

PROBLEM IDENTIFICATION, NURSING DIAGNOSES, AND PLANNING ACROSS THE LIFE SPAN

This chapter reviews the most common problems (psychiatric diagnoses) that compromise optimal functioning across populations. Common psychiatric disorders and criteria are presented in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM5; American Psychiatric Association [APA], 2013) and are presented for quick reference. In practice, the DSM5 is important for determining accurate diagnoses, which helps in determining appropriate medication and treatment regimens. The psychiatric and mental health nurse pursuing certification should have a good working knowledge and understanding of clinical presentations that help to substantiate particular diagnoses, serve as baseline indications at initial presentations, and provide targeted markers for determining effectiveness of interventions.

EUSTRESS AND DISTRESS

It should be noted that experiences of stress undergird the expression of many medical or psychological pathologies. In fact, stress is linked to “turning on” pathophysiological expressions. As discussed in chapter 2, one of the theories linking to psychopathology is environmental stressors, which may take the form of infections, traumas, or abuses. As it stands, many medical conditions mimic psychiatric symptoms. And no wonder; we are talking about the condition as it presents in one organism, a person who is not separated into fragmented body components. Each system of the body may express dysfunction, which may or may not be rooted in our psychological and emotional selves. Table 4–1 considers particular medical conditions that may be comorbid with certain psychological problems.

TABLE 4-1.
PHYSICAL AND PSYCHOLOGICAL PRESENTATIONS: CHICKEN OR EGG?

Cardiovascular	▶ Migraine
	▶ Essential hypertension
	▶ Angina
	▶ Tension headaches
Musculoskeletal	▶ Rheumatoid arthritis
	▶ Low back pain
	▶ Multiple sclerosis: anxiety, depression, euphoria, ataxia, muscle weakness, diffuse neurological signs with exacerbations and remissions
Respiratory	▶ Hyperventilation
	▶ Asthma
Endocrine	▶ Hyperthyroidism
	▶ Diabetes
	▶ Impotence
	▶ Frigidity
	▶ Premenstrual syndrome
	▶ Cushing's syndrome: depression, insomnia, emotional lability, mania, psychosis
	▶ Adrenocortical insufficiency: lethargy, depression, psychosis, delirium, anorexia, nausea, vomiting
	▶ Hyperthyroidism: nervousness, irritability, insomnia, pressured speech, fear, impending death, anxiety disorders, psychosis, heat intolerance, diaphoresis, tremor
	▶ Hypothyroidism: lethargy, depression, anxiety disorders, paranoia, psychosis, cold intolerance, dry skin, apathy
▶ Hyperglycemia: anxiety, agitation, delirium, acetone breath	
Neurological	▶ Tumor: judgment, seizures, loss of speech, or smell
	▶ Frontal lobe syndrome: mood or personality changes and irritability
Integumentary	▶ Neurodermatitis
	▶ Eczema
	▶ Psoriasis
	▶ Pruritus
Immunology	▶ AIDS: depression, personality changes, impaired memory, mutism, progressive dementia, mania, delirium
Gastrointestinal	▶ Anorexia
	▶ Peptic ulcer
	▶ Irritable bowel syndrome
	▶ Colitis
	▶ Obesity
	▶ Thiamine deficiency: confusion, confabulation, decreased concentration, neuropathy, Wernicke-Korsakoff's psychosis
	▶ Vitamin B12 deficiency: irritability, pallor, dizziness, ataxia, fatigue

TRAUMA-INFORMED CARE

Trauma is an overwhelming event that affects feelings of safety, creates a sense of helplessness, and continues to affect one's perception of reality. The World Health Organization (2014) notes that exposure to trauma and stress at a young age, in addition to genetics, nutrition, perinatal infections, and exposure to environmental hazards can cause mental disorders. Trauma-informed care models provides an important framework that focuses nurses to an understanding of impacts to the brain amygdala and stress hormone activation that results from trauma exposure.

Otto Rank's (1957) psychoanalytical speculation posited that our first experience with trauma occurred during the trauma of birth, reflected in recovery-based language expressions such as wanting to feel "new born" or "born again." Even earlier, consider the fetal environment during organogenesis and its effect on optimal neurological development. Did the mother-to-be have an optimal or non-optimal natal time frame? How might experiences of fear, abuse, and safety compromise the developing neonate? How about considering how historically laden trauma experienced by ancestors (slavery, Holocaust, genocide) actually may have altered the DNA structure within previous generations? Young infants and children who witness, or are victims of violence and violent acts experience triggered amygdala and HPA hormonal storms that may rewire the brain to heightened sensitivity. Impaired resilience and increased sensitivity to stress triggers to offspring may result. Manifestations may be apparent with observations of sleep disorders, learning and behavioral difficulties, or development of other traumatic anxiety disorders (see *Anxiety Disorders* on page 117). Sources estimate that 70% of U.S. adults have experienced some type of traumatic event at least once in their lifetimes with 20% going on to develop post-traumatic stress disorder (http://www.nurseptsdtoolkit.org/_/moreInfo/3.php).

Stress is understood as a normal life occurrence that is to be expected. The goal, therefore, is to identify how to cope with stress by engaging in adaptive responses rather than not coping, by engaging in maladaptive responses. A basic application of understanding stress is awareness that each patient experiences some level of stress by virtue of entering the unknowns involved in hospitalization or engagement with a healthcare provider. Personal control is often either given up or shared with a healthcare provider who is perceived as powerful and able to detect problems that people may be very sensitive about. By the same token, the nurse also experiences some level of stress and anxiety in patient encounters because of similar unknowns. With this reality out and on the table, it is paramount that the educated nurse take responsibility for setting a tone of trust-building through acceptance, openness, expressed concern, and compassion.

As discussed in chapter 2 in reference to the HPA axis, Hans Selye (1956) brought forth a theoretical explanation for stress as it is experienced, describing three stages of alarm, resistance, and exhaustion. Consider the tenets of Stuart (2009) regarding a model of stress adaptation. Stuart's stress adaptation model requires the psychiatric-mental health nurse to work with the patient to identify biological, psychological, environmental, legal, ethical, sociocultural, and other risk factors that trigger a stress response in the patient. Any factor is a stressor if the patient perceives it to be so. The cognitive meaning, the affective feeling, the behavioral response, as well

as the genetic predisposition of the patient-precipitant relationship are factors that will determine the patient's ultimate coping resources. These strengths and coping resources are drawn from a person's personal abilities, level of social support, material assets, and belief system. The nurse will explore these resources in planning care for the patient, as addressed later in this chapter. Criteria for diagnosing psychopathology are found in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM5; APA, 2013).

PSYCHIATRIC-MENTAL HEALTH PRACTICE STANDARD 2: NURSING DIAGNOSIS

Several diagnostic classification systems exist for identifying problems and specific directions of care for mental disorders. The resource for developing nursing diagnoses was developed by the NANDA International (NANDA-I). The NANDA-I classification system (NANDA International, n.d. a) was developed by nurses to identify problems treatable by nurses. NANDA-I nursing diagnoses, unlike DSM5 (APA, 2013) diagnoses, identify the patient's response to health problems, not the medical diagnosis. They are based upon the conceptualization of the human response to actual or potential health problems from the unique nursing perspective. The diagnosis is based upon an analysis and synthesis of collected data and the recognition of functional patterns and trends. Nursing diagnoses allow for recognition of emergent and urgent problems, patterns, and trends in comparison with normal standards. Diagnoses provide for prioritization; highest priorities are addressed first. An accurate diagnosis guides the direction of treatment and evaluation of care outcomes (NANDA International, n.d. a, n.d. b). A partial list of NANDA-I–approved diagnoses that might apply to patients with mental disorders are listed in Box 4.1.

Once problems have been identified and nursing diagnoses made, the psychiatric–mental health nurse plans and implements nursing care addressing priorities for treatment. The highest priority is given to conditions that, if untreated, could result in harm. These would include conditions that involve basic survival needs or safety needs related to suicidal or homicidal ideation (SI or HI) or threat of harm from others (e.g., domestic violence, child or elder abuse). Intermediate priority is given to nonemergent, non–life-threatening, but distressing, painful, or dysfunctional symptoms (e.g., hallucinations, agitation). Lower priority is given to issues that are not specifically related to the illness or prognosis (e.g., occupational, social stressors). Maslow's hierarchy of needs can be used to conceptualize the priorities for care planning.

The nursing care plan specifies, by priority, the diagnoses, short-term and long-term goals and expected outcomes, and interventions, including the what, when, where, how, and who. When available, current, evidence-based practice guidelines, clinical pathways, or clinical algorithms can be used. When new or unusual care needs arise, the nurse is advised to use current research to identify evidence-based approaches. In planning for safe and effective quality care, the Joint Commission (2015) establishes annual Behavioral Health Care National Patient Safety Goals:

BOX 4.1. SELECT LISTING OF NANDA-I NURSING DIAGNOSES

- ▶ Anxiety (mild, moderate, severe, panic)
- ▶ Adjustment, impaired
- ▶ Confusion (acute, chronic)
- ▶ Coping (ineffective, readiness for enhanced, compromised family, defensive)
- ▶ Denial, ineffective
- ▶ Decisional conflict
- ▶ Family processes (dysfunctional, interrupted, readiness for enhanced)
- ▶ Fatigue
- ▶ Fear
- ▶ Grieving (anticipatory, dysfunctional)
- ▶ Health maintenance, ineffective
- ▶ Health-seeking behavior
- ▶ Hopelessness
- ▶ Identity, disturbed personal
- ▶ Loneliness, risk for
- ▶ Memory, impaired
- ▶ Noncompliance; nonadherence
- ▶ Nutrition, altered; more or less than body requirements
- ▶ Pain (acute, chronic)
- ▶ Parenting (enhanced readiness, impaired, risk for impaired)
- ▶ Posttraumatic syndrome or risk
- ▶ Rape trauma syndrome
- ▶ Relocation stress syndrome or risk
- ▶ Role performance, ineffective
- ▶ Self-care deficit (bathing, dressing, feeding, etc.)
- ▶ Self-esteem (chronic low, situational low, risk for low)
- ▶ Self-mutilation or risk for
- ▶ Sensory perception, disturbed or altered
- ▶ Sexual dysfunction
- ▶ Sexuality pattern, disturbed
- ▶ Sleep pattern, disturbed
- ▶ Social interaction, impaired
- ▶ Social isolation
- ▶ Sorrow, chronic
- ▶ Spiritual distress, risk; readiness for
- ▶ Suicide risk
- ▶ Thought process disturbed or altered
- ▶ Trauma, actual or risk
- ▶ Violence, risk for other- or self-directed
- ▶ Wandering

- ▶ Identify persons served correctly. Use at least two ways to identify individuals served. for example, use the individual's name and date of birth. This is done to make sure that each individual served gets the correct medicine and treatment.
- ▶ Use medications safely. Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time he or she visits a doctor. Prevent infection. Use the goals to improve hand cleaning.
- ▶ Identify patient safety risks. Find out which individuals served are most likely to try to commit suicide.

PSYCHIATRIC-MENTAL HEALTH PRACTICE STANDARD 3: OUTCOMES IDENTIFICATION

Outcomes identify the desired results for improvements in patient functionality and well-being that are demonstrated from interaction with nurses and the healthcare environment. Guidelines are constructed to lay out consistency of elements, and they can be measured along several dimensions: clinical, functional, satisfaction, and financial.

Outcomes are clear statements indicating what “will” happen for patients as a course of clinical care. Regardless of the dimension, each outcome considers these guidelines:

- ▶ Patient and family-centered: focuses on diagnosis; suited to patient or population of interest
- ▶ Singular: separate goals for each identified problem or need
- ▶ Mutual: agreed upon by patient, family, or both and nurse, team, or healthcare providers
- ▶ Measurable, reliable, valid: describes quality, quantity, severity, frequency (standardized assessment tools and scales)
- ▶ Time-limited: set short- and long-term goals
- ▶ Realistic: attainable to provide a sense of accomplishment; sensitive to changes within or between persons
- ▶ Evidence-based: algorithms, practice guidelines, clinical pathways
- ▶ Cost-effective

Specific outcomes criteria in keeping with Psychiatric–Mental Health Practice Standard 4: Planning will be presented with each psychiatric problem presented in this chapter.

TABLE 4-2.
OUTCOME DIMENSIONS

Clinical Outcomes	Health status, relapse, recurrence, readmission, number of episodes, symptomatology, coping responses, high-risk behaviors, incidence reports
Functional Outcomes	Functional status (e.g., Global Assessment of Functioning or GAF), social interaction, activities of daily living (ADLs), occupational abilities, quality of life, family relationships, housing arrangements
Satisfaction Outcomes	Satisfaction with treatment, treatment outcomes, treatment team and organization, patient satisfaction measures
Financial Outcomes	Cost, revenue, length of stay, use of resources

MAJOR PSYCHIATRIC MENTAL HEALTH PROBLEMS

Psychotic (Thought) Disorders

Pathogenesis: Theories

Scientific research has determined that subtle prodromal symptoms of schizophrenia may be present from early childhood. They can include delayed language development and asymmetrical use of major muscles of the body. These early findings have led researchers to the hypothesis that schizophrenia is a neurodevelopmental condition. In other words, the brains of persons who develop schizophrenia may not develop normally. It has been hypothesized that the early migration of neurons in brain development may be faulty, resulting in abnormal connections (migrational defects), or excessive, inadequate, or improper pruning of synapses or neurons. It is also hypothesized that maternal flu infection or iron deficiency, as well as substance use by the person, increase the risk for development of psychotic-inducing disorders.

Neurodegeneration theories describe the process of pruning away unnecessary connections in the brain going awry, resulting in destruction of too many neurons and their connections. A process called *excitotoxicity* (Stahl, 2008) has been used to describe the potential self-destruction of neurons resulting from too much glutamate and excitatory neuronal activity. Support for a neurodegenerative mechanism in schizophrenia comes from monozygotic twin studies showing that affected twins tend to have enlarged ventricles of the brain in comparison to their healthy twin siblings. Ventricular enlargement is due to atrophy of the brain tissues, creating more space for fluid in the ventricles.

The pathophysiology of schizophrenia is also characterized by abnormal neurotransmission. Abnormally elevated levels of dopamine in the limbic system are thought to be responsible for positive symptoms (hallucinations, delusions, abnormal speech, and abnormal behavior). Because dopamine is essential for learning, memory, and motivation, the negative symptoms (amotivation, apathy, and anhedonia) and cognitive impairment may reflect lower-than-normal levels of dopamine in the prefrontal cortex. Although dopamine is the neurotransmitter most associated with schizophrenia, researchers are learning that other neurotransmitters, such as glutamate, may also have important roles.

Schizophrenia Syndrome

The experience of psychosis is evident in many subtypes of schizophrenia, pointing to a clearer understanding of what is now referred to as *schizophrenia syndrome*. Nasrallah and Weiden (2014) posit the following occurrences that precipitate increased risk for the development of schizophrenia syndrome:

- ▶ Childhood traumas
- ▶ Paternal age older than 45
- ▶ Migration from another country
- ▶ Pregnancy and delivery complications
- ▶ Urbanicity
- ▶ Winter birth (vitamin D deficiency)
- ▶ Antibodies to one's own N-nitrosodimethylamine (NDMA)
- ▶ Glutamate toxicity

Readers should view the Nasrallah & Weiden (2014) webinar listed in the references for details pertaining to these recent developments.

The average age of onset for schizophrenia, a major psychotic disorder, usually start between ages 16 and 30 with men experiencing symptoms a little earlier than women. Although it is rare, children can develop the disorder, and most of the time, people do not get schizophrenia after age 45 (National Institute of Mental Health, 2015). Support for the neurodevelopmental theory comes from the observation that during the late adolescence, when most people develop full access to the frontal executive functions of the brain, persons with schizophrenia start to demonstrate disordered thinking.

The date of onset is defined by a 6-month period of positive symptoms; however, the prodrome period leading up to the first acute episode may last days to years before the diagnosis. Family members often can look back after the diagnosis of schizophrenia and identify a period of altered behavior leading up to the first major episode of psychosis. During this time, an adolescent may withdraw from family or friends, use drugs, and exhibit changes in motivation and school performance. Subtle delays in language and motor skills may even have been present early in life.

The three major symptom categories of schizophrenia that reflect brain abnormalities are the positive symptoms, negative symptoms, and cognitive dysfunction (diminished executive functioning and working memory). Evidence of delusions, hallucinations, and disorganized behaviors are the hallmarks that define “positive” symptoms, whereas “negative” symptoms include tendencies to withdraw from others, lack of motivation or concern about appearance,

and anhedonia. Usually continuous social and occupational dysfunction for at least 6 months is present. In fact, according to Nasrallah and Weiden (2014), the abuse of phencyclidine (PCP, a veterinary anesthetic) perfectly mimics the symptoms of schizophrenia syndrome. Two or more of the following symptoms must have been present for a significant portion of time during a 1-month period for a diagnosis of schizophrenia:

- ▶ Positive symptoms
 - ▶ Delusions
 - ▶ Hallucinations
 - ▶ Disorganized speech
- ▶ Negative symptoms
 - ▶ Disorganized behavior
 - ▶ Withdrawal, apathy, alogia, amotivation

Schizophrenia can be further differentiated according to predominance in symptomology:

- ▶ Paranoid type
- ▶ Disorganized type
- ▶ Catatonic type
- ▶ Undifferentiated type

After an acute episode of psychosis, recovery to previous levels of functioning may be incomplete, often characterized by the persistence of negative symptoms (severe and persistent mental illness or SPMI). Because it afflicts young adults, this devastating and chronic illness can be characterized as the “Alzheimer’s disease of the young.”

Additional classifications of psychotic disorders are listed in Box 4–2. The specific criteria for each are not addressed in this text. The psychiatric–mental health nurse needs to understand the overarching signs of psychosis itself (delusions and hallucinations) as the focus of psychiatric and nursing interventions.

BOX 4–2.
PSYCHOTIC AND THOUGHT DISORDERS:
SCHIZOPHRENIA SYNDROME

- ▶ Schizophrenia
- ▶ Schizophreniform disorder
- ▶ Schizoaffective disorder
- ▶ Brief psychotic disorder
- ▶ Delusional disorder

Mood Disorders

Pathogenesis: Theories

Monoamine Dysregulation Theory

Monoamines are the neurotransmitters that include serotonin (5HT), norepinephrine (NE), and dopamine (DA). The hypothesis that depression is caused by a reduction or deficit in one or more of the monoamines forms the basis for treating with the traditional antidepressants. Cerebral blood flow is diminished and hippocampal volume is decreased (Rosedale et al., 2013). The actual mechanism of depression is probably more complicated, involving the monoamine receptors and other cellular events, including the regulation of gene expression (Stahl, 2008).

Dysregulation of the HPA Axis Theory

A second hypothesis about the pathophysiology of depression involves the stress response systems, in particular, the hypothalamic-pituitary-adrenal-axis (HPA axis). The HPA axis appears to be the main site where genetic, hormonal, and environmental influences converge in mood disorder etiology. In the autonomic and complex interplay between thoughts, emotions, and behaviors, when a person perceives stress, a circular biofeedback loop activates that stimulates the hypothalamus to secrete corticotropin-releasing hormone (CRH). This hormone stimulates the pituitary gland to release adrenocorticotropic hormone (ACTH). This systemically circulating hormone activates the adrenal glands (atop the kidneys) to release the hormone cortisol. Circulating cortisol results in activation of the “fight-or-flight” response. All senses become hyperalert, blood is physiologically shunted from the digestive system out to skeletal muscles, pupils become dilated, respiration deepens and becomes more rapid, and cardiac output increases. These neurophysiological responses can be represented as the physiological resistance stage, outlined by Hans Selye (1956), when the person is taxing multiple organ systems while simultaneously evoking homeostatic balance. When stressors remain high for long periods of time (such as a state of homelessness, being in a combat zone, living in terrorizing or traumatizing environments) with concomitantly high cortisol levels, major biochemical, physiological, anatomical, and psychological damages may ensue.

Early life stressors, such as the loss of a parent, trauma, or neglect, have been shown to produce lasting effects on the HPA axis, leading to chronic difficulty in managing stress and chronically elevated levels of cortisol. The support for this hypothesis of depression is that persons with major depressive disorder often present with hypercortisolemia, resistance of cortisol to suppression by dexamethasone, blunted ACTH responses to corticotrophin-releasing hormone (CRH) challenge, and elevated CRH concentrations in the cerebrospinal fluid (CSF).

Vitamin D Deficiency Theory

Recent evidence suggests that vitamin D, which exerts neurological benefits on cognition, memory, and mood, may be deficient among persons who develop mood disorders (Farrington, 2013).

Classifications of Mood Disorders

Disorders of mood can include depression (unipolar disorder) or bipolar disorder, or the less acute but long-lasting dysthymic and cyclothymic variations.

The distinction between unipolar depression and bipolar depression is important because the two disorders require different treatments.

Bipolar depression is more likely to have a heritable (genetic) component than unipolar depression, and a person with bipolar disorder is more likely to have had previous symptoms, treatments, or hospitalizations. Depression can occur at any age, including the first and last years of life. *Failure-to-thrive* (FTT) in infants, a clinical condition often requiring pediatric hospitalization, may be indicative of infantile depression. Geriatric failure-to-thrive (GFTT), seen among some older adults, may also have roots in mood disorders. The average ages of onset for the development of mood disorders are listed below.

- ▶ Disruptive mood disorder dysregulation
 - ▶ Can occur at any age (infantile failure-to-thrive; geriatric failure-to-thrive)
 - ▶ Generally between 20 and 50 years
 - ▶ Mean age of onset: 40 years
- ▶ Bipolar disorder
 - ▶ Childhood (5 to 6 years) to age 50
 - ▶ Mean age of onset: 21 to 30 years

Mood dysregulation can co-occur with other medical illnesses, such as cardiovascular disease, Parkinson's disease, neurodegenerative and neurocognitive disorders, traumatic brain injuries, hypothyroidism, and cancer, as well as with life stressors. Although the average age for diagnosing bipolar disorder is in the late 20s or early 30s, many of the symptoms, including impulsivity and difficulty controlling emotions, can be present as early as age 4 or 5. These early

BOX 4-3. MOOD DISORDERS

- ▶ Disruptive mood dysregulation disorder
- ▶ Dysthymia
- ▶ Seasonal affective disorder (SAD)
- ▶ Postpartum depression
- ▶ Adjustment disorder
- ▶ Bipolar I
- ▶ Bipolar II

symptoms of bipolar disorder are often misdiagnosed as attention-deficit hyperactivity disorder (ADHD). Mood disorders can be triggered by upsetting life events, life transitions, physical transitions or illness, and chronic stress. Remember, assessment of mood states is determined by subjective affirmation by the patient. The nurse or clinician cannot merely look at the patient's affect and infer mood. Therapeutic communication skills (reviewed later) guide the psychiatric nurse in eliciting mood states, and then considering congruence (agreement) between mood and affect.

Disruptive Mood Disorder Dysregulation

The diagnosis of disruptive mood disorder dysregulation (formerly referred to as major depressive disorder) is evident by symptoms in the affective, behavioral, cognitive, and emotional domains of functioning as outlined below:

- ▶ Affective
 - ▶ Hopelessness
 - ▶ Worthlessness and despair
 - ▶ Apathy
 - ▶ Anhedonia
 - ▶ Emptiness
 - ▶ Feelings of excessive guilt
- ▶ Behavioral
 - ▶ Psychomotor retardation or agitation
 - ▶ Verbal communication decreased
 - ▶ Hygiene and grooming decreased
 - ▶ Social isolation
- ▶ Cognitive
 - ▶ Confusion
 - ▶ Indecisiveness
 - ▶ Diminished ability to think or concentrate
 - ▶ Self blame
 - ▶ Suicidal ideation
 - ▶ Recurrent thoughts of death

- ▶ Physical
 - ▶ Body slowdown
 - ▶ Sleep disturbances
 - ▶ Weight loss or weight gain
 - ▶ Insomnia or hypersomnia
 - ▶ Fatigue or loss of energy

Dysthymic Disorder

As opposed to persistent, or chronic depression, in dysthymic disorder, people experience a depressed mood for most of the day more days than not, for at least 2 years. This describes people said to be in a “blue funk,” akin to Oscar the Grouch on *Sesame Street*. Persons with this mood dysregulation rarely present for psychiatric intervention.

Adjustment Disorder

Life changes can precipitate mood dysregulation, which may also be referred to as situational depression, or a primary stress response syndrome. Acknowledgement of some precipitant (e.g., recent divorce, change in school, off to military) that has occurred in the last 3 months or so may lead to this diagnosis.

Seasonal Affective Disorder

Some people experience depression during fall and winter, returning to normal moods in spring and summer. The fall-winter experience may be related to reduced natural light from sunshine that is evident in some parts of the world. Light inhibits the production of melatonin, a hormone that affects mood and induces sleep.

Postpartum Depression

Postpartum depression (“baby blues”) within the first 10 days postpartum that lasts at least 2 weeks is experienced by upwards of 70% of new mothers. The phenomenon is thought to be related to rapid fluctuations in hormones that occur around the perinatal period (before and after birth). Early recognition is critical for the health of both mother and infant. Untreated episodes may progress to an emergency situation of postpartum psychosis that could lead to infanticide.

NANDA-I: Mood Disorders

- ▶ Risk for suicide related to:
 - ▶ Feelings of hopelessness, helplessness, or worthlessness
 - ▶ Anger turned inwards
 - ▶ Reality distortions
- ▶ Low self-esteem related to:
 - ▶ Learned helplessness
 - ▶ Significant losses
 - ▶ Cognitive distortions leading to negative self-image
- ▶ Dysfunctional grieving related to:
 - ▶ Real or perceived loss
 - ▶ Bereavement overload (not adequately dealing with losses)
- ▶ Social isolation related to:
 - ▶ Negative self-perception
 - ▶ Egocentric behaviors

Bipolar I and II Pathogenesis: Monoamine Dysregulation Theory

Bipolar manic episodes may involve the same neurotransmitter systems as depression, with problems related to overactivity rather than underactivity. Elevated levels of serotonin (5HT), norepinephrine (NE), and dopamine (DA) in areas of the brain regulating mood and behavior could explain symptoms such as irritable or expansive mood, pressured speech, flight of ideas, decreased sleep, and increased goal-directed activity. *Sensitivity* and *kindling* are two terms that have been used to describe neuronal activity in bipolar disorder. Early in the course of the illness, mood episodes may be triggered by significant stressors. Over time, the brain appears to become sensitized to stress and much less stress is necessary to trigger an episode. The neurons respond to slight provocations like kindling wood for fire: a small spark and the kindling catches fire immediately.

Bipolar I disorder is characterized by episodes of severe mood swings, from mania to depression. Bipolar II disorder is a milder form, characterized by milder episodes of hypomania that alternate with depression. Both mood disorders can occur in children and adolescents. Mixed featured types may include the presence of psychosis or rapid cycling (cyclothymia—four or more episodes with a 12-month period). Observable symptoms that may be noted by the nurse include

- ▶ Expansive, cheerful mood,
- ▶ Irritable when wishes unfulfilled,
- ▶ Flighty, rapid flow of ideas,
- ▶ Inflated self-esteem,
- ▶ Decreased need for sleep,
- ▶ Distractibility,
- ▶ Increase in goal-directed activity,
- ▶ Excessive involvement in pleasurable activities,
- ▶ Lacking depth of personality and warmth,
- ▶ Increased libido or sexual promiscuity,
- ▶ Irresponsible financial management,
- ▶ Loquacious (more talkative than usual),
- ▶ Continuous high elation,
- ▶ Emotional lability: rapid changes,
- ▶ Fragmented, racing, and disjointed thoughts,
- ▶ Extreme hyperactivity,
- ▶ Delusions, hallucinations (psychotic features),
- ▶ Increased, disorganized, and incoherent speech,
- ▶ Flamboyant dress, and
- ▶ Grandiosity and inflated sense of self.

NANDA-I: Bipolar Disorders

- ▶ Risk for injury
- ▶ Risk for violence (self or other directed)
- ▶ Disturbed thought processes
- ▶ Disturbed sensory perception
- ▶ Nutritional deficiency
- ▶ Impaired social interaction

NANDA-I for Suicide, Homicide, Aggression, Abuse, Assault

- ▶ Risk for suicide, homicide, aggression, abuse, or assault
- ▶ Hopelessness
- ▶ Ineffective coping related to negative role-modeling
- ▶ Risk for violence to others related to childhood environment of violence

Psychiatric-Mental Health Practice Standard 4: Planning

Improvement outcomes for all patients with mood disorders:

- ▶ The patient will experience no harm or injury.
- ▶ The patient does not display physical agitation toward self or others.
- ▶ The patient eats well-balanced meals and gets adequate rest and sleep.
- ▶ The patient interacts appropriately.
- ▶ The patient maintains reality orientation.
- ▶ The patient discusses losses with staff and family or significant others.
- ▶ The patient sets realistic goals for him- or herself.
- ▶ The patient identifies aspects of self-control over his or her life situation.
- ▶ The patient can concentrate and make decisions.

Improvement outcomes for patients with suicidal (SI) or homicidal (HI) ideation or aggressive behaviors:

- ▶ The patient will seek help through the mental health system.
- ▶ The patient will state that he or she is no longer having SI, HI, or aggressive feelings.
- ▶ The patient will be able to recognize anger and seek staff to talk about feelings.
- ▶ The patient will exert internal control over anger.
- ▶ The patient will not cause harm to self or others.
- ▶ The patient will use problem-solving to seek solutions.

Anxiety Disorders

Pathogenesis: Anxiety

The anxiety disorders are characterized by fear and worry that can be polarizing. Polarization leads to dysfunction by interfering with the ability to make a decision. The neurobiology of fear is thought to involve brain circuits that are regulated by the amygdala—the small, almond-shaped brain structure that is responsible for detecting threat and initiating the stress response. Conditions of worrying may involve a different brain circuit that passes through the basal ganglia. The connection with the basal ganglia is especially important in obsessive-compulsive disorder (OCD), where we see overlap with other disorders linked to basal ganglia dysfunction, such as ADHD and tics.

Anxiety disorders and depression often share symptoms that are associated with a chronic stress response. Is anxiety a symptom, a syndrome, or a disorder? Symptoms associated with chronic stress include tension headaches, migraine headaches, and musculoskeletal pain. In addition, a chronic response to stress by way of the HPA axis (Chapter 2, Figure 2–1), with increased circulating levels of cortisol, has been linked to increased abdominal fat, impaired immune function, disrupted glucose metabolism, cardiovascular symptoms (e.g., hypertension), gastric ulcers, and hippocampal atrophy with learning and memory impairments.

As noted previously, sympathetic nervous system activation of the autonomic nervous system activates the fight-or-flight mechanism with its automation of increased heart and respiratory rates, dilation of pupils, and sweating responses due to noradrenergic norepinephrine release. HPA activation is elicited when anxious. Do anxiety disorders, therefore, suggest alteration of norepinephrine (NE), gamma-amino-butyric acid (GABA), epinephrine (E)?

The brain's GABA receptors can be modulated by central nervous system depressants such as alcohol and benzodiazepines. When people drink alcohol or take benzodiazepines, anxiety levels tend to subside. During withdrawal from those same substances, anxiety increases. These findings support the hypothesis that the neurotransmitter GABA and its receptors are important in the symptoms of anxiety, with too little GABA associated with symptoms of anxiety. On the other hand, too much arousal from NE or glutamate may also lead to symptoms of anxiety.

Anxiety can be a normal emotion in threatening circumstances. It is the emotional component of the “fight or flight” stress response and has important survival functions. Anxiety can also be part of a syndrome or symptom complex associated with certain medical or substance-related conditions. Examples include hyperthyroidism, attention-deficit hyperactivity disorder (ADHD), and alcohol or benzodiazepine withdrawal. Finally, anxiety can be the primary component of a disorder.

Anxiety is common at all ages. Children can develop all the anxiety disorders experienced by adults in addition to separation anxiety disorder. Separation anxiety is a normal stage of development at around 6 through 18 months of age. The infant or toddler with separation anxiety should exhibit some resistance to being passed to someone not as familiar as the primary caretaker. However, separation anxiety becomes a disorder when school-aged children continue to express fear of separation along with significant functional impairment. Anxiety states in children can manifest as enuresis (repeated voiding of urine in bed or clothing) or encopresis (voluntary or involuntary passage of stool in a child who has previously been toilet trained, typically over age 4). Although anxiety has a heritable component, anxiety disorders such as posttraumatic stress disorder (PTSD) and phobias occur after a threatening event. Evidence of self-mutilation (referred to as nonsuicidal self-injury disorder) may accompany many psychiatric presentations (e.g., psychosis, mood dysregulation, anxiety, substance use, feeding and eating disorders, gender dysphoria). Additional risk factors for the development of anxiety and anxiety disorders include:

- ▶ Genetics
- ▶ Biology
 - ▶ Temperament, physiologic abnormalities
- ▶ Medical conditions
 - ▶ For example, acute MI or hypoglycemia
- ▶ Psychoanalytic
 - ▶ Unconscious fear expressed symbolically
 - ▶ Lack of ego strength and coping resources
- ▶ Learning theory
 - ▶ Fears are learned and become conditioned responses
 - ▶ Lack of recovery environment (social supports)
- ▶ Cognitive theory
 - ▶ Faulty cognition or anxiety-inducing self-instructions

Common features of several anxiety disorders are reviewed below.

Panic Disorder

- ▶ Recurrent, unexpected panic attacks
- ▶ Can present before puberty; peak age 15 to 20 years
- ▶ At least one of the attacks has been followed by 1 month of:
 - ▶ Persistent concern about having additional attacks
 - ▶ Worry about implications (e.g., losing control, having a heart attack)

Generalized Anxiety Disorder (GAD)

- ▶ Excessive anxiety and worry; “worry warts” (worrying more days than not for at least 6 months, about a number of events or activities)
- ▶ Average age of onset is in 20s
- ▶ The anxiety and worry are associated with 3 or more of the following 6 symptoms:
 - ▶ Restlessness
 - ▶ Being easily fatigued
 - ▶ Difficulty concentrating
 - ▶ Irritability
 - ▶ Muscle tension
 - ▶ Sleep disturbance

Phobia: Specific, Social, or Agoraphobia

- ▶ Marked or persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation
- ▶ Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a panic attack.
- ▶ The person recognizes that the fear is excessive.
 - ▶ The phobic stimulus is avoided.

Obsessive-Compulsive Disorder (OCD)

- ▶ Highly co-occurring with ADHD and tic disorders
- ▶ Can occur before age 9 (rule out PANDAS)
- ▶ Either obsessions or compulsions that cause marked distress, are time-consuming, and interfere with functioning
 - ▶ Obsessions: recurrent and persistent thoughts, impulses, or images that are intrusive and inappropriate
 - ▶ Compulsions: repetitive behaviors that the person feels driven to perform; aimed at anxiety reduction

Body Dysmorphic Disorder

- ▶ Physically normal appearance and body, but patient believes that parts of the body are abnormal, misshapen, or ugly
- ▶ Impairs function

Hoarding Disorder

- ▶ Tendency to collect and accumulate objects without apparent value, to the point of functional impairment; functional paralysis

Trichotillomania

- ▶ Hair-pulling disorder; hair may be pulled from various areas of body (head, eyelashes, pubic area, armpits)
- ▶ Pulling is accompanied by tension release.
 - ▶ May result in development of a bezoar (hair ball in stomach) that may require surgical removal

Excoriation (Skin Picking) Disorder

- ▶ New to DSM5 (APA, 2013)
- ▶ Usually begins in adolescence; mostly focuses on face or head
 - ▶ Picking at skin to the point of trauma, bleeding

Separation Anxiety Disorder

- ▶ Normal developmental achievement at around 6 to 18 months of age
- ▶ Suggests significant functional impairment if continues in toddlers and older children.

Trauma-Related Anxiety Disorders***Posttraumatic Stress Disorder (PTSD)***

- ▶ Person has been exposed to a traumatic event
- ▶ Traumatic event is persistently re-experienced
- ▶ Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness
- ▶ Persistent symptoms of increased arousal
- ▶ Duration is longer than 1 month
 - ▶ Can occur in children and adolescents

Acute Stress Disorder

- ▶ Similar to PTSD except that onset follows during or immediately after a stressful event
- ▶ Lasts a month or less

Adjustment Disorder

- ▶ Person feels overwhelmed by one or multiple stressors (e.g., marriage, relocation, witnessing parental discord)
- ▶ Can occur in children and adolescents
 - ▶ Starts within 3 months of stressor; stops within 6 months of stressor's end

Rape Trauma Syndrome

- ▶ Similar to PTSD except that onset follows during or immediately after a rape or sexual assault
 - ▶ Lasts a month or less

NANDA-I: Anxiety and Anxiety Disorders

- ▶ Panic anxiety: real or perceived threat
- ▶ Powerlessness related to anxiety
- ▶ Ineffective coping related to intrusive or inappropriate thoughts
- ▶ Ineffective role performance related to ritual performance
- ▶ Posttrauma syndrome related to war exposure
- ▶ Posttraumatic rape syndrome related to sexual abuse, assault, or molestation
- ▶ Dysfunctional grieving
- ▶ Fear
- ▶ Social isolation

Psychiatric-Mental Health Practice Standard 4: Planning

Improved outcomes for patients with anxiety and anxiety disorders:

- ▶ The patient will recognize signs of anxiety and utilize anxiety reduction skills.
- ▶ The patient will verbalize an understanding of the relationship between anxiety and maladaptive coping.
- ▶ The patient will deal with stress using coping strategies.
 - ▶ Thought stopping
 - ▶ Relaxation techniques
 - ▶ Physical exercise
- ▶ The patient will attend to school or work.

PRIMARY FEEDING AND EATING DISORDERS

Pathogenesis: Theories for Obesity, Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorders

Obesity is defined as a condition of excess body fat in an amount large enough to have a negative effect on the person's health. The prevalence of childhood obesity has doubled since 1980 in the United States. Hormonal causes may include hypothyroidism, hypercortisolism, primary hyperinsulinism, pseudohypoparathyroidism, acquired hypothalamic problems (e.g., tumors, infections, traumatic syndromes). Psychological causes include complex self-perceptions, such as an unconscious wish to make oneself unattractive after experiencing sexual assault, abuse, or rape. Physical complications of obesity include a lower metabolic rate that results from a lack of exercise, and increased risk for other health problems including diabetes, hypertension, and premature heart disease.

Anorexia nervosa and bulimia nervosa are eating disorders found primarily in highly developed cultures such as in the United States, especially those with a focus on youth and beauty. They are serious conditions that can be fatal if not successfully treated. Both involve cognitive distortions concerning body shape and weight (a body dysmorphic disorder). General risk factors include:

- ▶ Biological
 - ▶ Illnesses that cause changes in appetite or weight
 - ▶ More common in females
- ▶ Sociocultural
 - ▶ Family dynamics.
 - ▶ Cultural focus on being thin
- ▶ Psychological
 - ▶ Difficulties with growing up
 - ▶ Poor sexual adjustment or sexual trauma or abuse history

Anorexia is characterized by refusal to maintain body weight at or above 85% of the expected based on age and height. Multiple physiological, psychological, and social factors are involved in the complex regulation of eating. The self-induced state of starvation seen in anorexia has serious physical consequences, including cardiac arrhythmias, bradycardia or tachycardia, hypotension, hypothermia, skin dryness with possible lanugo (a soft, fine, downy hair on the arms and other body parts that is normal in infancy), edema, and amenorrhea. Basically, all organ systems are affected by starvation. Hospitalization is indicated for patients who are 20% or more below the expected weight for their height.

Bulimia is characterized by recurrent episodes of binge eating followed by inappropriate compensatory mechanisms. Vomiting or laxative abuse can lead to metabolic disturbances and electrolyte abnormalities (e.g., hypokalemia, hypochloremic alkalosis, hypomagnesemia). Recurrent self-induced vomiting can result in the loss of dental enamel, scars on the hand, and esophageal tears. Nonpurging type of bulimia may include fasting or excessive exercise, but not laxatives, vomiting, or enemas.

TABLE 4-3.
PRIMARY FEEDING AND EATING DISORDERS

Anorexia Nervosa	▶ Refusal to maintain body weight at or above 85% of expected
	▶ Intense fear of gaining weight
	▶ Disturbance in self-perception
	▶ Amenorrhea for at least two consecutive cycles
	▶ Cachexia: loss of fat, muscle mass, reduced thyroid metabolism, cold intolerance, difficulty maintaining temperature
	▶ Cardiac: loss of muscle, arrhythmias, bradycardia, tachycardia
	▶ Dermatologic: lanugo; edema
	▶ Hematologic: leukopenia
	▶ Skeletal: osteoporosis
Bulimia Nervosa	▶ Recurrent episodes of binge eating
	▶ Eating greater amounts than most people
	▶ Sense of lack of control
	▶ Recurrent, inappropriate compensatory behavior
	▶ Compensatory behaviors at least two times a week for 3 months
	▶ Purging type or nonpurging type
Binge-Eating	▶ New to DSM5 (APA, 2013)
	▶ Recurring episodes of eating significantly more food in short period of time with feelings of lack of control
	▶ Eating quickly and uncontrollably despite feeling full
	▶ Feels guilt, shame, or disgust afterwards
	▶ Eats alone
	▶ Less common, more severe than simply overeating
	▶ Associated with significant physical and psychological problems

NANDA-I: Eating Disorders, Including Infantile Failure-to-Thrive and Geriatric Failure-to-Thrive

- ▶ Risk for electrolyte or fluid imbalance
- ▶ Nutrition, altered, and less or more than body requirements
- ▶ Readiness for enhanced nutrition
- ▶ Risk for self-injury
- ▶ Self-care deficit or feeding
- ▶ Body image disturbance
- ▶ Ineffective coping
- ▶ Risk for impaired attachment
- ▶ Dysfunctional family processes

Psychiatric–Mental Health Practice Standard 4: Planning

Improved outcomes for patients with feeding and eating disorders:

- ▶ The patient will regain healthy eating patterns.
- ▶ The patient will normalize BMI.
- ▶ The patient will accurately describe body dimensions.
- ▶ The family will demonstrate positive interactions.

SUBSTANCE USE DISORDERS

Substance use disorders are a problematic pattern of substance use leading to significant impairment with at least two criteria in a 12-month period (DSM5; APA, 2013). Biochemical and neuroanatomical brain alterations from chronic use may influence vulnerability and promote addiction. Abused substances derive their rewarding properties from altering dopamine levels in limbic system, triggering cravings. Dopamine in the brain mediates pleasure and motivation.

Substance use disorders and mental illnesses are linked and share both risk and protective factors (CDC, 2014a). Up to half of persons with a serious mental illness will develop a substance use disorder at some time in their lives. Substance users are almost three times as likely to have a serious mental illness as those who do not have a substance use disorder. Three in four mental illnesses emerge early in life, and 1 in 5 children have had a serious mental illness. Stress

increases alcohol and drug use and is associated with higher rates of relapse, and sociocultural factors point to social learning theories (e.g., cultural, ethnic, peer influences). The brain continues developing into young adulthood (age 25 or so). Risky behaviors and poor choices are characteristic of youth and young adults, reflective of the fact that the brain is still developing. Psychological factors that may increase risk are:

- ▶ Low self-esteem, frequent depression, or passivity
- ▶ Inability to relax or defer gratification
- ▶ Higher risk in impulsive groups (violent offenders, conduct disorder, intermittent explosive disorder)

BOX 4-4. **SUBSTANCE DISORDERS AND DEFINITIONS OF ABUSE, DEPENDENCE, INTOXICATION, AND WITHDRAWAL**

Substance Disorders

- | | | |
|---------------------|---|------------------------|
| ▶ Alcohol-Related | ▶ Opioid-Related | ▶ Cannabis-Related |
| ▶ Stimulant-Related | ▶ Sedatives, Hypnotics,
Anxiolytic-Related | ▶ Hallucinogen-Related |
| ▶ Inhalant-Related | | ▶ Tobacco-Related |

Abuse

- ▶ Administration of any drug in a culturally disapproved manner that causes adverse consequences
- ▶ Recurrent use causing:
 - ▶ Failure in role responsibilities
 - ▶ Physically hazardous situations
 - ▶ Legal problems
- ▶ Continued use despite social and interpersonal problems

- ▶ Substance is often taken in larger amounts or over a longer period than intended
- ▶ Time is spent in activities necessary to obtain the substance
- ▶ Social, occupational, recreational activities given up because of use
- ▶ Unsuccessful efforts to cut down use

Dependence

- ▶ Physical dependence:
 - ▶ A physiologic state of neuro-adaptation produced by repeated administration of a drug, necessitating continued administration to prevent withdrawal syndrome
 - ▶ Tolerance: need for increasing amounts for desired effect
- ▶ Psychological dependence:
 - ▶ Repeats use to produce pleasure or avoid discomfort
 - ▶ Cravings for the substance

Intoxication

- ▶ Reversible substance-specific syndrome caused by substance ingestion
- ▶ Maladaptive behaviors due to substances
- ▶ Symptoms not due to medical conditions or other mental disorder

Withdrawal

- ▶ Substance-specific syndrome caused by cessation of prolonged and heavy use
- ▶ Substance-specific syndrome causing impairment in social, occupational, and other areas of functioning
- ▶ Symptoms not due to medical condition or accounted for by other mental disorder
- ▶ Withdrawal symptoms are generally the opposite of intoxication symptoms

Genetic factors and environmentally induced alterations in brain neurochemistry appear to influence vulnerability for addiction. Addiction to drugs is a chronic, relapsing disease of the brain characterized by compulsive drug-seeking and use (Volkow, 2007). All drugs of abuse are thought to increase brain dopamine in the pathways that drive motivation and enhancements to reward systems. Chronic use of alcohol or other drugs may produce alterations in brain neurochemistry that help to maintain addictive behaviors. Higher rates of substance abuse are found in impulsive groups: violent offenders, and those with conduct disorder or intermittent explosive disorder. Stress increases alcohol and drug use, and is associated with higher rates of relapse. Substance use disorders are frequently comorbid with other mental disorders (dual diagnosis). New entries to DSM5 (APA, 2013) include cannabis withdrawal, caffeine withdrawal, and tobacco use disorder. Combined, addiction to substances is “a chronic, relapsing, disease of the brain that has imbedded behavioral and social context aspects” (Leshner, 1997; former head of NIDA. For further information about the effects of specific substances on brain neurophysiology, visit the website of the National Institute on Drug Abuse (<http://www.nida.nih.gov>)).

Alcohol

Alcohol is a central nervous system depressant. It exerts desired effects by enhancing GABA. It is a legal substance that is usually ingested by swallowing but may be taken in via new routes (e.g., smoking vapors or rectal instillation by way of tampon-soaked insertion). These routes bypass the liver’s cytochrome enzyme (CYP450) first-pass system, bringing the chemical directly into the bloodstream.

The nurse assesses current symptoms and history to determine intoxication or withdrawal state (evidenced by anxiety, tremor, seizure, delirium, alcohol poisoning which can lead to death). Screening, with the CAGE, Brief Drug Abuse Screening Test (B-DAST), or other tools is a standard of care. Structurally, with chronic use, affected brain structures such as the prefrontal cortex (executive functioning) and the hippocampus (memory) show evidence of less brain growth and more brain shrinkage (amount of shrinkage increases with age) as well as enlargement of the brain sulci, fissures, and ventricles from loss of gray and white matter. Chronic alcohol users may show evidence of

- ▶ Peripheral neuropathy, myopathy, or cardiomyopathy;
- ▶ Wernicke’s encephalopathy, Korsakoff’s psychosis;
- ▶ Esophagitis, pancreatitis, gastritis, hepatitis, cirrhosis;
- ▶ Serum or urine analysis: leukopenia, thrombocytopenia, increased liver enzymes (GGT, AST, ALT, ALP), mean corpuscular volume (MCV), ammonia, amylase, or triglycerides;
- ▶ Sexual dysfunction; and
- ▶ Jaundice.

Psychiatric-Mental Health Practice Standard 4: Planning

Improvement outcomes for patients in alcohol or benzodiazepine withdrawal may be facilitated by use of:

- ▶ Clinical Institute Withdrawal Assessment for Alcohol, revised version (CIWA-Ar): evidence-based tool
- ▶ Nurse-administered valid and reliable tool to monitor withdrawal and guide medication treatment while hospitalized
- ▶ 10 distinct symptom areas each scored between 0 and 7
 - ▶ Nausea and vomiting, tremor, paroxysmal sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache, orientation and clouded sensorium
 - ▶ Score 10 or more: plan to administer tapered benzodiazepine withdrawal prevention protocol
- ▶ CIWA-B for benzodiazepine withdrawal also available

Amphetamine and Other Substances

Amphetamines, methamphetamines, bath salts, khat, cocaine, caffeine, nicotine (nonamphetamine stimulant) and some over-the-counter (OTC) medications, such as ephedrine, are CNS stimulants that increase both dopamine (DA) and norepinephrine (N). The initial euphoria may be followed by crashing; repeated use can lead to acute paranoid psychosis. Basal ganglia effects can cause increased stereotypic behaviors (pacing, scratching) and peripheral nervous system (PNS) effects may appear as tremors, emotional lability, or restlessness. Physical examination reveals cardiovascular effects (tachycardia, ventricular irritability), respiratory depression, constipation, and urinary retention.

Inhalants

Inhaling or “huffing” substances such as gasoline, varnish remover, lighter fluid, glue, or spray paint results in intoxication presentations of belligerence, assaultiveness, apathy, impaired judgment, psychosis, dizziness, nystagmus, incoordination, slurred speech, unsteady gait, depressed reflexes, tremor, blurred vision, euphoria, or anorexia. Withdrawal profiles are similar to those of alcohol.

Opioids

Narcotics and analgesics, such as morphine, codeine, hydromorphone (Dilaudid), methadone, meperidine (Demerol), hydrocodone (Vicodin), and oxycodone are the most commonly abused legal drugs, whereas heroin is the most commonly abused illegal drug. Prescription drug abuse is the most common problem today and has been for several years. Intoxication with opioids can lead to death because of severe respiratory depression. Effects of opioid use are pain relief, euphoria (rush), tranquility, drowsiness (nodding), mood swings, mental clouding, apathy, and constricted pupils. The PNS exhibits slowed motor movements. In states of withdrawal, patients look as though they have a bad case of the flu with drug craving, lacrimation, rhinorrhea, yawning, diaphoresis, and flu-like symptoms. The Clinical Opioid Withdrawal Scale (COWS) or another standardized measure may be used to monitor patients as they come down from the intoxicated (high) state.

Sedative-Hypnotics

Central nervous system (CNS) depressants that enhance GABA include the benzodiazepines (including midazolam [Versed]), barbiturates, alcohol, and propofol. They are often prescribed on an as-needed basis and have psychoactive properties that make them highly sought after and abused. Assessment of patients using medications of the sedative-hypnotic types is evidenced by cognitive slowing or memory problems, sedation and desire to sleep, decreased anxiety or decreased musculoskeletal tension, and sexual impairment. Benzodiazepines are used to treat alcohol and other substance withdrawal; they have anticonvulsant and antiseizure effects.

Cannabis

Various substances containing cannabis include marijuana (active ingredient is tetrahydrocannabinol [THC]), hashish, and K2 (“spice”), a synthetic marijuana. According to Nasrallah and Weiden (2014), “marijuana is the number one trigger for the development of schizophrenia” among genetically vulnerable persons. He purports that “marijuana is very bad for the brain.” Marijuana has both stimulant and sedative effects on the CNS. It induces a state of well-being, relaxation, loss of temporal awareness, slowing of thought processes, shortened attention span, easy distractibility, impairment of short-term memory (hippocampal damage), apathy, panic, toxic delirium, and sometimes psychosis. Increased appetite and antinausea effects make it useful for oncology patients. Chronic use damages the hippocampus, with evidence of memory impairment. It has both physical and psychological dependence ramifications. Difficulty sleeping or irritability results when the drug is withdrawn.

Hallucinogens

Hallucinogens are psychedelic substances that interfere with glutamate functioning. They come in various forms, such as mescaline, psilocybin, LSD, STP, PCP (a veterinary anesthetic), “designer drugs” (ecstasy or Molly), or ketamine (Special K). Ecstasy or Molly is a synthetic psychoactive drug that is neurotoxic; it works by increasing serotonin, dopamine, and norepinephrine. The enhancement of serotonin triggers the release of oxytocin and vasopressin, which play important roles in love, trust, sexual arousal, and other prosocial experiences. A sense of emotional closeness and empathy results (NIDA, 2015). The surge of serotonin, however, depletes the brain of serotonin, causing negative after-effects on the CNS such as “trips” (changes in sensory experience, including illusions and hallucinations), impaired judgment, fear of losing one’s mind, anxiety, and delirium. Intoxication is evidenced by heightened sensory awareness, staggering gait, slurred speech, tachycardia, increased blood pressure, hyperthermia, nausea. Dangerous flashbacks have been reported. A new plant-based substance known as ayahuasca promoted in the popular press as a therapy for PTSD, anxiety, and suicidal ideation is attracting tourism in Iquitos, Peru, promising spiritual catharsis.

Nicotine (Tobacco)

Nicotine is a CNS stimulant. The mild euphoria experienced from nicotine results from affecting acetylcholine (Ach), dopamine (DA), and gamma-amino-butyric acid (GABA), and endogenous opioid peptides. Approximately 60% to 90% of patients with schizophrenia use nicotine by way of cigarette smoking in an attempt to relieve the negative symptoms of schizophrenia. By inducing liver enzymes, nicotine lowers serum plasma levels of antipsychotics (Ciraulo et al., 2006). A chemical biomarker called cotinine can be measured in saliva to determine whether a person currently uses nicotine. Nicotine is highly addictive, and withdrawal uncomfortable. The half-life of nicotine is about 2 hours, meaning users will experience physiological discomfort if they go without it for several hours. The Fagerstrom Test for Nicotine Dependence (smoker and smokeless versions) is a clinical scale to measure withdrawal severity. Replacements for cigarettes today are the newly popular hookah bars, which sell flavored smokes, and electronic cigarettes (e-cigs) that deliver nicotine by way of “vaping” without burning tobacco.

NANDA-I: Substance Use Disorders

- ▶ Impaired judgment
- ▶ Imbalanced nutrition
- ▶ Ineffective coping
- ▶ Risk of injury

Psychiatric-Mental Health Practice Standard 4: Planning

Improvements for patients with substance use disorders:

- ▶ The patient has not experienced injury.
- ▶ The patient demonstrates good judgment.
- ▶ The patient acknowledges problems and personal responsibility.
- ▶ The patient learns adaptive coping mechanisms when stressed.
- ▶ The patient will engage in patient and family (if applicable) education.
- ▶ The patient eats well-balanced meals.
- ▶ The patient obtains adequate rest.
- ▶ The patient is willing to follow through on his or her treatment plan.

PERSONALITY DISORDERS

Personality is the enduring pattern of inner experience and behavior that is established in the late adolescence or early adulthood. Temperamental traits are present at birth. Personality forms during childhood and is influenced by attachment, parenting style, and other experiences.

Personality traits are enduring characteristics that are present by late adolescence. Personality changes may occur because of conditions such as AIDS, dementia, or substance abuse, although the pathophysiology is not well understood.

Personality disorders have their onset in adolescence or early adulthood. They are long-standing and inflexible mental conditions, not usually the focus of clinical attention, especially in inpatient settings (Table 4-4). They are diagnosed when persons experience clinically significant distress or impairment related to long-standing, inflexible, and pervasive patterns of thought, emotion, and behavior. Problematic behaviors are manifested in two or more of the following:

- ▶ Cognition (ways of perceiving and interpreting self, other people, and events)
- ▶ Affectivity (the range, intensity, lability, and appropriateness of emotional response)
- ▶ Interpersonal functioning problems
- ▶ Impulse control problems

TABLE 4-4.
CLUSTER TYPES AND CHARACTERISTICS OF PERSONALITY DISORDERS

<p>Cluster A Odd and Eccentric Types</p>	<ul style="list-style-type: none"> ▶ Paranoid: suspicious, mistrustful, appears defensive or resistant to control, very skeptical of most things, copes by projection, attributes shortcomings to others to justify actions ▶ Schizoid: asocial pattern—aloof, introverted, seclusive, uninterested in social activities, apathetic, unengaged; thought to be schizophrenic prodrome; copes by intellectualizing ▶ Schizotypal: odd, bizarre, strange, magical, eccentric, socially anxious, secretive and private; copes by undoing; easily overwhelmed by stimulation; many bizarre acts or thoughts reflect a retraction of previous acts or thoughts
<p>Cluster B Dramatic and Emotional Types</p>	<ul style="list-style-type: none"> ▶ Antisocial: the psychopath; delinquent, criminal; lack of superego; impulsive, thrill-seeking, irresponsible; gets pleasure from swindling others; copes by acting out; highly manipulative ▶ Borderline: unstable, intense affect, impulsivity with self-damaging acts, identity disturbance, chaotic relationships, manipulative, abandonment concerns, demanding, unpredictable, “black or white,” “all or nothing;” copes by regression, projection, and denial ▶ Histrionic: gregarious, seductive, dramatic, tendency to sexualize all relationships, extreme extraversion, attention-seeking, superficial, difficulty in maintaining deep relationships; copes by creating facades ▶ Narcissistic: egotistical, preoccupied with power and prestige, sense of superiority, arrogant, entitled; copes by rationalizing, repressing, and using fantasy
<p>Cluster C Anxious and Fearful Types</p>	<ul style="list-style-type: none"> ▶ Avoidant: withdrawn pattern, sensitive to rejection and humiliation, slow and constrained speech, shy and uncomfortable with others, sees self as inferior; copes by using fantasy and daydreams ▶ Dependent: submissive pattern, need for social approval, clingy, feels inadequate, wants other to manage life, relates to others in an immature and childlike way, naïve; copes by using introjections—internalizing beliefs of others ▶ Obsessive–Compulsive: conforming, meticulous, rigid, disciplined, concerned with order and conformity, stubborn, usually copes by using reaction-formation (doing the opposite of their feelings), isolation, and undoing

HUMAN SEXUALITY

Gender Dysphoria (GD)

Gender dysphoria describes a person's desire to be treated as a member of the opposite sex than what has been biologically assigned. GD manifests as personal convictions that one has typical feelings, thoughts, and behaviors of the other gender; these perceptions may begin as early as 3 or 4 years of age. A desire to transform sex characteristics often accompanies these self-perceptions. Gender reassignment surgeries are currently available in the United States. Prepubertal patients (age 11 or so) may begin the transformation with specific hormonal therapies that either boost or inhibit testosterone and estrogen or may receive hormonal suppression therapy to delay puberty.

Particular struggles experienced by transgender persons include nonacceptance and stigma, which are believed to be the cause of higher than average rates of suicide among transgender persons. Gender reassignment outcomes are described in several publications geared to children and adolescents. *Some Assembly Required: The Not So Secret Life of a Transgender Teen* (Andrews, 2014) was co-written by a transgender pair (female-to-male and male-to-female). *Rethinking Normal: A Memoir in Transition* (Hill, 2014) was written by a transwoman. The highly popular and Emmy award-winning Netflix show *Orange Is the New Black* includes a storyline of a transwoman, played by an actress who is also a transwoman and incidentally an identical twin to a male sibling in real life; her twin portrayed her in pretransition scenes on the show. Open discussions about transgender lifestyles targeted to youth are planned in the upcoming MTV documentary entitled *The "T" Word*.

These and other portrayals in popular media reflect paradigm shifts in our understanding and recognition of diverse sexual identity. Organizations and groups that serve this population often also serve persons with diverse sexual orientations, generally referred to under the rubric LGBTQI (lesbian, gay, bisexual, transgender, queer, questioning, and intersex). In light of still-widespread lack of understanding, discrimination, and stigma associated with gender role nonconformity experienced by transgender persons, it is the psychiatric-mental health nurse who addresses the needs and concerns of the patient with compassion and empathy, and without prejudice or judgment.

NANDA-I: Gender Dysphoria

- ▶ Disturbed body image
- ▶ Disturbed personal identity
- ▶ Risk for compromised human dignity
- ▶ Role confusion
- ▶ Depression
- ▶ Hopelessness

SLEEP DISORDERS

Many variations of sleep disorders are recognized in DSM5 (APA, 2013). On the whole, sleep disorders emanate from one of the two principle phases of sleep: (1) rapid eye movement (REM) sleep, during which most dreaming occurs, or (2) non-REM sleep. For our purposes, we will review insomnia, the most commonly reported sleep disorder. Insomnia is defined as sleep that is too brief or unrestful. It is a common disorder that can be acute or chronic and is more prevalent in older adults, affecting approximately 30% to 50%, and in young and middle-aged African Americans. On the whole, African Americans take longer to fall asleep, experience lighter sleep, don't sleep as well, take more naps, and have more sleep-related breathing problems than others (National Heart, Lung, and Blood Institute [NHLBI], 2011). Children generally need at least 9 hours of sleep each night, but adult needs may vary. Insomnia is diagnosed by patient report of the issue or observation of sleep architecture (quality and quantity) in children.

Sleep quality and quantity are important. Sleep is a crucial time for learning and the way that memories are first encoded, transferred, and downloaded to other regions of the brain where they are thought to be processed and stored (Smith, 2013). Adequate sleep plays an important role in regulating metabolism; in fact, sleep inadequacy has been linked to problems in the immune system, resulting in low-grade inflammation and an undermining of responses to vaccines. Inflammatory markers are associated with cardiometabolic problems and atherosclerosis (Dolgin, 2013). Many medical conditions, such as Parkinson's disease, cognitive disorders, sleep apnea, cardiovascular disorders, hyperthyroidism, diabetes, esophageal reflux, urinary frequency or infections, pain and discomfort, CNS stimulants, some antidepressants, anti-arrhythmic drugs, corticosteroids, thyroid medications, diuretics, overuse of sleeping pills (rebound insomnia), and stress factor into sleep insufficiency.

Altered sleep and circadian rhythm disturbances may occur as a result of travel, (especially to different time zones), shift work, sundowner syndrome, narcolepsy, sleep apnea, restless leg syndrome, and hospitalization (increased exposure to noise and light at night). Fatigue states that result from insomnia can precipitate falls and motor vehicle accidents. Linkages between sleep disruption and psychiatric disorders are well established. Poor sleepers are more likely to develop depression; in fact, insomnia is often the first symptom to appear and the last to go. Sleep disturbances may also be an early sign of neurodegenerative disease (Costandi, 2013). Similarly, sleep loss may precipitate episodes of mania or hypomania (DeWeerd, 2013). Alterations in sleep can also result in hypervigilance, fear, or psychoses. What is unclear is whether sleep disorders trigger mood and anxiety disorders, or mood and anxiety disorders trigger sleep problems.

The psychiatric–mental health nurse recognizes that sleep is an opportune time to promote parasympathetic restoration and adapts the milieu to facilitate and closely monitors sleep hygiene. The hospital or home and social environment may generate obstacles to quality sleep. A polysomnogram (sleep study) that records brain activity, eye movements, heart rate, and blood pressure while a patient sleeps overnight may be ordered. It is important to accurately assess and document hours of sleep achieved to determine outcomes for improved sleep quality and quantity.

Dementia: Neurodegenerative Disorder

Dementia is a syndrome of acquired cognitive deficits that result from various levels of neurodegenerative and ischemic processes. Dementia manifests by a progressive, global deterioration of mental activity and self-care abilities, memory impairment, and cognitive deficits that are disabling and represents a decline from previous functioning. The progression is slow, insidious, and nonreversible. A score of 24/30 or less on the Mini Mental State Exam (MMSE) (Folstein et. al., 1975) is suggestive of cognitive difficulties and should be confirmed with more extensive neuropsychological testing. *Sundowning* is the term used for the disorientation that persons with dementia may experience when familiar environmental cues diminish at nighttime.

The most common cause of dementia is Alzheimer’s disease (AD). Nearly 13% of adults over the age of 65 and 45% of those over the age of 85 are estimated to have AD (Liu, Kanekiyo, Xu, & Bu, 2013). Early changes in Alzheimer’s disease and other dementias appear to be related to a decrease in the brain’s levels of acetylcholine (ACh), a neurotransmitter essential to learning and memory (cholinergic deficit hypothesis). Support for this assumption comes from the observation that by boosting cholinergic functioning with cholinesterase inhibitors (therefore reducing the metabolism and increasing the availability of ACh), memory function is enhanced in early dementia. As AD progresses, an accumulation of aggregation-prone proteins called beta-amyloids are not removed from the body (Kingwell, 2012), and bundles of tangled proteins called neurofibrillary tangles begin to interfere with the functioning of neuronal cells. The process of excitotoxicity related to glutamate overactivity is also thought to be responsible for some of the neurodegeneration and atrophy of the brain seen on magnetic resonance imaging (MRI) scans. Another recently identified factor is hippocampal atrophy, leading to development of mild cognitive impairment and dementia (Kingwell, 2012). Numerous studies demonstrate a reduction in hippocampal size associated with various cardiovascular diseases, diabetes, obesity, obstructive sleep apnea, vitamin B12 deficiency, head trauma, specific genotype, and psychiatric disorders (Fotuhi, Do, & Jack, 2013). A definitive diagnosis is made at autopsy. Three stages of dysfunction are noted:

- ▶ Early or mild
 - ▶ Forgetfulness and short-term memory loss
 - ▶ Difficulty with activities of daily living

- ▶ Disturbed executive functioning
- ▶ Impairment in social or occupational functioning
- ▶ Middle or moderate
 - ▶ Difficulty with activities of daily living and familiar tasks such as cooking or balancing a checkbook
 - ▶ Changes in ability to communicate
 - ▶ Agnosia
 - ▶ Apraxia
 - ▶ Aphasia
- ▶ Late or severe
 - ▶ Inability to perform activities of daily living; complete dependence
 - ▶ Becomes disoriented, incoherent, amnesic, or incontinent

Although two-thirds of all dementias are AD, there are other types and many secondary causes for neurodegeneration which include:

- ▶ Infection
- ▶ Vascular dementia: cognitive functioning declines in a stair-step fashion (rather than progressively) after cerebrovascular accidents, cerebrovascular disease, atherosclerosis
- ▶ Electrolyte (metabolic) imbalances
- ▶ Drug toxicity
- ▶ Sensory impairment or deprivation (visual or auditory)
- ▶ Emotional disturbances
- ▶ Nutritional disturbances
- ▶ Cerebral or head trauma: direct injury to brain tissue
- ▶ Pick's disease (frontotemporal impairment): characterized by atrophy in the frontotemporal brain regions due to neuronal loss, gliosis, Pick's bodies (masses of cytoskeletal elements), and protein build-up in areas of the brain
- ▶ Lewy body: more common in persons with Parkinson's disease and characterized by the deposition of Lewy bodies (protein) that accumulates in the neurons; persons with Lewy body dementia may have visual hallucinations, a characteristic that distinguishes it from other dementias
- ▶ Huntington's disease: autosomal-dominant degenerative disorder

- ▶ Tertiary syphilis (or neurosyphilis): occurs in persons who have untreated syphilis for many years; usually occurs about 10 to 20 years after a person is first infected with syphilis
- ▶ HIV/AIDS: dementia results from the direct effects of HIV infection in the brain, opportunistic infections, or the toxic effects of drug treatments; HIV may gain entrance to the central nervous system by infecting the macrophages and monocytes that cross the blood-brain barrier. Symptoms of the resulting AIDS dementia complex can be confused with clinical depression because of the presentation of apathy and cognitive and motor problems. HIV has an affinity for the brain.

Sexually Transmitted Infections

Among the many sexually transmitted infections, including syphilis, gonorrhea, chlamydia, trichomoniasis, human papillomavirus (HPV), herpes simplex virus, and human immunodeficiency virus (HIV), two are of particular interest to the psychiatric-mental health nurse because they can cause dementia: syphilis and HIV. Syphilis is caused by spirochete bacterium and, if not diagnosed and treated, can cause dementia in stage 3 by way of the slow, progressive infection of the brain.

Similarly, dementia can develop during the advanced stages of AIDS, the disease caused by HIV infection. The progression of AIDS dementia mimics depression in early stages (e.g., hopelessness, insomnia). Later, cognitive signs, such as forgetfulness, slowness, poor concentration, possible delirium, delusions, hallucinations, and difficulties with problem-solving; behavioral signs, such as apathy and social withdrawal; and neurological findings, such as tremors, impaired rapid repetitive movements, imbalance, ataxia, hypertonia, hyperreflexia, frontal release signs, or CD4 depression, appear.

NANDA-I: Dementia

- ▶ Risk for injury
- ▶ Impaired verbal communication
- ▶ Self-care deficits (in bathing, hygiene, dressing, and grooming) related to cognitive impairment
- ▶ Disturbed social interactions
- ▶ Disturbed thought processes as evidenced by memory loss
- ▶ Disturbed sleep pattern
- ▶ Caregiver role strain

Delirium

Delirium is a serious medical condition that can be caused by any number of disturbances. Unlike dementia, which is generally a slowly progressing condition, delirium is quite acute, comes on rapidly, and is characterized by a clouding of consciousness with disorientation. Cognition changes rapidly; acute confusion fluctuates; psychomotor agitation or depression may be present. The patient may display a reduced ability to maintain and shift attention.

This change in cognition cannot be better accounted for by a preexisting or evolving dementia. Whereas a patient with dementia may remain relatively oriented until the later stages of the illness, persons with delirium may shift between periods of orientation and disorientation.

If delirium is suspected, it is important to alert the medical team so a complete physical assessment can be completed. Often, in older persons, an infection such as pneumonia or a urinary tract infection is the etiology. Delirium occurs frequently in medical and rehabilitation settings but is often unrecognized and can result in considerable morbidity and mortality. Many medical issues may precipitate the onset of delirium. The mnemonic “I WATCH DEATH” serves as a reminder to rule out all potential medical causes as shown in Box 4.4 below.

BOX 4-4. DELIRIUM MNEMONIC: “I WATCH DEATH”

Infection
Withdrawal
Acute metabolic disturbance
Trauma
CNS pathology
Hypoxia
Deficiencies
Endocrinopathies
Acute vascular
Toxins
Heavy metals

Psychiatric-Mental Health Practice Standard 4: Planning

Improved outcomes for neurodegenerative and neurocognitive disorders:

- ▶ The patient will achieve optimal functioning across health systems or domains:
 - ▶ Health perception and health management, value-belief patterns
 - ▶ Nutritional-metabolic, elimination patterns
 - ▶ Activity-exercise, sleep-rest patterns
 - ▶ Cognitive-perceptual patterns
 - ▶ Self-perception and self-concept patterns
 - ▶ Role-relationship, sexuality-reproductive patterns
 - ▶ Coping-stress-tolerance patterns

NANDA-I Diagnoses: Spiritual Distress, Pain, Falls

Spiritual Distress

- ▶ Questioning life, death, pain, suffering
- ▶ Losing hope
- ▶ Requesting clergy; spiritual assistance
- ▶ Abandoning usual religious or spiritual practices

Psychiatric–Mental Health Practice Standard 4: Planning

Improvements for patients with spiritual distress:

- ▶ The patient verbalizes a sense of purpose.
- ▶ The patient accepts the reality of death.

Pain

- ▶ Anxiety
- ▶ Hopelessness
- ▶ Depressed mood
- ▶ Fear
- ▶ Insomnia
- ▶ Mobility and physical status impaired
- ▶ Acute and chronic
- ▶ Self-care deficit
- ▶ Sexual dysfunction
- ▶ Sleep pattern disturbance
- ▶ Caregiver role strain

Psychiatric–Mental Health Practice Standard 4: Planning

Improved outcomes for pain:

- ▶ The patient will participate in developing an individualized care plan based on multimodal therapies to achieve pain relief.
- ▶ The patient age 3 years or older, or with developmental or language deficits, will use the Wong-Baker FACES scale (range of faces going from happy to neutral to painful) to communicate pain. “point to the face that shows how bad the pain feels to you”; 0 = no hurt (smiling, happy face) to 10 = hurts worst (sad, crying face).

- ▶ The patient will report pain at an acceptable level.
- ▶ The patient will maintain a daily log of pain, interventions, and responses.
- ▶ The patient will participate in pain management in preparation for discharge.

Psychiatric–Mental Health Practice Standard 4: Planning

Improvements for patients experiencing pain:

- ▶ The patient will achieve an acceptable level of pain.
- ▶ The patient will engage in alternative and complementary practices designed to manage pain experiences.

Falls

- ▶ Risk for self-harm related to postural imbalance
- ▶ Impaired physical mobility
 - ▶ General: over age 60; history of falls; history of smoking, alcohol, or drug abuse
 - ▶ Mental status: lethargy, confusion, disorientation, inability to understand directions, impaired memory or judgment
 - ▶ Physical conditions: vertigo, unsteady gait, weight-bearing joint problems, weakness, paresis or paralysis, seizure disorder, impaired vision, impaired hearing, slow reaction times, diarrhea, urinary frequency, urgency, nocturia, insomnia
 - ▶ Vital signs alterations
 - ▶ Advanced age, which can lead to:
 - ▷ Increased sensitivity to environmental temperature
 - ▷ Increased risk for hypothermia
 - ▷ Increased blood pressure, especially systolic due to decreased vessel elasticity
 - ▷ Decreased efficiency of respiratory muscles with increased breathlessness
- ▶ Medications: diuretics, psychotropics, hypotensive, or CNS depressants and medications that increase GI motility (e.g., laxatives); side effects can lead to:
 - ▶ Orthostatic hypotension
 - ▶ Systolic falls to 90mmHg or below
 - ▶ Measure BP supine, sitting, and standing before initiating medications
- ▶ Ambulatory or other devices used: cane, crutches, walker, wheelchair, Geri chair, braces

Psychiatric–Mental Health Practice Standard 4: Planning

Improvements for patients at risk for falls:

- ▶ The patient will recognize the importance of dangling at the bedside and rising slowly before ambulation.
- ▶ The patient will accept the need for assistive devices that provide stability and support during ambulation.

**PROBLEM IDENTIFICATION ACROSS THE LIFE SPAN
(CHILD AND ADOLESCENT FOCUS)**

DSM5 (APA, 2013) reestablishes disorders usually first evident in infancy, childhood, or adolescence to focus on the patient's development during the formative years when the nervous system is still developing. Hence, some of the most common psychiatric disorders and criteria are referenced under the heading neurodevelopmental disorders. The most common problems (psychiatric diagnoses) that compromise optimal functioning seen in child and adolescent populations are presented below for review.

Child and adolescent psychiatric–mental health diagnoses can be atypical, constantly changing, and unusually comorbid with other disorders. Accurate diagnoses must be made with consideration of the rapid and complex physical, emotional, and psychological changes co-occurring as a process of growth and development. Additionally, accurate diagnosis is important to avoid misdiagnosing and overmedicating young persons. ADHD, for example, is frequently comorbid with anxiety, depression, conduct disorder, oppositional behavior, substance abuse, and tics (Stahl, 2008). Children and adolescents may also experience disorders found in adult populations such as anorexia nervosa, bulimia nervosa, binge-eating disorder, obesity, schizophrenia, bipolar disorder, PTSD, acute stress disorder, adjustment disorder, and gender dysphoria. The sequelae of symptoms and treatments are similar; however, considerations may be different insofar as pharmacologic agents and dosing, and recommended therapies.

Pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections (PANDAS) is associated with group A β -hemolytic streptococcus bacterial infection (GABHS), because it leads to a neural autoimmune response resulting in obsessive-compulsive disorder–like (OCD) behaviors and CNS symptoms (e.g., eye-blinking, hyperactivity, uncontrollable movements). PANDAS-induced OCD-type presentations typically are self-limiting after several weeks, and a clear association between the two events has not been satisfactorily established (Morrison, 2014).

TABLE 4-4.
NEURODEVELOPMENTAL DISORDERS

Intellectual Disability	▶ Usually begins in infancy
	▶ Low intelligence requires special help in coping with life
	▶ Communication, social interaction, and practical living skill impairments
	▶ Mild: IQ from 50–55 to approximately 70; this group is usually educable to the second to fifth grade functional level
	▶ Moderate: IQ from 35 to 55, trainable to live semi-independently
	▶ Severe: IQ from 20 to 40; cannot develop independent living skills; usually due to genetic causes
	▶ Profound: less than 20 to 25; dependent on others for self-care— institutionalized; genetic causes
Borderline Intellectual Functioning	▶ IQ range 71–84
Language Disorder	▶ Lag in spoken and written language compared to age group
	▶ Small vocabulary, impaired use of words to form sentences, reduced ability to use sentences to express ideas
Social (Pragmatic) Communication Disorder	▶ Difficulty with language usage, including ability to adapt communication to fit context, follow rules of conversation, and understand implied communication
Speech Sound Disorder	▶ Problems with producing sounds of speech, or errors in order of sounds
Childhood-Onset Fluency Disorder (Stuttering)	▶ Stuttering with consonant sounds; sounds drawn out or repeated
Selective Mutism	▶ Ability to speak normally, but doesn't speak in certain situations
Learning Disorders (Reading [Dyslexia], Mathematics [Dyscalculia], Written Expression [agraphia or dysgraphia], Drawing [Constructional Apraxia], Learning Disorder Not Otherwise Specified [NOS])	▶ Standardized test scores markedly less than expected for age:
	▶ Reading (dyslexia) <ul style="list-style-type: none"> ▶ 60%–80% with reading disorder are male
	▶ Mathematics (dyscalculia) <ul style="list-style-type: none"> ▶ Seldom diagnosed before second grade and may not become apparent until fifth grade or later
	▶ Written expression (agraphia or dysgraphia)
	▶ Difficulty copying simple drawings (constructional apraxia)
	▶ Approximately 5% of U.S. public school students are diagnosed with learning disorders; prevalence is 10%–25%
	▶ Co-occur with conduct disorders, oppositional defiant disorder, ADHD, major depressive disorder, or dysthymia
▶ School dropout rate almost 40%	
Stereotypic Movement Disorder	▶ Repetitive movements without goal attainment that begins in early childhood
	▶ Sometimes associated with congenital blindness, deafness, temporal lobe epilepsy, Wilson's disease, Lesch-Nyhan syndrome

(continued)

TABLE 4-4.
CONTINUED

Autism Spectrum Disorders (Autism, Rett's Syndrome, Asperger's Syndrome, Childhood Disintegrative Disorder)	▶ Affect 1 in 68 children (CDC, 2014b)
	▶ Social relationship difficulties vary from mild to almost complete lack of interaction since early childhood
	▶ Reduced use of eye contact, hand gestures, smiles, nods
	▶ Difficulty adapting to different social situations
	▶ Engages in repetitive and narrowly focused activities and interests
	▶ Needs routine; difficulty with changes in routine
	▶ Fascination with spinning or small parts of objects
	▶ Feeble or excessive reactions to stimuli
	▶ Stereotypic behaviors such as hand flapping, body rocking, or echolalia
	▶ Males 2 to 4 times more likely to be affected
	▶ Asperger's syndrome: cognitive and linguistic development intact; difficulties with social interaction and nonverbal communication
	▶ Rett syndrome only affects girls (genetic mutation on X chromosome; some live until middle age, then growth and development regression seen)
	▶ Childhood disintegrative disorder: apparently normal growth and development until age 3, then regression noted
Tourette's Syndrome	▶ Tics that begin by age 6 and affect various parts of the body; often beginning with eye blinks
	▶ Vocal tics that involve coprolalia (vocalizing obscenities)
	▶ More common in males
	▶ Strong family history present
Persistent (Chronic) Motor or Vocal Tic Disorder; Provisional Tic Disorder	▶ Involuntary, sudden vocalization or body movement that is repeated, rapid, nonrhythmic
	▶ May be complex: several simple tics in rapid succession
	▶ May be occasional twitch
	▶ Usually involves upper part of face (grimaces and twitching eye muscles)
	▶ Vocal can be barks, grunts, coughs, throat clearings, sniffs, single syllables
	▶ May disappear as child matures
	▶ More common in males

(continued)

TABLE 4-4.
CONTINUED

Attention-Deficit Hyperactivity Disorder	▶ Onset before age 7, although diagnosis can be made at any age
	▶ Impaired work or educational, social, personal function
	▶ Inattentive, hyperactive, impulsive predominance may occur, or combined presentation
	▶ Patient always in motion; disruptive because of restlessness, fidgeting, talking; difficulty paying attention and focusing; easily distracted, neglects details, makes careless mistakes
	▶ Nigrostriatal and prefrontal pathway implications of norepinephrine or dopamine to and from basal ganglia
Disruptive, Impulse-Control, and Conduct Disorders	
Oppositional Defiant Disorder	▶ Onset at age 3–4 years; diagnosis few years later (by age 8)
	▶ Negativism and defiance beyond quest for normal independence-seeking, lasting longer than 6 months
	▶ Hostile towards others
	▶ Blames others
	▶ Behavior must occur with persons other than siblings
Conduct Disorder	▶ Onset at age 5–6
	▶ Consistently violates basic right of others
	▶ Breaks rules, sets fires, shows cruelty to others or animals, lies, and steals
Intermittent Explosive Disorder	▶ Frequent, repeated, spontaneous outbursts of aggression towards people, property, or animals
Kleptomania	▶ Irresistible urge to steal things they really don't need
	▶ Provides tension release
Pyromania	▶ Fire-setters feel tension and release it by setting fires
Disruptive Mood Dysregulation Disorder	▶ Persistently negative mood with frequent, severe temper explosions
	▶ Minor provocations can provoke to extremes; bullying, threatening, fighting
	▶ Outbursts occur every few days on average for at least a year
	▶ Nonsuicidal self-injury (NSSI) or self-mutilation, cutting, or burning self-behaviors may co-occur; one hypothesis: do tattoos represent a socially acceptable way to engage in NSSI?
Trichotillomania	▶ Engages in chronic hair, eyelash, eyebrow, or pubic hair pulling to the point of baldness
	▶ Highly comorbid with OCD and Tourette's syndrome
	▶ Causes significant embarrassment and shame
	▶ Provides tension release

(continued)

TABLE 4-4.
CONTINUED

Feeding and Eating Disorders	
Pica	▶ Commonly found in young children and pregnant women, children with autism spectrum disorder, intellectual disability
	▶ Persistent eating of dirt or other nonfood items
	▶ May be related to mineral deficiency (iron, zinc)
Rumination Disorder	▶ Regurgitation and reswallowing of food for at least 1 month
	▶ Can be associated with bulimia nervosa, intellectual disability
	▶ Males more likely to be affected
Elimination Disorders	
Encopresis	▶ Age 4 or older, moves bowels in inappropriate places
	▶ More common in males
Enuresis	▶ Age 5 or older, day and nighttime wetting
	▶ May have primary (never been dry) or secondary (toilet training initially successful)
	▶ May accompany non-REM sleep problems, especially during first 3 hours of sleep
Anxiety Disorders	
Separation anxiety disorder	▶ Resistance and severe anxiety with being alone because of fear that something might happen to significant other; or fear they may become lost.
	▶ Can be diagnosed in all ages (children, adolescents, adults, older adults).
Trauma and Stress-Related Disorders	
Reactive Attachment Disorder	▶ Poor attachment; poor bonding to primary caregivers during early childhood
	▶ Child fails to seek comfort from parents or surrogates
	▶ Child extremely withdrawn
Disinhibited Social Engagement Disorder	▶ Child fails to show normal reticence in the company of strangers
	▶ Child pathologically outgoing; no social reserves evident

NANDA-I: Childhood Disorders in General

- ▶ Risk for self-directed violence
- ▶ Risk for other-directed violence
- ▶ Ineffective coping
- ▶ Enuresis or encopresis
- ▶ Problems with social skills, problem-solving, school performance
- ▶ Disturbed thought processes
- ▶ Disturbed sleep patterns
- ▶ Anxiety
- ▶ Chronic or situational low self-esteem
- ▶ Risk for caregiver role strain
- ▶ Readiness for enhanced family processes among family members

NANDA-I: Family-Related Nursing Diagnoses

- ▶ Ineffective therapeutic regime management
- ▶ Ineffective family coping
- ▶ Ineffective parenting
- ▶ Knowledge deficit
- ▶ Caregiver role strain
- ▶ Ineffective denial
- ▶ Complicated grieving

NANDA-I: Suicide, Abuse, and Violence (Intrapersonal, Interpersonal)

Ineffective (Maladaptive) Coping: Suicide

Suicide is the 10th leading cause of death in the United States and according to Puntill, et. al. (2013), there are approximately 90,000 psychiatric-mental health nurse generalists working on inpatient psychiatric units where the most acutely suicidal patients are cared for. Psychiatric-mental health nurses are particularly called upon to provide leadership in developing, implementing, and evaluating competency-based education and training in suicide prevention. The National Suicide Prevention Lifeline is a confidential, free network (800.273.TALK/800-273-8255) to educate and intervene with persons with suicidal ideation and with persons who are concerned about someone.

Ineffective (Maladaptive) Family Coping: Features of Domestic or Intimate Abuse, Sexual Abuse, Assault, and Violence and Neglect

Domestic or intimate partner violence refers to an escalating, and usually persistent, pattern of abuse in which a person in an intimate relationship controls a vulnerable person or persons through force, intimidation, threat of violence, control of finances, or any combination thereof. The three most common categories of violence associated with domestic violence involve child abuse, intimate partner abuse, and elder abuse. As nurses, we recognize family violence patterns that can originate early in life such as failure to thrive (manifestation of infantile depression; poor parent-child bonding?), shaken baby syndrome (maladaptive parenting or discipline?), domestic violence (personal boundary violations; rape, incest), and elder abuse and neglect. Does caregiver role strain play a role in our sandwich generation households (parents raising and caring for own children as well as their own parents)?

Vulnerable population groups include children, women ages 15 to 44 (reproductive age), frail older adults, persons with mental illnesses, cognitive impairments, and children and adults with mental delays and physical disabilities. Women are more at risk of suffering abusive behavior, particularly during pregnancy and the period immediately after a separation (Stuart, 2009). Intimate partner abuse in heterosexual relationships tends to be gender-related, with more women being victimized; the majority of spousal or intimate partner perpetrators are men. However, intimate partner abuse also occurs in gay relationships where it is not gender-related: both abuser and victim are of the same sex. Domestic violence is a serious event in which the victim can be physically injured, psychologically traumatized, or neglected. More pregnant women die as victims of domestic violence than from any other cause.

Perpetrators of abuse and violence come from all walks of life, socioeconomic strata, educational levels, races, ethnicities, and occupations. They are more likely to have grown up in an abusive household or been exposed to community or peer group violence. Most perpetrators have low self-esteem and dependent personalities. They tend to lack impulse control and frequently view their victims as their property. Poverty, stress, and cultural values supportive of violence as a way of controlling behavior contribute to the development of abusive behaviors. Alcohol and other substance abuse is frequently a precipitating factor, although not the cause of domestic violence. Perpetrators can be paid caregivers or long-term-care personnel as well as family members or persons with legal authority to make healthcare or financial decisions for a victim.

Abuse should be suspected when injuries are not explainable, family members provide different explanations, or the explanation does not fit the observed injuries. A history of similar injuries, multiple visits to the Emergency Department, and a delay between the onset of injury and seeking medical care should raise suspicion. Although no single injury informs the nurse that physical abuse has occurred, the nurse should look for patterns of injury or more than one indicator related to the possibility of physical and other forms of abuse. Always believe a patient who reports abuse.

There is a predictable cycle to spousal or intimate partner abuse. Without treatment, it always repeats.

- ▶ Tension-building (escalation or buildup) phase: Tension rises with minor abuses; the victim tries to appease the perpetrator.
- ▶ Explosion (acute battering) phase: Abuse in the form of physical injury, psychological harm, or both occurs.
- ▶ Honeymoon phase: The abuser is remorseful and apologetic, promising that the abuse will not happen again. Undoing, a common defense mechanism, may be observed.
- ▶ Later, the tension-building phase reappears and the cycle repeats (Dugan & Hock, 2006).

Domestic abuse, assault, and violence can take many forms:

- ▶ Emotional: systematic degradation of a person's self-worth through verbal attacks, controlling or limiting the victim's rights, isolating the victim from social contacts, and destroying the victim's personal property or pets.
- ▶ Physical: intentional infliction of bodily harm through punching, beating, kicking, burning, shoving, twisting hair or body limb, withholding food, or forcing compliance through actual or threatened physical force. Physical abuse also includes denying the victim food, fluids, or sleep. Indicators can include dislocations, fractures, burns, abrasions on limbs or torso consistent with strap or rope marks, bruising (particularly bilateral bruising to the arms or inner thighs), evidence of repeated bruising without medical cause, or traumatic loss of teeth or hair.
- ▶ Psychological indicators: requires further exploration with children when school performance suddenly changes; presenting as overly compliant, passive, withdrawn, or demanding without reason; running away or doesn't want to go home; descriptions of the relationship with parent or caregiver as negative; inability to concentrate that cannot be attributed to a physical or psychological cause; reports physical or sexual abuse by a parent or caregiver; refuses to change clothes for gym periods.
- ▶ Sexual: forcing sex on an unwilling person, unsolicited sexual intimacy (fondling breasts or buttocks, or genital contact with no penetration), indecent exposure, or forced exposure to sexually explicit material or unusual sex practices. It also includes sexual behaviors with a person who is unable to give valid consent (e.g., a minor, a person with cognitive impairments, an unconscious person). Use of a child for pornography or other sexually exploitive activities is sexual abuse. Sexual abuse can consist of not revealing a sexually transmitted disease and failing to take precautions to safeguard the other person. Women with disabilities may be at greater risk.

- ▶ The most common form of sexual abuse of children is incest —sex with a family member. Possible indicators requiring further exploration with children include
 - ▶ Unusual incidence of urinary tract infections,
 - ▶ Bruises, itching, rawness in the perineal area or inner thighs,
 - ▶ Nightmares, fear of going to bed,
 - ▶ Changes in behavior, extreme mood swings, or withdrawal,
 - ▶ Unusual interest or highly developed knowledge in sexual matters,
 - ▶ Enuresis; encopresis, and
 - ▶ Presence of a sexually transmitted disease.

- ▶ Neglect: the most common form of child and elder abuse; can be active or passive. Active neglect refers to the intentional disregard by caregivers and others for the physical, emotional, or financial needs and welfare of a child, disabled or cognitively impaired adult, or frail older adult. It can include withholding of care or finances, or failure to provide adequate supervision needed by the victim. Passive neglect is not intentional; the caregiver may not be able to provide appropriate care or supervision because of his or her own disability, lack of resources, lack of maturity, or ignorance. Possible indicators of child or frail older adult neglect include
 - ▶ Consistently dirty or has a distinct body odor,
 - ▶ Lacks appropriate clothing for the weather,
 - ▶ Doesn't have lunch or lunch money,
 - ▶ Lacks adequate medical or dental care, medications, or eyeglasses,
 - ▶ Appears apathetic, or afraid something is happening to her or him,
 - ▶ Lack or inappropriate supervision of a child's leisure and adolescent sexual activities,
 - ▶ Abuses alcohol or other drugs,
 - ▶ Child frequently absent from school,
 - ▶ Not in approved age-appropriate car seat, and
 - ▶ Left alone; unattended.

Referral to have a rape kit collected by a Sexual Assault Nurse Examiner (SANE), if available, is prudent. SANEs are experts in history-taking, physical and emotional assessment, recognition, and documentation of trauma response and injury—experts at collecting and managing forensic evidence. SANEs also provide emotional and social support during the courtroom testimony if required by the judicial system (see www.iafn.org for more information).

Nurses must follow state laws that mandate reporting of child or elder abuse. In most states, healthcare professionals are protected from breach of confidentiality in reporting suspected child or elder abuse and neglect. Specific reporting guidelines are incorporated into state laws. In a court of law, the judgment about reporting of child or elder abuse or neglect will be made on the basis of these published guidelines, and what a reasonable and prudent nurse would do in a similar situation.

Treatment of the victim begins with the assessment. Interview the alleged victim alone. Believe the abuse claim. Validate the person's feelings. Document signs of abuse and encourage treatment; children entering treatment for depression, anxiety, or eating disorders often have underlying abuse issues, requiring assessment.

Children in abusive situations may need to be removed from the home or placed temporarily with a relative to prevent further episodes of abuse. Educate the abused child about self-protective strategies and remind the child that the abuse was not his or her fault. Treatment approaches for children should reflect their developmental level.

For adult victims of abuse, help to identify and explore a safe environment in which the person has safe alternatives should she or he need them (e.g., a shelter, staying with a friend or relative). Develop a safety plan that details the steps the adult victim should take in case of abuse, including collecting of important papers, money, and phone numbers. Educate adult victims about the cycle of abuse, and explore and correct misperceptions that the victim provokes the perpetrator to become abusive.

Patient Injuries in Healthcare Facilities

The Joint Commission mandates that any unexpected occurrence involving death or serious physical or psychological injury in a healthcare facility be reported. The purpose of identifying unexpected occurrences, referred to as sentinel events, is to reduce their frequency. A sentinel event is defined as any unanticipated event in a healthcare setting not related to the natural course of the patient's illness that results in serious physical or psychological injury to, or death of, a person or persons. *Root cause analyses* are enacted to identify lapses or oversights in processes for the purpose of constructing safety nets to close those gaps. The aviation industry boasts of thousands of flights worldwide on a daily basis with very few casualties. Many healthcare facilities have adopted the check-check-recheck with a partner strategy similar to that used by the aviation industry to eliminate errors, sentinel events, near-misses, and injuries and fatalities. Examples of sentinel events relevant to mental health settings include medication error, restraint resulting in injury or death, suicide or suicide attempt, patient elopement, delayed treatment, and fall resulting in injury or death.

Psychiatric–Mental Health Practice Standard 4: Planning

Improved Outcomes for Children and Adolescents in General

- ▶ Teach proactive interventions systematically.
- ▶ Respond warmly to positive behaviors.
- ▶ Ignore negative behavior when appropriate.
- ▶ Refrain from giving unnecessary commands (demonstrating control when unnecessary).
- ▶ Avoid unrealistic demands.
- ▶ Use therapeutic play with children.
- ▶ Involve family, school, and other supports.
- ▶ Believe reports of bullying, reports of sexual abuse.

Improved Outcomes for Children and Adolescents: Tools

- ▶ Therapeutic play
- ▶ Pharmacotherapy
- ▶ Expressive therapies
- ▶ Bibliotherapy
- ▶ Children's games
- ▶ Storytelling
- ▶ Cognitive behavioral therapy (CBT)
- ▶ Milieu management
- ▶ Special education
- ▶ Computer-based treatment
- ▶ Speech and language therapies
- ▶ Social skills training
- ▶ Sensory integration training
- ▶ Music therapy

Improved Outcomes for Autism Spectrum Disorders

- ▶ The patient will maintain safety (self and others).
- ▶ The patient will use socially appropriate behaviors.
- ▶ The patient will use coping skills.
- ▶ The patient will gain restorative sleep.

Improved Outcomes for ADHD

- ▶ Targeted symptoms:
 - ▶ Problems with social skills
 - ▶ Problem-solving
 - ▶ School performance
 - ▶ Behavioral inhibition
 - ▶ Communication

CRISIS AND CRISIS INTERVENTION

Gerald Caplan (1964), a pioneer in crisis intervention, described crisis as a psychological state that occurs when a person is faced with insurmountable situations or problems and their usual ways of coping are inadequate to deal with the stress. Every crisis presents an opportunity for personal growth. Caplan believed that the crisis state resolves itself in 4 to 6 weeks. Crises are typically self-limiting, with resolution occurring within 72 hours without intervention. There are three general types of crises:

- ▶ Situational: specific external event upsets equilibrium, occurring at a personal or family level (e.g., cancer diagnosis, job loss)
- ▶ Maturation: occurs at transition points in life (e.g., menopause, puberty, childbirth)
- ▶ Adventitious or global: accidental, unexpected, usually occurring to larger segments of the population (e.g., natural disaster)

The *crisis state* is conceptualized as a normal response or reaction to an overwhelming, traumatic event. Flannery (2002) reviews this crisis response as one in which a person's psychological homeostasis is disrupted, usual coping strategies are unable to reestablish homeostasis, and the level of stress associated with the crisis has resulted in functional impairment. When people are unable to resolve significant problems in their lives, they can begin to experience tension and

anxiety, a decline in their overall functioning, inability to organize and regulate behavior, and increased defensiveness. What can result are somatic complaints, perceptual changes, intense feelings (e.g., sense of urgency, “going crazy” hallucinations), impaired impulse control, and limited capacity to express feelings or draw support from their usual sources of help (support system). A person in a crisis state may even experience survivor guilt.

Of course, preventing crises from occurring in the first place is ideal. The psychiatric-mental health nurse, in adopting tenets proposed by Hildegard Peplau (1988) invoking the “therapeutic use of self” (Chapter 7), can go a long way, in some cases, toward averting patient decompensation before it happens. First-line implementations focus on the therapeutic alliance, patient triggers, feelings, and environmental monitoring. It behooves nurses to take time to implement basic strategies to strengthen alliances with patients who already are presenting with a myriad of psychosocial stressors, psychiatric impairments, and substance-induced intoxication or withdrawal that compromise good judgment and *best behaviors*. Behaviors are attempts to get needs met; these behaviors may be healthy, straightforward, and adaptive ways; or unhealthy, subversive, destructive, and maladaptive ways for the patient to meet his or her needs. Prevention strategies compel nursing staff to pay attention to, and addresses:

▶ Basic physical needs

- ▶ Offer water, food; plan to sit with patient and patient groups at varying times without intention to focus solely on their problems; identify supports and strengths.
- ▶ Attend to emergencies and complaints of pain.

▶ Basic psychological needs

- ▶ Listen, give support, support adaptive defenses, provide structure, encourage constructive activity.
- ▶ Encourage preferred coping mechanisms.
- ▶ Teach simple techniques for reducing stress (journaling, adequate sleep or rest, diet and exercise, sublimation through safe outlets for strong energy, deep breathing, meditation and prayer).
- ▶ Support previous successes and beliefs in self-efficacy.
- ▶ Assist in setting up new supports or activating those already available.
- ▶ Refer or link to social services for assistance with basic living needs.

Crisis intervention is an acute, short-term therapeutic intervention. The goal is to return persons in crisis to their precrisis adaptive level of functioning and to prevent or reduce the negative effects of the stressors creating the stress. Constructive resolution of a crisis can provide a person with stronger coping ability, whereas an inability to resolve a crisis can lead to psychiatric symptoms or personal breakdown. A generalized model of crisis intervention is built on a four-phase strategy:

1. Develop an alliance with patients.
 - ▶ Build trust and use empathy.
 - ▶ Begin where the person wants.
 - ▶ Acknowledge helplessness.
2. Gather information about triggers and events.
 - ▶ Focus on precipitating event.
 - ▷ It may not be therapeutic to describe a traumatic event in detail.
 - ▷ Gather timeline and precipitating events.
 - ▶ Determine precrisis level of functioning.
 - ▷ Review similar past symptoms.
 - ▶ Determine acute and long-term needs, threats, and challenges.
 - ▶ Review past successful coping mechanisms.
 - ▶ Identify usual resources.
3. Problem-solve with patients; give them some credit for input.
 - ▶ Begin basic problem-solving.
 - ▶ Set realistic goals.
 - ▶ Focus on termination from the beginning.
 - ▶ Support patient strengths.
 - ▶ Suggest additional coping strategies.
4. Evaluate.
 - ▶ Have identified outcomes been achieved?
 - ▶ Are adequate support systems in place?
 - ▶ What does the patient need?

Nursing Model of Crisis Intervention

According to Aguilera's (1998) nursing model, a person, family, or group can experience a biological or psychosocial event that creates a state of disequilibrium and anxiety. If balancing factors are present in the form of realistic perception of the event, adequate situational support, and adequate coping mechanisms, the person will be able to resolve the problem, regain a sense of equilibrium, and avert the crisis state. On the other hand, if one or more balancing factors are absent, then the problem remains unresolved, the disequilibrium and anxiety continue or escalate, and the person experiences the crisis state. Crisis intervention treatment focuses on helping patients to create or restore these essential balancing factors to achieve the precrisis level of functional coping. Three phases are described; stabilization, problem-solving, and resolution.

Aguilera's First Phase of Crisis Intervention

The *first* priorities in treating a person in a crisis state are to *stabilize* the patient and to ensure the safety of the patient, family, and others in the immediate environment. This requires the nurse to remain calm and in control of the situation, setting limits when needed. Depending on the nature and severity of the crisis state, short-term medication may be indicated. When a patient is threatening the safety of the milieu, nursing interventions focus on reducing the likelihood of harm. Interventions are focused on an immediate crisis situation or problem that is perceived as overwhelming and traumatic to the patient. Because immediate relief is called for, it is essential to determine the services and resources needed to return the patient to his or her precrisis level of functioning. Support networks can help persons in crisis begin to function independently.

- ▶ Reduce stimulation in the milieu.
- ▶ Remove lethal material.
- ▶ Separate the person from other patients.
- ▶ Establish a contract for safety.
- ▶ Provide constant one-on-one monitoring.
- ▶ Maintain safety: observe for escalation.
- ▶ Remain calm: defuse with least restrictive means.

Use deescalating communication strategies:

- ▶ Speak in a calm, low voice.
- ▶ Respect the need for personal space.
- ▶ Avoid intense eye contact.
- ▶ Acknowledge the patient's feelings and reassure that staff is there to help.
- ▶ Avoid power struggles.

- ▶ Communicate expected behavior.
- ▶ Communicate consequences of unacceptable behavior.
- ▶ Give an opportunity for time out.

Use seclusion or restraints only if necessary, as last resort. In high-risk, potentially violent, or life-threatening situations where preventive and deescalating strategies have failed, seclusion or restraints might be required. It is always understood that all patients have a basic right to treatment in the least restrictive setting. State regulations vary on rules about seclusion and restraint; however, the psychiatric–mental health nurse must always adhere to the strictest standard, whether defined by state regulatory agencies, The Joint Commission, or the Centers for Medicaid and Medicare Services (CMS). Families must be notified when a patient has been in restraints and the patient must be checked for injuries or bruising that may have occurred because of the restraint.

- ▶ Seclusion and restraint require a team response with a designated team leader.
- ▶ Notify security if necessary.
- ▶ Remove all other patients from the area.
- ▶ The leader should express concern for the patient’s safety and behavior.
- ▶ At given signal, the team secures the patient’s limbs.
- ▶ The patient is escorted to an appropriate room and informed of the intervention.
- ▶ If necessary, administer restraints or medications.

Aguilera’s Second Phase of Crisis Intervention

In the second phase of intervention, it is important that nurses take an active role with patients and families to engage in problem-solving strategies. Once the patient is stabilized medically and is safe, the focus turns to collecting comprehensive assessment data. This is accomplished by gathering specific information about the crisis—that is, concentrating on recent events, what led up to the present state of disequilibrium, the duration of the crisis state, and its impact on others. This is also the time to explore information about support systems, previous coping strategies, and the meaning of the crisis to the patient. These strategies include:

- ▶ Developing a working alliance with the patient and his or her family. Appeal to the fact that you are the nurse (most trusted healthcare providers) and are there to help. Suggest the need to obtain blood pressure (as a distraction). Offer the patient water and a seat at the table with you.
- ▶ Identify and encourage patient strengths and abilities.
- ▶ Identify coping mechanisms used successfully in the past.

- ▶ Give the patient an opportunity to express emotions; acknowledge fear, anger, helplessness, or resentment.
- ▶ Help the patient externalize the events of the crisis in a realistic manner.
- ▶ Set realistic goals. Help the patient explore other options when strong feelings recur.
- ▶ Mutually identify possible solutions, and encourage self-responsibility.
- ▶ Help the patient to identify and mobilize social supports and develop new ones.
- ▶ Assist the patient, when needed, to make appropriate community support contacts.

Aguilera's Third Phase of Crisis Intervention

In the *resolution phase* of crisis intervention, the nurse assists crisis patients to restabilize their lives and to achieve precrisis adaptive functioning. This involves helping crisis victims understand the negative impact of the crisis on their lives, and active assistance with use of available resources and support networks to achieve independent functioning. This potentially is a teachable moment.

Successful resolution is evidenced by a decrease in the original presenting symptoms to manageable proportions, satisfaction with the outcome of the crisis intervention, and articulated plans for future action. During this phase, the nurse helps the patient summarize goal achievement and identify healthy ways of coping to prevent further problems. If the patient needs further assistance, or the problems for which the person sought crisis intervention are not resolved to the patient's and nurse's satisfaction, referrals for psychotherapy or additional support can be made.

PSYCHIATRIC-MENTAL HEALTH PRACTICE STANDARD 5F: MILIEU THERAPY

Milieu therapy is a form of spatial interaction that uses the social environment of the unit or facility as a primary therapeutic agent. People are in constant interaction and transaction with their environments. The psychiatric-mental health registered nurse has responsibility for providing the socio-cultural-environmental structure and for maintaining a safe and therapeutic (purposeful) environment. Essential components of a therapeutic milieu includes safety, structure, norms, limit-setting, and balance. These components, discussed in this chapter, include consideration of treatment in the least restrictive environment. Milieu therapy components that pertain to patient basic rights, and education needs that are obtained through individual, group, family, and community modalities, are presented in Chapter 7.

Safety in the Milieu

Safety is the priority goal in patient care. Every healthcare provider avows to a basic tenet to do no harm. This compels healthcare providers to know how to promote safety, how to evaluate sentinel events and near misses, and how to avoid and prevent compromises to safety. Safety standards are articulated by The Joint Commission (TJC) through annual published standards referred to as National Patient Safety Goals (2015), one of which is to identify safety risks among patients; find out which patients are most likely to try to commit suicide.

Of late, the healthcare industry is taking note of the highly rated safety margin found within the aviation industry. Among all the thousands of flights that occur all over the earth, flight mishaps are few. Some of the check-recheck policies and practices occurring in operating room suites and in personal protective equipment dressing and undressing practices noted today stem from application of aviation safety-check modeling. In psychiatric care settings, prevention of suicide and homicide, assaults, aggression, and violence are top priority. Crisis states, theories, and interventions are discussed here to facilitate nurses' understanding of this level of patient decompensation.

Seclusion and Restraint Safety: Regulatory Guidelines

Restraint-free environments are the ultimate goal. The Joint Commission (2009) invokes federal guidelines for the use of seclusion or restraints to manage violent or self-destructive behaviors or reduce the risk of harming patients. Anyone restrained must be evaluated by a physician or licensed independent practitioner within 1 hour. The patient must be monitored continuously and the procedure must be terminated as soon as the patient meets the criteria for release. The nurse must document the behaviors, the attempts to use less restrictive interventions, nursing care provided, the patient's response to the treatments, and rationale for terminating the intervention. TJC (2009) also provides very specific guidelines for implementing restraints. Types of available restraints are:

- ▶ Physical: any device, garment, or hold that restricts a person's voluntary movement and cannot be easily removed by the person
- ▶ Chemical: psychotropic medication given for the specific purpose of controlling behavior; its therapeutic value lies in decreasing a patient's escalating anxiety and potential to harm self or others. When restrictive measures are necessary, nurses should document which less restrictive measures were tried unsuccessfully, and specifically why the particular restrictive measure is necessary.

Patients can be restrained temporarily for serious medical or behavioral symptoms. Examples of medical reasons for restraints include the patient's inability to cooperate with an essential physical treatment or device such as an IV, in-dwelling catheter, respirator, or dressing; or because of confusion or irrational thinking. Behavioral health reasons consist of severe behaviors that potentially could cause injury to self or others because of violent, aggressive, or acute agitation related to an emotional or behavioral disorder, or symptoms associated with acute drug use. Restraining a patient, either physically or chemically with medication, is an emergency form of treatment reserved for situations in which the patient's behavioral symptoms justify temporary restraint or seclusion to protect the patient from harming him- or herself or others. Nurses and staff who restrain patients must be trained in cardiopulmonary resuscitation (CPR) techniques.

Regardless of the reason for the restraint or seclusion, TJC standards apply. The CMS outlines require written and time-frame guidelines when implementing restraint or seclusion. Only the minimal amount of restraint necessary to ensure the safety of the patient and others, while promoting the patient's personal autonomy to the highest level possible, can be used. The initial evaluation of the person must be made within 1 hour by a licensed independent practitioner (LIP) and length-of-time maximums are based on age:

- ▶ Adults: 4 hours
- ▶ Adolescents (ages 9–17): 2 hours
- ▶ Children (ages younger than 9): 1 hour

During the entire time of emergency treatment, physical assessment of the patient in seclusion or restraints must be documented in the chart at designated intervals. Remember, the legal assumption is that if it's not documented, it wasn't done! Required documentation of the care offered to the person in restraints or seclusion and evidence of staff debriefing includes

- ▶ Document that risk was assessed
- ▶ Least restrictive options tried without success
- ▶ Description of the event (triggers?); rationale for use
- ▶ Rationale for the restraint or seclusion, including the patient's condition or symptoms
- ▶ Evidence of at least hourly face-to-face medical and behavioral evaluation, including a description of the behavior and interventions attempted
- ▶ Patient's physical condition
- ▶ Adequate nutrition and hydration offered regularly
- ▶ Circulation and range of motion in extremities checked frequently
- ▶ Vital signs, especially respiratory functioning monitored
- ▶ Hygiene and elimination offered

- ▶ Physical and psychosocial status and comfort provided
- ▶ Medications administered
- ▶ Notification of family of need for intervention
- ▶ Discontinuation of restraints as soon as feasible
- ▶ Signs of injury associated with the application of restraint or seclusion, if any
- ▶ Rationale for terminating the intervention
- ▶ Debriefing with patient, patient's family, and staff to identify triggers precipitating loss of control, options for alternatives that can be used in the future, barriers to providing least restrictive interventions
- ▶ The patient's response to treatment interventions, and rationale for continued use of restraint or seclusion, if warranted

Structure in the Milieu

The structure and process environment of milieu therapy is particularly helpful with disorganized patients or those who require close supervision and guidance. Milieu therapy is used in inpatient, partial hospitalization, community, and rehabilitation settings. This planned treatment environment acts as a therapeutic agent, where patients must be willing to actively participate in group and decision-making activities. Communication is open and direct between staff and patients, and reality testing and problem-solving exercises are the goal of implementations. When the nurse opens curtains to bring in sunshine during the day, throws scrunched tissues in the trash, empties the urinal, arranges tables and chairs for a group, or is involved in developing unit rules or patient orientation handbooks, or weighs in on the new color suggested for renovation, this represents engagement in the tenets of milieu therapy. Structure and environmental modification focuses on the following:

- ▶ Comfort during treatment
- ▶ Confidentiality of sensitive information
- ▶ Organization of healthful activities
- ▶ Structuring time and monitoring fatigue in both patients and staff
- ▶ Cleanliness of environment
- ▶ Access to communication (mail, visitors)
- ▶ Provision of space for privacy
- ▶ Provision of space when needed

Norms in the Milieu

Clear communication is vital to enhance effectiveness and promote recovery for all. Norms, or expectation should be clearly spelled out in patient handbooks and posted as reminders. They include elements such as being respectful to all others, speaking in turn, calling others by given name not derogatory names, using respectful language, attending groups and classes on time, remaining for groups and classes until the end, allowance to go to room if anxious or too acutely ill for interaction (give attention to the number of days that patient has been in hospital; presentations expectedly are variant depending on whether it is day one or day 5. The longer a patient has been in the hospital, the higher your expectations, given the patient is responsive to medications, is used to the milieu, and has gained increased comfort and confidence). Other areas for setting norms include

- ▶ Community rules posted or accessible,
- ▶ Consequences discussed before actions occur,
- ▶ Violence, aggression, abuse prohibited,
- ▶ Independence encouraged,
- ▶ Communication safeguarded within group, milieu,
- ▶ Cultural differences accepted,
- ▶ Feedback promoted if positive, and
- ▶ Visitors and visitation monitored.

Limit-Setting in the Milieu

Another clearly effective way to promote a therapeutic milieu is to be consistent in engagements with patients and other staff. Each patient, despite his or her particular presentation or nuances, deserves the understanding by the nurse that it is the patient who is sick and in need, not the nurse. It behooves the psychiatric-mental health nurse to remember that patients, because of their illness, may not be engaging in their best behaviors. Testing staff and manipulating others are tactics that many patients, even nonpatients, have learned to get personal needs met in their socioeconomic, family, and community environments. At the end of the day, this is exactly what we all engage in—getting personal needs met, perhaps in more prosocial ways.

Modification of the therapeutic milieu results from continual evaluation of effectiveness of the interventions and recognition of the need for improvements. Rules can change in accordance to the patient mix. At times there may be grey areas. This is the time for team decisions and conflict resolution (Chapter 7). Behavior modification strategies assist with limit-setting in the environment. These elements address several of the following concerns:

- ▶ Limits are set appropriately; no power plays.
- ▶ Staff enforces rules consistently.
- ▶ Individual uniqueness and needs considered.
- ▶ Time-out opportunities offered.
- ▶ Crisis intervention implemented.
- ▶ Advocacy promoted.
- ▶ One-on-one observation available.
- ▶ Seclusion and restraints are last resort.
- ▶ Medications taken as prescribed.
- ▶ Token economy implemented:
 - ▶ Interpersonal skills and self-care behaviors rewarded
 - ▶ Positive and negative reinforcement used

Balance, the desired outcome, “is the process of gradually allowing independent behaviors in a dependent situation” (Keltner, Schwecke, & Bostrom, 2003, pp. 280–281). Independence needs to be gained in increments and staff monitors to ensure that one’s need does not overpower another’s need, both in and between patients.

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