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

## Concept Map Activity

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

## Case Study: Somatic Symptom Disorder

### Case Scenario

Shenique, a 44-year-old, lives in a small apartment with her spouse. She has been under significant stress related to increased work demands. Shenique frequently complains of severe, unexplained physical pain and has undergone numerous medical tests with no conclusive findings.

### Reflective Case Study Questions:

1. Explain the concept of somatic symptom disorder.
2. Discuss potential psychological factors contributing to Shenique's physical symptoms.
3. How can the nurse utilize therapeutic communication to address Shenique's concerns?
4. What patient education should be provided to help Shenique understand her condition?

# EATING DISORDERS

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

## Module Outline

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

## Module Learning Outcomes

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

## Concepts

- Nutrition

- Self
- Coping

---

## Overview

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

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

## Anorexia Nervosa

Balasundaram and Santhanam (2022) describe several key

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

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

## Bulimia Nervosa

Unlike anorexia nervosa where there is solely restriction of food, bulimia nervosa involves a pattern of recurrent binge eating behaviors. Individuals with bulimia nervosa often report a sense of lack of control over eating during these binge-eating episodes. While not always, these binge-eating episodes are usually followed by a feeling of disgust with oneself, which

leads to **compensatory behavior** in an attempt to rid the body of the excessive calories. These compensatory behaviors include vomiting, use of laxatives, fasting (or severe restriction), or excessive exercise.

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

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

## Binge-Eating Disorder (BED)

**Binge-Eating Disorder** is similar to Bulimia Nervosa in that

it involves recurrent binge-eating episodes along with feelings of lack of control during the binge-eating episode; however, these episodes are *not* followed by compensatory behavior to rid the body of calories.

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

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

## Assessment

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

- Extremely underweight (Anorexia Nervosa)
- Amenorrhea, osteopenia, brittle hair/nails, dry skin, constipation, hypotension, bradycardia, hypothermia, lanugo hair, infertility, or muscle wasting (Anorexia

Nervosa)

- Underweight, normal weight or slightly overweight (Bulimia Nervosa)
- Sore throat, swollen salivary glands, tooth decay, acid reflux, severe dehydration, electrolyte imbalance, and hormonal disturbances (Bulimia Nervosa)
- Intense fear of weight gain
- Distorted body image
- Food restriction, binging, or use of compensatory behaviors
- Preoccupation with food and weight (Balasundaram and Santhanam, 2022).

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=50#oembed-1*

National Eating Disorders Association. (2018). *Warning signs & symptoms of an eating disorder* [Video]. YouTube. https://youtube.com/watch?v=nJMtReAg1DI&si=EnSIkaIECMiOmarE

An interactive H5P element has been excluded from this version

of the text. You can view it online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=50#h5p-8

### Instruments

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

## Problems

Problems associated with an Eating disorder diagnosis are:

- Ineffective coping
- Risk for injury
- Altered nutrition

## Treatment

The immediate goal for the treatment of anorexia nervosa is weight gain and recovery from malnourishment. This is often established via an intensive outpatient program, or if needed, through an inpatient hospitalization program where caloric intake can be managed and controlled. Both the inpatient and outpatient programs use a combination of therapies and support to help restore proper eating habits. Just as anorexia

nervosa treatment initially focuses on weight gain, the first goal of bulimia nervosa treatment is to eliminate binge eating episodes and compensatory behaviors. The most common (and successful) treatments are Enhanced Cognitive-Behavioral Therapy (CBT-E) and Family-Based Therapy (FBT). Psychopharmacological agents may be used to help with comorbid diagnoses such as depression and anxiety.

## CBT-E

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

## FBT

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

## Psychotropics

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

## Nutritional Therapy

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

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=50#oembed-2*

Psych Hub. (2020). *Treatment for eating disorders* [Video].

YouTube. https://youtube.com/watch?v=n9o_ZtUlsgI&si=EnSIkaIECMiOmarE

## Additional Resource

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

- National Eating Disorders Association (NEDA)

### Key Takeaways and Learning Activities

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

- Anorexia nervosa involves the restriction of food, which leads to significantly low body weight relative to the individual's age, sex, and development, and an intense fear of gaining weight or becoming fat.
- Bulimia nervosa is characterized by a pattern of recurrent binge eating behaviors.
- Binge-eating disorder is characterized by recurrent binge-eating episodes along with a feeling of lack of control but no compensatory

behavior to rid the body of the calories.
- Some treatment options for eating disorders include CBT-E, FBT, and Nutrition therapy.

## Concept Map Activity

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

## Case Study: Eating Disorder

### Case Scenario

Emily, an 18-year-old high school student, has a distorted body image and engages in excessive exercise and restrictive eating. She avoids social situations involving food. She is a competitive long-distance runner. She began running competitively with her dad at 10 years of age. She feels as if her family would be proud of her if she qualified for the upcoming Olympics.

### Reflective Case Study Questions:

1. Identify the signs and symptoms of anorexia nervosa in Emily's case.
2. Discuss the potential physical and psychological consequences of Emily's behavior.
3. Develop a holistic care plan for Emily addressing both physical and mental health needs.
4. How can the nurse involve Emily's family in her treatment plan?
5. What strategies can be employed to promote positive body image and self-esteem in Emily?

# SUBSTANCE ABUSE AND ADDICTION

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

## Module Outline

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

## Module Learning Outcomes

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

## Concepts

- Addiction
- Behavior
- Coping
- Safety

---

## Overview

This chapter covers matters related to substance-related and addictive disorders. Our discussion will include substance intoxication, substance use disorder, and substance withdrawal. Substance abuse, in general, has a high comorbidity rate within itself (meaning abuse of multiple different substances), as well as with other mental health disorders. Individuals diagnosed with a mental health disorder may turn to substances for self-medication and coping (Rebar et al., 2020). If a patient has both a mental health disorder and a substance use disorder, this may be referred to as a dual diagnosis (National Alliance on Mental Illness, 2020).

What are substances? Substances are any ingested materials that cause temporary cognitive, behavioral, or physiological symptoms within the individual. Substance intoxication symptoms vary greatly and are dependent on the type of

substance ingested. Specific substances and their effects will be discussed later in the module.

Repeated use of these substances or frequent substance intoxication can develop into a long-term problem known as **substance abuse.** Abuse typically occurs when an individual consumes the substance for an extended period and develops a **tolerance** to the ingested substance. As tolerance builds, additional physical and psychological symptoms present, often causing significant disturbances in an individual's personal and professional life. Individuals with substance abuse often spend a significant amount of time engaging in activities that revolve around their substance use, thus spending less time in recreational activities that once consumed their time. Sometimes, there is a desire to reduce or abstain from substance use. However, cravings and **withdrawal** symptoms often prohibit this from occurring on one's attempts. Detoxification from some substances, including prescription medications, may require **tapering**. Common withdrawal symptoms include but are not limited to cramps, anxiety attacks, sweating, nausea, tremors, and hallucinations. Depending on the substance and the tolerance level, most withdrawal symptoms last anywhere from a few days to a week. For those with extensive substance abuse or abuse of multiple substances, withdrawal should be closely monitored in a hospital setting to avoid severe consequences such as seizures, stroke, or even death.

# Types of Substances Abused

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

## Depressants

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

While **alcohol** is one of the only legal (over-the-counter) substances we will discuss, it is also the most commonly consumed substance. The "active" substance of alcohol, *ethyl alcohol*, is a chemical that is absorbed quickly into the blood via the lining of the stomach and intestine. Once in the bloodstream, ethyl alcohol travels to the central nervous system (i.e., brain and spinal cord) and produces *depressive* symptoms such as impaired reaction time, disorientation, and slurred speech.

The effect of ethyl alcohol in moderation allows for an individual to relax, engage more readily in conversation, and in general, produce a confident and happy personality. However, when consumption is increased or excessive, the central

nervous system is unable to metabolize the ethyl alcohol adequately, and adverse effects begin to present. Symptoms such as blurred vision, difficulty walking, slurred speech, slowed reaction time, and sometimes, aggressive behaviors are observed.

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

**Opioids** are naturally occurring, derived from the sap of the opium poppy. Opioids are unique in that they provide both euphoria and drowsiness. Tolerance to these drugs builds quickly, thus resulting in an increased need for the medication to produce the desired effects. This rapid tolerance is also likely responsible for opioids' highly addictive nature. Opioid withdrawal symptoms can range from restlessness, muscle pain, fatigue, anxiety, and insomnia. Unfortunately, these withdrawal symptoms, as well as intense cravings for the drug, can persist for several months, with some reports up to years.

## Stimulants

The two most common types of stimulants abused are cocaine and amphetamines. Unlike depressants that reduce the activity of the central nervous system, stimulants have the opposite effect, increasing the activity in the central nervous system. Physiological changes that occur with stimulants are increased

blood pressure, heart rate, pressured thinking/speaking, and rapid, often jerky behaviors. Because of these symptoms, stimulants are commonly used for their feelings of euphoria, to reduce appetite, and to prevent sleep.

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

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

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

of amphetamine, is often abused due to its low cost and feelings of euphoria and confidence.

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

## Hallucinogens/Cannabis/ Combination

The final category includes both hallucinogens and cannabis-both of which produce sensory changes after ingestion. While hallucinogens are known for their ability to produce more severe delusions and hallucinations, cannabis also has the capability of producing delusions or hallucinations; however, this typically occurs only when large amounts of cannabis are ingested. More commonly, cannabis has been known to have stimulant and depressive effects, thus classifying itself in a group of its own due to the many different effects of the substance.

**Hallucinogens** come from natural sources and have been involved in cultural and religious ceremonies for thousands of years. Synthetic forms of hallucinogens have also been created—the most common of which are *PCP*, *Ketamine, LSD*, and *Ecstasy*. In general, hallucinogens produce powerful changes in sensory perception. Depending on the type of drug

ingested, effects can range from hallucinations, changes in color perception, or distortion of objects. Interestingly, the effect of hallucinogens can vary both between individuals, as well as *within* the same individual. This means that the same amount of the same drug may produce a positive experience one time, but a negative experience the next time.

Similar to hallucinogens and a few other substances, **cannabis** is also derived from a natural plant—the hemp plant. Many external factors impact the potency of cannabis, such as the climate it was grown in, the method of preparation, and the duration of storage. Of the active chemicals within cannabis, **tetrahydrocannabinol (THC)** appears to be the single component that determines the potent nature of the drug. Various strains of marijuana have varying amounts of THC; hashish contains a high concentration of THC, while marijuana has a small concentration. **Cannabidiol (CBD)** and THC both are derived from the hemp plant (marijuana). Both THC and CBD act on the body's cannabinoid receptors, located throughout the central and peripheral nervous systems. However, CBD does not is non-psychotropic and is not associated with the euphoric characteristics of THC (Jahan and Burgess, 2022).

It is not uncommon for substance abusers to consume more than one type of substance at a time. This **combination** of substance use can have dangerous results depending on the interactions between substances. For example, if multiple depressant drugs (i.e., alcohol, benzodiazepines, and/or

opiates) are consumed at one time, an individual is at risk for severe respiratory distress or even death due to the compounding depressive effects on the central nervous system. Additionally, when an individual is under the influence of one substance, judgment may be impaired, and ingestion of a larger amount of another drug may lead to an accidental overdose. Finally, the use of one drug to counteract the effects of another drug—taking a depressant to combat the effects of a stimulant—is equally as dangerous as the body is unable to regulate homeostasis.

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

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

## Assessment

When gathering data for a thorough assessment, effective communication strategies are imperative. Wu and Baker (2022) present several key communication initiatives to use when communicating with an individual diagnosed with a

substance abuse disorder and gathering information specific to the substance abuse. An overview of these communication strategies is presented below.

## Overview of Communication Strategies

- Be professional, but avoid medical jargon (e.g., instead of "illicit" drugs, use "street" or "recreational") to facilitate the patient's understanding
- Be mindful of non-verbal communication which can affect a patient's perception of you as their healthcare provider
- Assume a neutral position and refrain from spontaneous judgments, especially in the case of interacting with a patient presenting with irrigation or anger
    - Attempt to identify the cause of their emotion, acknowledge their feelings, and address the situation
- Use a patient-centered approach by communicating with **person-first language**, involve the patient in their healthcare decisions, and allow an opportunity to ask questions
- Reduce patient anxiety by informing patients that substance use questions are routine questions asked to all patients and provide an explanation as to the pertinence of the information to their healthcare (e.g., to

proactively address risk for ETOH withdrawal)

### Signs and Symptoms of Substance Abuse and Addiction

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=52#oembed-1*

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

## Problems

Problems associated with a Substance Abuse and Addiction diagnosis include:

- Ineffective Denial
- Ineffective Coping
- Powerlessness

# Treatment

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

## Biological

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

**Agonist drugs.** As researchers continue to learn more about both the mechanisms of substances commonly abused, as well as the mechanisms in which the body processes these substances, alternative medications are created to

**Complete this online learning course to better understand the application of**

**CIWA-Ar.**

essentially replace the drug on which the individual is dependent. These **agonist drugs** provide the individual with a "safe" drug that has a similar chemical makeup to the addicted drug.

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

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=52#h5p-9

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

## Sociocultural

**Alcoholics Anonymous (AA). AA** and **Twelve Step Traditions** as a way to help guide members in spiritual and character development. Due to the popularity of the treatment program, other programs such as **Narcotics Anonymous** and **Cocaine Anonymous** adopted and adapted the Twelve Steps for their respective substance abuse. Similarly, **Al-Anon** and

**Alateen** are two support groups that offer support for families and teenagers of individuals struggling with alcohol abuse.

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

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

**Residential treatment centers.** Another type of treatment similar to self-help is **residential treatment programs.** In this placement, individuals are completely removed from their environment and live, work, and socialize within a drug-free community while also attending regular individual, group, and family therapy. The types of treatment used within a residential program vary from program to program, with most focusing on cognitive-behavioral and behavioral techniques. Several also incorporate **12-step**

**programs** into treatment, as many patients transition from a residential treatment center to a 12-step program post-discharge. As one would expect, the residential treatment goal is abstinence, and any evidence of substance abuse during the program is grounds for immediate termination.

## Additional Resource

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

- Substance Abuse and Mental Health Services Administration (SAMSHA)
- "Meeting Guide" is a free meeting finder app on Google Play and the App Stores (General Service Office of Alcoholics Anonymous, 2022).

### Key Takeaways and Learning Activities

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

- Many substances have abuse and addiction potential. They include

    - Depressants include alcohol, sedative-hypnotic drugs, and opioids
    - Stimulants include cocaine and amphetamines, but caffeine as well.
    - Hallucinogens come from natural sources and produce powerful changes in sensory perception.
    - Cannabis is also derived from a natural plant and produces psychoactive effects.

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

## Concept Map Activity

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

## Case Study: Substance Abuse and

## Addiction

### Case Scenario:

Mark, a 28-year-old construction worker, has a history of alcohol abuse. Previously, he seemed to be able to manage his professional responsibilities. Last month, he began hanging out with a new buddy that he met at a social gathering. The two friends go to dance clubs three to four times during the week in addition to weekend trips to a nearby casino. Lately, he's been missing work and neglecting responsibilities, and his relationships are strained due to his drinking.

### Reflective Case Study Questions:

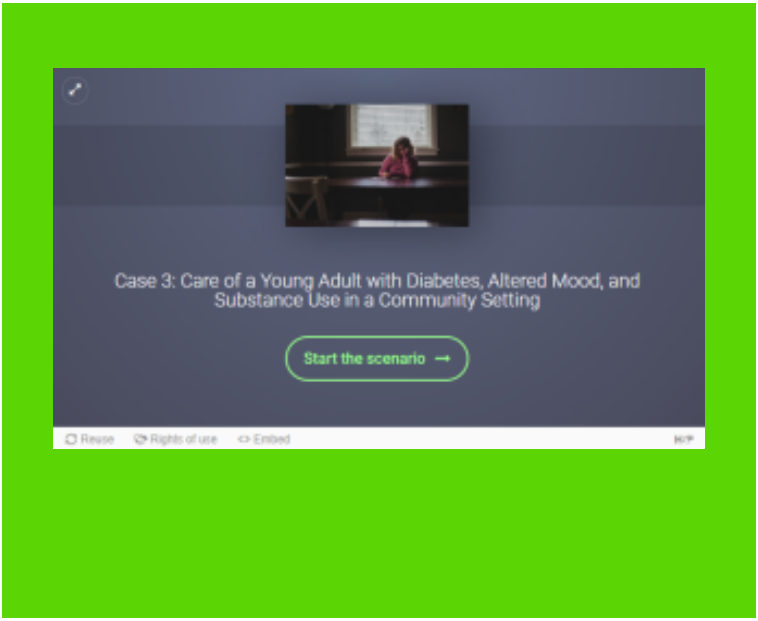
1. Describe the signs of alcohol (ETOH) abuse and withdrawal as well as methods to assess ETOH withdrawal.
2. Discuss the potential impact of substance abuse on Mark's physical and mental health.
3. Suppose Mark was admitted to acute care for alcohol (ETOH) withdrawal management. Develop a nursing care plan for managing Mark's withdrawal symptoms.

4. How would you approach Mark about his substance use and motivate him for treatment?

## Virtual Case Scenario

### Instructions

1. Complete the following scenario using the information in the pre-brief to guide your decisions. Allow for about 30 minutes to complete the activity.
2. Advance through each decision by clicking on the **green arrow** and then selecting the correct response.
3. If you choose an incorrect response, you will have an opportunity to select another option.




The virtual simulation "Case 3: Care of Young Adult with Diabetes, Altered Mood, and Substance Abuse in a Community Setting" contained within this chapter was adapted from Egert, A., & D'llio, A. (2022). Case 3: Scenario. Licensed under a Creative Commons Attribution 4.0 International License.

Adapted from *Fundamentals of Psychological Disorders 2nd Edition- Module 11* by Alexis Bridley, Ph.D. and Lee W. Daffin Jr., Ph.D. licensed under a Creative Commons Attribution 4.0 International License. Modifications: revised for clarity and flow.

# SCHIZOPHRENIA

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

## Module Outline

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

## Module Learning Outcomes

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

## Concepts

- Cognition

- Psychosis
- Mood and Affect
- Safety

---

## Overview

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

The hallmark symptoms of schizophrenia include the presentation of at least two of the following: delusions, hallucinations, disorganized speech, disorganized/abnormal behavior, or negative symptoms. These symptoms create significant impairment in an individual's ability to engage in

normal daily functioning such as work, school, relationships with others, or self-care.

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=54#oembed-1*

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

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

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

# Assessment

## Positive signs and symptoms

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

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

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

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

**thinking**. That is, the individual is focused on one aspect of a concept or thing and neglects all other aspects.

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

## Negative signs and symptoms

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

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

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

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

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=54#h5p-10

## Problems

Problems associated with a Schizophrenia diagnosis include:

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

## Treatment

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

### Psychopharmacological

Among the first antipsychotic medications used for the treatment of schizophrenia was Thorazine. Due to the harsh side effects of conventional antipsychotic drugs, newer, arguably more effective *second-*

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

## Psychological Interventions

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

**Social Skills Training.** Given the poor interpersonal functioning among individuals with schizophrenia, social skills training is another type of treatment commonly suggested to improve psychosocial functioning. Research has indicated that poor interpersonal skills not only predate the onset of the disorder but also remain significant even with the management of symptoms via antipsychotic medications. Social support has been identified as a protective factor and helps patients relate to others (Calabrese et al., 2022). Learning

how to interact with others appropriately (e.g., establish eye contact, engage in reciprocal conversations, etc.) through role-play in a group therapy setting is one effective way to teach positive social skills.

## Family Interventions

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

### Key Takeaways and Learning Activities

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

- Schizophrenia is characterized by delusions, hallucinations, disorganized speech, disorganized/abnormal behavior, or negative symptoms.
- Positive versus negative signs/symptoms are differentiated by remembering that the former at not normally present in a typical individual.

- Antipsychotics are the psychotropic medication class used to treat Schizophrenia.
- Psychological treatment options include CBT and Social Skills Training.

## Concept Map Activity

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

## Case Study: Schizophrenia

### Case Scenario

James, a 30-year-old graphic designer, is experiencing hallucinations, delusions, and disorganized thoughts. He received an initial diagnosis of schizophrenia in his twenties. Since the initial diagnosis, he has been able to experience periods of stability with occasional exacerbations, requiring in-patient management. His behavior has been increasingly erratic, affecting his professional and personal lives. During the nursing admission assessment, James indicated he had been

experiencing financial strain and was unable to purchase his antipsychotic medication. He also stated that his roommate had implanted a tracking device into his cellphone to allow the government to monitor his conversations and GPS coordinates. He pauses during the interview and appears to be communicating with an unseen individual, stating, "Yes, I have received the mission instructions."

### Reflective Case Study Questions:

1. Define and differentiate positive versus negative symptoms of schizophrenia.
2. What positive and negative symptoms are evident in James?
3. Develop a nursing care plan for James during acute psychotic episodes.
4. How can the nurse promote medication adherence and manage side effects?

# PERSONALITY DISORDERS

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

## Module Outline

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

## Module Learning Outcomes

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

## Concepts

- Self
- Behavior
- Coping

---

## Overview

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

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

Personality disorders have four defining features, which include *distorted thinking patterns*, *problematic emotional responses*, *over-* or *under-regulated impulse control*, and *interpersonal difficulties*. While these four core features are

universal among all ten personality disorders, the DSM-5 divides the personality disorders into three different clusters based on symptom similarities.

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

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=56#oembed-1*

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

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

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

## Assessment

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

- **Paranoid** – suspicious and distrustful

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

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

## Problems

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

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

## Treatment

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

1. One's personality and associated behaviors are deeply ingrained
2. When change occurs, it is slow
3. Many do not recognize their behaviors as dysfunctional or maladaptive
4. There is no specific medication to change personality.

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

1. Cultivate a therapeutic relationship and use therapeutic

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

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

## Key Takeaways and Learning Activities

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

- Personality disorders share the features of distorted thinking patterns, problematic

emotional responses, over- or under-regulated impulse control, and interpersonal difficulties and divide into three clusters.
- Many diagnosed with a personality disorder have another coexisting mental health diagnosis.

## Concept Map Activity

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

## Case Study: Personality Disorder

### Case Scenario

Lisa, a 35-year-old nurse, has a history of unstable relationships, impulsive behavior, and intense mood swings. She often struggles with feelings of emptiness and has difficulty regulating her emotions. She works at a local hospital as an emergency room nurse. She communicates increased stress related to work and a recent

breakup. She is currently admitted to an inpatient psychiatric unit, following self-harm behaviors and a suicide attempt.

### Reflective Case Study Questions:

1. Identify and describe the features of borderline personality disorder in Lisa's case.
2. Discuss potential challenges in establishing a therapeutic nurse-patient relationship with Lisa as well as strategies to facilitate a therapeutic relationship.
3. Describe therapeutic communication strategies and nursing interventions that facilitate a therapeutic relationship with any individual having a personality disorder.
4. Develop strategies to help Lisa cope with intense emotions, reduce impulsive behaviors, and self-harm behavior.
5. How can the nurse involve Lisa in her treatment planning?

International License. Modifications: revised for clarity and flow  .

# NEUROCOGNITIVE DISORDERS

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

## Module Outline

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

## Module Learning Outcomes

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

## Concepts

- Cognition
- Coping
- Safety

---

## Overview

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

## Dementia

Within the DSM-V-TR dementia is referred to as Major Neurocognitive Disorder (Buser and Cruz, 2022; Emmady et al., 2022). It is important to understand dementia is not synonymous with Alzheimer's disease. Rather, dementia is the broader term referring to "significant cognitive decline in one or more areas (learning and memory, language, executive functioning, complex attention, perceptual-motor, or social cognition) (Buser and Cruz, 2022). Subtypes of a Major

Neurocognitive Disorder include Alzheimer's, Vascular, Substance-Induced, Traumatic Brain Injury, HIV, Parkinson's Disease, Lewy Bodies, Prion Disease, Huntington's Disease, and Frontotemporal Degeneration (Buser and Cruz, 2022). The diagnosis can be further characterized as mild, moderate, or severe (Buser and Cruz, 2022; Videbeck, 2020).

## Alzheimer's Disease

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

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

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

## Delirium

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

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

See Emmady et al. (2022) [Dementia] and De Lourdes Ramirez Echeverria et al. (2022) [Delirium]to read more about this topic.

## Assessment

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

## Dementia Versus Delirium

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

## Dementia

Alzheimer's Dementia accounts for approximately 70% of the

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

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=58#oembed-1*

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

## Delirium

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

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

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

*One or more interactive elements has been excluded from this version of the text. You can view them online here:*
*https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=58#oembed-2*

Osmosis from Elsevier. (2017). *Delirium-causes, symptoms, diagnosis, treatment & pathology* [Video]. YouTube. https://youtube.com/watch?v=qmMYsVaZ0zo&si=EnSIkaIECMiOmarE

## Instruments

The **Mini-Mental State Exam** and the **Mini-Cog** are two

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

## Problems

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

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

## Treatment

### Delirium

**The main treatment goal**

The major goal of delirium treatment is to identify the underlying cause. De Lourdes Ramirez Echeverria et al. (2022) and Rhoads (2021) provided

several nursing interventions to help treat delirium. These interventions include:

**for delirium is to identify and treat the underlying cause**.

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

## Dementia

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

- Promoting adequate sleep

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

### Pharmacological

Pharmacological interventions for Alzheimer's disease, and more specifically medications designed to target acetylcholine and glutamate, the primary neurotransmitters affected by the disease, have been the most effective treatment options in alleviating symptoms and reducing the speed of cognitive decline. Remember, there is no medication to stop or cure this disease. Specific medications such as *donepezil* (Aricept), *rivastigmine* (Exelon), *galantamine* (Razadyne), and *memantine* (Namenda) are prescribed to slow the progression of Alzheimer's disease (Rhoads, 2021). See the MODULE 4: PSYCHOPHARMACOLOGY chapter for a review of these medications.

## Support for Caregivers

Supporting caregivers is an important treatment option to include as the emotional and physical toll on caring for an individual with a neurocognitive disorder is often underestimated. It is important that medical providers

routinely assess caregivers' psychosocial functioning, and encourage caregivers to participate in caregiver support groups, or individual psychotherapy to address their own emotional needs.

## Additional Resources

See the Alzheimer's Association website for more information.

### Key Takeaways and Learning Activities

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

- The rate of occurrence of delirium and dementia increases with age.
- Delirium is a state of acute confusion.
    - The main goal is to identify and treat the underlying cause.
- Major neurocognitive disorder (i.e., dementia) is characterized by a significant gradual decline in both overall cognitive functioning as well as the ability to independently meet the demands of daily living.

    - The most common type of is Alzheimer's disease.

- Pharmacological interventions for Alzheimer's disease target the neurotransmitters acetylcholine and glutamate.
- Caregivers may benefit from support groups.

## Concept Map Activity

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

## Case Study: Dementia versus Delirium

### Case Scenario

Mary, an 80-year-old woman, presents with her son to her primary care nurse practitioner with confusion, altered consciousness, and difficulty focusing. Mary lives alone, and her son comes to her house before and after work to check on her. He states that he places her medication in a pill organizer for his mom. He reports a gradual decline

in memory and cognitive function. Lately, he has noticed an increase in Mary's confusion. He indicates that "this is different" and "she seems more confused than usual."

### Reflective Case Study Questions:

1. Differentiate between dementia and delirium, noting the similarities and differences in the diagnoses.
2. Assess and discuss the potential causes of Mary's confusion.
3. Develop a nursing care plan for managing Mary's symptoms and providing support.
4. How can the nurse involve Mary's family in her care, considering her long-term needs?
5. Discuss the importance of early recognition and intervention in cases of delirium and dementia.

CHILDHOOD DISORDERS

# CHILDHOOD DISORDERS

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

## Module Outline

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

## Module Learning Outcomes

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

## Concepts

- Development
- Coping
- Safety

---

## Overview

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

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

- May lack abstract cognitive and language skills to describe their symptomology
- Have a limited sense of stable and normal sense of self-

related to constant developmental changes; thus, may not be able to discriminate unusual versus typical/expected feelings/sensations
- Abnormal or problematic behaviors may vary depending on developmental stage and/or age

## ADHD

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

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

**ADHD Diagnosis: look for consistency in signs and symptoms in multiple settings with various caregivers.**

Historically, ADHD has been misdiagnosed. Alternative explanations for abnormal child behavior may be related to another mental health diagnosis (i.e., not ADHD, but another diagnosis) or stressful family situations (e.g., divorce) (Videbeck, 2020). The key is to

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

## ASD

**ASD** presents with repetitive schemes affecting behaviors, interests, or activities which may be present in early childhood, or the child may begin with typical development, but then may have a regression of skills (Mughal et al., 2022). Diagnostically, Rhoads (2021) provides an overview of the DSM-5 signs and symptoms of ASD that affect the three areas of abnormal or impairment in social interactions, communication impairment, and restricted repetitive or stereotyped behavior patterns. Keep in mind, at this time, there is no cure, nor is there any specific medication for ASD; rather, certain psychotropic medications may be used to treat underlying behaviors (e.g., Risperidone and Aripiprazole) (Rebar et al., 2020). Early identification and treatment of ASD may improve outcomes (Mughal et al., 2022).

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

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

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

*One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=60#oembed-1*

Level Up RN. (2022). *ADHD and autism-pediatric nursing-nervous system disorders* [Video]. YouTube.

https://youtube.com/watch?v=PzFpNWZwl3Q&si=EnSIkaIECMiOmarE

## ID

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

*One or more interactive elements has been excluded from this version of the text. You can view them online here:* *https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=60#oembed-2*

**ID** affects intellectual function and adaptive behavior.

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

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

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

## Assessment

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

### Instruments

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

- The Reiss Scales (ID)

## Problems

The problems that may be associated with childhood disorders include:

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

## Treatment

There are four general treatment considerations for childhood disorders.

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

### ADHD

Those diagnosed with ADHD need help to manage inattentiveness, hyperactivity, and impulsivity. As mentioned in the previous paragraph, safety is a priority. Children

diagnosed with ADHD may act without thinking of their safety. In the acute care setting, stimulant medications are first-line treatment options (e.g., Methylphenidate/Ritalin) and non-stimulants tend to be the 2nd line of treatment (e.g., Atomoxetine/Strattera) (Rhoads, 2020). See MODULE 4: PSYCHOPHARMACOLOGY for a review of these medications.

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

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

### ASD

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

- Behavioral and communication approaches (e.g., positive reinforcement and social skills training)
- Biomedical and dietary approaches (e.g., medications used to treat problem behaviors or underlying conditions)

- Community support and parent training (e.g., teach the family about ASD and management strategies)
- Specialized therapies (e.g., speech, occupational, and physical therapy)
- Complementary approaches (e.g., music, play, art, and animal therapy)

### ID

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

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

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

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

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

## Additional Resources

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

### Key Takeaways and Learning Activities

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

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

communication, and repetitive or stereotyped behavior impairments

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

- ID affects intellectual function and adaptive behavior

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

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

## Concept Map Activity

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

concept map tutorial.

## Case Study: Autism Spectrum Disorder versus Attention Deficit Hyperactivity Disorder

### Case Scenario

Dario, a 6-year-old boy, struggles with social interactions, repetitive behaviors, and has difficulty maintaining attention in school. His parents are concerned about his developmental milestones. They indicate that Dario spends most of his time alone, often mesmerized by fans, elevators, and the washing machine. His teacher requested a parent meeting. She stated, "Dario does not socialize with any of the other children. He requires several prompts to pay attention." On a recent multiple-family vacation to a lavish beach home, Dario spent considerable time washing and re-washing clothes. He declined pool time in favor of offering to keep everyone's clothes washed and dried.

### Reflective Case Study Questions:

1. Identify and discuss the key characteristics of

autism spectrum disorder in Dario's case.
2. Differentiate between autism spectrum disorder and attention deficit hyperactivity disorder.
3. Develop a plan for inclusive care to support Dario in school and social settings.
4. How can the nurse collaborate with Dario's teachers and other healthcare professionals?
5. What education should be provided to Dario's parents about managing his condition at home?

# PSYCHIATRIC EMERGENCIES

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

## Module Outline

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

## Module Learning Outcomes

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

## Concepts

- Behavior

- Coping
- Safety
- Legal Issues

---

## Overview

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

- Suicide
- Agitated/aggressive patients
- Rape
- Disaster
- Panic attack
- Delirium
- Neuroleptic malignant syndrome (NMS)
- Serotonin syndrome
- Overdose and withdrawal (Rhoads,2021).

Our discussion will consist of types of crises, suicide, aggression/violence, and abuse/neglect. Prior to discussing

these clinical disorders, we will explain crises, as well as identify common crisis types.

## Crises

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

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

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

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

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


Below is an overview of a nurse's consideration

for the assessment, problems, and treatment of psychiatric emergencies.

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

## Assessment

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

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

### Suicide

An individual's expression of **suicidal ideation** should always be taken seriously and requires immediate intervention. In many acute clinical settings, it is routine practice to ask each

patient about suicidal or homicidal thoughts on admission and daily with each set of vital signs. Videbeck (2020) provides a list of suicide myths. Let's summarize these myths.

## Summarization of Suicide Myths

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

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

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


## Aggression and Violence

Anger is a normal human emotion. However, when anger

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

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

## Abuse and Neglect

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

### Warning Signs of Abuse and Neglect

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

## Problems

The problems that may be associated with psychiatric emergencies include:

- Risk for Suicide

- Ineffective Coping
- Hopelessness
- Risk of violence against self or others

## Treatment

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

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

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

## Suicide

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

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

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

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

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

## Aggression/Violence

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

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

### How can nurses manage aggressive behavior?

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

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

1. Ensure scene safety, when in doubt do not act alone
2. Attempt verbal de-escalation-use a calm, firm voice
3. Direct the patient to take a voluntary time-out in a quiet area
4. Inform the patient that aggressive behavior is not acceptable
5. Offer PRN medications to help the patient return to a calm state (e.g., Lorazepam)

**Patients have a right to the least restrictive environment necessary to meet their care needs.**

6. Provide a "show of force/strength" (i.e., gather 4-6 team members to remain in sight with patient interactions; this may be enough to take control of the situation. If the patient continues to escalate to violent behavior, these staff will help to ensure safety should restraints and/or seclusion become necessary
7. Use of restraint and/or seclusion per institutional policy with consideration for the Joint Commission standards
8. Debrief: Ask the patient about any triggers and alternatives to avoid future patient violent behavior; hold a debriefing session for all involved staff to discuss elements of the situation that were handled well, needed improvement, and any ideas to enhance defusing (Videbeck, 2020).

## Abuse and Neglect

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

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

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

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

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

## General Nursing Considerations for a Psychiatric Emergency

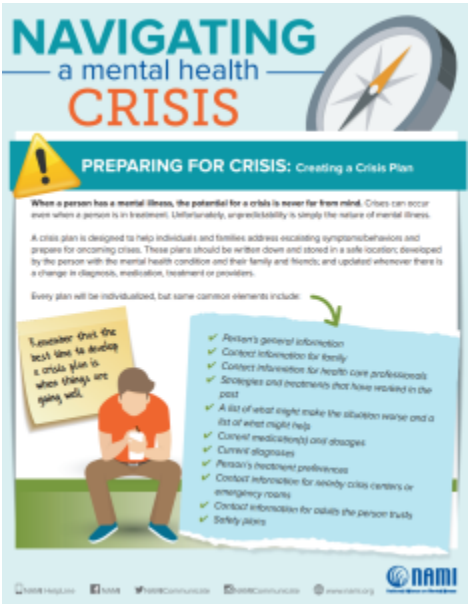
Let's consider a few tenets to consider for **psychiatric emergency interventions.**

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

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

## CREATE A PLAN

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




## Additional Resources

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

## Key Takeaways and Learning Activities

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

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

mandated to report known or suspected abuse/neglect of children, elderly, and dependent adults.

## Concept Map Activity

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

## Case Study: Psychiatric Emergency

### Case Scenario

Natalia, a 24-year-old college student, presents to the emergency room with acute suicidal ideation and self-harm attempts. She denies any medical or psychiatric history. She completed her bachelor's degree in nursing last month. She works full-time and just received an acceptance letter for a nurse practitioner program. She indicates recently losing her mother in a motor vehicle accident.

### Reflective Case Study Questions:

1. Assess and describe the immediate nursing interventions for Natalia's safety.
2. Develop a crisis intervention plan for managing Natalia's suicidal ideation.
3. Discuss the ethical considerations in the management of psychiatric emergencies.
4. Develop a follow-up plan for Natalia's ongoing mental health care.

# GRIEF AND LOSS

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

## Module Outline

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

## Module Learning Outcomes

- Summarize the types of Grief and Loss
- Describe the signs and symptoms of Grief and Loss
- Review Kubler-Ross' five stages of grief
- Identify the common nursing problems associated with Grief and Loss
- Summarize the treatment of Grief and Loss

## Concepts

- End of Life
- Spiritual
- Grief and Loss

---

## Overview

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

## Types of Loss

Generally, a loss precipitates the experience of grief. The experience of grief is a normal response to losing something. The **types of loss** can be understood within Maslow's Hierarchy of Needs theoretical framework (Videbeck, 2020). See MODULE 2: THEORETICAL MODELS USED IN MENTAL HEALTH NURSING for a review of this theory. Let's look at this application.

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

## Types of Grief

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

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

Individuals may be at **increased risk or vulnerable to experiencing complicated grieving** for several reasons. Some of these reasons are:

- The loss is the death of a spouse, child, or parent (especially as a child/adolescent)

- Low self-esteem
- Perception of the loss (Oates and Maani-Fogelman; 2022; Videbeck, 2020).

## Kubler-Ross' Stages of Grief

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

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

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

https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=68#oembed-1

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

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

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

## Assessment

It is not uncommon for individuals to express a variation of signs and symptoms of grief. Reviewing Kubler-Ross' Five Stages of Grief will allow you to anticipate the clinical presentation of grief.

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

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

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

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

## Problems

The problems that may be associated with childhood disorders include:

- Ineffective Coping
- Grieving
- Risk for Complicated Grieving

## Treatment

The main treatment goal for nurses is to **provide comfort and support** for the patient and family. Let's summarize some

**specific strategies** for nurses to help grieving patients and families.

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

## Additional Resources

Check out the resources listed on:

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

webpage.

## Key Takeaways and Learning Activities

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

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

### Concept Map Activity

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

## Case Study: Grief and Loss

### Case Scenario

Kai, a 45-year-old widower, presents to his primary care nurse practitioner. He recently lost his spouse to cancer. He is struggling with intense grief, feelings of loneliness, and difficulty adapting to life. He states that some days he is overwhelmed with intense sadness, and other days he is angry. He communicates that he made this appointment for "sleeping pills," reporting difficulty sleeping for the last two weeks.

### Reflective Case Study Questions:

1. Name and describe Kubler-Ross' stages of grief.
2. Assess and describe the stages of grief Kai may be experiencing.
3. Develop a nursing care plan to support Kai through the grieving process.
4. How can the nurse facilitate healthy coping mechanisms for Kai?
5. Discuss the importance of cultural competence in providing grief support.

# An Overview of Foundational Concepts and Common Psychotropics

Jake Bush

This file can be downloaded as a study guide for mental health nursing foundational concepts and includes an overview of common psychotropic medications.

File: MH CUMULATIVE OVERVIEW

## References

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mughal, S., Faizy, R.M., Saadabadi, A., & Doerr, C. (2022). Autism spectrum disorder (nursing) [E-book]. In *StatPearls*. StatPearls Publishing.

National Alliance on Mental Illness (NAMI). (2020, May).

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

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

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

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

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

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

Office of Disease Prevention and Health Promotion. (2021, August). *Social determinants of health*. Social Determinants of Health – Healthy People 2030. Retrieved

July 21, 2022, from https://health.gov/healthypeople/priority-areas/social-determinants-health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

U.S. Department of Health & Human Services. (n.d.). *Information related to mental and behavioral health, including opioid overdose*. HHS.gov. Retrieved January 3, 2023, from https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html

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

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

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

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