

MENTAL HEALTH IS A VERB Second Edition

MENTAL HEALTH IS A VERB

A Pocket Guide to Mental Health for Nursing Students

Jake Bush, Ph.D., RN, CNE

Jill Van Der Like, DNP, MSN, RNC

Contact Information about this OER:

1. Jake Bush, Ph.D., RN, CNE, Lecturer, jbush@uwf.edu
2. Jill Van Der Like, DNP, MSN, RNC, Clinical Assistant Professor, jvanderlike@uwf.edu



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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.

- Jake Bush, Ph.D., RN, CNE, Lecturer, jbush@ufw.edu
- Jill Van Der Like, DNP, MSN, RNC, Clinical Assistant Professor, jvanderlike@ufw.edu

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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. 
- Thank you to Ms. Cindy Gruwell, Health Sciences

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- 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/uwfmmentalhealthnursing2e/?p=17#oembed-1>

4 | INTRODUCTION

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.



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uwfmmentalhealthnursing2e/?p=20#h5p-2](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?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.



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

14 | MODULE 1: MENTAL HEALTH VERSUS MENTAL ILLNESS

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.

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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...”
 - **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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uwfmmentalhealthnursing2e/?p=22#h5p-3](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?p=22#h5p-3)

Read more about Maslow's Hierarchy of Needs here: [https://www.simplypsychology.org/
maslow.html](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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<https://pressbooks.uwf.edu/uwfmhmentalhealthnursing2e/?p=24#h5p-5>

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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MODULE 3: CLINICAL ASSESSMENT, PROBLEMS, AND
TREATMENT | 33

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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) Receptor Antagonists**-treat dementia

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

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).



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[https://pressbooks.uwf.edu/
uwfmmentalhealthnursing2e/?p=27#oembed-1](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?p=27#oembed-1)

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

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

Tardive Dyskinesia

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

Neuroleptic Malignant Syndrome

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

NMS is:

- F**ever
- E**ncephalopathy
- V**ital sign instability
- E**levated WBC & CPK

Rigidity (Heldt, 2017)



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[https://pressbooks.uwf.edu/
ufwmentalhealthnursing2e/?p=27#oembed-2](https://pressbooks.uwf.edu/ufwmentalhealthnursing2e/?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>



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<https://pressbooks.uwf.edu/mentalhealthnursing2e/?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.



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[https://pressbooks.uwf.edu/
uwfmmentalhealthnursing2e/?p=29#oembed-1](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?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://ww
w.peerhealthexch
ange.org/](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](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](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.



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uwfmentalhealthnursing2e/?p=31#oembed-1](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=EnSlkalECMiOmarE>

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



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

rappor and a therapeutic relationship with the patient

- Non-therapeutic communication actions can erode a therapeutic relationship

Virtual Case Scenario



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uwfmmentalhealthnursing2e/?p=33#h5p-14](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?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.](#)

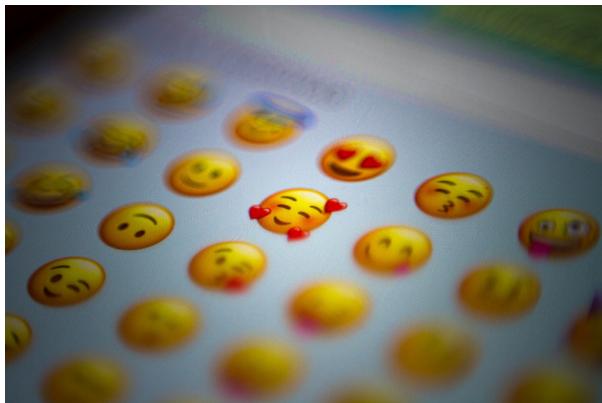
Assessment

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**: anergia, anhedonia, avolition, alogia, appetite 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 \(MDI\)](#) ("Psych Tools", 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.



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<https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?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?

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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.ufw.edu/
uwfmmentalhealthnursing2e/?p=42#oembed-1](https://pressbooks.ufw.edu/uwfmmentalhealthnursing2e/?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.



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[https://pressbooks.uwf.edu/
uwfmmentalhealthnursing2e/?p=42#oembed-2](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?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](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 diagnosis 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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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.



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[https://pressbooks.uwf.edu/
uwfmmentalhealthnursing2e/?p=45#oembed-1](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?p=45#oembed-1)

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



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uwfmmentalhealthnursing2e/?p=45#h5p-7](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?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).



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<https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?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.

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

Concept Map Activity

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

Case Study: Somatic Symptom Disorder

Case Scenario

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

Reflective Case Study Questions:

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

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EATING DISORDERS

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Nutrition

- Self
 - Coping
-

Overview

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

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

Anorexia Nervosa

Balasundaram and Santhanam (2022) describe several key

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

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

Bulimia Nervosa

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

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

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

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

Binge-Eating Disorder (BED)

Binge-Eating Disorder is similar to Bulimia Nervosa in that

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

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

See [Balasundaram and Santhanam \(2022\)](#) to read more about this topic.

Assessment

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

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

Nervosa)

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



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[https://pressbooks.uwf.edu/
uwfmmentalhealthnursing2e/?p=50#oembed-1](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?p=50#oembed-1)

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



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Instruments

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

Problems

Problems associated with an Eating disorder diagnosis are:

- Ineffective coping
- Risk for injury
- Altered nutrition

Treatment

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

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

CBT-E

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

FBT

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

Psychotropics

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

Nutritional Therapy

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



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uwfmmentalhealthnursing2e/?p=50#oembed-2](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?p=50#oembed-2)

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

YouTube.

[https://youtube.com/](https://youtube.com/watch?v=n9o_ZtUlsgI&si=EnSIkaIECMiOmarE)

[watch?v=n9o_ZtUlsgI&si=EnSIkaIECMiOmarE](https://youtube.com/watch?v=n9o_ZtUlsgI&si=EnSIkaIECMiOmarE)

Additional Resource

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

- [National Eating Disorders Association \(NEDA\)](#)

Key Takeaways and Learning Activities

You should have learned the following in this section:

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

behavior to rid the body of the calories.

- Some treatment options for eating disorders include CBT-E, FBT, and Nutrition therapy.

Concept Map Activity

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

Case Study: Eating Disorder

Case Scenario

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

Reflective Case Study Questions:

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

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SUBSTANCE ABUSE AND ADDICTION

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Addiction
 - Behavior
 - Coping
 - Safety
-

Overview

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

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

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

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

Types of Substances Abused

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

Depressants

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

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

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

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

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

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

Stimulants

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

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

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

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

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

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

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

Hallucinogens/Cannabis/ Combination

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

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

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

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

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

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

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

See [Jahan and Burgess, 2022](#) to read more about this topic.

Assessment

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

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

Overview of Communication Strategies

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

proactively address risk for ETOH withdrawal)

Signs and Symptoms of Substance Abuse and Addiction



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

Problems

Problems associated with a Substance Abuse and Addiction diagnosis include:

- Ineffective Denial
- Ineffective Coping
- Powerlessness

Treatment

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

Biological

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

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

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

CIWA-Ar.

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

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



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<https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?p=52#h5p-9>

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

Sociocultural

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

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

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

Do this: Google “find an aa meeting near me” or “na meetings.”

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

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

Additional Resource

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

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

Key Takeaways and Learning Activities

You should have learned the following in this section:

- Many substances have abuse and addiction potential. They include

- Depressants include alcohol, sedative-hypnotic drugs, and opioids
 - Stimulants include cocaine and amphetamines, but caffeine as well.
 - Hallucinogens come from natural sources and produce powerful changes in sensory perception.
 - Cannabis is also derived from a natural plant and produces psychoactive effects.
- Substance abuse coupled with a mental health diagnosis is known as a dual diagnosis.
 - There are various treatment options for substance abuse and addiction such as Biological and Sociocultural treatment options.

Concept Map Activity

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

Case Study: Substance Abuse and

Addiction

Case Scenario:

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

Reflective Case Study Questions:

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

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

Virtual Case Scenario

Instructions

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

The screenshot shows a digital interface for a virtual simulation. At the top, there's a small circular icon with a camera symbol. Below it is a video thumbnail showing a person from the chest up, sitting at a desk in a room with a window. Underneath the thumbnail is a title: "Case 3: Care of a Young Adult with Diabetes, Altered Mood, and Substance Use in a Community Setting". To the right of the title is a green rounded rectangle containing the text "Start the scenario →". At the bottom of the interface, there are three small icons: a "Reuse" icon, a "Rights of use" icon, and an "Embed" icon. To the right of these icons is a "Help" link.

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



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SCHIZOPHRENIA

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Cognition

- Psychosis
 - Mood and Affect
 - Safety
-

Overview

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

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

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



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

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

See [Calabrese et al. \(2022\)](#) to read more about this topic.

Assessment

Positive signs and symptoms

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

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

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

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

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

- **Disorganized/Abnormal motor behavior.**

Psychomotor symptoms can also be observed in individuals with schizophrenia. These behaviors may manifest as awkward movements or even ritualistic/repetitive behaviors.

- **Catatonic behavior.** Catatonic behavior, the decreased or complete lack of reactivity to the environment, is among the most commonly seen disorganized motor behaviors in schizophrenia. There runs a range of **catatonic** behaviors.

Negative signs and symptoms

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

Hallucinations:

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

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

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



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

[https://pressbooks.uwf.edu/
mentalhealthnursing2e/?p=54#h5p-10](https://pressbooks.uwf.edu/mentalhealthnursing2e/?p=54#h5p-10)

Problems

Problems associated with a Schizophrenia diagnosis include:

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

Treatment

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

Psychopharmacological

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

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

Psychological Interventions

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

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

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

Family Interventions

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

Key Takeaways and Learning Activities

You should have learned the following in this section:

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

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

Concept Map Activity

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

Case Study: Schizophrenia

Case Scenario

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

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

Reflective Case Study Questions:

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

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PERSONALITY DISORDERS

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Self
 - Behavior
 - Coping
-

Overview

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

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

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

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

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



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[https://pressbooks.uwf.edu/
uwfmhernursing2e/?p=56#oembed-1](https://pressbooks.uwf.edu/uwfmhernursing2e/?p=56#oembed-1)

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

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

See [Fariba et al. \(2022\)](#) to read more about this topic.

Assessment

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

- **Paranoid** – suspicious and distrustful

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

What is your personality type? Take this free personality test. [Click here.](#)

Problems

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

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

Treatment

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

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

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

1. Cultivate a therapeutic relationship and use therapeutic

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

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

Key Takeaways and Learning Activities

You should have learned the following in this section:

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

emotional responses, over- or under-regulated impulse control, and interpersonal difficulties and divide into three clusters.

- Many diagnosed with a personality disorder have another coexisting mental health diagnosis.

Concept Map Activity

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

Case Study: Personality Disorder

Case Scenario

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

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

Reflective Case Study Questions:

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

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NEUROCOGNITIVE DISORDERS

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Cognition
 - Coping
 - Safety
-

Overview

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

Dementia

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

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

Alzheimer's Disease

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

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

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

Delirium

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

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

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

Assessment

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

Dementia Versus Delirium

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

Dementia

Alzheimer's Dementia accounts for approximately 70% of the

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



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[https://pressbooks.uwf.edu/
uwfmmentalhealthnursing2e/?p=58#oembed-1](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?p=58#oembed-1)

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

Delirium

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

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

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



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

Instruments

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

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

Problems

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

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

Treatment

Delirium

The main treatment goal

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

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

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

for delirium is to identify and treat the underlying cause.

Dementia

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

- Promoting adequate sleep

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

Pharmacological

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

Support for Caregivers

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

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

Additional Resources

See the [Alzheimer's Association](#) website for more information.

Key Takeaways and Learning Activities

You should have learned the following in this section:

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

- The most common type of is Alzheimer’s disease.
- Pharmacological interventions for Alzheimer’s disease target the neurotransmitters acetylcholine and glutamate.
- Caregivers may benefit from support groups.

Concept Map Activity

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

Case Study: Dementia versus Delirium

Case Scenario

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

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

Reflective Case Study Questions:

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

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CHILDHOOD DISORDERS

CHILDHOOD DISORDERS

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Development
 - Coping
 - Safety
-

Overview

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

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

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

related to constant developmental changes; thus, may not be able to discriminate unusual versus typical/expected feelings/sensations

- Abnormal or problematic behaviors may vary depending on developmental stage and/or age

ADHD

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

- inattention

- hyperactivity
- and impulsiveness

(Magnus et al., 2022;
Videbeck, 2020).

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

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

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

ASD

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

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

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

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



*One or more interactive elements has been excluded from this version of the text. You can view them online here:
<https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?p=60#oembed-1>*

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

ID

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



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<https://pressbooks.uwf.edu/ufwmentalhealthnursing2e/?p=60#oembed-2>

ID affects intellectual function and adaptive behavior.

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

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

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

Assessment

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

Instruments

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

- The Reiss Scales (ID)

Problems

The problems that may be associated with childhood disorders include:

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

Treatment

There are four general treatment considerations for childhood disorders.

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

ADHD

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

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

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

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

ASD

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

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

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

ID

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

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

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

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

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

- Check out the resources listed on the [Society for Adolescent Health and Medicine](#) website.

Key Takeaways and Learning Activities

You should have learned the following in this section:

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

communication, and repetitive or stereotyped behavior impairments

- There is no cure or specific medication for ASD. However, specific medications may be used to treat problematic behaviors
- ID affects intellectual function and adaptive behavior
 - There is no cure or specific medication for ID. Medications may be used to control aggressive behavior
- General nursing considerations: safety is a priority, learn how the child best communicates, promote self-confidence and independence as much as possible with consideration for safety.

Concept Map Activity

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

concept map tutorial.

Case Study: Autism Spectrum Disorder versus Attention Deficit Hyperactivity Disorder

Case Scenario

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

Reflective Case Study Questions:

1. Identify and discuss the key characteristics of

autism spectrum disorder in Dario's case.

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

PSYCHIATRIC EMERGENCIES

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- Behavior

- Coping
 - Safety
 - Legal Issues
-

Overview

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

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

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

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

Crises

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

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

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

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

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



Below is an overview of a nurse's consideration

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

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

Assessment

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

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

Suicide

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

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

Summarization of Suicide Myths

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

Individuals, who were a suicide risk, will always be a suicide risk.	Individuals, who complete suicide, typically have attempted suicide in the past. However, proper support and adaptive coping mechanisms can help individuals with suicidal ideation learn to become emotionally secure and learn adaptive ways to resolve problems.
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See NAMI's (2022b) resource below for warning signs of crisis and interventions.



Aggression and Violence

Anger is a normal human emotion. However, when anger

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

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

Abuse and Neglect

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

Warning Signs of Abuse and Neglect

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

Problems

The problems that may be associated with psychiatric emergencies include:

- Risk for Suicide

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

Treatment

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

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

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

Suicide

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

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

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

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

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

Aggression/Violence

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

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

How can nurses manage aggressive behavior?

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

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



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

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

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

Abuse and Neglect

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

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

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

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

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

General Nursing Considerations for a Psychiatric Emergency

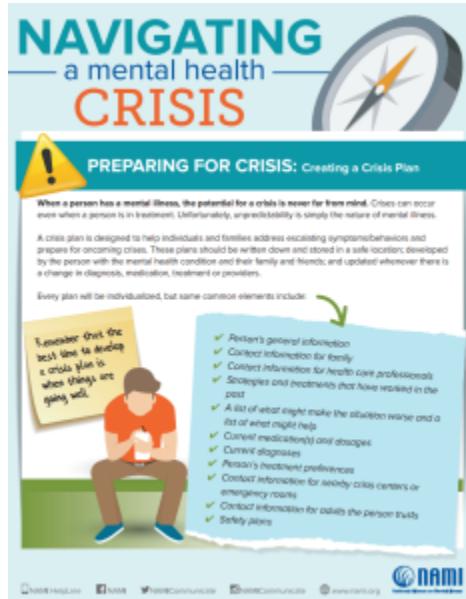
Let's consider a few tenets to consider for **psychiatric emergency interventions.**

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

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

CREATE A PLAN

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



Additional Resources

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

Key Takeaways and Learning Activities

You should have learned the following in this section:

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

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

Concept Map Activity

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

Case Study: Psychiatric Emergency

Case Scenario

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

Reflective Case Study Questions:

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

GRIEF AND LOSS

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

Module Outline

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

Module Learning Outcomes

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

Concepts

- End of Life
 - Spiritual
 - Grief and Loss
-

Overview

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

Types of Loss

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

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

Types of Grief

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

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

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

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

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

Kubler-Ross' Stages of Grief

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

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



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

[https://pressbooks.uwf.edu/
uwfmmentalhealthnursing2e/?p=68#oembed-1](https://pressbooks.uwf.edu/uwfmmentalhealthnursing2e/?p=68#oembed-1)

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

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

See [Oates and Maani-Fogelman \(2022\)](#) for further reading.

Assessment

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

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

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

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

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

Problems

The problems that may be associated with childhood disorders include:

- Ineffective Coping
- Grieving
- Risk for Complicated Grieving

Treatment

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

specific strategies for nurses to help grieving patients and families.

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

Additional Resources

Check out the resources listed on:

- [CDC's Grief and Loss webpage](#)
- [The Center for Prolonged Grief at Columbia University](#)

webpage.

Key Takeaways and Learning Activities

You should have learned the following in this section:

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

Concept Map Activity

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

Case Study: Grief and Loss

Case Scenario

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

Reflective Case Study Questions:

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

An Overview of Foundational Concepts and Common Psychotropics

Jake Bush

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

File: [MH CUMULATIVE OVERVIEW](#)

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