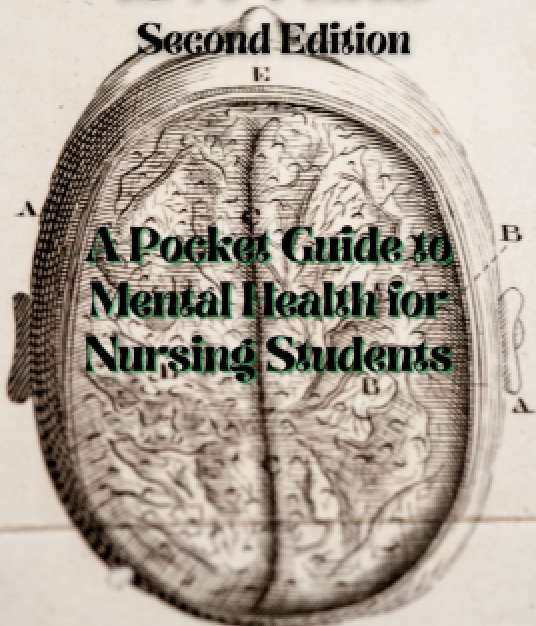
MENTAL HEALTH IS A VERB

Second Edition



A Pocket Guide to Mental Health for Nursing Students

Jake Bush, Ph.D., RN, CNE

Jill Van Der Like, DNP, MSN, RNC

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CONTENTS

INTRODUCTION 1

MODULE 1: MENTAL HEALTH VERSUS MENTAL ILLNESS 5

MODULE 2: THEORETICAL MODELS USED IN MENTAL HEALTH NURSING 15

MODULE 3: CLINICAL ASSESSMENT, PROBLEMS, AND TREATMENT 23

MODULE 4: PSYCHOPHARMACOLOGY 34

MODULE 5-MENTAL HEALTH PROMOTION 50

MODULE 6: LEGAL AND ETHICAL ISSUES 56

MODULE 7: THERAPEUTIC COMMUNICATION 65

THERAPEUTIC COMMUNICATION

MODULE 8: DEPRESSION 70

MODULE 9: ANXIETY 84

MODULE 10: BIPOLAR 95

MODULE 11: SOMATIC SYMPTOM AND RELATED DISORDERS 104

MODULE 12: EATING DISORDERS 116

MODULE 13: SUBSTANCE ABUSE AND ADDICTION 128

MODULE 14: SCHIZOPHRENIA 148

MODULE 15: PERSONALITY DISORDERS 160

MODULE 16: NEUROCOGNITIVE DISORDERS 170

MODULE 17: CHILDHOOD DISORDERS 184

CHILDHOOD DISORDERS

MODULE 18: PSYCHIATRIC EMERGENCIES 199

MODULE 19: GRIEF AND LOSS 221

Appendix 232

An Overview of Foundational Concepts and Common Psychotropics

Jake Bush

References 233

Welcome to our mental health nursing pocket guide for students! We have designed this text to be a nuts-and-bolts type reference interspersed with activities to help you digest the information. This second edition includes the addition of case studies (modules 8-19), two virtual simulation activities (module 7 and module 13), and a mental health cumulative study guide as an appendix.

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

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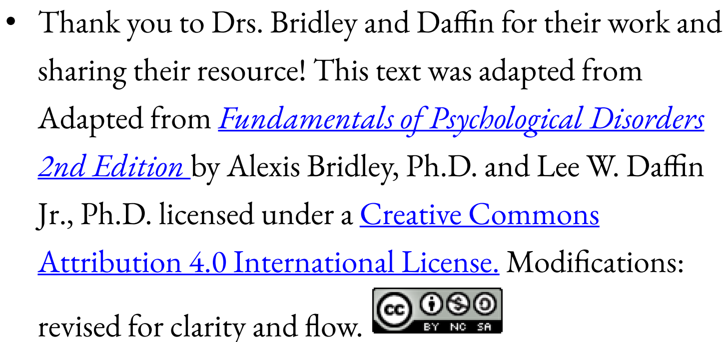
- Thank you to Drs. Bridley and Daffin for their work and sharing their resource! This text was adapted from Adapted from *Fundamentals of Psychological Disorders 2nd Edition* by Alexis Bridley, Ph.D. and Lee W. Daffin Jr., Ph.D. licensed under a Creative Commons Attribution 4.0 International License. Modifications: revised for clarity and flow. 
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- Thank you to Dr. Karen White-Trevino and Dr. William Mikulas for being leaders in Nursing and Psychology, respectively. Also, thank you both for your mentorship and kindness.
- Cover Image: "Human Brain 1839" by Vintage Medical (Canva.com)
- Thank you to our readers for embarking on this mental health nursing journey with us. We hope you enjoy the book!

A few notes about organization and format:

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

Other keywords are bolded in blue font color and are included in the glossary. To access the glossary, click the blue bolded word.

A few notes about the text's activities:

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

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=17#oembed-1

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

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

MENTAL HEALTH VERSUS MENTAL ILLNESS

Module Outline

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

Module Learning Outcomes

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

Undergraduate Education Mental Health Essentials

The American Psychiatric Nurses Association (APNA) developed the Essentials for Undergraduate Education in Psychiatric-Mental Health (American Psychiatric Nurses

Association Education Council, Undergraduate Branch, 2022). These essentials will guide as a framework for many of the topics throughout this book. Visit this resource to learn more about the APNA's Undergraduate Education Toolkit.

Mental Health Versus Mental Illness

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

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

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

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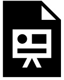
Many people who need care never seek it out. Why is that? We already know that society dictates what is considered abnormal behavior through culture and social norms, and you can likely think of a few implications of that. Overlapping with prejudice and discrimination in terms of how people with mental

disorders are treated is **stigma**, or negative stereotyping, labeling, rejection, and loss of status occur.



An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=20#h5p-2

The History of Mental Illness

Abnormal behavior is often dictated by the culture or society a person lives in, and unfortunately, the past has not treated the afflicted very well. In this section, we will examine how past societies viewed and dealt with mental illness.

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

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

During the **Middle Ages** with the increase in power of the Church and the fall of the Roman Empire, mental illness was yet again explained as possession by the Devil and methods such as exorcism, flogging, prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of demonic influence. In extreme cases, the afflicted were exposed to confinement, beatings, and even execution.

The number of asylums, or places of refuge for the mentally ill where they could receive care, began to rise during the 16th century. Hospitals and monasteries were converted into asylums. Though the intent was benign in the beginning, as the facilities were overcrowded, the patients came to be treated

more like animals than people. Patients were chained up, placed on public display, and often heard crying out in pain.

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

Due to the rise of the moral treatment movement in both Europe and the United States, asylums became habitable places where those afflicted with mental illness could recover. The number of mental hospitals greatly increased, leading to staffing shortages and a lack of funds to support them. Waves of immigrants arriving in the U.S. after the Civil War overwhelmed the facilities, and patient counts soared to 1,000 or more.

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

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

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=20#oembed-2

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

Mental Health America (MHA) provides education about people with mental illness and their need for care with dignity. Today, MHA has over 200 affiliates in 41 states and employs 6,500 affiliate staff and over 10,000 volunteers.

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

them from happening, or at least minimize their deleterious effects.

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

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

Key Takeaways

You should have learned the following in this section:

- Mental disorders are characterized by psychological dysfunction, which causes physical and/or psychological distress or impaired functioning.
- Healthcare professionals have a duty to report when an individual expresses intent to harm another person or themselves.
- Stigma is negative stereotyping, labeling, rejection, and loss of status occur and take the form of public or self-stigma, and label avoidance.
- Some of the earliest views of mental illness related to the work of evil spirits, demons, gods, or witches who took control of the person, and in the Middle Ages it was seen as possession by the Devil, and methods such as exorcism, flogging, prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of demonic influence.

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

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THEORETICAL MODELS USED IN MENTAL HEALTH NURSING

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

Module Outline

- Utilizing Theory to Conceptualize and Prioritize Mental Health Nursing Care

Module Learning Outcomes

- Review Leininger's Theory of Culture Care Diversity and Universality
- Describe Sigmund Freud's Personality Development
- Describe Ego Defense Mechanisms
- Describe Maslow's Hierarchy of Needs
- Describe Erik Erikson's Psychosocial Stages of Development

Leininger's Theory of Culture Care Diversity and Universality

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

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

Sigmund Freud's Personality Development

According to Freud, our personality has three parts – the id, superego, and ego, and from these, our behavior arises. First, the **id** is the impulsive part that expresses our sexual and aggressive instincts. It is present at birth, completely unconscious, and operates on the *pleasure principle*, resulting

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

Ego Defense Mechanisms

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

- **Repression** – When unacceptable ideas, wishes, desires, or memories are blocked from consciousness such as forgetting a horrific car accident that you caused. Eventually, though, it must be dealt with or the repressed memory can cause problems later in life.
- **Reaction formation** – When an impulse is repressed and then expressed by its opposite. For example, you are angry with your boss but cannot lash out at him, so you are super friendly instead. Another example is having lustful thoughts about a coworker that you cannot express because you are married, so you are extremely hateful to this person.
- **Displacement** – When we satisfy an impulse with a different object because focusing on the primary object may get us in trouble. A classic example is taking out your frustration with your boss on your wife and/or kids when you get home. If you lash out at your boss, you could be fired. The substitute target is less dangerous than the primary target.
- **Projection** – When we attribute threatening desires or unacceptable motives to others. An example is when we do not have the skills necessary to complete a task, but we blame the other members of our group for being incompetent and unreliable.
- **Sublimation** – When we find a socially acceptable way to express a desire. If we are stressed out or upset, we may go to the gym and box or lift weights. A person who

desires to cut things may become a surgeon.

- **Denial** – Sometimes, life is so hard that all we can do is deny how bad it is. An example is denying a diagnosis of lung cancer given by your doctor.
- **Identification** – When we find someone who has found a socially acceptable way to satisfy their unconscious wishes and desires, and we model that behavior.
- **Regression** – When we move from a mature behavior to one that is infantile. If your significant other is nagging you, you might regress by putting your hands over your ears and saying, "La la la la la la la la..."
- **Rationalization** – When we offer well-thought-out reasons for why we did what we did, but these are not the real reasons. Students sometimes rationalize not doing well in a class by stating that they are not interested in the subject or saying the instructor writes impossible-to-pass tests.
- **Intellectualization** – When we avoid emotion by focusing on the intellectual aspects of a situation such as ignoring the sadness we are feeling after the death of our mother by focusing on planning the funeral.

Abraham Maslow's Hierarchy of Needs

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

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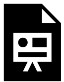
Read more about Maslow's Hierarchy of Needs here: https://www.simplypsychology.org/maslow.html.

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

Erik Erikson Psychosocial Stages of Development

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



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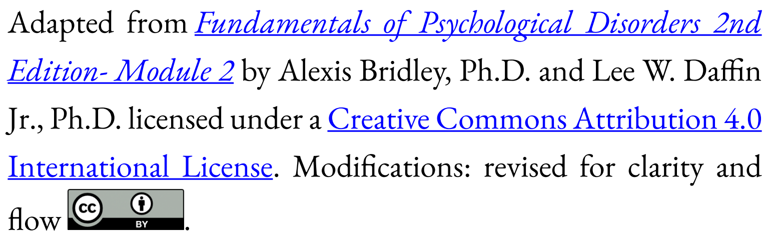
Key Takeaways

You should have learned the following in this section:

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



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CLINICAL ASSESSMENT, PROBLEMS, AND TREATMENT

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

Module Outline

- Using the nursing process to guide mental health nursing care

Module Learning Outcomes

- Describe the nursing process
- Discuss various treatment options

The Nursing Process

Traditionally, the nursing process involves assessment,

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

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

Assessment

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

- allergies and code status
- list of current medications (dose, frequency, route)
- current assessment of presenting signs/symptoms, any

effects on daily functioning
- pertinent physical, surgical, and psychosocial history
- cultural, spiritual, sexual, and gender identity

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

Mental Health Assessment

Specific to a mental health assessment, a nurse would also incorporate additional attention to a mental status examination. A mental status examination is used to organize the information collected during the interview and systematically evaluate the patient through a series of questions assessing appearance and behavior. The latter includes grooming and body posture, thought processes and content to include disorganized speech or thought and false beliefs, mood and **affect** such that whether the person feels hopeless or elated, intellectual functioning to include speech

and memory, and awareness of surroundings to include where the person is and what the day and time are. The exam covers areas not normally part of the interview and allows the mental health professional to determine which areas need to be examined further. See Voss and Das's (2021) resource for further explanation of the mental status examination.

Additional Assessment Resources

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

Problems

Nursing students will notice patients' medical records may often contain several diagnoses (e.g., medical and psychological). Diagnoses serve as a communication tool to members of the healthcare team and relay the patient's health needs as well as to insurance providers. Specific to mental health needs, the American Psychiatric Association (APA) publishes the most widely used classification system in the United States (i.e., the *Diagnostic and Statistical Manual of*

Mental Disorders (DSM) (APA, 2022). The DSM is currently in its 5th edition Text-Revision (DSM-5-TR) and is produced by the American Psychiatric Association (APA, 2022). The DSM-5-TR is used to formally document the presence of a mental health diagnosis.

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

This text will focus on the problem statement of the nursing diagnosis. For example, in the nursing diagnosis statement: **Anxiety** related to situational crisis as evidenced by the statement "I feel overwhelmed by the loss of my job!" Anxiety is the identified problem.

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

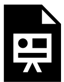
Planning Outcomes

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

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

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

Implementation



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There are numerous approaches to mental health care. Some examples include Cognitive therapy, Cognitive-Behavioral

Therapy (CBT), Complementary and Alternative Medicine (CAM), Psychopharmacology, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), and Psychosurgery. Knowing what the person's baselines are for different aspects of psychological functioning will help us to see when improvement occurs.

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

Cognitive therapy/CBT

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

Complementary Alternative Medicine (CAM)

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

Electroconvulsive therapy

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

Psychosurgery

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

Transcranial Magnetic Stimulation

Transcranial magnetic stimulation (TMS) is a non-invasive procedure that uses low or high-intensity magnetic fields to stimulate brain tissue (Mann & Malhi, 2022). Repetitive transcranial magnetic stimulation (rTMS) refers to utilizing repetitive TMS pulses to a specific region of the brain (Mann & Malhi, 2022). TMS can be performed outpatient. The patient is alert and will feel a tapping sensation. Possible side effects include headache, neck pain, local pain, and transient

tinnitus (Mann & Malhi, 2022). These side effects are typically mild and resolve in a short period of time (Mann & Malhi, 2022). Seizures are rare with a higher incidence for those having epilepsy (Mann & Malhi, 2022).

Psychopharmacology

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

NAMI's Resources

Review the National Alliance on Mental Illness (NAMI) webpage for an overview of the above mental health treatments (NAMI, 2022a).

Evaluation

The final step in the nursing process is the evaluation of

interventions toward the achievement of the outcomes (Toney-Butler & Thayer, 2022). Evaluation is imperative as it provides information to maintain, modify, add additional, and/or stop current interventions.

Key Takeaways

You should have learned the following in this section:

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

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PSYCHOPHARMACOLOGY

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

Module Outline

- Psychiatric Drugs and Deinstitutionalization
- Neurotransmitters
- Psychotropic Medication Classes

Module Learning Outcomes

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

Psychopharmacology

Use of psychiatric drugs and deinstitutionalization.

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

Classes of psychiatric drugs include:

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

A result of the use of psychiatric drugs was deinstitutionalization or the release of patients from mental health facilities. This shifted resources from inpatient to outpatient care and placed the spotlight back on the biological or somatogenic perspective. When people with severe mental illness do need inpatient care, it is typically in the form of short-term hospitalization.

Neurotransmitters

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

- **Dopamine** – controls voluntary movements and is associated with the reward mechanism in the brain
- **Serotonin** – regulates pain, sleep cycle, and digestion; leads to a stable mood, so low levels lead to depression
- **Endorphins** – involved in reducing pain and making the person calm and happy
- **Norepinephrine** – increases the heart rate and blood pressure and regulates mood
- **Gamma-aminobutyric acid (GABA)** – inhibitory; blocks the signals of excitatory neurotransmitters responsible for anxiety and panic
- **Glutamate** – excitatory; associated with learning and memory
- **Histamine** – mediates homeostasis functions, promotes wakefulness, modulates feeding, and motivational behavior

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

Psychopharmacology Classes

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

Antidepressants

Antidepressants are used to treat depression, but also anxiety, insomnia, and pain. They typically require 4-8 weeks to reach full therapeutic benefit (National Institute of Mental Health, 2022). The most common types of antidepressants are **selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs),** and **norepinephrine-dopamine reuptake inhibitors (NDRIs)** (National Institute of Mental Health, 2022). Examples of SSRIs include Citalopram, Paroxetine, and Fluoxetine (Prozac). **Tricyclic antidepressants** and **Monoamine Oxidase Inhibitors (MAOIs)** are two other older types of antidepressants. Tricyclics and MAOIs are not typically first-line options as they have more side effects compared to SSRIs and SNRIs. The common side effects of

antidepressants are upset stomach, headache, and sexual dysfunction, but generally improve with time (National Institute of Mental Health, 2022).

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

Individuals prescribed MAOIs need to avoid foods containing high amounts of tyramine (i.e., aged cheeses, aged/picked/smoked meats, beer, wine, yeast extracts, ginseng, sauerkraut, and avocado) to avoid MAOI toxicity (Garcia & Santos, 2022). MAOI toxicity can also occur with an overdose of an MAOI medication and a drug-drug interaction. Potential signs and symptoms related to MAOI toxicity can vary from mild to life-threatening. Monoamine oxidase breaks down epinephrine, norepinephrine, dopamine, serotonin, and tyramine in the body. Excess of these substances can result in tachycardia, hyperthermia, myoclonus, hypertension, and agitation (Garcia & Santos, 2022). See this reference to read more about MAOI toxicity.

Serotonin syndrome a potentially is a rare, but potentially

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

- Agitation
- Anxiety
- Restlessness
- Disorientation
- Diaphoresis
- Hyperthermia
- Tachycardia
- Nausea & Vomiting
- Tremor
- Muscle Rigidity
- Hyperreflexia
- Myoclonus
- Dilated Pupils
- Ocular Clonus
- Dry Mucous Membranes
- Flushed Skin
- Increased Bowel Sounds
- Bilateral Babinski Sign (Simon & Keenaghan, 2022).

Read more about Serotonin Syndrome here.

Anxiolytics

Anxiolytics/Anti-anxiety medications help with the symptoms of anxiety and include benzodiazepines (a class of sedative-hypnotic drugs) such as Clonazepam, Alprazolam, and Lorazepam. Anti-anxiety medications such as **benzodiazepines** are effective in relieving anxiety and take effect more quickly than the antidepressant medications (or buspirone) often prescribed for anxiety. However, there is a potential for dependence and tolerance to benzodiazepines if they are taken over a long period and may need higher and higher doses to get the same effect. **Side effects** include drowsiness, dizziness, nausea, difficulty urinating, and irregular heartbeat, to name a few. It is important to note that some SSRIs and SNRIs as well as beta blockers are used to treat anxiety (National Institute of Mental Health, 2022). Buspirone is an anxiolytic medication prescribed to treat anxiety but requires 3-4 weeks to reach full therapeutic effect (National Institute of Mental Health, 2022).

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

Stimulants

Stimulants increase one's alertness and attention and are frequently used to treat **Attention Deficit Hyperactivity Disorder (ADHD)**. They include Lisdexamfetamine, the combination of dextroamphetamine and amphetamine, and Methylphenidate. Stimulants are generally effective and produce a calming effect. Possible side effects include loss of appetite, headache, motor or verbal tics, and personality changes such as appearing emotionless. There is a potential for abuse related to high feelings (Heldt, 2017). Additionally, stimulants may be associated with growth restriction and sleep disturbance; thus, both should be monitored (Heldt, 2017).

Antipsychotics

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

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

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

characteristics of Schizophrenia.

Extrapyramidal side effects

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

EPS side effects **ADAPT** over **hours, days, weeks, and years**.
Acute **D**ystonia – hours
Akathisia – days
Parkinsonism – weeks
Tardive Dyskinesia – years (Heldt, 2017).

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=27#oembed-1

O'Dell, E. (2016). *Recognizing extrapyramidal symptoms*

[Video]. YouTube. https://youtube.com/watch?v=2xfu-d_aYWs&si=EnSIkaIECMiOmarE

Tardive Dyskinesia

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

Neuroleptic Malignant Syndrome

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

NMS is:
Fever
Encephalopathy
Vital sign instability
Elevated WBC & CPK

Rigidity (Heldt, 2017)

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=27#oembed-2

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

Mood stabilizers

Mood stabilizers are used to treat bipolar disorder and, at times, depression, schizoaffective disorder, and disorders of impulse control. A common example is **Lithium**; side effects include loss of coordination, hallucinations, seizures, and frequent urination. Lithium has a narrow therapeutic range (0.8-1.2) and therefore a high risk of toxicity (>2.0) (Heldt, 2017). **Lithium toxicity** ranges from mild to severe (Heyda

et al., 2022). Heyda et al. (2022) note symptoms of lithium toxicity can include:

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

Lithium Risks

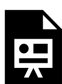
1. Lithium has a narrow therapeutic range, increasing the risk of toxicity. Serum levels should be around 1.0 mEq/L (Videbeck, 2020).
2. Lithium is a teratogen and is not recommended during pregnancy (Videbeck, 2020).
3. Lithium is excreted by the kidneys. It is a salt in the human body and competes for the body's salt receptor sites. Lastly, low volume can increase lithium serum levels. For these reasons, patients should ingest adequate amounts of salt and water

(Heyda et al., 2022).

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

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

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



An interactive H5P element has been excluded from this version of the text. You can view it online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=27#h5p-6

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

You should have learned the following in this section:

- Neurotransmitter imbalances can result in

mental disorders

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

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MENTAL HEALTH PROMOTION

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

Module Outline

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

Module Learning Outcomes

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

Mental Health Promotion

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

Self-Care

Self-care is merely, just that, caring for oneself. Generally, as a society, we are all busy and do not prioritize caring self-care. Business can translate to high-stress levels. Increased stress in the body is associated with ill-health outcomes. An informal Google search "stress and health" will provide a host of returned entries documenting the effects of stress on and within the body. Chronic stress may also impact mental health outcomes. Psychoimmunology is a new field of study that examines the effects of psychosocial stressors on the immune system (Videbeck, 2020).

As nurses, we certainly need to practice self-care. Please sit

back and take a moment to listen to one of our colleagues, Dr. Karen White-Trevino, take on self-care and the crucial need for nurses to practice self-care.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=29#oembed-1

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

Check out this resource for self-care: https://www.peerhealthexchange.org/

Complementary and Alternative Medicine

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

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

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

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

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

Caritas: Yoga & Meditation YouTube channel.

https://youtube.com/watch?v=OqbRGuI6eqM&si=EnSIkaIECMiOmarE

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

Additional Resources

Check out some of the following resources:

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

Key Takeaways

You should have learned the following in this section:

- Mental health promotion is vital to achieving

positive mental health outcomes.

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

LEGAL AND ETHICAL ISSUES

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

Module Outline

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

Module Learning Outcomes

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

Overview

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

Legal Issues Related to Mental Illness

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

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=31#oembed-1

Level Up RN. (2022). *Psychiatric mental health nursing: introduction, patient rights* [Video].

YouTube. https://youtube.com/watch?v=ZsEyrOWH6Mk&si=EnSIkaIECMiOmarE

Civil Commitment

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

Criteria for Involuntary Commitment

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

1. First, the individual must present a clear danger to either

themselves or others.

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

Procedures in Involuntary Commitment

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

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

last from 6 months to 1 year, but an indefinite period can be specified too. In the latter case, the individual has periodic reviews and assessments.

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

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

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

Patient's Rights

Patients admitted to a psychiatric treatment facility **maintain all their civil rights with one exception**; if they have been admitted involuntarily, they may not be able to leave the facility (Videbeck, 2020). The following are several rights pertaining to patients and mental health treatment settings.

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

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

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

The Therapist-Client Relationship

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

- **Confidentiality** – As you might have learned in an

introductory nursing course, confidentiality guarantees that information about the patient is not disseminated without their consent. The **Health Insurance Portability and Accountability Act (HIPAA)** also guides nurses on when and who should receive information concerning individuals admitted to a psychiatric treatment facility. See the resource located under "Additional Resources" below.

- **Duty to Warn** – In the 1976 *Tarasoff v. the Board of Regents of the University of California* ruling, the California Supreme Court said that a patient's right to confidentiality ends when there is a danger to the public, and that if a therapist determines that such a danger exists, there is an obligation to warn the potential victim. Tatiana Tarasoff, a student at UC, was stabbed to death by graduate student, Prosenjit Poddar in 1969, when she rejected his romantic overtures, despite warnings by Poddar's therapist that he was an imminent threat. The case highlights the fact that therapists have a legal and ethical obligation to their clients but, at the same time, a legal obligation to society. How exactly should they balance these competing obligations, especially when they are vague? The 1980 case of *Thompson v. County of Alameda* ruled that a therapist does not have a duty to warn if the threat is nonspecific.

Additional Resources

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

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

Key Takeaways

You should have learned the following in this section:

- Civil commitment occurs when a person acts in potentially dangerous ways to themselves or others and can be initiated by the person (voluntary commitment) or another professional (involuntary commitment).
- Patients admitted involuntarily to a psychiatric treatment facility maintain all civil rights except the right to leave. The American Psychiatric Association also established a Bill of Rights for mental health patients.
- Two main concerns are important where the therapist-client relationship is concerned –

confidentiality and the duty to warn.

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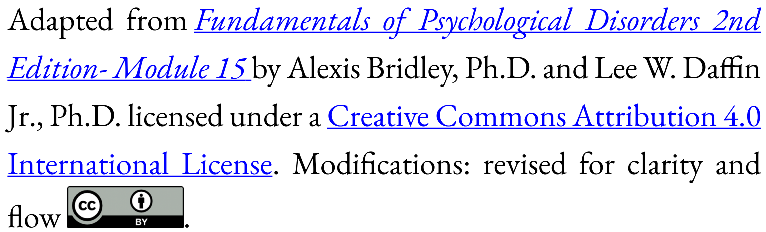
.

THERAPEUTIC COMMUNICATION

THERAPEUTIC COMMUNICATION

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

Module Outline

- Therapeutic Communication
- Non-Therapeutic Communication

Module Learning Outcomes

- Summarize therapeutic communication techniques
- Summarize non-therapeutic communication techniques

Concepts

- Therapeutic Communication
- Empathy

- Rapport

Overview

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

See Sharma and Gupta (2022) for further reading.

Therapeutic Communication Strategies

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

- **Open-ended questions**-ask open ended questions to learn more about the patient and enable a free-flow of

information exchange; closed-ended questions can be used to focus on specific information

- **Active listening**-active listening involves behaviors such as making eye contact and nodding
- **Non-verbal indicators**-be mindful of non-verbal indicators such as looking frequently at the clock/watch, toe-tapping, having an open body stance
- **Silence**-sitting with a patient during a difficult time and listening without interruption can be therapeutic
- **Reflecting**-the nurse repeats the patient's communication back to them; encourages the patient to reflect on their feelings

Non-Therapeutic Communication Strategies

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

- **Value judgments/Approval/Disapproval**-avoid interjecting one's biases and judgments, providing approval or disapproval of the patient's thoughts or actions
- **Negative body language**-avoid crossing arms, appearing distracting, and standing over the patient during engagement/conversation
- **Advice**-avoid providing patient advice on recommended

action(s)

- **False reassurance**-avoid false reassurance; can lead to mistrust, especially in the case that an expected outcome is not realized

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=33#oembed-1

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

Key Takeaways and Learning Activity

You should have learned the following in this section:

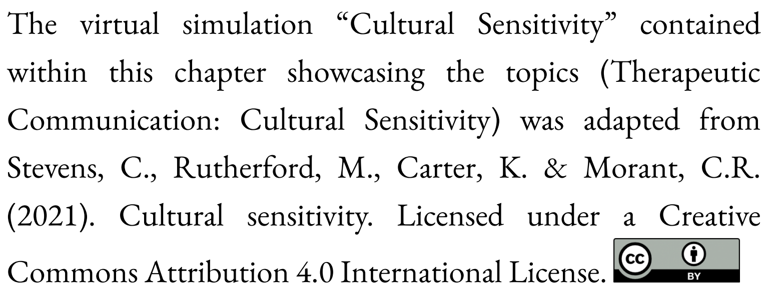
- The use of therapeutic communication techniques and empathy helps the nurse build

rapport and a therapeutic relationship with the patient

- Non-therapeutic communication actions can erode a therapeutic relationship

Virtual Case Scenario

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=33#h5p-14



The virtual simulation “Cultural Sensitivity” contained within this chapter showcasing the topics (Therapeutic Communication: Cultural Sensitivity) was adapted from Stevens, C., Rutherford, M., Carter, K. & Morant, C.R. (2021). Cultural sensitivity. Licensed under a Creative Commons Attribution 4.0 International License.

DEPRESSION

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Mood
- Affect
- Safety
- Legal and Ethical Issues

Depressive Disorders

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

The two most common types of depressive disorders are **Major Depressive Disorder** and **Persistent Depressive Disorder**. Persistent Depressive Disorder, previously known as Dysthymia, is a continuous and chronic form of depression. While the symptoms of Persistent Depressive Disorder are very similar to Major Depressive Disorder, they are usually less

acute, as symptoms tend to ebb and flow over a long period (more than two years).

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

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

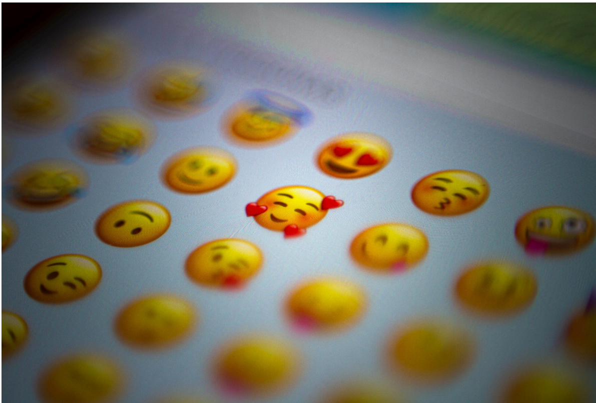
Assessment

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

Mood

While clinical depression can vary in its presentation among individuals, most, if not all individuals with depression will report significant mood disturbances such as a depressed mood for most of the day and/or feelings of ***anhedonia***, which is the loss of interest in previously interesting activities. **Affect** (i.e.,

the outward expression of mood) is typically blunted or flat. You might think of affect as you would emojis.



Behavioral

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

Cognitive

It should not come as a surprise that there is a serious disruption in cognition as individuals with depressive disorders typically hold a negative view of themselves and the world around them. They are quick to blame themselves when

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

Physical

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

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

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

- Think of **A Words** when assessing **S/S of depression**: **a**nergia, **a**nhedonia, **a**volition, **a**logia, **a**ppetite change, **a** change in sleep.
- Heldt (2017) uses the mnemonic **SIGECAPS** to remember the S/S of depression.
  Sleep Disturbance, **I**nterest (decreased), **G**uilt and/or hopelessness, **E**nergy (decreased), **C**oncentration (impaired),

Appetite (decreased), **P**sychomotor retardation, **S**uicidal thoughts

- It is imperative to **assess for suicidal/ homicidal thoughts**. Nurses should ask about suicidal/homicidal thoughts **matter-of-factly.**
- ***"Are you having thoughts of harming yourself or someone else?"*** Followed by, ***"Do you have a plan to harm***

yourself or someone else? If the response is affirmative, ask about the plan and place the patient on **suicide precautions**.

Instruments

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

Problems

Problems commonly associated with a Depression diagnosis are:

- Self-directed violence, the risk for
- Hopelessness
- Coping, ineffective
- Self-Esteem, chronic low
- Fatigue
- Nutrition is imbalanced, less than body requirements (Chand, Arif, et al., 2022).

Treatment

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

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

Multimodal treatment

While both pharmacological and psychological treatment alone is very effective in treating depression, a combination of the two treatments may offer additional benefits, particularly in the maintenance of wellness and long-term relief of symptoms. Additionally, multimodal treatment options may be helpful for individuals who have not achieved wellness in a single modality.

Nursing Care

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

Typical Signs and Symptoms of Depression with example interventions:

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

- Depressed mood-evaluate depressed mood rating on a numerical scale, where 1 is a low rating and 10 is a highly depressed mood.
- **All patients with depression should be evaluated for suicidal risk. Any suicide risk must be given prompt attention which could include hospitalization or close and frequent monitoring** (Chand, Arif, et al., 2022).

Mental Health Promotion

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

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

- Improve screening and diagnosis in primary care settings
- Create a crisis or relapse prevention plan
- Cultivate a social support network
- Incorporate behavioral changes that promote optimum health
- Encourage the patient to develop solutions.

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

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=38#oembed-1

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

Key Takeaways & Learning Activities

You should have learned the following in this section:

- Treatment of depressive disorders includes psychopharmacological options AND/OR psychotherapy options including CBT and interpersonal therapy (IPT). A combination of the two main approaches often works best, especially concerning the maintenance of wellness.
- Ask about suicidal/homicidal thoughts matter

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

Concept Map Activity

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

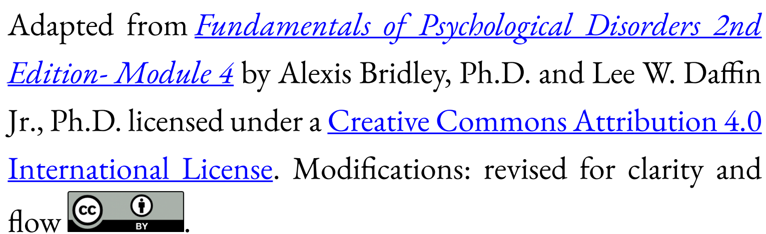
Case Study: Depression

Case Scenario

Sarah is a 25-year-old nursing student who has been feeling persistently sad and fatigued for the past several months. She has lost interest in her studies, social activities, and has difficulty concentrating. She is a full-time student and works part-time on the weekends. She lives at home with an elderly grandparent, whom she helps with day-to-day activities of daily living.

Reflective Case Study Questions:

1. Identify and describe the common symptoms of depression exhibited by Sarah.
2. How would you differentiate between sadness and clinical depression?
3. Discuss the potential risk factors contributing to Sarah's depression.
4. Develop a nursing care plan to address Sarah's immediate needs.
5. What patient education would you provide to Sarah and her family about managing depression?

Adapted from *Fundamentals of Psychological Disorders 2nd Edition- Module 4* 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 .

ANXIETY

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Stress

- Safety
- Coping
- Legal and Ethical Issues

Anxiety Disorders

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

As you will see throughout the chapter, individuals may experience anxiety in many different forms. **Generalized anxiety disorder**, **(GAD)** the most common of the anxiety

disorders, is characterized by a global and persistent feeling of anxiety. A **specific phobia** is observed when an individual experiences anxiety related to a specific object or subject. Similarly, an individual may experience **agoraphobia** when they feel fear specific to leaving their home and traveling to public places. **Social anxiety disorder** occurs when an individual experiences anxiety related to social or performance situations, where there is the possibility of being evaluated negatively. Finally, there is **panic disorder**, where an individual experiences recurrent panic attacks consisting of physical and cognitive symptoms.

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

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

Assessment

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

Mood

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

Behavioral

Anxious individuals may avoid certain situations, pursue a

sense of safety, and/or exhibit various external characteristics such as restlessness, agitation, pacing, hyperventilation, appear motionless, and difficulty speaking (Chand, Marwaha, et al., 2022).

Cognitive

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

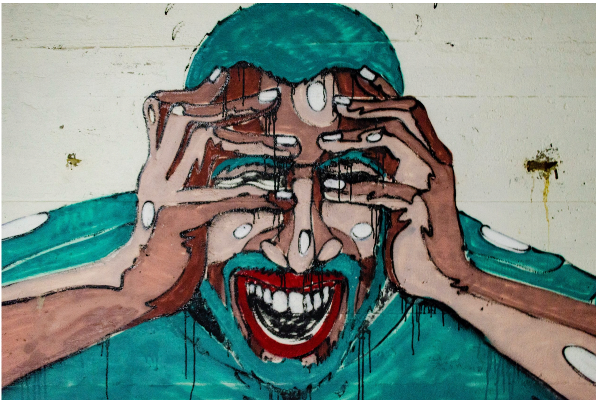
One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=42#oembed-1

University of York. (2019). Breaking the wall of ruminative

anxious thought [Video]. YouTube. https://youtube.com/watch?v=AD_Ay-mwLoc&si=EnSIkaIECMiOmarE

Physical

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



Instruments

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

Problems

Problems commonly associated with an Anxiety diagnosis are:

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

Treatment

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

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=42#oembed-2

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

Mental Health Promotion

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

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

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

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

Key Takeaways and Learning Activities

You should have learned the following in this section:

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

Concept Map Activity

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

Case Study: Anxiety

Case Scenario

Jamarius, a 30-year-old teacher, experiences excessive worry and avoids certain social situations

due to overwhelming fear. He has been experiencing insomnia and stress eating. He is the single father of two young children, ages 5 and 8. His spouse died six months ago. He regularly attends church. He utilizes the local community center for after-school care.

Reflective Case Study Questions:

1. Differentiate between generalized anxiety disorder from day-to-day worry in Jamarius' case.
2. Identify potential triggers for Jamarius' anxiety.
3. What therapeutic communication techniques would you use to assess Jamarius' anxiety?
4. Propose three non-pharmacological interventions to manage Jamarius' anxiety.
5. How would you involve Jamarius' support system in his care plan?

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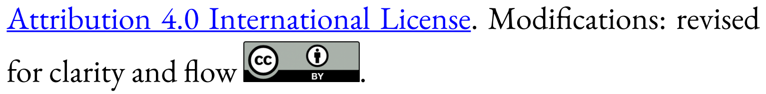
Attribution 4.0 International License. Modifications: revised for clarity and flow .

BIPOLAR

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Mood

- Affect
- Safety
- Legal and Ethical Issues

Bipolar Disorder

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

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

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

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=45#oembed-1

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

Assessment

Assessment of Mania

The signs and symptoms associated with a manic episode are:

- Increased activity or energy
- Appear excessively happy, often engaging haphazardly in sexual or personal interactions
- Rapid shifts in mood, also known as **mood lability**,

ranging from happy, neutral, to irritable

- Inflated self-esteem or grandiosity, occasionally can appear as delusional
- Require a decreased need for sleep, sleeping as little as a few hours a night yet still feeling rested, reduced need for sleep may also be a precursor to a manic episode, suggesting that a manic episode is to begin imminently
- Rapid, pressured speech, disorganized or incoherent speech
- Racing thoughts and flights of ideas.

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

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

Instruments

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

Problems

Problems associated with a Bipolar diagnosis are:

- Risk for injury
- Imbalanced nutrition: less than body requirements

- Disturbed thought processes
- Self-Care deficit

Treatment

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

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

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

Mental Health Promotion

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

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

- Improve screening and diagnosis in primary care settings
- Create a crisis or relapse prevention plan
- Cultivate a social support network

- Incorporate behavioral changes that promote optimum health
- Encourage the patient to develop solutions (Videbeck, 2020).

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

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=45#h5p-7

Key Takeaways and Learning Activities

You should have learned the following in this section:

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

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

Concept Map Activity

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

Case Study: Bipolar

Case Scenario

Akira, a 22-year-old college student, has begun to exhibit periods of extreme energy and excitement followed by deep depressive episodes this semester. During periods of extreme energy, she stays out late and disrupts her roommate's sleep. She has opened several credit cards and goes on shopping sprees. Her behavior is impacting her academic performance

and relationships. Her sorority sisters are worried about her but don't know how to help her or talk with her about the changes they have noticed.

Reflective Case Study Questions:

1. Describe the key characteristics of bipolar disorder evident in Akira's case.
2. Discuss the nursing interventions during Akira's manic phase.
3. What considerations should be made in developing a medication plan for Akira?
4. How can a nurse support Akira during depressive episodes?
5. What education should be provided to Akira and her family about managing bipolar disorder?

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SOMATIC SYMPTOM AND RELATED DISORDERS

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Stress
- Coping
- Safety
- Legal and Ethical Issues

Overview

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

Psychological disorders that feature somatic symptoms are often challenging to diagnose due to the internalizing nature of the disorder, meaning there is no real way for a clinician to measure the somatic symptom. Furthermore, the somatic symptoms could take on many forms. For example, the individual may be *faking* the physical symptoms, *imagining* the symptoms, *exaggerating* the symptoms, or they could be real and triggered by external factors such as stress or other psychological disorders. The symptoms also may be part of a real medical illness or disorder, and therefore, the symptoms should be treated medicinally.

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

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

Somatic Symptom Disorder

Individuals with somatic symptom disorder (SSD) often present with multiple somatic symptoms at one time. Individuals with SSD often report excessive thoughts, feelings, or behaviors surrounding their somatic symptoms; thus, leading to distress and/or dysfunction (e.g., missing time from work) (D'Souza and Hooten, 2022). A lack of medical explanation is not needed for a diagnosis of SSD, as it is

assumed that the individual's suffering is *authentic.* Somatic symptom disorder may be diagnosed when another medical condition is present, as these two diagnoses are not mutually exclusive.

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

Illness Anxiety Disorder

Illness anxiety disorder, previously known as **hypochondriasis**, involves an excessive preoccupation with having or acquiring a serious medical illness. The key distinction between illness anxiety disorder and somatic symptom disorder is that an individual with illness anxiety disorder does not typically present with any somatic symptoms. Occasionally an individual will present with a somatic symptom; however, the intensity of the symptom is mild and does not drive the anxiety. Acquiring a serious illness drives concerns.

Conversion Disorder

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

Factitious Disorder

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

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

Psychological Factors Affecting Other Medical Conditions

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

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

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

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

Assessment

Nurses will assess for three elements:

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

Problems

Problems associated with a Somatic Symptom diagnosis are:

- Risk for injury
- Ineffective coping
- Pain
- Anxiety

Treatment

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

Psychopharmacology

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

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/uwfmentalhealthnursing2e/?p=48#oembed-1

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

Key Takeaways and Learning Activities

You should have learned the following in this section:

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