has few friends and states, "I'm usually not much fun to hang out with, but I'm okay with that." She has also been picking up many extra shifts at work due to short staffing in recent weeks. Kinsey states, "I'm worried that this positive HIV test will cause me to no longer be able to work as a nurse."

Kinsey is instructed to go to the nearest Emergency Department (ED) for further assessment and follow-up. Sara takes her to the ED. The nurse from the urgent care clinic called the ED nurse with brief report. When Kinsey and Sarah arrive, they are placed in a private ED room immediately upon arrival.

Reflective Questions:

1. What CUES do you recognize as relevant in planning and providing care for Kinsey?
2. What is Kinsey's priority nursing problem?
3. What are your first steps in caring for Kinsey?

ASSESSMENT

The ED nurse performs an assessment and collects the following data.

Vital signs: BP 110/64, P 48, T 35.8, O2 sat 97% on room air, R 16

Pain (PQRST): Pain location: knees and ankles bilaterally. Provocation (P): "Always there, does feel a bit better after sleeping for a while." Quality (Q): "Achy." Radiation (R): None,

Severity (S): 3/10. Timing (T): Started about 3 weeks ago after falling on the ice at work when leaving after a night shift.

Focused Assessment Findings

Neuro: Reports a history of migraine headaches but has had none in recent years. Wears contacts most of the time, sometimes wears glasses. Denies dizziness, changes in vision, or any numbness in limbs.
Respiratory: Breathing is unlabored and regular, but occasionally shallow when resting.
Cardiac: Denies any complaints.
GI: Weight: 52.3 kg, a 3 kg decrease from previous visit to the hospital 1 year ago.
Eating 1 meal daily but only eats if roommate makes food and brings it to her in bed. "I'm just too tired to eat most of the time." Nibbles on snacks and drinks Gatorade and protein shakes at work. Last BM yesterday, pattern is regular. Denies nausea or vomiting.
GU: Denies any complaints.
Skin: Three small scratches are present on her left forearm that are evenly spaced and superficial. No redness, tenderness, or warmth noted. Face is pale. Small rash across chest that is non-raised, light pink, not warm or itching.

Psychosocial Assessment Findings
General appearance and behavior: Wearing pajamas, hair is in loose bun, no makeup. Apprehensive and detached, avoiding eye contact. Slouched in chair, with feet up in a modified fetal position. Cooperative, but passive.
Affect and mood: Sad facial expression, blunted affect, slow movements, and quiet monotone voice
Speech pattern: Slow, minimal speech. Quiet, logical sentences.
Thought content: Depressive thought content, without evidence

of delusions or hallucinations.
Cognition: Alert and oriented x 3. Has Bachelor's degree in Nursing and an RN license and is articulate and intelligent.
Judgment: No evidence of changes in judgment.

Labs Results

Results are unremarkable, negative for ETOH and cannabis. CD4 is 641 u/L

Additional Reflective Questions

4. What additional CUES are relevant for planning Kinsey's care based on the nurse assessment?
5. What is your hypothesis for Kinsey after analyzing the nursing assessment data?
6. Write a SMART goal for Kinsey's care based on priority nursing problem(s).
7. What priority nursing interventions are important to implement when caring for Kinsey?

- Test your clinical judgment related to the case study provided with a NCLEX Next Generation-style question: Chapter 7, Assignment 1[4]

4. "Depression Next Gen Question 1" by OpenRN is licensed under CC BY-NC 4.0

- Test your clinical judgment related to the case study provided with a NCLEX Next Generation-style case study: Chapter 7, Case Study 1[5]

5. "Depression Next Gen Case Study" by Kellea Ewen is licensed under CC BY-NC 4.0

VII Glossary

Cognitive behavioral therapy (CBT): A type of psychotherapy that helps a person recognize distorted/negative thinking with the goal of changing thought and behaviors to respond to changes in a more positive manner.

Depressive episode: An episode where the person experiences a depressed mood (feeling sad, irritable, empty) or a loss of pleasure or interest in activities for most of the day, nearly every day, for at least two weeks. Several other symptoms are also present, which may include poor concentration, feelings of excessive guilt or low self-worth, hopelessness about the future, thoughts about dying or suicide, disrupted sleep, changes in appetite or weight, and feeling especially tired or low in energy.

Depressive Disorder Due to Another Medical Condition: When a person experiences a persistent depressed mood or a significant loss of interest or pleasure in activities, and these symptoms are directly caused by a medical illness or condition.

Electroconvulsive therapy (ECT): A medical treatment reserved for clients with severe major depression who have not responded to medications, psychotherapy, or other treatments. It involves a brief electrical stimulation of the brain while the client is under anesthesia.

Group therapy: A type of psychotherapy that brings people with similar disorders together in a supportive environment to learn how others cope in similar situations.

Hypertensive crisis: An acute rise and significantly elevated blood pressure, typically over 180/120 mm Hg, that causes acute end-organ damage such as stroke, myocardial infarction, or acute kidney damage. It can be caused by MAOIs, a class of antidepressants.

Latency: A delayed response to a question or comment.

Light therapy: Therapy for seasonal affective disorder (SAD) that involves sitting in front of a light therapy box that emits a very bright light. It usually

requires 20 minutes or more per day, typically first thing in the morning during the winter months. Most people see some improvements from light therapy within one or two weeks of beginning treatment.

Major depressive episode: A period of at least two weeks during which a person experiences a persistently depressed mood or a loss of interest or pleasure in nearly all activities, most of the day, nearly every day.

Perinatal depression: Depressive disorder that occurs during pregnancy.

Peristent depressive disorder: A chronic form of depression that is typically less severe in intensity than Major Depressive Disorder but lasts much longer.

Postpartum depression: Feelings of extreme sadness, anxiety, and exhaustion that may make it difficult for mothers of newborns to complete daily care activities for themselves and/or for their babies. Severe postpartum depression can lead to postpartum psychosis.

Postpartum psychosis: Severe postpartum depression can cause delusions (thoughts or beliefs that are not true), hallucinations (seeing, hearing, or smelling things that are not there), mania (a high, elated mood that often seems out of touch with reality), paranoia, and confusion. Women who have postpartum psychosis are at risk for harming themselves or their child and should receive help as soon as possible by calling 911 or taking the mother to the emergency room.

Premenstrual Dysphoric Disorder (PMDD): A severe and disabling form of premenstrual syndrome (PMS) that involves significant mood disturbances and physical symptoms occurring in the week or two before menstruation.

Prolonged Grief Disorder: A disorder that is characterized by intense longing and preoccupation with the deceased person that persists beyond 12 months and causes significant impairment.

Rhabdomyolysis: Severe muscle breakdown which releases myoglobin into the bloodstream and subsequently clogging renal filtrations and causing kidney damage.

Seasonal affective disorder (SAD): A type of depression causing symptoms during the fall and winter months when there is less sunlight and usually improves with the arrival of spring. SAD is more than just "winter blues." The symptoms can be distressing and overwhelming and can interfere with daily functioning.

Serotonin syndrome: A medical emergency that can occur in clients taking medications that affect serotonin levels.

Substance/Medication-Induced Depressive Disorder: A type of depression that occurs as a direct result of using, misusing, or withdrawing from certain substances or medications.

Transcranial Magnetic Stimulation (TMS): A noninvasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression when other depression treatments haven't been effective.

PART VIII

CHAPTER 8 BIPOLAR DISORDERS

8.1 Introduction

Learning Objectives

- Identify assessment cues of bipolar disorders
- Identify nursing priorities for clients with bipolar disorders
- Plan outcomes for clients with bipolar disorders
- Describe safety/protective interventions for clients with bipolar disorders
- Apply evidence-based practice when planning care and interventions for clients with bipolar disorders
- Analyze treatments for clients with bipolar disorders
- Apply the nursing process to clients with bipolar disorders at risk for suicide

Bipolar disorder is a mental illness that causes dramatic shifts in a person's mood, energy, and ability to think clearly. Moods shift from abnormally elevated moods called manic episodes to abnormal low moods of depression. See Figure 8.1[1] for a depiction of the shifts in mood that occur with bipolar disorder. Severe bipolar episodes of mania can also include hallucinations or delusions, which can be confused with symptoms of schizophrenia.[2] This chapter will discuss the signs, symptoms, and treatments for bipolar disorder

1. "P_culture.svg" by משתמש:נעמה מ:he is licensed under CC BY-SA 3.0
2. National Alliance on Mental Illness. (2017). *Bipolar disorder.* https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Bipolar-Disorder

and explain how to apply the nursing process when caring for clients with bipolar disorder.

Figure 8.1 Bipolar Disorder

Manic Episodes

Bipolar disorders include shifts in mood from abnormal highs (called manic episodes) to abnormal lows (i.e., depressive episodes). A **manic episode** is a persistently elevated or irritable mood with abnormally increased energy lasting at least one week. The mood disturbance is severe and causes marked impairment in social or occupational function. Severe episodes often require hospitalization to prevent harm to self or others. As the manic episode intensifies, the individual may become psychotic with hallucinations, delusions, and disturbed thoughts. The episode is not caused by the physiological effects of a substance (such as drug abuse, prescribed medication, or other treatment) or by another medical condition.[1]

According to the *DSM-5-TR*, three or more of the following symptoms are present during a manic episode[2]:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (i.e., feels rested after only three hours of sleep)
- More talkative than usual or pressure to keep talking
- Flight of ideas or subjective experience that thoughts are racing
- Distractibility (i.e., attention is too easily drawn to unimportant or irrelevant stimuli)
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
- Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual

1. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
2. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

indiscretions, or foolish business investments)

People experiencing a manic episode may become physically exhausted.

Hypomanic episodes

Hypomanic episodes have similar symptoms to a manic episode but are less severe and do not cause significant impairment in social or occupational functioning or require hospitalization. A **hypomanic episode** is defined as a distinct period of abnormally and persistently elevated, expansive, or irritable mood, accompanied by increased activity or energy, lasting at least four consecutive days and present most of the day, nearly every day.[3]

During this period, three or more of the following symptoms (or four if the mood is only irritable) must be present to a significant degree, representing a noticeable change from the individual's typical behavior[4]:

- Inflated self-esteem or grandiosity, decreased need for sleep (e.g., feeling rested after only three hours)
- Being more talkative than usual or feeling pressure to keep talking
- Experiencing flight of ideas or racing thoughts, distractibility
- Increased goal-directed activity or psychomotor agitation
- Excessive involvement in activities with a high potential for painful consequences (such as reckless spending, risky sexual behavior, or unwise business investments).

The episode must be associated with a clear change in functioning that is uncharacteristic of the person when asymptomatic, and this change must be

3. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

4. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

observable by others. However, unlike manic episodes, hypomanic episodes are not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization. If psychotic features are present, the episode is considered manic by definition. The symptoms must not be attributable to the physiological effects of a substance or another medical condition.[5]

Depressive Episodes

A **depressive episode[/pb_glossary**] is characterized by a persistently low or sad mood and a significant loss of interest or pleasure in most activities. These symptoms must last for at least two weeks and represent a noticeable change from the individual's typical functioning. Depressive episodes in bipolar disorder are severe and debilitating, often causing marked impairment in social, academic, or occupational performance. Depressive episodes associated with bipolar disorder can lead to suicide. The mortality ratio due to suicide for people with bipolar disorder is 20 times above the general population rate and exceeds rates for other mental health disorders.[footnote]Baldessarini, R.J., Vázquez, G.H. & Tondo, L. (2020, January 6). Bipolar depression: A major unsolved challenge. *International Journal of Bipolar Disorders 8*, (1). https://doi.org/10.1186/s40345-019-0160-1[/footnote]

Like manic episodes, depressive episodes are not attributable to the physiological effects of a substance or another medical condition.

According to the DSM-5-TR, five (or more) of the following symptoms must be present during the same two-week period, with at least one of the symptoms being either (1) depressed mood or (2) loss of interest or pleasure.[footnote]American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.[/footnote]:

5. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

- Depressed mood most of the day, nearly every day (e.g., feels sad, empty, hopeless, or appears tearful)
- Markedly diminished interest or pleasure in all, or almost all, activities
- Significant weight loss when not dieting, weight gain, or a decrease or increase in appetite
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation observable by others
- Fatigue or loss of energy
- Feelings of worthlessness or excessive, inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, suicidal ideation, or suicide attempt

Unlike the increased energy and impulsive behaviors of a manic episode, depressive episodes are characterized by slowed thinking, physical fatigue, and feelings of hopelessness. Individuals may withdraw from others and experience difficulty performing basic daily tasks. In some cases, symptoms become so intense that individuals may experience delusions or hallucinations with depressive content (e.g., believing they are responsible for catastrophic events or hearing voices that reinforce feelings of worthlessness).

Bipolar Disorders

There are three major types of bipolar and related disorders called Bipolar I, Bipolar II, and Cyclothymia. See Figure 8.2[footnote]"Bipolar_mood_shifts.png" by Osmosis is licensed under CC BY-SA 4.0[/footnote] for an illustration comparing these three types of bipolar disorders.

[caption id="attachment_1467" align="aligncenter" width="457"]

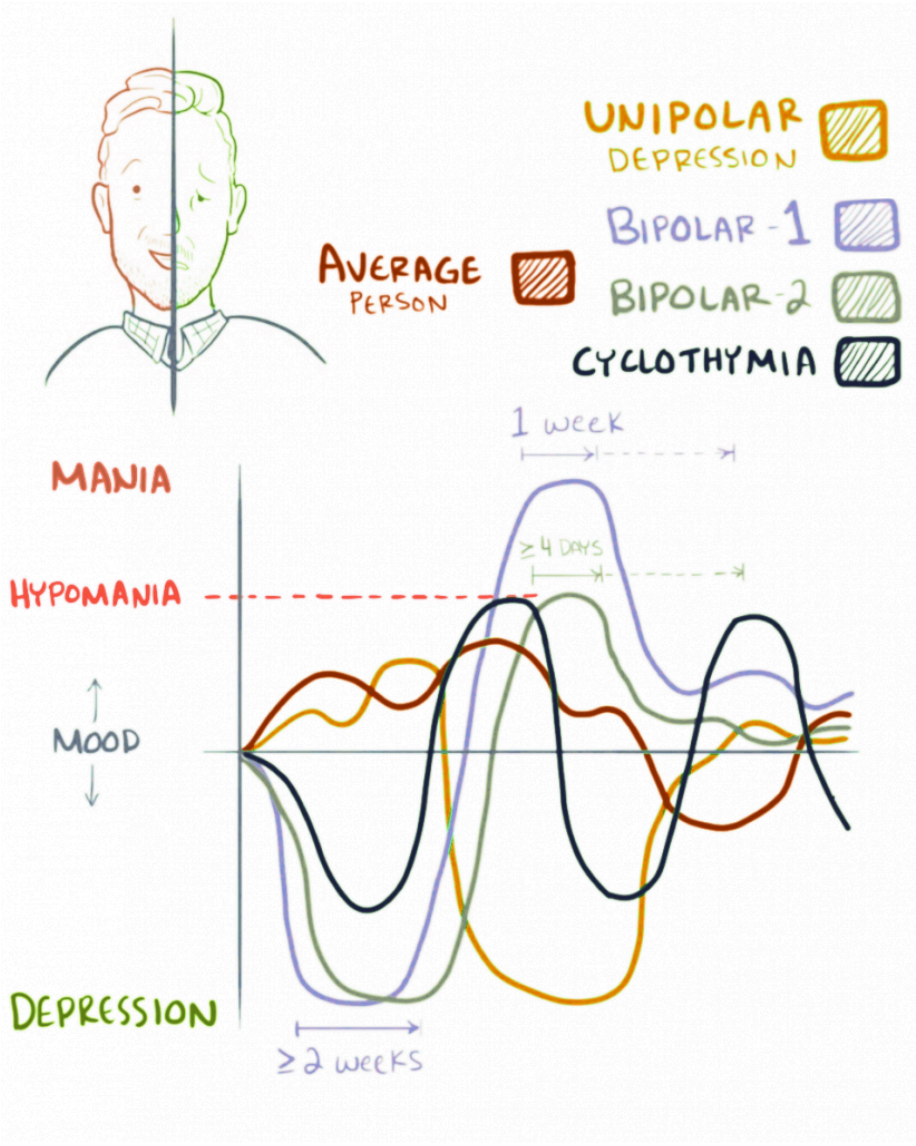


Figure 8.3 Bipolar Disorders[/caption]

[pb_glossary id="363"]Bipolar I Disorder is the most severe bipolar disorder. Individuals with Bipolar 1 Disorder have had at least one manic episode and often experience additional hypomanic and depressive episodes. (Read about the symptoms of depressive episodes in the "Depressive Disorders" chapter of this book.) One manic episode in the course of an individual's life can change an individual's diagnosis from depression to bipolar disorder. Manic episodes last at least one week and are present for most of the day, nearly every day. They can be so severe that the person requires hospitalization. Depressive episodes typically last at least two weeks. Episodes of depression with mixed

features (having depressive symptoms and manic symptoms at the same time) are also possible.[6,7]

Bipolar II Disorder is defined by a pattern of depressive episodes and hypomanic episodes. The hypomania episodes last at least 4 consecutive days and present most of the day, nearly every day, but individuals do not experience the full-blown manic episodes typical of Bipolar I disorder. Individuals with Bipolar II Disorder often have higher productivity when they are hypomanic and may exhibit increased irritability.[8,9]

Cyclothymia is defined by periods of hypomanic symptoms and depressive symptoms lasting for at least two years (1 year in children and adolescents). However, the symptoms do not meet the diagnostic requirements for hypomanic episodes or depressive episodes.[10,11]

Some people with Bipolar I or Bipolar II disorders experience rapid cycling with at least four mood episodes in a 12-month period. These mood episodes

6. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder
7. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
8. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder
9. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
10. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder
11. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

can be manic episodes, hypomanic episodes, or major depressive episodes. Cycling can also occur within a month or even a 24-hour period. **Rapid cycling** is associated with severe symptoms and impaired functioning and is more difficult to treat.[12]

Coexisting Disorders

It is common for people with bipolar disorder to also have anxiety disorders, attention deficit hyperactivity disorder, or substance use disorders[13]. Sometimes, a person with severe episodes of mania or depression may experience psychotic symptoms, such as hallucinations or delusions, resulting in an incorrect diagnosis of schizophrenia. People with bipolar disorder may misuse alcohol or drugs and engage in other high-risk behaviors in times of impaired judgment during manic episodes. In some cases, people with bipolar disorder also have an eating disorder, such as binge eating or bulimia.[14]

Physiological causes can also cause mania-like symptoms. For example, hyperthyroidism can cause difficulty sleeping, irritability, anxiety, and unintentional weight loss. Individuals can also experience substance-induced bipolar symptoms that develop during intoxication by a substance or withdrawal from a substance. For example, alcohol, sedatives, cocaine, methamphetamines, and phencyclidine (PCP) can cause bipolar-like

12. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

13. Hunt, G.E., Malhi, G.S., Cleary, M., Lai, H.M., & Sitharthan, T. (2016). Prevalence of comorbid bipolar and substance use disorders in clinical settings, 1990-2015: Systematic review and meta-analysis, *Journal of Affective Disorders, 206,* 331-349. doi 10.1016/j.jad.2016.07.011

14. National Institute of Mental Health. (2023). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder

symptoms.[15] For these reasons, on initial evaluation of a client experiencing a manic episode, screening is often typically performed for thyroid disorders and substance use.

Causes of Bipolar Disorder

Researchers continue to study the possible causes of bipolar disorder. Similar to depressive disorders, most experts agree there is no single cause, and there are many factors that contribute to bipolar disorder. Research shows that people who have a parent or sibling with bipolar disorder have genetic predisposition toward having the disorder. Some studies indicate that neurobiological factors may also predispose individuals to bipolar disorder. The brains of people with bipolar disorder may differ from the brains of people who do not have bipolar disorder. People with certain genes are more likely to develop bipolar disorder. Newer research indicates altered intracellular calcium signaling occurs in people with bipolar disorders, and antiseizure medications can provide effective treatment.[16,17]

Environmental factors may also causative role in the development of bipolar disorders. Stress is a common trigger for mania and depression in adults, and previous adverse childhood events (ACEs) are significantly associated with bipolar disorder.[18] For example, a person with an unstable, chaotic childhood may experience bipolar disorder later in adulthood that is triggered by

15. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

16. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder

17. The Emerging Neurobiology of Bipolar Disorder by Harrison, Geddes, & Tunbridge is licensed under CC BY 4.0

18. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

extreme stress. Read more about ACEs in the "Mental Health and Mental Illness" section in Chapter 1.

- Read more on the National Institute of Mental Health's Bipolar Disorder webpage.

8.3 Treatments for Bipolar Disorders

Bipolar disorder is often a lifelong illness, and episodes of mania and depression typically recur. Between episodes, many people with bipolar disorder are free of mood disruption, but some people have lingering symptoms. Long-term, continuous treatment can help people manage symptoms and prevent relapse. An effective treatment plan for bipolar disorder typically includes a combination of pharmacologic, psychotherapy, lifestyle changes, and other medical treatments.[1]

Pharmacologic Treatments

Pharmacologic treatments for bipolar disorder include mood stabilizers, anti-seizure medications, and second-generation ("atypical") antipsychotics. Treatment plans may also include medications that target sleep disruption or anxiety. Antidepressant medication may be used to treat depressive episodes in bipolar disorder in combination with a mood stabilizer and/or an antipsychotic to prevent precipitating a manic episode.[2] See Table 8.3 for a list of common medications used to treat bipolar disorders.[3] Review information about the associated neurotransmitters in the "Psychotropic Medications" chapter.

Table 8.3 Common Medications Used to Treat Bipolar Disorders

1. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder
2. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder
3. Post, R. M. (2022). Bipolar treatment in adults: Choosing maintenance treatment. *UpToDate*. https://www.uptodate.com/

Medication Class	Nursing Considerations	Common Side Effects (*Indicates medical emergency)
Mood Stabilizers	**Used to treat symptoms of mania and mood lability.**	
Lithium	Used as a first-line mood stabilizing agent to treat mania when symptoms are acute or as maintenance therapy Improved tolerance with food and better drug absorption Recommended water intake is 1.5 – 3 liters/day Given in divided doses if gastrointestinal distress occurs NSAIDs are not recommended because they increase lithium levels Therapeutic blood levels are required. Blood levels are drawn 10-12 hours after the last dose taken. The therapeutic lithium serum level is 0.6-1.2 mEq/L	Lithium blocks antidiuretic hormone (ADH), so monitor for symptoms of diabetes insipidus (i.e., excessive thirst and urination) Long-term use increases risk for hypothyroidism, hyperparathyroidism, and impaired kidney functioning ***Lithium toxicity** (notify the health care provider) Early signs (<1.5 mEq/L): nausea, vomiting, diarrhea, thirst, polyuria, slurred speech, muscle weakness, or fine tremors Moderate signs (1.6-1.9 mEq/L): coarse hand tremors, mental confusion, persistent GI complaints, muscle hyperirritability, EEG changes, or uncoordinated movements Severe signs (>2.0 mEq/L): ataxia, blurred vision, large output of dilute urine, severe hypotension, clonic movements, overt confusion, cardiac dysrhythmias, proteinuria, or death secondary to pulmonary complications ***Lithium levels > 2.5 mEq/L constitute a medical emergency, even if the client is asymptomatic.**

Anti-seizure Medications	Used to treat mania and other symptoms.	
Valproic Acid (Depakote)	Used for rapid cycling in acute manic phase when not responding to other mood stabilizers Requires periodic therapeutic serum valproic acid blood levels. Therapeutic range is 50-125 mcg/mL Requires laboratory monitoring, including liver function tests, amylase, and lipase and platelet levels due to higher risk for blood dyscrasias and pancreatitis	• Weight gain • Sedation • Nausea and/or vomiting • Hair loss • Tremors • Gastrointestinal discomfort ***Signs of toxicity** (notify the health care provider): • **Abdominal pain** • **Dark colored urine** • **Jaundice**
Carbamazepine (Tegretol)	Used in combination with lithium and antipsychotic drugs for resistive symptoms Used when treatment resistant due to rapid cycling, paranoia, and extreme hyperactivity Requires routine laboratory monitoring, including white blood cells and liver function tests because it can cause bone marrow suppression and liver damage Therapeutic serum blood levels are 4-12 mcg/mL	• Hyponatremia • Fatigue • Blurred vision • Nausea • Ataxia Risk for toxicity if tegretol blood level is >20 mcg/mL. If suspect toxicity, hold the drug and notify the health care provider.

Lamotrigine (Lamictal)	Used with acute mania or as maintenance therapy Therapeutic serum blood level is 2.5 to 15 mcg/mL Improved tolerance in divided doses	• Stevens-Johnson syndrome (A rare but potentially life-threatening reaction to medication that starts with flu-like symptoms, followed by a painful rash that spreads and blisters.) • Other common side effects: nausea/vomiting, headache, dizziness, photosensitivity, rash
Topiramate (Topamax) **Oxcarbazepine (Oxtellar)**	Used for treatment resistant mania	Topiramate • Weight loss • Fatigue • Visual disturbances Oxcarbazepine • Hyponatremia
Antipsychotics Medications	**Used to treat symptoms of psychosis, agitation, insomnia, or anxiety.**	

Olanzapine (Zyprexa) Risperidone (Risperdal) Quetiapine (Seroquel) Ziprasidone (Geodon) Aripiprazole (Abilify) Clozapine (Clozaril)	Help stabilize mood and slow down hyperactive motor activity Several drugs come in oral, parental, liquid, oral disintegrating tablets, and long-acting injections	Review common adverse effects in the "Schizophrenia" section of the "Psychosis and Schizophrenia" chapter.
Antianxiety Medications	**Used to treat symptoms of anxiety and irritability.**	
Benzodiazepines Lorazepam (Ativan) Alprazolam (Xanax) **Other** Gabapentin (Neurontin) Buspirone (Buspar)	Help reduce the level of hyperactivity during an acute manic phase as a supplement with mood stabilizing drugs Avoid benzodiazepines in clients with substance use disorders due to high risk of addiction	Review common adverse effects in the "Treatments for Anxiety" section of the "Anxiety Disorders" chapter.
Antidepressants Medications	**Used to treat symptoms of depressive episodes.**	

Medication Classes: SSRIs SNRIs TCAs MAOIs	Can precipitate a manic episode if not used in combination with a mood stabilizer and/or antipsychotic.	Review common adverse effects in the "Treatments for Depression" section of the "Depressive Disorders" chapter.

Lithium

When administered to a client experiencing a manic episode, lithium may reduce symptoms within 1 to 3 weeks. It also possesses unique antisuicidal properties that sets it apart from antidepressants.[4,5] Lithium levels must be monitored closely during treatment to ensure clients remain within therapeutic and safe parameters.

BLACK BOX WARNING

A Black Box Warning for lithium states that lithium toxicity is closely related to serum lithium levels and can occur at doses close to therapeutic levels. Before initiating therapy, ensure that lithium levels will be able to be measured promptly and accurately.[6]

4. National Institutes of Health. (2024). *Antisuicidal properties*. DailyMed. https://www.nlm.nih.gov/

5. Malhi, G. S., Tanious, M., Das, P., Coulston, C. M., & Berk, M. (2013). Potential mechanisms of action of lithium in bipolar disorder. Current understanding. *CNS Drugs, 27*(2), 135–153. https://doi.org/10.1007/s40263-013-0039-0

6. National Institutes of Health. (2024). *Lithium*. DailyMed. https://www.nlm.nih.gov/

ADVERSE/SIDE EFFECTS

Lithium must be closely monitored with routine blood work because it has a narrow therapeutic range of 0.8 to 1.2 mEq/L. Levels above this range cause **lithium toxicity**. Lithium levels > 2.5 mEq/L constitute a medical emergency, even if the client is asymptomatic. Signs of early lithium toxicity include diarrhea, vomiting, drowsiness, muscular weakness, and lack of coordination. At higher levels giddiness, ataxia, blurred vision, tinnitus, and a large output of dilute urine may be seen. Treatment of lithium toxicity includes withholding the lithium and pushing fluids; IV fluids may be required. In severe cases, gastric lavage, mannitol, urea, aminophylline, or dialysis may be used to hasten the excretion of the drug. Lithium is contraindicated in clients with renal or cardiovascular disease, severe dehydration or sodium depletion, and those receiving diuretics because these conditions increase the risk of lithium toxicity.[7,8]

Fine hand tremor, polyuria, and mild thirst may persist throughout treatment. Lithium can cause abnormal electrocardiographic (ECG) findings and risk of sudden death. Clients should be advised to seek immediate emergency assistance if they experience fainting, light-headedness, abnormal heartbeats, or shortness of breath.[9]

Renal function is adversely affected by lithium and requires routine laboratory testing including urinalysis, blood urea nitrogen, and creatinine. Thyroid and parathyroid functioning can also be adversely affected by lithium, requiring

7. National Institutes of Health. (2024). *Lithium*. DailyMed. https://www.nlm.nih.gov/
8. Janicak, P. G. (2022). Bipolar disorder in adults and lithium: Pharmacology, administration, and management of adverse effects. *UpToDate*. https://www.uptodate.com
9. National Institutes of Health. (2024). *Lithium*. DailyMed. https://www.nlm.nih.gov/

routine laboratory testing including thyroid function studies and calcium levels.[10]

Lithium can cause fetal harm in pregnant women. Safety has not been established for children under 12 and is not recommended.[11]

CLIENT EDUCATION FOR LITHIUM

Lithium must be taken as prescribed or serious side effects can occur. Blood tests to measure lithium levels will be ordered regularly by the provider. The provider should be immediately notified of symptoms of elevated levels of lithium, including diarrhea, vomiting, drowsiness, muscular weakness, lack of coordination, ringing in the ears (tinnitus), or large amounts of dilute urine. Driving or operating heavy machinery should be avoided when first starting lithium because it can impair mental alertness. Lithium should not be taken during pregnancy or while breastfeeding unless it is determined that the benefits to the mother outweigh the potential risks to the baby. Clients taking lithium must also be taught to monitor their dietary intake of sodium consistent as drastic reduction in sodium can lead to lithium toxicity and a drastic increase in sodium intake can lead to sub-therapeutic lithium[12]

Psychotherapy

Psychotherapy is a term for a variety of treatment techniques that help an individual identify and change troubling emotions, thoughts, and behaviors.

10. Janicak, P. G. (2021). Bipolar disorder in adults and lithium pharmacology, administration, and management of adverse effects. *UpToDate*. https://www.uptodate.com/
11. National Institutes of Health. (2024). *Lithium*. DailyMed. https://www.nlm.nih.gov/
12. National Institutes of Health. (2024). *Lithium*. DailyMed. https://www.nlm.nih.gov/

Treatment may include therapies such as cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), and psychoeducation. Read more information about CBT and DBT in the "Treatments for Depression" section in the "Depressive Disorders" chapter.

Treatment may also include newer therapies designed specifically for the treatment of bipolar disorder, including **Interpersonal and Social Rhythm Therapy (IPSRT)** and **family-focused therapy**. IPSRT emphasizes the importance of establishing stable daily routines such as sleeping, waking up, working, and eating meals. Family-focused therapy focuses on psychoeducation, communication enhancement training, and problem-solving skills. It includes attention to family dynamics and relationships as contributing factors to the client's mood.

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is used to treat bipolar disorders. ECT is a brain stimulation procedure delivered under general anesthesia. It can be effective in treating severe depressive and manic episodes when medication and psychotherapy are not effective. ECT can also be effective when a rapid response is needed, as in the case of suicide risk or **catatonia** (a state of unresponsiveness). Read more about electroconvulsive therapy (ECT) in the "Depressive Disorders" chapter.

Repetitive Transcranial Magnetic Stimulation

Repetitive transcranial magnetic stimulation (rTMS) is a brain stimulation procedure that uses magnetic waves to relieve depressive episodes associated with bipolar disorders and does not require general anesthesia.

Lifestyle Changes and Coping

Lifestyle changes can play a significant role in managing symptoms of bipolar disorder. Implementing these lifestyle changes can complement pharmacotherapy and psychotherapy, leading to better management of bipolar disorder symptoms and overall quality of life.

Regular aerobic exercise, such as jogging, brisk walking, swimming, or bicycling, helps with depression and anxiety, promotes better sleep, and is healthy for the heart and brain. There is also some evidence that anaerobic exercise such as weightlifting, yoga, and Pilates can be helpful.[13] Adopting a balanced diet, such as the Mediterranean diet, can positively impact mood and metabolic health. A vegetarian diet has been associated with reduced depression scores, better psychosocial functioning, and improved metabolic parameters. Individuals should also maintain a regular sleep schedule and practice mindfulness or meditation to help manage stress. Alcohol, tobacco products, and recreational drug use should be avoided. Individuals should build and maintain strong social connections to help develop emotional support systems for symptom management.[14]

Even with proper treatment, mood changes can occur. Treatment is more effective when a client and health care provider work together and talk openly about concerns and choices. Keeping a life chart that records daily mood symptoms, treatments, sleep patterns, and life events can help clients and health care providers track and treat bipolar disorder over time. Clients can easily share data collected via smartphone apps – including self-reports, self-ratings, and activity data – with their health care providers and therapists.[15]

13. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder

14. Simjanoski, M., Patel, S., Boni, R., Balanzá-Martínez, V., Frey, B. N., Minuzzi, L., Kapczinski, F., Cardoso, T. A. (2023). Lifestyle interventions for bipolar disorders: A systematic review and meta-analysis. *Neuroscience and Biobehavavioral Reviews. 152,* 105257. doi: 10.1016/j.neubiorev.2023.105257.

15. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder

- Take the American Psychiatric Association's free course: The Treatment of Bipolar Depression: From Pills to Words.

8.4 Applying the Nursing Process to Bipolar Disorders

Assessment (Recognize Cues)

Assessment of a client with a mood disorder focuses on both verbal and nonverbal cues. People with bipolar disorder experience periods of unusually intense emotion, grandiose delusions, changes in sleep patterns and activity levels, and impulsive behaviors, often without recognizing potential harmful effects.[1] See Figure 8.3[2] for an artistic depiction of grandiose delusions when a cat looking in a mirror sees a lion.

1. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder

2. "Cat_and_lion_in_mirror_illustration.svg" by Arlo Barnes is licensed under CC BY 3.0

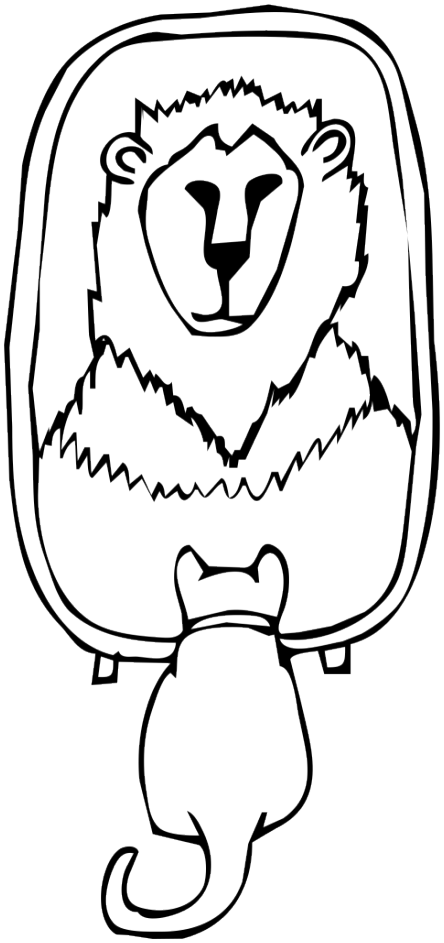


Figure 8.3 Grandiose Delusions

It is often helpful to interview family members or significant others of clients with mood disorders. Clients with mania, hypomania, or psychosis often have poor insight and may have difficulty providing an accurate history.[3]

Safety guidelines for assessing a client with a bipolar disorder include the following:[4]

- Assess if the client is a danger to self or others. The client may have suicidal or homicidal ideation. Poor impulse control may result in harm to

3. Suppes, T. (2021). Bipolar disorder in adults: Assessment and diagnosis. *UpToDate*. https://www.uptodate.com/

4. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

self or others. Assess the need for protection from uninhibited behaviors. For example, external controls may be needed to protect the client from consequences such as bankruptcy.

- Assess physiological stability while obtaining vital signs and lab results including electrolytes. The client may not eat or sleep for days at a time with potential physiological consequences.

Mental Status Examination

Table 8.4a outlines typical assessment findings a nurse may observe in a client experiencing a manic episode. Typical findings relate to mood, behavior, thought processes, speech patterns, and cognitive function.

Table 8.4a Typical Mental Status Examination Findings for a Client Experiencing a Manic Episode[5,6,7]

5. National Institute of Mental Health. (2024). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder

6. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

7. Suppes, T. (2021). Bipolar disorder in adults: Assessment and diagnosis. *UpToDate*. https://www.uptodate.com/

Assessment	Typical Findings During a Manic Episode
Level of Consciousness and Orientation	May be disoriented/confused, but can be oriented to person, place, and time.
Mood and Affect	Exhibits an unstable, euphoric mood. Client may state they feel "up," "high," "jumpy," or "wired," but mood can quickly change to irritation and anger.
Appearance and General Behavior	Typically exhibits a decreased need for sleep and a loss of appetite that may result in dehydration or poor nutritional status. May exhibit inappropriate dress or grooming or dress provocatively, sloppily, flamboyantly, or bizarrely. May change clothes frequently throughout the day. May use excessive makeup or demonstrate little attention to grooming. May demonstrate risky behaviors with poor impulse control and poor judgment, such as eating and drinking excessively, spending or giving away a lot of money, or having reckless sex. Excessive spending can lead to financial hardship from credit card debt from buying items they don't need.
Speech	Typically talk very fast (e.g., pressured speech) about many different topics (hyperverbal). May have difficulty in accurately communicating needs due to flight of ideas or slurred or garbled speech.
Motor Activity	Typically hyperactive with an inability to recognize need for rest or sleep.
Thought and Perception	Client may state they feel as if their "thoughts are racing." May feel as if they are unusually important, talented, or powerful. May describe hallucinations, illusions, or paranoia. May exhibit flight of ideas, loose associations, and clang associations. (See definitions of terms in the "Application of the Nursing Process in Mental Health Care" chapter.) May exhibit suicidal, homicidal, or violence ideation.
Attitude and Insight	Typically exhibit limited insight with an inability to make sound decisions impacting their adherence to taking prescribed medications.

Cognitive Abilities	Typically exhibit decreased attention span, distraction, and impaired judgement.

Psychosocial Assessment

It is helpful to begin the psychosocial assessment by obtaining the reason why the client is seeking health care in their own words. For example, the client may identify a problem such as a relationship issue, stressful job, or school challenges that could be addressed by counseling.[8]

A comprehensive psychosocial assessment includes the following components:

Reason for seeking health care (i.e., "chief complaint")
Thoughts of suicide or self injury
Cultural assessment
Spiritual assessment
Family dynamics
Current and past medical history
Current medications
History of previously diagnosed mental health disorders
Previous hospitalizations
Educational background
Occupational background
History of exposure to psychological trauma, violence, and domestic abuse
Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
Family history of mental illness
Coping mechanisms
Functional ability/Activities of daily living

8. Halter, M. (2022). Varcarolis' foundations of psychiatric-mental health nursing (9th ed.). Saunders.

After identifying the reason the client is seeking health care, additional focused questions are used to obtain detailed information. The mnemonic PQRSTU can be used to ask questions in an organized fashion. See Table 8.4b for a sample PQRSTU assessment for assessing mania.

Table 8.4b Sample PQRSTU Questions for Assessing Mania[9]

PQRSTU	Sample Questions
Provocation/ Palliation	"What tends to trigger or worsen your high energy or mood? What helps
Quality	"How would you describe what you're feeling when you're in a high or ele
Region	"Do you experience physical symptoms or sensations when you're in a ma
Severity	"On a scale of 0 to 10, how intense do your manic symptoms feel when the
Timing/ Treatment	"When did this elevated mood or energy begin? How long does it usually
Understanding	"What do you think is happening when you feel this way? Do you think yo

9. National Institute of Mental Health. (2024). *Bipolar disorder*. National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder

SUICIDE AND SELF INJURY SCREENING

Clients being evaluated or treated for bipolar disorder may have suicidal ideation. The Patient Safety Screener (PSS-3) is an example of a brief screening tool to detect suicide risk in all client presenting to acute care settings.[10]

Non-suicidal self-injury (NSSI) refers to intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting. It is considered a maladaptive coping strategy without the desire to die. NSSI is a common finding among adolescents and young adults in psychiatric inpatient settings.[11]

Review information about suicide screening, the Patient Safety Screener, and screening for non-suicidal self-injury (NSSI) in the "Assessment" section of the Applying the Nursing Process to Mental Health Care" chapter.

CULTURAL ASSESSMENT

Cultural Formulation Interview (CFI) questions help nurses understand a client's cultural background and how it influences their experience of mental health symptoms, including manic and depressive episodes.[12] Sample CFI

10. Suicide Prevention Resource Center. (n.d.). The patient safety screener: A brief tool to detect suicide risk. https://sprc.org/micro-learning/patientsafetyscreener

11. Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. Frontiers in Psychology, 8. https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full

12. DeSilva, R., Aggarwall, N. K., & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry. *Psychiatric Times, 32*(6). https://www.psychiatrictimes.com/view/

questions focused specifically on understanding mania and bipolar disorders within a cultural context include the following:

- Cultural Definition of the Problem
  - “How would you describe the changes in your mood or energy that you’ve been experiencing?”
  - “In your community or family, what do people call this kind of problem—feeling very ‘up’ or energetic at times, and very ‘down’ at others?”
  - Do you feel this is as a medical issue, a spiritual issue, or something else?”
- Cultural Perceptions of Cause, Context, and Support
  - “What do you think has caused these shifts in your mood or energy?”
  - “Have there been any stressors, life events, or spiritual changes that you believe might explain this?”
  - “Do other people in your family or community view these mood changes as a strength, a weakness, or something else?”
- Cultural Factors Affecting Coping and Help-Seeking
  - “When you feel very energetic or very low, how do you usually cope with those feelings?”
  - “Have you sought help from anyone—such as a spiritual leader, traditional healer, or family member?”
  - “Are there treatments or practices you trust or prefer when managing your health?”
- Cultural Features of the Nurse–Client Relationship
  - “Are there any concerns you have about talking to a mental health professional?”
  - “Would you feel more comfortable speaking with someone of a similar gender, cultural, or religious background?”

dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry

- “What would help you feel more supported or understood during treatment?”

Findings from the cultural formulation interview are used to individualize a client’s plan of care to their preferences, values, beliefs, and goals.

SPIRITUAL ASSESSMENT

The FICA Spiritual History Tool is a widely used assessment model for evaluating a client’s spiritual beliefs and how they may influence health, illness, and coping. It’s especially helpful in understanding how clients with bipolar disorder draw on spirituality or religion for support. Addressing a client’s spirituality and advocating spiritual care have been shown to improve clients’ health and quality of life.[13,14]

The FICA Spiritual History Tool© is a common tool used to gather information about a client’s spiritual history and preferences. FICA© is a mnemonic for the domains of Faith, Importance, Community, and Address in Care.[15] Table 8.4c

13. Pilger, C., Molzahn, A. E., de Oliveira, M. P., & Kusumota, L. (2016). The relationship of the spiritual and religious dimensions with quality of life and health of patients with chronic kidney disease: An integrative literature review. Nephrology Nursing Journal: Journal of the American Nephrology Nurses’ Association, 43(5), 411–426. https://pubmed.ncbi.nlm.nih.gov/30550069/

14. Puchalski, C., Jafari, N., Buller, H., Haythorn, T., Jacobs, C., & Ferrell, B. (2020). Interprofessional spiritual care education curriculum: A milestone toward the provision of spiritual care. Journal of Palliative Medicine, 23(6), 777–784. https://doi.org/10.1089/jpm.2019.0375

15. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*. https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool

summarizes a sample FICA Spiritual Assessment and sample responses from a client experiencing bipolar disorder.

Table 8.4c Sample FICA Spiritual Assessment Questions For Clients With Bipolar Disorder

Domain	Sample Assessment Question	Sample Client Response
Faith	"Do you consider yourself spiritual or religious? What gives your life meaning?"	"During my high periods, I sometimes feel like I'm on a mission from God. When I crash, I feel abandoned or punished."
Importance	"What importance does your faith or belief have in your life? Has it influenced how you cope with your mood changes?"	"My faith can be confusing at times depending on how I'm feeling. When I'm up, it can feel like a blessing because I am so productive and can get so much done. When I'm down, I question everything and wonder why I am being punished with these up and down periods."
Community	"Are you part of a spiritual or religious community? Do they provide support to help manage your health or emotions?"	"When I'm feeling depressed, I don't feel like going to church. I haven't talked to anyone about what happens during my up periods."
Address in Care	"How would you like me (or the health care team) to address spiritual issues during your care? Would you like to speak with a chaplain or contact your pastor?"	"Yes I would be interested in speaking to a chaplain."

Nurses may recognize cues of spiritual distress related to feelings or behaviors that occur during manic and depressive episodes. Nurses can offer to connect the client with a chaplain or spiritual care services. Spiritual goals may be included in the nursing care plan if the client finds them valuable.

FAMILY DYNAMICS

Family dynamics are included in a psychosocial assessment, especially for children, adolescents, and older adults. **Family dynamics** refers to the patterns of interactions among relatives, their roles and relationships, and the

various factors that shape their interactions. Because family members rely on each other for emotional, physical, and economic support, they are primary sources of relationship security or stress. Family dynamics and the quality of family relationships can have either a positive or negative impact on an individual's mental health. For example, secure and supportive family relationships can provide love, advice, and care, whereas stressful family relationships can be burdened with arguments, unhealthy relationships, and a lack of support.[16]

Screening Tools

Many screening tools exist to assess mood disorders. Common examples include the following:

- **Mood Disorder Questionnaire (MDQ) PDF:** Thirteen questions with yes/no responses for assessing mania.
- **Young Mania Rating Scale (YMRS) PDF:** An 11-item assessment based on the client's subjective report of behaviors over the past 24 hours regarding manic symptoms. It is useful to evaluate baseline functioning and progress being made. There is also a parent version for assessing children and adolescents.
- **Altman Self-Rating Mania Scale:** A self-assessment questionnaire to evaluate the severity of mania or hypomania.

Laboratory Testing

Initial medical evaluation of clients with a possible or established diagnosis of bipolar disorder typically includes the following:

16. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). Family dynamics. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK560487/

- Thyroid stimulating hormone
- Complete blood count
- Chemistry panel
- Urine toxicology to screen for substances of abuse

Thereafter, routine laboratory testing for clients with bipolar disorders can include these items:

- Therapeutic Medication Levels: Medication dosages may need adjustment based on blood levels to avoid toxicity and ensure they are in therapeutic range. Read more about therapeutic drug levels under the "Medications" subsection of the "Treatments for Bipolar Disorders" section of this chapter.
- Kidney or liver function tests, based on medications prescribed.
- Thyroid function studies and calcium levels.
- Nutrition or hydration status, such as serum sodium levels, hematocrit, albumin, and prealbumin levels, which can become impaired during manic episodes due to poor intake.

Reflective Questions

1. What are some common underlying medical conditions that could potentially mimic the symptoms of mania in older adults?
2. Why are some individuals with bipolar disorder misdiagnosed with schizophrenia?

Life Span Considerations

Life span considerations influence how the client is assessed, as well as the selection of appropriate nursing interventions.

CHILDREN AND ADOLESCENTS

Most cases of bipolar disorder are diagnosed in adolescence or adulthood, but the symptoms can appear earlier in childhood. While less common than in adults, it is possible for children to experience manic and depressive episodes, especially if there is a family history of bipolar disorder. Research also indicates that trauma and adverse childhood experiences (ACEs) may increase the chances of developing bipolar disorder in people with a genetic risk of having the condition. The symptoms of manic episodes may look different in children than in adults, often presenting as significant irritability mood swings, changes in sleep patterns, and destructive outbursts. Depressive episodes may present as somatic complaints or withdrawal. Bipolar disorder may be misdiagnosed as ADHD, ODD, or conduct disorder.[17] Review information about adverse childhood experiences (ACEs) in the "Mental Health and Mental Illness" section of Chapter 1.

OLDER ADULTS

Onset of bipolar disorder after age 60 is rare. Individuals often present with depression as the primary symptom rather than hypomania or mania. New symptoms of mania and should be communicated to the health care provider for investigation of medical causes such as stroke, thyroid dysfunction, or dementia.[18]

Diagnosis (Analyze Cues)

Mental health disorders are diagnosed by trained mental health professionals

17. Cleveland Clinic. (2022). Bipolar disorder in children. https://my.clevelandclinic.org/health/diseases/14669-bipolar-disorder-in-children

18. Tampi, R. (2023). Assessment and management of bipolar disorder in older adults. *Psychiatric Times, 40(12)*. https://www.psychiatrictimes.com/view/assessment-and-management-of-bipolar-disorder-in-older-adults

using the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)*. Nurses create individualized nursing care plans using nursing diagnoses based on the client's response to their mental health disorders. Examples of common nursing diagnoses associated with bipolar disorders are listed in Table 8.4d.

Table 8.4d Common Nursing Diagnoses Related to Bipolar Disorder[19,20]

19. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

20. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Nursing Diagnosis	Associated Behaviors and Characteristics
Safety: Risk for Injury Risk for Suicide Risk for Violence	Impulsive, risky behaviors with poor personal boundaries. Lack of insight into illness. May exhibit agitation, self-harm, or threatening behaviors.
Communication: Impaired Cognition Impaired Communication	Grandiose thinking with poor judgment, flight of ideas, or pressured speech with loose associations.
Self-Care Deficit: Bathing, Grooming, Hygiene, Dressing	Poor hygiene and distracted from tasks.
Impaired Nutrition	Unable to sit long enough to eat; poor appetite. May eat excessive amounts of food during hypomanic episodes.
Disturbed Sleep Patterns	Inability to rest or sleep without frequent awakenings; often hyperactive at night.
Fatigue r/t Psychological Demands	Hyperactive and restless.
Social Isolation r/t Ineffective Coping or Intrusive Behaviors	Feel different from others and preoccupied with own thoughts. Social behavior may be incongruent with norms. May demonstrate an excessive amount of verbal exchange or violation of personal boundaries. May engage in inappropriate sexual language or behavior.
Risk for Spiritual Distress	Demonstrate ineffective coping strategies, separation from support system, or hopelessness.

Outcome Identification (Generate Solutions)

During an acute manic episode, the overall goals are symptom management, achieving remission of symptoms, preventing injury, and supporting

physiological integrity. Examples of goals during the acute phase include the following[21]:

- Maintain stable cardiac status.
- Be well-hydrated.
- Get sufficient sleep and rest.
- Make no attempt at self-harm.
- Demonstrate thought control with the aid of staff and/or medication.
- Maintain tissue integrity.

The maintenance phase occurs after acute symptoms have been controlled and the goals become focused on preventing future exacerbations of manic episodes through education, support, and problem-solving skills. The following are examples of goals during the maintenance phase[22]:

- Identifying and avoiding triggers for developing acute mania
- Attending therapy sessions
- Developing new coping skills

Outcome criteria are identified based on the phase of bipolar illness the client is experiencing, either acute or maintenance phase.[23] SMART outcomes are Specific, Measurable, Attainable/Actionable, Relevant, and Timely. Read more about SMART outcomes in the "Application of the Nursing Process in Mental Health Care" chapter. The following are sample SMART outcomes for clients with bipolar disorders:

21. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
22. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
23. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

- The client will communicate feelings and thoughts of self-harm (self-injury) to the health care team, prior to acting on thoughts, during this shift.
- The client will eat breakfast within one hour of the arrival of the breakfast tray.
- The client will attend one or more group meetings each day while in the outpatient setting.

Planning (Generate Solutions)

Safety

Clients with bipolar disorders are monitored closely for risk of suicide, and interventions are planned according to their level of risk. Review interventions for clients at risk of suicide in the "Application of the Nursing Process in Mental Health Care" chapter.

Planning Interventions During Acute Manic Episodes

When a client is hospitalized during an acute manic episode, planning focuses on stabilizing the client while maintaining safety. Nursing care focuses on managing medications, decreasing physical activity, increasing food and fluid intake, reinforcing a minimum of 4 to 6 hours of sleep per night, and ensuring self-care needs are met.[24]

Planning Interventions During the Maintenance Phase

During the maintenance phase, planning focuses on preventing relapse and limiting the severity and duration of future episodes. During this period, individuals with bipolar disorders often face multiple hardships resulting from

24. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

their behaviors during previous acute manic episodes. Interpersonal, occupational, educational, and financial consequences may occur. Clients need support as they recover from acute illness and repair their lives.[25]

Individuals are often ambivalent about treatment, but bipolar disorders typically require medications to be taken over long periods of time or for a lifetime to prevent relapse. Self-medication through alcohol or other substances often complicates recovery and treatment. Nurses must establish a therapeutic nurse-client relationship to support continued treatment. See Chapter 2 for additional information on establishing a therapeutic nurse-client relationship. Individuals are typically referred to community resources and outpatient mental health care settings. In addition to medication management, outpatient services provide structure and decrease social isolation.[26]

Implementation (Take Action)

Nursing Interventions for Clients With Bipolar Disorder Based on Categories of the APNA Implementation Standard

Nursing interventions for clients with bipolar disorders can be categorized based on the American Psychiatric Nurses Association (APNA) standard for *Implementation* that includes the *Coordination of Care; Health Teaching and Health Promotion; Pharmacological, Biological, and Integrative Therapies; Milieu Therapy;* and *Therapeutic Relationship and Counseling*. Read more about these subcategories in the "Application of the Nursing Process in

25. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

26. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Mental Health Care" chapter. See examples of interventions for each of these categories for clients with bipolar disorders in Table 8.4e.

Table 8.4e Nursing Interventions for Mania Based on the Categories of the APNA Implementation Standard[27]

27. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Categories of Interventions Based on the APNA Standard of Implementation	What the nurse will do...	Rationale

Coordination of care	• Collaborate with psychiatrists, social workers, and therapists for integrated care. • Maintain safety by communicating safety precautions with interprofessional team members as needed to prevent self-harm, suicide, or homicide risks. • Ensure consistency of behavioral expectations among all staff on the unit by including expectations in the nursing care plan. • Assist in care transitions (e.g., hospitalization, discharge planning). • Provide referrals to outpatient mental health care settings, community resources, support groups, peer programs, and housing resources.	Bipolar disorder requires a multidisciplinary approach to address mood stabilization, medication adherence, psychosocial needs, and relapse prevention. The client may exhibit high risk or impulsive behaviors that could pose a risk of harm to self/others. They may experience altered thought processes with poor insight and judgment. Consistent expectations help prevent manipulative behaviors and pushing of limits. The nurse assists in coordinating care delivery during inpatient care and for after discharge.

	Plan for quality of life, independence, and optimal recovery.	
Health Teaching and Health Promotion	• Educate about bipolar disorder, medication side effects, early warning signs, and mood tracking. • Promote healthy lifestyle behaviors such as good sleep hygiene, healthy diet, and avoiding the use of alcohol and illicit drugs. • Address stigma and support self-advocacy. • See “Client Education” topics for bipolar disorder in the box following these tables.	Teaching promotes insight, helps prevent relapse, and empowers the client to participate actively in their care and safety planning. Nurses encourage resilience by promoting positive coping strategies.

Pharmacological, Biological, and Integrative Therapies	• Provide health teaching about prescribed mood stabilizers and other medications with expected time frames for improvement. • Monitor for side effects of medications and signs of medication toxicity by reviewing lab results (e.g., lithium levels and liver function tests) • Teach about integrative therapies like journaling, mindfulness or yoga, as appropriate. • Open all medications in front of the client.	Medication adherence is critical in bipolar management. The client's understanding of their medications and potential side effects can increase medication adherence. Monitoring lab results helps prevent the development of complications. There is a small margin of safety between therapeutic and toxic doses of lithium. Holistic therapies enhance emotional regulation and stability. Opening all medications in front of the client may decrease paranoia that may occur with bipolar disorder.

Milieu Therapy	• Maintain a structured, low-stimulation, and safe environment. Avoid competitive activities or games. Encourage frequent rest periods and "down time." Redirect aggressive behavior with structured activities to help decrease tension and provide focus. • Limit environmental triggers (e.g., excessive noise, stimulation). The client may require a private room. • Provide cues for orientation and routine (e.g., activity schedules). • During acute mania, use prescribed medications, seclusion, or restraint to minimize physical harm.	A therapeutic milieu supports emotional containment during mania and reduces confusion or distress during depressive phases. Reducing stimuli may prevent escalation of anxiety and agitation. Structured activities provide security and focus, but competitive activities should be avoided because they may be too stimulating and can cause escalation of anxiety and agitation. Rest can prevent exhaustion that can result from constant physical activity. The nurse's priority is to protect the client and others from harm. Storing valued items protects the client from giving away money and possessions. Group therapy can encourage effective coping skills.

	• Store valuables in the hospital safe until safe judgment returns. • Encourage participation in group therapy after acute manic episode has resolved, addressing social skills, personal grooming, mindfulness, and stress management.	

Therapeutic Relationship and Counseling	• Build trust with clear boundaries, active listening, and nonjudgmental support. • Use limit setting to address risky or intrusive behavior during manic episodes. • Encourage exploration of thoughts and feelings during depressive episodes. • Assist in developing insight and realistic goals. • Be consistent in approach and expectations. Use a firm and calm approach with short and concise statements. For example, "John, come with me. Eat this sandwich." Identify expectations in simple, concrete terms with consequences. For example, "John, do	A therapeutic relationship helps clients feel safe, fosters self-awareness, and facilitates engagement. Limit setting and empathy help stabilize mood and improve self-control. Structure and control can improve feelings of security for a client who is feeling out of control. Consistent limits and expectations minimize the potential for the client's manipulation of staff and provide feelings of security. Clear expectations help the client experience outside controls and understand reasons for medication, seclusion, or restraints if they are not able to control their behaviors. Listening to legitimate complaints can reduce underlying feelings of helplessness and can minimize acting-out behaviors. Clients may be impulsive and hyperverbal and interrupt, blame, ridicule, or manipulate others, so personal boundaries must be set.

	not yell at or hit Peter. If you cannot control your behaviors, you will be escorted to the seclusion room to prevent harm to yourself and others." • Listen to and act on legitimate complaints. • Redirect energy into appropriate and constructive channels. • Set limits with personal boundaries. • See additional "Communication Tips" in the box below.	

Nursing Interventions for Physiological Symptoms of Manic and Depressive Episodes

Nurses implement interventions for common physiological symptoms that occur during manic and depressive episodes. Table 8.4f summarizes these interventions.

Table 8.4f Nursing Interventions to Promote Physiological Integrity During Manic Episodes[28]

28. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Problem/ Intervention	Rationale
Nutrition • **Monitor weight, dietary and fluid intake, and hydration.** • **Encourage regular meals/ snacks, especially in clients with mania who may forget to eat. Offer frequent, high-calorie, high-protein snacks, drinks, and finger foods.** • **Limit caffeine and excessive sugar intake.** • **Collaborate with a dietician as indicated.**	During manic phases, clients may experience hyperactivity and decreased appetite, whereas during depressive phases, they may have overeating or loss of appetite. Medication can also cause weight gain or metabolic syndrome, requiring dietary management. Ensure adequate dietary and fluid intake and minimize development of dehydration. "Finger foods" allow for "eating on the run."

Sleep/Rest • **Promote a calm, quiet environment with consistent bedtime routines.** • **Limit evening stimulation and screen time. Encourage relaxation techniques and avoidance of caffeine.** • **Monitor for symptoms of insomnia or hypersomnia.** • **Administer sleep aids as prescribed and monitor for side effects.** • **During manic episodes, set limits on excessive activity to prevent exhaustion. Encourage frequent rest periods during the day and adequate sleep.**	Manic episodes often cause reduced need for sleep or insomnia, which can worsen symptoms. Depressive episodes may cause excessive sleep or poor sleep quality, impacting recovery and energy. Sleep regulation supports mood stabilization. Bedtime routines and relaxation techniques induce sleep. Encouraging bedtime routines and decreasing caffeine intake increases the possibility of sleep.[29]

29. Centers for Disease Control and Prevention. (2024). *About sleep*. https://www.cdc.gov/sleep/about/index.html#cdc_behavioral_basics_steps-what-to-do

Elimination (Constipation) • **Assess bowel and bladder patterns** • **Encourage regular toileting.** • **Encourage fluids and foods high in fiber.** • **Evaluate the need for a bowel management program with stool softeners and laxatives.**	Psychotropic medications commonly cause constipation or urinary retention, which may be exacerbated by poor diet or decreased mobility during depressive episodes. Regular monitoring ensures comfort and safety. Fluids and fiber stimulate peristalsis and soft stools. The client experiencing acute mania is easily distracted and not aware of bodily needs. Bowel management programs may be needed to avoid fecal impaction.

Self-Care Deficits • **Assess independence in ADL performance: bathing, grooming, dressing.** • **Encourage the use of a toothbrush, washcloth, soap, and makeup or shaving supplies with concrete instructions as needed.** • **Encourage appropriate clothing choices based on environmental conditions.** • **Use visual reminders, schedules, or prompts to encourage hygiene.** • **Assist with tasks as needed while promoting independence.**	Both manic and depressive episodes can lead to neglect of hygiene and daily routines due to distractibility, low energy, or impaired insight. Supporting ADLs helps maintain dignity, identity, and structure. Distractibility and poor concentration are countered through simple, concrete instructions.

Communication Tips for Clients with Bipolar Disorder

Clients experiencing mania may be easily agitated or hyperverbal. Communication tips are summarized in the following box.

Effective Communication Tips for Clients with Manic Episode of Bipolar Disorder

- Maintain a calm, non-reactive demeanor.
    - **Rationale:** A calm and steady tone helps de-escalate emotional intensity and provides a model of self-regulation.
- Use short, clear, and concrete statements.
    - **Rationale:** During mania, attention span and focus are impaired. Direct, simple communication prevents confusion and helps the client process instructions more effective.
- Avoid arguing or challenging grandiose ideas.
    - **Rationale:** Debating delusional or inflated beliefs can increase defensiveness and agitation. Instead, acknowledge the emotion behind the belief and gently redirect without confrontation.
- Set firm but respectful personal boundaries and limits on behaviors.
    - **Rationale:** Clients may become intrusive, impulsive, or overstimulated. Clear, consistent boundaries help ensure safety for the client and

others.

- Validate emotions. For example, say, “It sounds like you’re feeling really energized today” instead of reinforcing behaviors by saying, “Wow, you’ve done so much!”).
    - Validating emotions promotes insight into behaviors.
- Reinforce reality gently and consistently.
    - During manic episodes, reality orientation may be impaired. Use clear reminders such as, “Today is Monday, and the group therapy session is this afternoon” to ground the conversation.
- Monitor for rapid topic changes and redirect.
    - Clients experiencing mania often exhibit flight of ideas. Respectfully bring the focus back to the established topic to gather accurate information. For example, “Earlier you mentioned you were having problems sleeping – let’s talk more about that.
- Acknowledge progress and small successes.
    - Positive reinforcement builds self-esteem. Celebrate even small steps toward recovery.
- Assess safety and ask directly about suicidal or homicidal risk, such as, “Have you had any thoughts of hurting yourself or others?”

- Direct questioning ensures timely intervention to reduce risk of harm. If a client demonstrates agitation with escalation of manic behavior, review interventions described in the "Crisis and Crisis Intervention" section of the "Stress, Coping, and Crisis Intervention" chapter. Additional de-escalation techniques to maintain safety are described in the "Workplace Violence" section of the "Trauma, Abuse, and Violence" chapter.

Client Education for Bipolar Disorder

Living with bipolar disorder can be challenging, but there are ways to control symptoms and live a healthy life. The client may be resistant to teaching during the acute phase of a manic episode, so it is beneficial to wait until manic symptoms begin to resolve. Client education topics are described in the following box.

Client Education: Bipolar Disorder

Client education regarding bipolar disorder includes the following guidelines[30]:

30. National Institute of Mental Health. (2020). *Bipolar disorder.* National Institutes of Health. https://www.nimh.nih.gov/health/topics/bipolar-disorder

- Get treatment and stay committed to it. Recovery from a manic episode takes time and it's not easy, but treatment is the best way to start feeling better.
- Keep medical and therapy appointments and talk with the provider about treatment options.
- Take all medicines as directed.
- Maintain a structure for daily activities; keep a routine for eating, getting enough sleep, and exercising.
- Learn to recognize mood swings and warning signs for manic episodes such as decreased need for sleep.
- Ask for help when experiencing barriers or challenges for treatment. Social support helps coping.
- Be patient; improvement takes time.
- Avoid using alcohol and illicit drugs.
- Encourage participation in cognitive behavioral therapy (CBT) or dialectical behavioral therapy (DBT).
- Use stress management, relaxation techniques, and coping strategies to minimize anxiety.
- Participate in support groups

Read more information about the following support groups using these links:

- National Alliance on Mental Illness (NAMI)
- Depression and Bipolar Support Alliance (DBSA).

Implementing Seclusion or Restraints

De-escalation techniques should be attempted at early signs of escalating agitation to avoid the need for seclusion or restraints. However, if a client is escalating out of control to a point where they pose an immediate risk of injury to themselves or others, the use of medications, seclusion, or restraints may become necessary to maintain a safe environment. Most state laws prevent the use of unnecessary restraint or seclusion, so their use is associated with complex ethical, legal, and therapeutic issues.[31] Review ANA guidelines on using restraints in the "Client Rights" section of the "Legal and Ethical Considerations in Mental Health Care" chapter and information on safely implementing restraints in the "Workplace Violence" section of the "Trauma, Abuse, and Violence" chapter.

Controlling escalating agitation during the acute phase of a manic episode may include immediate administration of a prescribed antipsychotic and/or benzodiazepine. A combination of haloperidol (Haldol) and lorazepam (Ativan) that can be injected for rapid onset of action is commonly used. The nurse must monitor for respiratory depression, hypotension, and oversedation after administering these types of medication.

Evaluation (Evaluate Outcomes)

Evaluation occurs continuously throughout the treatment of bipolar disorders. The registered nurse individualizes assessments based on the established goals and SMART outcomes for each client. The effectiveness of nursing and collaborative interventions is evaluated and revised as needed. Questions used to guide the evaluation process include the following:

- Is the client medically stable with nutritional intake, sleep patterns, labs, or activity levels?

31. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

- Is the client engaging in self-care measures?
- Is the client safe with no self-harm behaviors, statements, gestures, or threats of harm towards others?
- Is the client engaging appropriately in unit-based activities and the therapeutic milieu?
- Is the client able to maintain appropriate personal boundaries with others?
- Is the client able to engage appropriately in verbal conversations and interactions with others?
- Is the client able to demonstrate insight into own illness?
- Is the client tolerating prescriptive medications at therapeutic serum levels and without key side effects?
- Is the client at or near baseline optimal functioning without manic symptoms?
- Is the client able to participate in their own plan of care including discharge planning?

Sample Nursing Documentation

Here is a sample nursing narrative note for a client recently admitted who is currently experiencing an acute phase of a manic episode.

S: Client reports feeling "very happy" with "high energy"' and "no need for sleep." She states, "I've got lots to accomplish today; now move out of my way."

O: Euphoric mood with full range affect. Denies suicidal or homicidal ideation. Is skipping in the hallways and singing loudly with rapid, pressured speech. Is easily distracted and unable to focus on the current conversation. Is intrusive with others with a poor sense of personal boundaries; she is giving away clothing items and going into other clients' rooms and taking their belongings. Dressing in multiple layers of clothes and unable to sit to eat or finish meals. She has experienced weight loss of four pounds in the past three days.

A: Acute mania nearing exhaustion with disruptive behaviors.

P: Reduce stimuli with calming milieu and redirect firmly to maintain appropriate personal boundaries with others. Encourage nutritional intake with hydration and finger foods, along with rest periods twice a day. Refrain from large group activities with short 1:1 time for unit programming needs.

8.6 Learning Activities

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https://wtcs.pressbooks.pub/nursingmhcc/?p=380#h5p-20

1

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https://wtcs.pressbooks.pub/nursingmhcc/?p=380#h5p-21

2

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https://wtcs.pressbooks.pub/nursingmhcc/?p=380#h5p-23

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2. "MH Bipolar Disorders Question Set 1" by OpenRN is licensed under CC BY-NC 4.0

3

Case Study

Jennifer Rogers is a 31-year-old female with bipolar I disorder who was admitted to the hospital last night for surgical repair of a left tibial fracture sustained in a fall during a manic episode. She was diagnosed with bipolar disorder in her mid-twenties, shortly after she was married and graduated from law school. Her most recent manic episode occurred 6 months after her wedding and required hospitalization at that time. She recently stopped taking her medication.

Staff initially had difficulty communicating with Jennifer due to her profound hearing loss and deafness. Jennifer is able to read lips and communicates using American Sign Language. She went to surgery early this morning, shortly after arriving at the ED via ambulance. Post-surgery, she has been admitted to the orthopedic unit and has been there for a couple of hours. She is currently manic, expressing grandiose ideas that she is urgently needed in Washington, D.C., to solve current political issues.

Jennifer is married and has no children. Her sister lives in the area and is supportive. Jennifer works as an attorney who specializes in tax law.

Her husband, Joe Rogers, is in the room with her and is serving as her interpreter at this time.

3. "MH Bipolar Disorders Drag and Drop" by OpenRN is licensed under CC BY-NC 4.0

Jennifer's injuries were sustained from a fall and altercation at a bar. Paramedics who responded to the 911 call at the bar stated that she was ranting about the government and talking about how her destiny is to be "an angel," who can help solve all of our government's problems. She climbed onto a table in the bar, and in the struggle that ensued with security, she fell off of the table and sustained a tibial fracture.

Jennifer's husband had contacted the emergency room when he discovered that she was missing from their home last evening, and he was here prior to her surgery. Her sister and he had been searching for her for hours before the accident when they were informed that she had left work early that day. Joe reported that she had not been sleeping or eating much for the past 2 weeks. The last time she stopped taking her medications was 2 years ago, resulting in a manic episode. At that time, she accumulated over $12,000 in credit card debt on excessive shopping.

Reflective Questions

1. What CUES do you recognize as relevant in providing nursing care for Jennifer?
2. What is your hypothesis for Jennifer's priority nursing problem(s)?
3. What initial steps should be taken to provide client-centered care to Jennifer?

- Test your clinical judgment with a NCLEX Next Generation-style question: Chapter 8, Assignment 1[4]

- Test your clinical judgment with a NCLEX Next Generation-style question: Chapter 8, Assignment 2[5]

- Test your clinical judgment with a NCLEX Next Generation-style case study: Chapter 8, Case Study 1[6]

4. "MH Bipolar Disorders Next Gen Question 1" by OpenRN is licensed under CC BY-NC 4.0
5. "MH Bipolar Disorders Next Gen Question 2" by OpenRN is licensed under CC BY-NC 4.0
6. "MH Bipolar Disorders Next Gen Case Study" by Kellea Ewen is licensed under CC BY-NC 4.0

VIII Glossary

Bipolar I Disorder: The most severe bipolar disorder with at least one manic episode; most individuals experience additional hypomanic and depressive episodes.

Bipolar II Disorder: A pattern of depressive episodes and hypomanic episodes, but individuals have never experienced a full-blown manic episode typical of Bipolar I Disorder.

Catatonia: A state of unresponsiveness due to a person's mental state.

Cyclothymia: A disorder defined by periods of hypomanic symptoms and periods of depressive symptoms lasting for at least two years (1 year in children and adolescents). However, the symptoms do not meet the diagnostic requirements for hypomanic episodes or depressive episodes.

Family-focused therapy: Psychotherapy that focuses on psychoeducation, communication enhancement training, and problem-solving skills. It includes attention to family dynamics and relationships as contributing factors to the client's mood.

Grandiose delusions: A symptom associated with bipolar disorders of feeling unusually important, talented, or powerful.

Hypomanic episode: Episodes similar to symptoms of a manic episode, but they are less severe and do not cause significant impairment in social or occupational functioning or require hospitalization.

Interpersonal and social rhythm therapy (IPSRT): Psychotherapy that emphasizes the importance of establishing stable daily routines such as sleeping, waking up, working, and eating meals.

Manic episode: A persistently elevated or irritable mood with abnormally increased energy lasting at least one week. The mood disturbance is severe and causes marked impairment in social or occupational function. Severe episodes often require hospitalization to prevent harm to self or others.

Psychotherapy: A variety of treatment techniques that help an individual identify and change troubling emotions, thoughts, and behaviors.

Rapid cycling: At least four mood episodes associated with bipolar disorder occurring in a 12-month period.

PART IX

CHAPTER 9 ANXIETY DISORDERS

9.1 Introduction

Learning Objectives

- Identify assessment cues of anxiety disorder behaviors, obsessive-compulsive disorder, and post-traumatic stress disorder
- Identify nursing priorities for clients with anxiety disorders, obsessive-compulsive disorder, and post-traumatic stress disorder
- Plan outcomes for clients with anxiety disorders, obsessive-compulsive disorder, and post-traumatic stress disorder
- Differentiate safety/protective interventions for clients with anxiety disorders, obsessive-compulsive disorder, and post-traumatic stress disorder
- Apply evidence-based practice when planning care and interventions for clients with anxiety disorders, obsessive-compulsive disorder, and post-traumatic stress disorder
- Analyze treatments for clients with anxiety disorders, obsessive-compulsive disorder, and post-traumatic stress disorder
- Apply the nursing process to clients with anxiety disorders, obsessive-compulsive disorder, and post-traumatic stress disorder at risk for suicide

Anxiety is a natural part of everyday life and can range from helpful to harmful, depending on the situation and intensity. It is the body's response to stress, whether the stressor is perceived as positive or negative. For example, positive stressors—such as cleaning the house before a holiday gathering or

studying for an exam—can create a sense of urgency that enhances focus and productivity. In contrast, negative stressors—like losing one's car keys or getting into a disagreement with a loved one—may trigger distress and frustration. Mild anxiety can be beneficial by providing the energy and concentration needed to complete important tasks or motivating healthy behavioral changes. However, excessive anxiety can become overwhelming, leading to significant distress and impairing a person's ability to function in social, educational, occupational, or other areas of life.

This chapter will explore the levels of anxiety and common anxiety disorders, such as generalized anxiety disorder, panic disorder, and various phobias. It will also examine how anxiety is related to conditions like obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and certain medical conditions. Finally, the chapter will demonstrate how the nursing process can be applied to caring for individuals experiencing anxiety.

9.2 Basic Concepts

Anxiety is a universal human experience that often includes feelings of apprehension, uneasiness, uncertainty, or dread in response to a real or perceived threat.[1] While fear is a reaction to a specific and present danger, anxiety often involves a vague sense of dread to a specific or unknown danger. However, the body reacts physiologically with the stress response to both anxiety and fear.[2] See an artistic depiction of a person facing their feelings of anxiety from a perceived threat in Figure 9.1.[3] Review the stress response in the "Stress, Coping, and Crisis Intervention" chapter.

Figure 9.1 Anxiety

1. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
2. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
3. "fear-g84d457182_1280" by mohamed_hassan on Pixabay.com is licensed under CC0

Levels of Anxiety

Hildegard Peplau, a psychiatric mental health nurse theorist, developed a model describing four levels of anxiety which are categorized as mild, moderate, severe, and panic. Behaviors and characteristics can overlap across these levels, but it can be helpful to tailor interventions based on the level of anxiety the client is experiencing.[4]

Mild

Mild anxiety is a natural part of everyday life and can help an individual use their senses to perceive reality in sharp focus. Symptoms of mild anxiety include restlessness, irritability, or mild tension-relieving behaviors such as finger tapping, fidgeting, or nail biting.[5] These symptoms are generally manageable and do not significantly impair daily functioning.

Moderate Anxiety

As anxiety increases, the perceptual field narrows, and the ability of the individual to fully observe their surroundings is diminished/reduced. The person experiencing moderate anxiety may demonstrate selective inattention where only certain things in the environment are seen or heard unless they are pointed out. The individual's ability to think clearly, learn, and problem solve is hampered, but can still take place. The physiological stress response kicks in with symptoms such as perspiration, elevated heart rate, and elevated respiratory rate. The individual may also experience headaches, gastric

4. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
5. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

discomfort, urinary urgency, voice tremors, and shakiness; however, they may not be aware these symptoms are related to their level of stress and anxiety.[6]

Severe Anxiety

In severe anxiety, the perceptual field is significantly diminished, causing the individual to focus on either one specific detail or many scattered details. They often have difficulty noticing what is going on in their environment, even if it is pointed out, and may appear dazed or confused, exhibiting automatic behavior. Learning, problem-solving, and critical thinking become impossible at this level. Symptoms of the stress response intensify and may include hyperventilation, a pounding heart, insomnia, and/or a sense of impending doom.[7] See Figure 9.2[8] for an artist's rendition of severe anxiety.

6. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

7. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

8. "Walter_Gramatté,_Die_Grosse_Angst_(The_Great_Anxiety),_1918,_NGA_71292.jpg" by Walter Gramatté is licensed in the Public Domain

Figure 9.2 Severe Anxiety

Panic

Panic is the most extreme level of anxiety that results in significantly dysregulated behavior. The individual is unable to process information from the environment and may lose touch with reality. They may demonstrate behavior such as pacing, running, shouting, screaming, or withdrawal, and hallucinations may occur. Acute panic can lead to exhaustion.[9] It is important to distinguish between the broad concept of panic and a panic attack. While panic refers to an intense experience of fear, a panic attack is a specific, acute episode marked by defined symptoms and diagnostic criteria. Panic attack is discussed in Chapter 9.3 Anxiety-Related Disorders.

9. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Coping with Anxiety

Individuals may use several strategies to cope with anxiety. **Coping strategies** are an action, a series of actions, or a thought process used to address a stressful or unpleasant situation or modify one's reaction to such a situation. Coping strategies are classified as adaptive or maladaptive. Adaptive coping strategies include problem-focused coping and emotion-focused coping. Problem-focused coping typically focuses on seeking treatment such as counseling or cognitive behavioral therapy. Emotion-focused coping includes strategies such as engaging in mindfulness, meditation, or yoga; using humor and jokes; seeking spiritual or religious pursuits; engaging in physical activity or breathing exercises; and seeking social support. Maladaptive coping responses include responses such as avoidance of the stressful condition, withdrawal from a stressful environment, disengagement from stressful relationships, and misuse of alcohol or other substances.

Defense mechanisms are reaction patterns used by individuals to protect themselves from anxiety that arises from stress and conflict. Adaptive use of defense mechanisms can help people achieve their goals, but excessive or maladaptive use of defense mechanisms can be unhealthy.[10] Excessive use of defense mechanisms are associated with specific mental health disorders.

Read more about coping strategies and defense mechanisms in the "Stress, Coping, and Crisis Intervention" chapter.

10. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

9.3 Anxiety - Related Disorders

Anxiety disorders are one of the most common mental health disorders in the United States, with about one in five adults reporting symptoms of anxiety. In 2022, of those reporting symptoms of anxiety, 11.4% were categorized as having mild anxiety symptoms, 3.9% were categorized as having moderate anxiety symptoms, and 2.8% were categorized as having severe anxiety. A higher percentage of women report anxiety symptoms compared to men, and anxiety is more prevalent among younger adults.[1]

Anxiety disorders often co-occur with other psychiatric conditions such as depression and substance use disorders.[2] An **anxiety disorder** is characterized by persistent and excessive anxiety that is disproportionate to the actual threat and leads to significant distress or impairment in social, occupational, or other important areas of functioning.[3] According to the DSM-5-TR, an anxiety disorder is diagnosed when specific criteria are met, including the frequency, duration, and intensity of symptoms, as well as the presence of functional impairment and distress[4]

There are several types of anxiety-related disorders, including generalized anxiety disorder, social anxiety disorder, panic disorder, phobia-related disorders, separation anxiety, and selective mutism.

1. Terlizzi, E. & Zablotsky, B. (2024). Symptoms of anxiety and depression among adults: United States, 2019 and 2022 [PDF]. N*ational Health Statistics Report, 213.* https://www.cdc.gov/nchs/data/nhsr/nhsr213.pdf

2. Penninx, B. W., Pine, D. S., Holmes, E. A., & Reif, A. (2021). Anxiety disorders. *Lancet, 397*(10277), 914-927. doi: 10.1016/S0140-6736(21)00359-7

3. Penninx, B. W., Pine, D. S., Holmes, E. A., & Reif, A. (2021). Anxiety disorders. *Lancet, 397*(10277), 914-927. doi: 10.1016/S0140-6736(21)00359-7

4. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing..

Generalized Anxiety Disorder

The *Diagnostic and Statistical Manual of Mental Disorders (DSM*-5-TR) defines **generalized anxiety disorder (GAD)** as excessive anxiety and worry, occurring on more days than not for at least six months, about a number of events or activities (such as work or school performance). The individual finds it difficult to control the anxiety and worry, and it is associated with at least three of the following symptoms[5]:

- Restless or feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or going mentally blank
- Irritability
- Muscle tension
- Sleep disturbance (difficulty falling or staying asleep or restless, unsatisfying sleep)

The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning and are not attributable to the physiological effects of a substance, medical condition, or other mental disorder.[6] See Figure 9.3[7] for an artist's depiction of feelings of anxiety.

5. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
6. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
7. "Edvard_Munch_-_Anxiety_-_Google_Art_Project.jpg" by Edvard Munch is licensed in the Public Domain

Figure 9.3 Anxiety

Social Anxiety Disorder

The *DSM-5* defines **social anxiety disorder** as marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech). The individual fears they will act in a way or show anxiety symptoms that will be negatively evaluated by others, so social situations are avoided or endured with intense fear or anxiety. This fear, anxiety, or avoidance is persistent and typically lasts for six months or more and is not related to a substance, another mental health disorder, or medical condition. It results in clinically significant impairment in social, occupational, or other important areas of

functioning. In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.[8]

Panic Disorder

People with panic disorder have recurrent unexpected panic attacks. **Panic attacks** are sudden periods of intense fear that come on quickly and reach their peak within minutes. Attacks can occur unexpectedly or can be brought on by a trigger, such as a feared object or situation. A panic attack can be caused solely by the fear of having a panic attack.[9] See Figure 9.4.[10]

Figure 9.4 Panic Attack

8. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
9. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
10. "A_subjective_impression_of_a_panic_attack.png" by Yitzilitt is licensed under CC BY-SA 4.0

The *DSM-5* defines a panic attack when four or more of the following symptoms occur[11]:

- Palpitations, a pounding heartbeat, or an accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, light-headed, or faint
- Chills or heat sensations
- Paresthesia (numbness or tingling sensations)
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Feelings of losing control or "going crazy"
- Fear of dying

A panic attack is not related to the physiological effects of a substance, medical condition, or another mental disorder. Culture-specific symptoms may also be seen, such as physical symptoms of anxiety of tinnitus, soreness, headache, and uncontrollable screaming or crying, but these should not be counted as one of the four symptoms.[12]

To be diagnosed as a panic disorder, at least one of the panic attacks has

11. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

12. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

been followed by one month (or more) of one or both of the following characteristics[13]:

- Persistent concern or worry about additional panic attacks or their consequences
- A significant maladaptive change in behavior related to the attacks (such as avoiding unfamiliar situations)

People with panic disorder often worry about when the next attack will happen and actively try to prevent future attacks by avoiding places, situations, or behaviors they associate with panic attacks. Worry about panic attacks and the effort spent trying to avoid attacks cause significant problems in various areas of the person's life, including the potential development of agoraphobia.[14] Read more about agoraphobia in the following "Phobia-Related Disorders" section.

Phobia-Specific Disorders

A **phobia** is an intense fear or aversion to specific objects or situations (e.g., flying, heights, animals, receiving an injection, or seeing blood). Although it can be realistic to feel anxious about certain objects or circumstances, the fear felt by people with phobias is out of proportion to the actual danger caused by the situation or object.[15] Although individuals with specific phobias often recognize their reactions as disproportionate, they tend to overestimate

13. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

14. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

15. National Institute of Mental Health. (n.d.). *Any anxiety disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder

the danger in their feared situations and thus the judgment of being out of proportion is made by the clinician.[16] See Figure 9.5[17] for an illustration of a phobia called arachnophobia (fear of spiders).

Figure 9.5 Arachnophobia

The phobic object almost always provokes immediate fear or anxiety and is actively avoided or endured with intense fear or anxiety. This fear, anxiety, or avoidance is persistent and typically lasts for six months or more.[18] Physical symptoms can include palpitations, sweating, trembling, shortness of breath, dizziness, and gastrointestinal distress.

16. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

17. "Depiction_of_a_person_living_with_a_phobia.png" by https://www.myupchar.com/en is licensed under CC BY-SA 4.0

18. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

Three common phobias are social anxiety disorder, agoraphobia, and separation anxiety disorder.[19]

Agoraphobia

The *DSM-5* defines **agoraphobia** as intense fear of two or more of the following situations:

- Using public transportation
- Being in open spaces (e.g., parking lots, marketplaces, or bridges)
- Being in enclosed spaces (e.g., shops or theaters)
- Standing in line or being in a crowd
- Being outside of the home alone

People with agoraphobia often avoid these situations because they think it may be difficult or impossible to leave in the event they have a panic-like reaction or other embarrassing symptoms such as incontinence. In the most severe form of agoraphobia, the individual can become housebound. Physical symptoms can include palpitations, sweating, trembling, shortness of breath, dizziness, and gastrointestinal distress when exposed to or anticipating the feared situations. Agoraphobia can occur with or without a panic disorder.[20] See Figure 9.6[21] for an artistic rendition of agoraphobia.

19. National Institute of Mental Health. (n.d.). *Any anxiety disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder

20. National Institute of Mental Health. (n.d.). *Any anxiety disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder

21. "Agoraphobia" by Ali Emad is licensed under CC BY-NC-ND 4.0

Figure 9.6 Agoraphobia

Separation Anxiety Disorder

Separation anxiety is often thought of as something that occurs in children, but adults can also be diagnosed with separation anxiety disorder. People who have **separation anxiety disorder** have fears about being separated from people to whom they are attached. They often worry that some sort of harm will happen to those to whom they are attached while they are separated. This fear leads them to avoid being separated from their attachment figures and to avoid being alone. People with separation anxiety may have nightmares about being separated from attachment figures or experience physical symptoms when separation occurs or is anticipated. The fear, anxiety, or avoidance is persistent, lasting at least four weeks in children and typically

six months or more in adults, causing significant distress or impairment to social, occupational, or other important areas of functioning.[22,23]

Selective Mutism

Selective mutism is a rare disorder associated with anxiety. **Selective mutism** occurs when people fail to speak in specific social situations despite having normal language skills. Selective mutism usually occurs before the age of five and is often associated with extreme shyness and fear of social embarrassment.

- **Freezing:** A common response where the child becomes physically immobile or rigid when expected to speak.
- **Avoidance and security behaviors:** These behaviors include avoiding eye contact, hiding behind objects or people, and using gestures or nonverbal communication to avoid speaking.
- **Physical symptoms:** These can include blushing, sweating, trembling, and gastrointestinal distress when faced with speaking situations.

It can also be a symptom of post-traumatic stress syndrome. Individuals who are diagnosed with selective mutism are often also diagnosed with other anxiety disorders, and their symptoms are not related to a communication disorder, autism, schizophrenia, or other psychotic disorder.[24,25]

22. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

23. National Institute of Mental Health. (n.d.). *Any anxiety disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder

24. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

25. National Institute of Mental Health. (n.d.). *Any anxiety disorder.* U.S.

View the following YouTube video on anxiety disorders: Mental Health Minute: Anxiety Disorders in Adults.[26]

Risk Factors for Anxiety Disorders

Occasional anxiety is an expected part of life. It is common to feel anxious when faced with a problem at work, before taking a test, or before making an important decision. However, anxiety disorders involve more than temporary worry or fear. For a person with an anxiety disorder, the anxiety does not go away and can worsen over time, and their symptoms can interfere with daily activities such as job performance, schoolwork, and relationships.[27]

Researchers have found that both genetic and environmental factors contribute to the risk of developing an anxiety disorder. Although the risk factors for each type of anxiety disorder can vary, some general risk factors for all types of anxiety disorders include the following[28]:

Department of Health and Human Services. https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder

26. National Institute of Mental Health (NIMH). (2021, December 20). *Mental health minute: Anxiety disorders in adults* [Video]. YouTube. All rights reserved. https://youtu.be/UjPRVKS4OBg

27. Herdman, T. H., & Kamitsuru, S. (Eds.). (2018). *Nursing diagnoses: Definitions and classification, 2018-2020.* Thieme Publishers New York.

28. National Institute of Mental Health. (n.d.). *Any anxiety disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder

- Temperamental traits of shyness or behavioral inhibition in childhood
- Exposure to traumatic life or environmental events in early childhood or adulthood
- A history of anxiety or other mental health disorders in biological relatives

> Review information about adverse childhood events in the "Mental Health and Mental Illness" section in Chapter 1.

Some medical conditions (such as thyroid problems, chronic obstructive pulmonary disease, and angina) or substances (such as caffeine, certain prescribed medications, or illicit drugs) can also cause symptoms of anxiety. When a client is initially evaluated for anxiety, a physical health examination is performed to rule out other potential causes of their anxiety symptoms.

9.4 Treatments for Anxiety

Anxiety disorders are generally treated with psychotherapy, medication, or a combination of both treatments.[1] Support groups, coping strategies, and psychoeducation can also help individuals manage their anxiety.

Psychotherapy

Psychotherapy or "talk therapy" can help people with anxiety disorders. To be effective, psychotherapy must be directed at the person's specific anxieties and tailored to their needs. Examples of psychotherapy include **cognitive behavioral therapy (CBT)** and **dialectal behavior therapy (DBT)**. CBT teaches people different ways of thinking, behaving, and reacting to anxiety-producing situations and fearful objects. It can also help people learn and practice social skills, which is vital for treating social anxiety disorder. DBT assists individuals to develop distress tolerance skills and emotional regulation skills in managing their anxiety. CBT and DBT can be conducted individually or with a group of people who have similar difficulties.[2] Read more about CBT and DBT in the "Depressive Disorders" chapter.

Exposure therapy is a form of CBT which may be used alone or with other types of CBT to treat social anxiety disorder. Exposure therapy focuses on confronting the fears underlying an anxiety disorder to help people engage in activities they have been avoiding. Exposure therapy can be used in combination with relaxation exercises and/or imagery.[3] A similar therapy that

1. National Institute of Mental Health. (2024). *Anxiety disorders.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders
2. National Institute of Mental Health. (2024). *Anxiety disorders.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders
3. National Institute of Mental Health. (2024). *Anxiety disorders.* U.S. Department

is particularly helpful with phobias is systematic desensitization. Systematic desensitization is a graduated exposure therapy conducted at a very slow pace used in combination with relaxation techniques and imagery.[4]

Medications

Medications do not cure anxiety disorders but are used to help relieve symptoms of anxiety, panic attacks, extreme fear, and worry. The most common classes of medications used to combat anxiety disorders are antianxiety (anxiolytic) drugs (such as benzodiazepines), antidepressants, and beta-blockers.[5]

> Review information regarding the effects of benzodiazepines and beta-blockers on neurotransmitters in the "Antianxiety Medications" section of the "Psychotropic Medications" chapter.

of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders

4. Udayangani, S. (2021). *What is the difference between systematic desensitization and exposure therapy.* Difference Between. https://www.differencebetween.com/what-is-the-difference-between-systematic-desensitization-and-exposure-therapy/#Systematic%20Desensitization

5. National Institute of Mental Health. (2024). *Anxiety disorders.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders

Benzodiazepines

Benzodiazepines are prescribed for their immediate effect in relieving anxiety. For long-term use, benzodiazepines are considered a second-line treatment for anxiety (with antidepressants or buspirone considered first-line treatment), as well as an "as-needed" treatment for any distressing flare-ups of symptoms. These drugs are known for their rapid onset. However, people can build up a tolerance if taken over a long period of time, and they may need higher and higher doses to get the same effect. Benzodiazepines are a Schedule IV controlled substance because they have a potential for misuse and can cause dependence. To avoid these problems, benzodiazepines are typically prescribed for short periods of time, especially for people who have a history of substance use disorders. Short-acting benzodiazepines (such as lorazepam) and beta-blockers are used to treat the short-term symptoms of anxiety. Lorazepam is available for oral, intramuscular, or intravenous routes of administration.[6,7]

If people suddenly stop taking benzodiazepines after taking them for a long period of time, they may have withdrawal symptoms, or their anxiety may return. Withdrawal symptoms include sleep disturbances, irritability, increased tension and anxiety, hand tremors, sweating, difficulty concentrating, nausea and vomiting, weight loss, palpitations, headache,

6. National Institute of Mental Health. (2024). *Anxiety disorders*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders
7. National Institutes of Health. (2023). Lorazepam. DailyMed. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=73bfaeab-94db-48c2-a194-8b173025de78

muscular pain, and perceptual changes.[8] Therefore, benzodiazepines should be tapered off slowly.[9]

BLACK BOX WARNING

A Black Box Warning states that concurrent use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. The use of benzodiazepines exposes users to risks of misuse, substance use disorder, and addiction. Misuse of benzodiazepines commonly involves concomitant use of other medications, alcohol, and/or illicit substances, which is associated with an increased frequency of serious adverse outcomes. Additionally, the continued use of benzodiazepines may lead to clinically significant physical dependence. The risks of dependence and withdrawal increase with longer treatment duration and higher daily doses, and abrupt discontinuation or rapid dosage reduction may precipitate life-threatening withdrawal reactions. To reduce the risk of withdrawal reactions, a gradual taper should be used to stop or reduce the dosage.[10]

ADVERSE/SIDE EFFECTS

Children and older adults are more susceptible to the sedative and respiratory depressive effects of benzodiazepines and may experience paradoxical reactions such as tremors, agitation, or visual hallucinations. Debilitated

8. Pétursson, H. (1994). The benzodiazepine withdrawal syndrome. *Addiction*, 89(11):1455-9. doi:10.1111/j.1360-0443.1994.tb03743.x.

9. National Institute of Mental Health. (2024). *Anxiety disorders*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders

10. National Institutes of Health. (2023). *Lorazepam*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=73bfaeab-94db-48c2-a194-8b173025de78

clients should be monitored frequently and have their dosage adjusted carefully according to their response; the initial dosage should not exceed 2 mg. Dosage for clients with severe hepatic insufficiency should be adjusted carefully according to client response. Benzodiazepines may cause fetal harm when administered to pregnant women.[11]

OVERDOSAGE

Overdosage of benzodiazepines is manifested by varying degrees of central nervous system depression, ranging from drowsiness to coma. If overdose occurs, call 911 or the rapid response team during inpatient care. Treatment of overdosage is mainly supportive until the drug is eliminated from the body. Vital signs and fluid balance should be carefully monitored in conjunction with close observation of the client. An adequate airway should be maintained; intubation and mechanical ventilation may be required. The benzodiazepine antagonist flumazenil may be used to manage benzodiazepine overdose. There is a risk of seizure in association with flumazenil treatment, particularly in chronic users of benzodiazepines.

CLIENT EDUCATION

Clients should be cautioned that driving a motor vehicle, operating machinery, or engaging in hazardous or other activities requiring attention and coordination should be delayed for 24 to 48 hours following administration of benzodiazepines or until the effects of the drug, such as drowsiness, have subsided. Alcoholic beverages should not be consumed for at least 24 to 48 hours after receiving benzodiazepines due to the additive effects on central nervous system depression. Hospitalized clients should be advised that benzodiazepines increase fall risk, and getting out of bed

11. National Institutes of Health. (2023). *Lorazepam*. DailyMed. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=73bfaeab-94db-48c2-a194-8b173025de78

unassisted may result in falling and potential injury if undertaken within eight hours of taking benzodiazepines.

Antidepressants

Selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are commonly used as first-line treatments for anxiety. Less commonly used treatments for anxiety disorders are older classes of antidepressants, such as tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs).[12] Read more about antidepressants in the "Depressive Disorders" chapter. If antidepressants are prescribed, they can take several weeks to reach their optimal effectiveness, so it is important to teach clients to give the medication appropriate time before reaching a conclusion about its effectiveness. They should be advised to avoid abruptly stopping the medication or without talking to their prescribing provider. Antidepressants should be tapered off slowly to safely decrease the dose because stopping them abruptly can cause withdrawal symptoms.

Buspirone

Buspirone is a non-benzodiazepine medication indicated for the treatment of chronic anxiety. It is included in the class of medications called anxiolytics, but it is not chemically related to benzodiazepines, barbiturates, or other sedatives. Buspirone should not be taken concurrently with a monoamine oxidase inhibitor (MAOI) due to the risk of fatal side effects. It can also cause serotonin syndrome if used in combination with MAOIs, SSRIs, or SNRIs.[13]

12. National Institute of Mental Health. (2024). *Anxiety disorders*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders

13. National Institutes of Health. (2019). *Buspirone*. DailyMed. https://www.nlm.nih.gov/

Buspirone increases serotonin and dopamine levels in the brain. In contrast to benzodiazepines, buspirone must be taken every day for a few weeks to reach its full effect; it is not useful on an "as-needed" basis. A common side effect of buspirone is dizziness.[14] Buspirone is non-addictive and safer for long-term use than benzodiazepines.

Beta-Blockers

Although beta-blockers are typically used to treat high blood pressure and other cardiac conditions, they can also be used to help relieve the physical symptoms of anxiety, such as rapid heartbeat, shaking, trembling, and flushing. These medications, when taken for a short period of time, can help people keep their physical symptoms under control. Beta-blockers can also be used "as needed" to reduce acute anxiety or as a preventive intervention for predictable forms of performance anxieties.[15] For example, some students who experience severe test anxiety that impairs their exam performance may take prescribed beta-blockers before their exams.

Common side effects of beta-blockers are fatigue, hypotension, dizziness, weakness, and cold hands. Beta-blockers are typically avoided in clients with asthma or diabetes.[16]

14. Wilson, T. K., Tripp, J. (2023). *Buspirone*. StatPearls [Internet].https://www.ncbi.nlm.nih.gov/books/NBK531477/

15. National Institute of Mental Health. (2024). *Anxiety disorders*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders

16. National Institute of Mental Health. (2023). *Mental health medications.* U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

Hydroxyzine

Hydroxyzine is type of antihistamine which may be prescribed to alleviate anxiety for individuals for whom benzodiazepines are not appropriate. It causes sedation, so it must be used cautiously if used in combination with opioids or barbiturates. Hydroxyzine is recommended for short-term use in the treatment of anxiety and tension. The effectiveness of hydroxyzine for long-term use, defined as more than 4 months, has not been systematically assessed in clinical studies. Therefore, it is advised that physicians periodically reassess the usefulness of the drug for each individual client.[17]

Client Education

Clients should be educated about symptoms of their diagnosed anxiety disorder and techniques to manage it. For some individuals, even being aware that something is a symptom of anxiety, naming it, and connecting it to anxiety can help reduce the intensity of the anxiety.

Stress management techniques and coping strategies can help people with anxiety disorders calm themselves and enhance the effects of therapy. Research suggests that aerobic exercise can help some people manage their anxiety. Other coping strategies include meditation, yoga, journaling, prayer, or spending time in nature. Read more about stress management and coping strategies in the "Stress, Coping, and Crisis Intervention" chapter.

Support groups can be helpful for individuals experiencing anxiety disorders by sharing their problems and achievements with others experiencing similar symptoms. Talking with a trusted family member, friend, chaplain, or clergy member can also provide support.

Certain substances such as caffeine, some over-the-counter cold medicines, illicit drugs, and herbal supplements may aggravate the symptoms of anxiety

17. National Institutes of Health. (2019). *Hydroxyzine*. DailyMed. https://www.nlm.nih.gov/

disorders or interact with prescribed medications. Clients should be advised to avoid these substances.

View the following YouTube video on teaching adolescents how to deal with anxiety disorders: Mental Health Minute: Stress and Anxiety in Adolescents.[18]

18. National Institute of Mental Health (NIMH). (2021, September 21). *Mental health minute: Stress and anxiety in adolescents* [Video]. YouTube. All rights reserved. https://youtu.be/wr4N-SdekqY

9.5 Obsessive - Compulsive Disorder

Obsessive-compulsive disorder (OCD) is a common chronic disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and/or behaviors (compulsions) they feel the urge to repeat over and over. These compulsions often temporarily relieve the stress/tension of the obsession.[1]

Historically, the relationship of OCD with anxiety disorders was strongly emphasized. However, the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* classified OCD under a separate group of disorders called "Obsessive-Compulsive and Related Disorders" due to the presence of obsessions and compulsions.[2] A systematic review found that lifetime psychiatric comorbidities were present in 69% of individuals with OCD, with anxiety disorders the most common comorbidity in children, and depressive disorders being the most common comorbidity in adults.[3]

Signs and Symptoms

Symptoms of OCD can interfere with all aspects of life, such as work, school, and personal relationships. Symptoms may come and go, ease over time, or

1. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

2. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

3. Sharma, E, Sharma, L. P., Balachander, S., Lin, B., Manohar, H., Khanna, P., Lu, C., Garg, K., Thomas, T. L., Au, A. C. L., Selles, R. R., Højgaard, D. R. M. A., Skarphedinsson, G, Stewart, S. E. (2021). *Comorbidities in obsessive-compulsive disorder across the lifespan: A systematic review and meta-analysis.* Frontiers in Psychiatry, 12:703701. https://doi.org/10.3389%2Ffpsyt.2021.703701

worsen.[4] See Figure 9.7[5] for an artist's depiction of obsessive thoughts related to OCD.

Figure 9.7 Obsessive Compulsive Disorder

Obsessions are recurrent and persistent thoughts, urges, or images that are

4. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

5. "Cope-With-Obsessive-Compulsive-Disorder-Step-15.jpg" by unknown author at wikihow.com is licensed under CC BY-NC-SA 3.0

experienced as intrusive and unwanted, and in most individuals cause anxiety.[6] Common obsessions are as follows[7]:

- Fear of germs or contamination
- Unwanted forbidden or taboo thoughts involving sex, religion, or harm
- Aggressive thoughts towards self or others
- Having things symmetrical or in a perfect order

Compulsions are repetitive behaviors or mental acts that a person feels driven to perform in response to an obsession or according to their rules that must be applied rigidly. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, but are excessive and are not connected realistically with what they are intended to neutralize or prevent.[8] Examples of compulsions include the following[9]:

- Excessive cleaning and/or handwashing
- Ordering and arranging things in a particular, precise way
- Repeatedly checking on things, such as repeatedly checking to see if the door is locked or that the oven is off
- Compulsive counting

6. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

7. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

8. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

9. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

Not all rituals or habits are compulsions; everyone double-checks things sometimes. For example, many people double-check that their doors are locked as they exit the vehicle. However, a person with OCD generally exhibits the following characteristics[10]:

- Spends at least one hour a day on these thoughts
- Can't control their thoughts or behaviors, even when those thoughts or behaviors are recognized as excessive
- Does not experience pleasure when performing the behaviors or rituals, but may feel relief from the anxiety the obsessive thoughts cause
- Experiences significant problems in their daily life due to these thoughts or behaviors

Sometimes compulsions are accompanied by a fear of potential consequences if they are not carried out. For this reason, an individual with OCD may become distressed if not able to complete a compulsive act.

Some individuals with OCD also have a tic disorder. Motor tics are sudden, brief, repetitive movements, such as eye blinking and other eye movements, facial grimacing, shoulder shrugging, and head or shoulder jerking. Vocal tics include repetitive throat-clearing, sniffing, or grunting sounds.[11]

People with OCD may try to cope by avoiding situations that trigger their obsessions or use alcohol or drugs to calm themselves. Although most adults with OCD have good insight and recognize what they are doing doesn't make sense, some may not realize that their behavior is out of the ordinary (i.e., they

10. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

11. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

demonstrate “poor insight”). Most children do not have good insight into their thoughts and behaviors, so parents or teachers typically recognize OCD symptoms in children.

Risk Factors

The causes of OCD are unknown, but risk factors include genetics, brain structure and functioning, and environmental factors such as adverse childhood events (ACEs).[12]

Genetics

Twin and family studies have shown that people with first-degree relatives (such as a parent, sibling, or child) who have OCD are at a higher risk for developing OCD. The risk is higher if the first-degree relative developed OCD as a child or teen.[13]

Brain Structure and Functioning

Imaging studies have shown differences in the frontal cortex and subcortical structures of the brain in clients with OCD, but the connection with symptoms is not clear. Research is still underway because understanding potential causes may help determine specific, personalized treatments to treat OCD.[14]

12. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd
13. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd
14. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*.

Environment

Research has found an association between childhood trauma (otherwise known as adverse childhood events (ACEs) and obsessive-compulsive symptoms. Some studies also found that children may develop OCD symptoms following a streptococcal infection, referred to as Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS). Children with PANDAS have a very sudden onset or worsening of their symptoms after a streptococcal infection, followed by a slow, gradual improvement.[15]

- Review information about adverse childhood events (ACEs) in the "Mental Health and Mental Illness" section in Chapter 1.

- Read more at the National Institute of Mental Health (NIMH) PANDAS – Questions and Answers webpage.

Treatment

OCD is typically treated with medication, psychotherapy, or a combination of both. Although most clients with OCD improve with treatment, some clients continue to experience symptoms. Individuals with OCD may also have other

U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

15. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

mental health disorders, such as anxiety, depression, and body dysmorphic disorder (a disorder in which someone mistakenly believes that a part of their body is abnormal). It is important to consider these other comorbid disorders when planning interventions related to treatment.[16]

Medication

Selective serotonin reuptake inhibitors (SSRIs) are used to help reduce OCD symptoms. SSRIs often require higher daily doses in the treatment of OCD than of depression and may take 8 to 12 weeks to start working. If symptoms do not improve with SSRIs, research shows that some clients may respond well to an antipsychotic medication, especially if they also have a tic disorder.[17]

> Read more about SSRIs and antipsychotics in the "Psychotropic Medications" chapter.

Psychotherapy

Psychotherapy can be an effective treatment for adults and children with OCD. Research shows that certain types of psychotherapy, including cognitive behavior therapy (CBT) and other related therapies (such as habit reversal training), can be as effective as medication for many individuals. Research

16. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

17. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

also shows that a type of CBT called **Exposure and Response Prevention (EX/RP)** is effective in reducing compulsive behaviors in clients with OCD. EX/RP includes spending time in the very situation that triggers compulsions (for example, touching dirty objects) but then being prevented from undertaking the usual resulting compulsion (handwashing). For many clients, EX/RP is an add-on treatment when SSRIs do not effectively treat OCD symptoms.[18]

Other Treatment Options

In 2018 the FDA approved transcranial magnetic stimulation as an adjunct in the treatment of OCD in adults. **Repetitive Transcranial Magnetic Stimulation (rTMS)** uses a magnet to activate the brain. Unlike electroconvulsive therapy (ECT), in which electrical stimulation is more generalized, rTMS can be targeted to a specific site in the brain. A typical rTMS session lasts 30 to 60 minutes and does not require anesthesia. During the procedure, an electromagnetic coil is held against the forehead near an area of the brain that is thought to be involved in mood regulation. Short electromagnetic pulses are administered through the coil. The magnetic pulses easily pass through the skull and cause small electrical currents that stimulate nerve cells in the targeted brain region. The magnetic field is about the same strength as that of a magnetic resonance imaging (MRI) scan. The person generally feels a slight knocking or tapping on the head as the pulses are administered. The muscles of the scalp, jaw, or face may contract or tingle during the procedure, and mild headaches or brief light-headedness may result after the procedure. It is also possible that the procedure could cause a seizure, although this adverse effect is uncommon. Because the treatment is relatively new, long-term side effects are unknown.[19]

18. National Institute of Mental Health. (2024). *Obsessive-compulsive disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

19. National Institute of Mental Health. (2024). *Brain stimulation therapies*. U.S.

Client Education

In addition to teaching clients about the symptoms of OCD, prescribed medications, and other treatments, nurses should teach clients how to manage stress and anxiety associated with OCD:

- Create a consistent sleep schedule
- Make regular exercise a part of your routine
- Eat a healthy, balanced diet
- Seek support from capable family and friends

View a supplementary YouTube video[20] on OCD: Obsessive compulsive disorder (OCD) – causes, symptoms & pathology

Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies

20. Osmosis for Elsevier. (2016, March 7). *Obsessive compulsive disorder (OCD) – causes, symptoms & pathology* [Video]. YouTube. All rights reserved. https://www.youtube.com/watch?v=I8Jofzx_8p4

9.6 Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is diagnosed in individuals who have been exposed to a traumatic event with chronic stress symptoms lasting more than one month that are so severe they interfere with relationships, school, or work. PTSD was formerly classified as an anxiety disorder but was placed in a new diagnostic category in the DSM-5 called "Trauma and Stressor-Related Disorders."

Post-traumatic stress disorder has similar characteristics to severe anxiety and phobia-related disorders because of the physiological stress response that occurs. Post-traumatic stress disorder (PTSD) can develop in some people who have experienced a shocking, frightening, or dangerous event. It is natural to feel afraid during and after a traumatic situation, and the "fight-or-flight" stress response is a physiological reaction intended to protect a person from harm. Most people recover from the range of reactions that can occur after experiencing trauma. However, people who do not recover from these reactions and continue to experience problems are diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger.[1]

Symptoms

Symptoms of PTSD typically begin three months after the traumatic incident, but they may also begin years afterward. If symptoms occur within one month of the traumatic event, it is diagnosed as acute stress disorder. Symptoms must last more than a month and be severe enough to interfere with social or occupational functioning to be considered PTSD. The course of the illness varies; some people recover within six months, while others have

1. National Institute of Mental Health. (2024). *Post-traumatic stress disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

symptoms that last much longer. In some people, the condition becomes chronic.[2,3]

To be diagnosed with PTSD, an adult must have the following types of symptoms for at least one month[4,5]:

- At least one “re-experiencing” symptom
- At least one “avoidance” symptom
- At least two “arousal and reactivity” symptoms
- At least two “cognition and mood” symptoms

Re-Experiencing Symptoms

Re-experiencing symptoms include the following[6]:

- Flashbacks—reliving the trauma over and over, including physical

2. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd
3. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.
4. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd
5. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.
6. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

symptoms like a racing heart or sweating
- Bad dreams
- Frightening thoughts

Re-experiencing symptoms can start from the person's own thoughts and feelings. Words, objects, or situations that are reminders of the event can also trigger re-experiencing symptoms. Re-experiencing symptoms may cause problems in a person's everyday routine and relationships.[7]

Avoidance Symptoms

Avoidance symptoms are as follows[8]:

- Staying away from places, events, or objects that are reminders of the traumatic experience
- Avoiding thoughts or feelings related to the traumatic event

These symptoms may cause a person to change their personal routine. For example, after a car accident, a person who usually drives may avoid driving or riding in a car.

7. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

8. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

Arousal and Reactivity Symptoms

Arousal and reactivity symptoms include the following[9]:

- Being easily startled
- Feeling tense or “on edge”
- Having difficulty sleeping
- Having angry outbursts

Arousal symptoms are usually constant instead of being triggered by things that remind one of the traumatic events. These symptoms can make the person feel stressed and angry and can make it hard to do daily tasks, such as sleeping, eating, or concentrating.[10]

Cognition and Mood Symptoms

Cognition and mood symptoms are as follows[11]:

- Trouble remembering key features of the traumatic event
- Negative thoughts about oneself or the world
- Distorted feelings like guilt or blame
- Loss of interest in enjoyable activities

9. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd
10. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd
11. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

Cognition and mood symptoms can begin or worsen after the traumatic event and make the person feel alienated or detached from friends or family members.[12]

It is natural to have some of these types of symptoms for a few weeks after a traumatic event. However, when the symptoms last more than a month, seriously affect a person's functioning, and are not related to substance use, medical illness, or anything except the event itself, they can be symptoms of PTSD. PTSD is also often accompanied by depression, substance abuse, or other anxiety disorders.[13]

Life Span Considerations

Children and teens can have extreme reactions to trauma, but they may exhibit different symptoms than adults. Symptoms of PTSD can be seen in young children (less than six years old) and may include the following:

- Bedwetting after having learned to use the toilet
- Forgetting how to talk or being unable to talk (i.e., selective mutism)
- Acting out the scary event during playtime
- Being unusually clingy with a parent or other adult

Older children and teens are more likely to show symptoms similar to those seen in adults. They may also develop disruptive, disrespectful, or destructive behaviors. Hypersexual behavior may occur if the trauma was related to a sexual assault. Older children and teens may also feel guilty for not preventing

12. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

13. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

injury or death in certain traumatic situations and may have thoughts of revenge.[14]

Risk and Resilience Factors

Anyone can develop PTSD at any age, including war veterans; children who have experienced trauma; or adults who have experienced a physical or sexual assault, abuse, accident, disaster, being a refugee, or some other serious event. According to the National Center for PTSD, about 6 out of every 100 people will experience PTSD symptoms at some point in their lives. Women are more likely to develop PTSD than men, and genes may make some people more likely to develop PTSD than others.[15]

Not everyone with PTSD has directly experienced a dangerous event. Some people develop PTSD after a friend or family member experiences danger or harm. The sudden, unexpected death of a loved one can also lead to PTSD.[16] PTSD is triggered by events that are perceived to be life-threatening, and this can vary from individual to individual. It disrupts the general sense of safety that allows individuals to function in the world.

It is important to remember that not everyone who lives through a dangerous event develops PTSD. In fact, most people will not develop the disorder. Many factors play a part in whether a person will develop PTSD. Risk factors make a

14. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

15. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

16. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

person more likely to develop PTSD, but other factors, called resilience factors, can help reduce the risk of developing the disorder or promote recovery from the disorder.[17]

These factors increase the risk for developing PTSD[18]:

- Living through dangerous events and traumas
- Being injured from a traumatic event
- Seeing another person hurt or seeing a dead body
- Experiencing childhood trauma or adverse childhood events (ACEs)
- Feeling horror, helplessness, or extreme fear
- Having little or no social support after the event
- Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home
- Having a history of mental illness or substance abuse

> Review information about adverse childhood events (ACEs) in the "Mental Health and Mental Illness" section of Chapter 1.

Resilience factors that may promote recovery after trauma include the following[19]:

17. National Institute of Mental Health. (2024). *Post-traumatic stress disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

18. National Institute of Mental Health. (2024). *Post-traumatic stress disorder*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

19. National Institute of Mental Health. (2024). *Post-traumatic stress disorder*. U.S.

- Receiving support from other people, such as friends and family
- Finding a support group after a traumatic event
- Learning to feel good about one's own actions in the face of danger, recognizing that we controlled what we could in an uncontrollable situation
- Having a positive coping strategy or a way of getting through the bad event and learning from it
- Being able to act and respond effectively despite feeling fear

If a child or adolescent discloses traumatic events to caregivers, teachers, or other adults, it is important for them to feel their concerns are validated by the adult in order to develop resilience.

Researchers are studying the importance of risk and resilience factors, as well as the impact of genetics and neurobiology. With more research, it may be possible to someday predict who is likely to develop PTSD and how to prevent it from occurring.[20] See Figure 9.8[21] for an image of a veteran with PTSD using a service dog as an effective coping strategy.

Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

20. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

21. "Local_veterans_group_gets_national_exposure_141127-F-ZZ999-001.jpg" by unknown author is licensed in the Public Domain

Figure 9.8 A Veteran with PTSD Using a Service Dog as a Coping Strategy

Treatments

For people with PTSD, treatments include medications, psychotherapy, or a combination of both. Everyone is different, and PTSD affects people differently, so a treatment that works for one person may not work for another. It is important for anyone with PTSD to be treated by a mental health provider who has experience treating PTSD.[22]

If someone with PTSD is also experiencing an ongoing trauma, such as an abusive relationship, both of the problems need to be addressed. Other ongoing problems can include panic disorder, depression, substance use disorder, and suicidal ideation.[23]

22. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

23. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S.

Medications

Antidepressants can help control PTSD symptoms such as sadness, worry, anger, and feeling numb inside. For example, two FDA-approved medications for PTSD are the antidepressants sertraline and paroxetine. Other medications may be helpful for treating specific PTSD symptoms, such as sleep problems and nightmares.[24] Read more information about antidepressants in the "Antidepressants" section of the "Psychotropic Medications" chapter.

Psychotherapy

Psychotherapy can occur one-on-one or in a group setting. It typically lasts 6 to 12 weeks, but it can continue for as long as the individual finds it helpful. Research shows that additional support from family and friends can be an important part of recovery.[25]

Many types of psychotherapy can help people with PTSD. Some target the symptoms of PTSD directly, whereas other therapies focus on social, family, or job-related problems. Effective psychotherapies emphasize key components such as education about symptoms, identification of triggers or symptoms, and skills to manage the symptoms. Examples of psychotherapies used to treat PTSD are cognitive behavioral therapy, exposure therapy, eye movement

Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

24. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

25. National Institute of Mental Health. (2024). *Post-traumatic stress disorder.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

desensitization and reprocessing, animal therapy programs, and MDMA-assisted psychotherapy.

Cognitive behavioral therapy (CBT) combined with exposure therapy helps people face and control their fear by gradually exposing them to the trauma they experienced in a safe way. It uses imagining, writing, or visiting the place where the event happened to help reduce the intensity of PTSD symptoms. Read more about CBT in the "Depressive Disorders" chapter.

Cognitive restructuring helps individuals create new thought patterns about the trauma. Sometimes events are remembered differently than how they truly happened, and individuals may experience feelings of guilt or shame in relation to the trauma, regardless of whether they played an active role or not. They may feel guilt or shame about something that is not their fault. Therapists can help individuals assess the trauma through a variety of lenses to process and continue the healing journey.

Eye movement desensitization and reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. During EMDR therapy, the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Therapist-directed lateral eye movements are the most commonly used external stimulus, but a variety of other stimuli such as hand-tapping and audio stimulation are also used. It is hypothesized that EMDR therapy facilitates the individual's access of their traumatic memory network so that new associations can be forged between the traumatic memory and more adaptive memories or information. These new associations are thought to result in elimination of emotional distress and development of cognitive insights.[26,27]

26. EDMR Institute. (n.d.) *What is EDMR?* https://www.emdr.com/what-is-emdr/

27. American Psychological Association. (2025). *Clinical practice guidelines for the treatment of post-traumatic stress disorder: Eye Movement*

Animal assisted intervention (AAI), also referred to as animal therapy, is a commonly used complementary treatment for PTSD. It most often includes dogs or horses. A systematic review examined the outcomes in studies using AAI with trauma survivors. Although the reviewed studies were diverse and limited, all reported positive outcomes of AAI, such as reduced depression, PTSD symptoms, and anxiety.[28]

View a supplementary YouTube video[29] on EMDR therapy: What is Eye Movement Desensitization Reprocessing Therapy?

View a supplementary YouTube video on PTSD[30]: NIMH-

Desensitization and Reprocessing (EMDR) Therapy. https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing

28. O'Haire, M., Guerin, N., & Kirkham, A. (2015). Animal-Assisted Intervention for trauma: a systematic literature review. *Frontiers in Psychology, 6*. https://doi.org/10.3389/fpsyg.2015.01121

29. Pysch Hub. (2019, April 16). *What is eye movement desensitization reprocessing therapy?* [Video]. YouTube. All rights reserved. https://www.youtube.com/watch?v=1IPsBPH2M1U

30. National Institute of Mental Health (NIMH). (2021, June 21). *NIMH-funded researcher Dr. Barbara Rothbaum discusses post-traumatic stress*

Funded Researcher Dr. Barbara Rothbaum Discusses Post-Traumatic Stress Disorder.

disorder [Video]. YouTube. All rights reserved. https://youtu.be/wIcWIbM4hLE

9.7 Applying the Nursing Process to Anxiety Disorders

People with anxiety disorders rarely require hospitalization unless they are suicidal, although anxiety can occur with other mental disorders requiring hospitalization. As a nurse working with individuals with diagnosed anxiety disorders, be aware of your self-reaction. It is not uncommon to have feelings of frustration, especially if you feel as if the symptoms are a matter of choice or under the client's control. The client often acknowledges the fear is unrealistic or exaggerated but continues to engage in avoidant behavior. Recall that avoidant behavior is a symptom, and behavioral changes are accomplished slowly with treatment.[1]

It is also important to be aware that hospitalized clients may develop anxiety in association with other medical conditions (i.e., chronic obstructive pulmonary disease [COPD], angina, or hyperthyroidism) or medical procedures. Anxiety is a nursing diagnosis, as well as a potential mental health disorder. While implementing interventions that address medical conditions, often the nurse must also implement interventions that address associated anxiety.

Assessment (Recognize Cues)

Mental Status Examination

See Table 9.7a for common findings when assessing a client with an anxiety disorder. (See expected findings for these components of a mental status examination in the "Assessment" section in Chapter 4.) Critical findings that require immediate notification of the provider are bolded with an asterisk.

1. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Table 9. 7a Common Findings During Mental Status Examinations for Clients With Anxiety Disorders[2]

2. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Mental Status Examination Component	Common Findings in Anxiety Disorders (*Indicates immediately notify provider)
Signs of Distress	Determine the client's current level of anxiety (mild, moderate, severe, or panic) and assess for risk of suicide or self-harm. If a client is experiencing a panic attack, they may exhibit ***shortness of breath**, ***chest pain** or tightness, a choking sensation, dizziness, ***palpitations**, nausea, abdominal pain, diaphoresis, or a fear of dying or losing control. Anxiety often coexists with depression and can lead to feelings of being overwhelmed and unable to cope, which can be a significant risk factor for suicidal ideation. ***Note: Suicidal ideations indicate increased risk for self-injury, suicide, or injury to others and must be reported to provider. Do not leave clients alone if statements such as these are being made.**
Level of Consciousness and Orientation	Typically alert and oriented to person, place, time, and situation. However, during acute panic episodes, transient confusion or disorientation may occur.
Appearance and General Behavior	May appear nervous and restless with fidgeting, wringing hands, foot tapping, facial tension, and tremors. Posture may be rigid or defensive. May avoid eye contact, appear guarded, or display frequent checking behaviors (e.g., looking around the environment for threats). May experience urinary frequency. May appear disheveled. May report altered sleep patterns. ***Verbal and nonverbal threats of harm** or ***self-harming behaviors** such as cutting, picking at skin, knocking head against the wall, tightening string or items on wrists, or stabbing self with anything fashioned into a weapon should be immediately reported to the provider.
Speech	Speech may be rapid, pressured, or hesitant; may include stammering, especially in social anxiety; often driven by urgency to express worries or fears.
Motor Activity	Psychomotor agitation is common (e.g., pacing, fidgeting, tapping fingers) with restless movements and muscle tension evident. May display shakiness or tremors.

Mood and Affect	Affect is often irritable. Mood is often reported as “worried,” “on edge,” “nervous,” or “panicked.” Mood and affect are generally congruent.
Thought and Perception	Thought content is dominated by worry, anticipatory fear, or intrusive thoughts (especially in clients with OCD). Thought process may be circumstantial with excessive unnecessary details, tangents, and related ideas included before addressing the core topic. Perceptions are generally intact with no hallucinations.
Attitude and Insight	Often cooperative but may be guarded or overly compliant. May recognize thoughts as excessive or irrational (especially in clients with GAD or OCD), but still struggles to control them.
Cognitive Abilities and Level of Judgment	Usually intact, although attention and concentration may be impaired by excessive worry. Working memory and decision-making may be affected with severe anxiety or panic.

Psychosocial Assessment

It is helpful to begin the psychosocial assessment by obtaining the reason why the client is seeking health care in their own words and focus on what factors could be contributing to their anxiety. For example, the client may identify a problem such as a relationship issue, stressful job, or school challenges that could be addressed by counseling.[3]

A comprehensive psychosocial assessment includes the following components:

- Reason for seeking health care (i.e., “chief complaint”)

3. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

- Thoughts of suicide or self injury
- Cultural assessment
- Spiritual assessment
- Family dynamics
- Current and past medical history
- Current medications
- History of previously diagnosed mental health disorders
- Previous hospitalizations
- Educational background
- Occupational background
- History of exposure to psychological trauma, violence, and domestic abuse
- Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
- Family history of mental illness
- Coping mechanisms
- Functional ability/Activities of daily living

After identifying the reason the client is seeking health care, additional focused questions are used to obtain detailed information. The mnemonic PQRSTU can be used to ask questions in an organized fashion. See Table 9.7b for a sample PQRST assessment for anxiety.

Table 9.7b Sample PQRSTU Questions for Assessing Anxiety

PQRSTU	Sample Questions
Provocation/ Palliation	"What makes your anxiety get worse?" "What helps calm your anxiety?"
Quality	"Can you describe what it feels like when you have anxiety?"
Region	"Do you feel the anxiety in specific places in your body?"
Severity	"On a scale of 0 to 10, how bad is your anxiety right now?"
Timing/ Treatment	"When did the anxiety start? How long does it usually last? Is it constant c
Understanding	"What do you think is causing your anxiety?"

SUICIDE AND SELF INJURY SCREENING

Clients being evaluated or treated for anxiety may have suicidal ideation. It is important for the nurse to introduce suicide screening in a way that helps the client understand its purpose and normalize questions that might otherwise seem intrusive. The Patient Safety Screener (PSS-3) is an example of a brief screening tool to detect suicide risk in all client presenting to acute care settings.[4]

4. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief*

Non-suicidal self-injury (NSSI) refers to intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting. It is considered a maladaptive coping strategy without the desire to die. NSSI is a common finding among adolescents and young adults in psychiatric inpatient settings.[5]

Review information about suicide screening, the Patient Safety Screener, and screening for non-suicidal self-injury (NSSI) in the "Assessment" section of the Applying the Nursing Process to Mental Health Care" chapter.

CULTURAL ASSESSMENT

Cultural Formulation Interview (CFI) questions help nurses understand a client's cultural background and how it influences their experience of mental health symptoms, including anxiety.[6] Sample CFI questions focused specifically on understanding anxiety within a cultural context include the following:

- Cultural Definition of the Problem
    - "Can you tell me more about your experience of feeling anxious or

tool to detect suicide risk. https://sprc.org/micro-learning/patientsafetyscreener

5. Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, 8. https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full

6. DeSilva, R., Aggarwall, N. K., & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry. *Psychiatric Times, 32*(6). https://www.psychiatrictimes.com/view/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry

nervous?"
    - "What do you call these feelings or symptoms in your own words or language?"
    - "What do people in your family or community think is going on when someone feels like this?"
- Cultural Perceptions of Cause, Context, and Support
    - "Why do you think this anxiety started?"
    - "Are there any stressors in your life or community that you believe contribute to these feelings?"
    - "Do you believe your anxiety is related to physical health, spiritual issues, or emotional distress?"
    - "What do others in your family or community (parents, elders, spiritual leaders) believe causes anxiety?"
- Cultural Factors Affecting Coping and Help-Seeking
    - "How have you tried to deal with your anxiety so far?"
    - "Are there any traditional practices, herbs, or dietary supplements you have tried to use to manage it?"
    - "Have you sought help from community leaders, healers, or religious figures?"
    - "What kinds of treatment or help do you think would be most useful or acceptable to you?"
- Cultural Features of the Nurse–Client Relationship
    - "Are there any concerns you have about talking to a mental health professional?"
    - "Would you feel more comfortable speaking with someone of a similar gender, cultural, or religious background?"
    - "What would help you feel more supported or understood during treatment?"

Findings from the cultural formulation interview are used to individualize a client's plan of care to their preferences, values, beliefs, and goals.

Cultural beliefs can affect an individual's expression of their feelings of anxiety. An example of a culture-mediated response related to anxiety and panic disorder is ataque de nervios (ADN) or "attack of the nerves" that may be exhibited in Hispanic populations. Symptoms of ADNs can vary widely but are typically described as an experience of distress characterized by a general sense of being out of control. The most common symptoms include uncontrollable shouting, attacks of crying, trembling, and heat in the chest rising into the head. Suicidal gestures, seizures, or fainting episodes may be observed. These symptoms are reported to typically occur following a distressing event such as an interpersonal conflict or the death of a loved one.[7]

SPIRITUAL ASSESSMENT

The FICA Spiritual History Tool is a widely used assessment model for evaluating a client's spiritual beliefs and how they may influence health, illness, and coping. It's especially helpful in understanding how clients with anxiety draw on spirituality or religion for support—or how spiritual distress may be contributing to feelings of anxiety. Spiritual distress is very common for clients experiencing serious illness, and nurses assist clients to adopt healthy coping strategies to deal with these life events. Addressing a client's

7. Keough, M. E., Timpano, K. R., & Schmidt, N. B. (2009). Ataques de nervios: Culturally bound and distinct from panic attacks? *Depression & Anxiety, 26*(1), 16-21. https://onlinelibrary.wiley.com/doi/10.1002/da.20498

spirituality and advocating spiritual care have been shown to improve clients' health and quality of life.[8,9]

The FICA Spiritual History Tool© is a common tool used to gather information about a client's spiritual history and preferences. FICA© is a mnemonic for the domains of Faith, Importance, Community, and Address in Care.[10] Table 9.7c summarizes a sample FICA Spiritual Assessment for a client experiencing anxiety.

Table 9.7c Sample FICA Spiritual Assessment Questions for Clients with Anxiety

8. Pilger, C., Molzahn, A. E., de Oliveira, M. P., & Kusumota, L. (2016). The relationship of the spiritual and religious dimensions with quality of life and health of patients with chronic kidney disease: An integrative literature review. *Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association, 43*(5), 411–426. https://pubmed.ncbi.nlm.nih.gov/30550069/

9. Puchalski, C., Jafari, N., Buller, H., Haythorn, T., Jacobs, C., & Ferrell, B. (2020). Interprofessional spiritual care education curriculum: A milestone toward the provision of spiritual care. *Journal of Palliative Medicine, 23*(6), 777–784. https://doi.org/10.1089/jpm.2019.0375

10. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*. https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool

Domain	Sample Assessment Question	Sample Client Response
Faith	"Do you consider yourself spiritual or religious? What gives your life meaning?"	"Yes, I believe in God. My faith gives me strength when I feel overwhelmed."
Importance	"What importance does your faith or belief have in your life? Has it influenced how you cope with stress or your anxiety?"	"I believe that everything happens for a reason. I try to trust in God when I feel anxious, but sometimes I wonder if I'm being punished for something I have done."
Community	"Are you part of a spiritual or religious community? Does participation in this community provide support when you're feeling anxious or stressed?"	"Sometimes I go to church on Sundays. Being with others who have similar beliefs helps me feel less alone."
Address in Care	"How would you like me (or the health care team) to address spiritual issues during your care? Would you like to speak with a chaplain?"	"Yes I would be interested in speaking to a chaplain."

Nurses may recognize cues of spiritual distress or beliefs in divine punishment that may exacerbate feelings of anxiety. Nurses can offer to connect the client with a chaplain or spiritual care services. Spiritual goals may be included in the nursing care plan if the client finds them valuable.

FAMILY DYNAMICS

Family dynamics are included in a psychosocial assessment, especially for children, adolescents, and older adults. **Family dynamics** refers to the patterns of interactions among relatives, their roles and relationships, and the various factors that shape their interactions. Because family members rely on each other for emotional, physical, and economic support, they are primary sources of relationship security or stress. Family dynamics and the quality of family relationships can have either a positive or negative impact on an individual's mental health. For example, secure and supportive family relationships can provide love, advice, and care, whereas stressful family

relationships can be burdened with arguments, unhealthy relationships, and a lack of support.[11]

Unhealthy family dynamics can cause children to experience trauma and stress as they grow up. This type of exposure, known as adverse childhood experiences (ACEs), is linked to an increased risk of developing physical and mental health problems such as heart, lung, and liver disease, depression, and anxiety. Unhealthy family dynamics also correlate with an increased risk of substance use and addiction among adolescents.[12]

> Review information about adverse childhood experiences (ACEs) in the "Mental Health and Mental Illness" section of Chapter 1.

Screening Tools

The Severity Measure for Generalized Anxiety Disorder in Adults is a common tool for measuring anxiety. High scores may indicate generalized anxiety disorder or panic disorder, although it can also be associated with major depressive disorder.

11. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK560487/

12. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK560487/

View the Severity Measure for Generalized Anxiety Disorder—Adult PDF screening tool.

Diagnostic and Lab Work

When assessing for anxiety disorders, the provider will typically order lab work to rule out common medical causes of anxiety, such as hyperthyroidism, hypoglycemia, hypercalcemia, hyperkalemia, hyponatremia, or hypoxia. Toxicology screen to identify potential substance abuse. Review and/or monitor the results of these tests as part of the nursing assessment.

Lifespan Considerations

CHILDREN AND ADOLESCENTS

All children experience some anxiety, and anxiety is expected at specific times of a child's development. For example, from approximately age eight months through the preschool years, healthy children may show anxiety when separated from their parents or caregivers, called separation anxiety. Young children also commonly have fears, such as fear of the dark, storms, animals, or strangers. Anxiety is considered normal when situational. Consider the fear of dangerous situations such as approaching a rattlesnake or standing on a steep cliff; at crucial times such as these, anxiety is important because it provides safety. Anxiety can also be also motivational if it drives clients to accomplish goals.

When a child is overly worried or anxious, a nurse's initial assessment should determine if conditions in the child's environment are causing this feeling. For example, is the anxiety resulting from being bullied or from adverse childhood experiences (ACEs)? If so, protective interventions should be put into place. If no realistic threat exists and the anxiety causes significant life

dysfunction, then the child should be referred to a mental health provider to determine if an anxiety disorder exists.

Children with anxiety disorders are overly tense or fearful and their worries interfere with daily activities. Some children may require significant amounts of reassurance. Because anxious children may also be quiet, compliant, and eager to please, their feelings of anxiety can be easily missed. When a child does not outgrow the typical fears and anxieties in childhood or when there are so many fears and worries they interfere with school, home, or play activities, the child may be diagnosed with an anxiety disorder.

Anxiety can also make children irritable and angry and can include physical symptoms like fatigue, headaches, stomachaches, or trouble sleeping. Early treatment of anxiety disorders in children and adolescents can enhance friendships, social and academic potential, and self-esteem.

OLDER ADULTS

Anxiety disorders in older adults may be impacted by age-related physical, psychological, and social factors. Older adults may not use the word “anxiety”, but may instead describe feeling “worried,” “nervous,” “or “tense.” Some older adults may view anxiety or expression of their emotions as a personal weakness due to generational beliefs. Nurses can normalize mental health conversations and reduce stigma by framing care in terms of well-being, quality of life, and stress reduction. Hearing or memory issues may affect how an older adult responds to questions, so nurses should allow more time for responses. Death of a spouse, family members, or friends can lead to increased feelings of loss and isolation. It is often beneficial to include social engagement and reminiscence therapy in treatment of anxiety in older adults. Chronic illnesses like chronic obstructive pulmonary disease (COPD), cardiovascular disease, or diabetes mellitus can increase levels of anxiety due to medical concerns and may be compounded by issues like fear of falling, losing autonomy, or being placed in a long-term care setting. Symptoms of anxiety may be mistaken for signs of early dementia, such as restlessness and difficulty concentrating. Side effects from certain medications can also cause

or worsen feelings of anxiety, such corticosteroids, bronchodilators, or stimulants. Benzodiazepines are not recommended for use by older adults to treat anxiety due to side effects of oversedation, confusion, and increased fall risk.

Diagnosis (Analyze Cues)

Anxiety is a NANDA-I nursing diagnosis and described as "vague, uneasy feeling of discomfort or dread accompanied by an autonomic response; a feeling of apprehension caused by anticipation of danger. It is an alerting sign that warns of impending danger and enables the individual to take measures to deal with the threat."[13] Review signs and symptoms of anxiety in the preceding "Assessment" subsection or consult an evidence-based nursing care plan resource for defining characteristics of this nursing diagnosis.

Outcome Identification (Generate Solutions)

The overall goal for clients experiencing anxiety is to reduce the frequency and intensity of the anxiety symptoms. SMART outcomes are individualized to the client's specific diagnosed conditions, situational factors, and current status. Planning outcomes in small, attainable steps can help a client gain a sense of control over their anxiety.[14]

Examples of SMART outcomes include:

- The client's vital signs will return to baseline within one hour.
- The client will identify and verbalize symptoms of anxiety by the end of the shift.

13. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
14. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

- The client will verbalize three preferred stress management and coping strategies for controlling their anxiety by the end of Week 1.

Planning (Generate Solutions)

The client should be encouraged to participate in planning outcomes and interventions tailored to their situation and needs. This will increase the likelihood that the interventions will be successful. Keep in mind that clients with severe anxiety or panic may not be able to participate in planning and rely on the nurse to take a directive role.[15]

Safety

Immediately planning and implementing interventions to maintain client safety receive priority. Review interventions for clients with a risk for suicide in the "Application of the Nursing Process in Mental Health Care" chapter.

If a client's anxiety continues to escalate and they become severely agitated, measures must be taken to keep them and others safe. The nurse may find that administering prescribed medications, initiating time in a quiet room, seclusion, or restraints is required. Review crisis intervention in the "Stress, Coping, and Crisis Intervention" chapter. Review information regarding the use of seclusion and restraints in the "Psychosis and Schizophrenia" chapter. Review ANA guidelines on using restraints in the "Client Rights" section of the "Legal and Ethical Considerations in Mental Health Care" chapter and information on safely implementing restraints in the "Workplace Violence" section of the "Trauma, Abuse, and Violence" chapter.

Mild to Moderate Anxiety

The nurse can reduce a client's anxiety level and prevent escalation by

15. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

providing a calm presence in a quiet environment, acknowledging their feelings of distress, and actively listening. Using therapeutic techniques like open-ended questions, distraction, exploring, and seeking clarification can be used to relieve the client's feelings of tension and focus on previously successful coping strategies.[16] Review therapeutic communication techniques in the "Therapeutic Communication and the Nurse-Client Relationship" chapter.

It may be helpful to encourage the client to participate in physical activities that may provide relief from tension and increase endorphin levels. For example, the nurse can encourage the mildly anxious client to walk or play ping-pong.[17]

Severe Anxiety to Panic

A person experiencing severe anxiety to panic is often unable to solve problems or grasp what is going on in the environment. The nurse should also remain with a client experiencing acute, severe, or panic levels of anxiety. Therapeutic communication should focus on helping the client feel safe. Firm, short, simple statements using a slow, low-pitched voice are helpful.[18]

In addition to keeping the client and others safe, priority nursing interventions for a client experiencing severe anxiety focus on the client's physical needs, such as fluids to prevent dehydration, blankets for warmth, and rest to prevent exhaustion. If a person continues to constantly move or

16. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
17. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
18. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

pace despite interventions, high-calorie finger foods may be offered to maintain their nutrition.[19] Read additional interventions related to crisis intervention in the "Stress, Coping, and Crisis Intervention" chapter.

Implementation (Take Action)

Nursing Interventions for Anxiety Based on Categories of the APNA Implementation Standard

Nursing interventions for anxiety disorders can be categorized based on the American Psychiatric Nurses Association (APNA) standard for *Implementation* that includes the *Coordination of Care; Health Teaching and Health Promotion; Pharmacological, Biological, and Integrative Therapies; Milieu Therapy;* and *Therapeutic Relationship and Counseling*. Read more about these subcategories in the "Application of the Nursing Process in Mental Health Care" chapter. See examples of interventions for each of these categories for clients with anxiety disorders in Table 9.7d.

Table 9.7d Examples of Nursing Interventions for Anxiety by APNA Subcategories[20,21]

19. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
20. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
21. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

Subcategory of the APNA Standard of Implementation	The nurse will …	Rationale
Coordination of Care	– Collaborate with interdisciplinary team members to develop a comprehensive anxiety management plan. – Ensure continuity of care during transitions. – Facilitate referrals to specialists or community programs.	Anxiety is often multifactorial, requiring input from various disciplines. Coordinated care ensures consistent, holistic support across settings and improves outcomes.
Health Teaching and Health Promotion	– Teach about the physiological signs of anxiety. – Teach stress management techniques (eating a healthy diet, avoiding caffeine and other stimulants, participating in regular physical activity, obtaining adequate sleep, using mindfulness activities).-Teach positive coping strategies (mediation, prayer, deep breathing exercises, grounding, yoga, journaling, mindfulness activities).	Increasing the client's understanding of the symptoms of anxiety helps empowers self-management. Lifestyle changes and coping strategies reduce physiological arousal and improve resilience.
Pharmacological, Biological, and Integrative Therapies	– Monitor effectiveness prescribed medications and for side effects. – Educate client and family members on medication purpose and adherence. – Support safe use of integrative therapies (e.g., mindfulness, aromatherapy). – Monitor for misuse of benzodiazepines.	Pharmacologic treatment can reduce symptom severity. Client education improves adherence and safety. Integrative therapies can enhance relaxation and overall well-being. Monitoring reduces the risk of adverse effects or dependence.

Milieu Therapy	– Maintain a calm and structured unit with minimal overstimulation. – Provide quiet, safe spaces for de-escalation. – Encourage participation in group therapy or activities. – Use environmental cues to reduce uncertainty.	A structured, low-stimulation environment reduces external stressors and promotes emotional stability. Group participation fosters connection, reduces isolation, and models healthy coping behaviors.
Therapeutic Relationship and Counseling	– Establish trust and rapport using active listening and empathy. – Use therapeutic communication techniques. – Encourage expression of thoughts and fears. – Support realistic goal-setting and problem-solving.	A strong nurse–client relationship and therapeutic communication provides emotional safety, fosters insight, and motivates engagement in treatment.

Nursing Interventions for Physiological Signs of Anxiety

Nursing interventions also target common physiological signs of anxiety and associated self-care deficits. See common interventions for these conditions in Table 9.7e.

Table 9.7e Nursing Interventions Targeting Physiological Signs of Anxiety and Self-Care Deficit[22]

22. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Problem/Intervention	Rationale
Nutrition • **Monitor nutritional intake and weight regularly.** • **Encourage small, frequent meals if appetite is decreased.** • **Teach about avoiding caffeinated beverages and excessive sugar intake.** • **Refer the client to a dietician if necessary.**	Anxiety may reduce appetite or lead to emotio high-sugar foods can exacerbate physiological restlessness). Balanced nutrition supports ener
Sleep • **Assess sleep patterns and quality using sleep diary.** • **Promote sleep hygiene: establish bedtime routine, limit screen time, avoid stimulants.** • **Teach relaxation techniques such as deep breathing or guided imagery before bed.** • **Consult with health care provider for sleep medications or referral for CBT if insomnia persists.**	Anxiety can cause difficulty falling asleep or sta worsens anxiety and impairs coping. Non-phar better rest without dependence.

Elimination • **-Monitor for constipation, diarrhea, or urinary frequency, which may be exacerbated by anxiety.** • **Encourage hydration and high-fiber foods.** • **Promote regular toileting schedule and privacy.** • **Evaluate for side effects of anxiety medications affecting elimination.**	Autonomic arousal due to feelings of anxiety ca urinary patterns. Supporting elimination helps increased levels of anxiety. Some medications (function.
Self-Care Deficits • **Assess for performance of Activities of Daily Living (ADL) including bathing, grooming, and dressing.** • **Provide structure and gentle prompts for hygiene tasks as needed.** • **Encourage participation in morning routines and setting daily goals.** • **Promote positive reinforcement for completing self-care tasks.**	Anxiety can cause fatigue, low motivation, or av hygiene and self-care. Structured support help functioning.

Communication Tips for Clients With Anxiety

Communicating effectively with someone experiencing severe anxiety must foster feelings of trust, safety, and therapeutic alliance. People in states of heightened anxiety may struggle to process information, express themselves clearly, or feel emotionally overwhelmed. Table 9.7f provides communication tips when speaking with clients with severe anxiety.

Table 9.7f Communication Tips for Clients With Severe Anxiety[23]

Tip	Explanation
Use a Calm, Reassuring Tone	Speak slowly and in a steady, gentle voice. A calm tone can reduce the client's arousal level and model a sense of control.
Keep Language Simple and Clear	Avoid complex instructions and medical jargon. Use short sentences and one idea at a time. Anxiety impairs concentration and memory, so information must be simplified.
Validate Feelings Without Dismissing Them	For example, validate feelings by saying things like "I can see this is really overwhelming for you," or "It's okay to feel scared." Avoid saying "Calm down" or "You're overreacting," which can feel invalidating to the client.
Avoid Rapid-Fire Questions	Ask one question at a time and give the person time to respond. Allow silence for processing. Over-questioning can escalate anxiety and create cognitive overload.
Offer Grounding Techniques	Gently guide the person to the present: "Can you tell me 3 things you see in the room?" or "Let's take a slow breath together." This helps redirect their focus away from anxious thoughts.
Be Patient and Nonjudgmental	Avoid correcting or challenging irrational fears if a person is experiencing severe anxiety or panic. Focus on providing support and safety rather than using logic to try to dispel fear. Use therapeutic presence.
Respect Personal Space	Stay at a comfortable distance to avoid making the person feel trapped. Maintain non-threatening body language with a relaxed posture and uncrossed arms.
Provide Structure and Predictability	Explain what you're doing step by step: "I'm going to put this cuff on your arm to take your blood pressure now." Uncertainty increases anxiety.
Encourage Autonomy and Choices	Offer choices when possible (e.g., "Would you prefer to sit here or over by the window?"). Choices restore a sense of control that is often lost during severe anxiety.

23. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Client Education

Nurses teach clients how to recognize signs of anxiety and panic attacks and how to use coping strategies to help manage symptoms.

> Read additional information about anxiety triggers and coping strategies on the "Anxiety Checklist University" website.

Evaluation (Evaluate Outcomes)

Nurses refer to the individualized SMART outcomes established for each client when evaluating the effectiveness of interventions in the care plan. In general, evaluation of goals for clients with anxiety disorders includes the following questions[24]:

- Is the client experiencing a reduced level of anxiety?
- Does the client recognize their symptoms are related to anxiety?
- Is the client successfully implementing adaptive coping strategies to manage their anxiety?
- Is the client adequately performing self-care activities (e.g., hygiene, eating, and elimination)?
- Is the client able to maintain satisfying interpersonal relationships?
- Is the client able to successfully function socially, occupationally, or in other important areas of functioning?

24. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

If the client outcomes or goals are not met or only partially met, the nursing care plan should be revised and reimplemented.

9.8 Spotlight Application

Melissa is a 20-year-old nursing student who visits her primary care provider for a refill on her birth control pills. During the admission assessment, Melissa shares with the intake nurse that her "anxiety has gotten much worse" during nursing school. She states, "I always feel tired, but I can't sit down and relax. I feel like there is always more studying that I should be doing for my classes. Even though I'm tired at night, I don't sleep well and wake up frequently throughout the night. If I can't go back to sleep, I turn on my computer and study. I have also been getting headaches every day, and I think it is from being on the computer so much. My boyfriend keeps asking me why I am so crabby. Lately I have had a lot of test anxiety, and sometimes my mind goes blank during an exam even though I have memorized all of the material."

The primary care provider diagnoses Melissa with Generalized Anxiety Disorder and encourages her to attend a local support group with other people experiencing anxiety. A beta-blocker is prescribed on an "as needed" basis for before exams or other types of performance assessments, and a referral is made to a psychotherapist for cognitive behavioral therapy. Melissa is encouraged to follow up with her primary health care provider in two weeks for evaluation of her progress.

1. What priority assessment data should the nurse collect at this time? (Assessment/Recognizing Cues)

The frequency, duration and triggers of her anxiety; including how her anxiety affects her daily life, academic performance and relationship with others. The number of hours Melissa sleeps at night, the quality of her sleep and how often she wakes up during the night. Further assessment of Melissa's headaches, including frequency, severity, location and possible triggers. Coping mechanisms that Melissa has tried to use to manage her stress. Signs of fatigue or nutritional imbalances. Presence of support system. Signs and symptoms associated with the "flight or fight" stress response. The levels of anxiety Melissa has been experiencing (mild, moderate, severe or panic). Screening tools, such as the Severity Measure for Generalized Anxiety Disorder. Lab work to assess for physiological causes of Melissa's anxiety.

Cultural beliefs that may affect Melissa's perception of anxiety or treatment options.

2. Based on the assessment data provided, which nursing diagnoses would be appropriate at this time? (Diagnosis/Analyzing Cues)

- *Anxiety r/t academic demands*
- *Disturbed sleep pattern r/t anxiety*
- *Chronic pain r/t excessive screen use*
- *Impaired social interaction r/t irritability*
- *Ineffective coping r/t inability to manage anxiety*

3. Provide a sample of expected outcomes that would be appropriate for Melissa. (Outcome Identification/Generate Solutions)

- *Melissa will report a decrease in anxiety symptoms within two weeks.*
- *Melissa will sleep 6-8 hours per night without frequent awakenings within two weeks.*
- *Melissa will experience a reduction in headache frequency and severity within two weeks.*
- *Melissa will maintain healthy relationships by managing her irritability within two weeks.*
- *Melissa will list three different stress management techniques prior to leaving the clinic.*

4. What nursing interventions would be appropriate for this client? (Planning & Implementation/Generate Solutions & Take Action)

- *Use therapeutic communication techniques such as actively listening, providing a calm environment and validating Melissa's feelings.*
- *Teach Melissa how create a realistic study schedule that balances study time with self-care activities.*
- *Provide Melissa with resources on stress management techniques such as exercise, guided imagery, journaling or practicing mindfulness.*
- *Encourage Melissa to limit screen time before bed and avoid studying*

in bed to help improve quality of sleep.

- *Provide education on how a well-balanced diet can improve anxiety and overall wellbeing.*
- *Reinforce the importance of support groups and following through with psychotherapy referral.*
- *Teach Melissa to recognize the early signs of anxiety so it can be managed effectively.*
- *Educate Melissa on her prescribed beta-blocker, including proper timing and potential side effects.*
- *Encourage Melissa to avoid caffeine as this can exacerbate anxiety as well as interfere with sleep.*

5. How would you evaluate if Melissa's outcomes were met? (Evaluation/ Evaluate Outcomes)

Every time the nurse interacts with Melissa, outcomes should be evaluated. Continued assessment of Melissa's anxiety levels, sleep patterns, headaches, relationship status and ability to apply stress management techniques will help the nurse determine if outcomes are met, partially met, or not met. If outcomes are partially met or not met, the nurse may need to continue monitoring Melissa's progress or the care plan may need revision.

9.9 Learning Activities

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https://wtcs.pressbooks.pub/nursingmhcc/?p=492#h5p-24

1

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https://wtcs.pressbooks.pub/nursingmhcc/?p=492#h5p-25

2

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmhcc/?p=492#h5p-27

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