



Caring for Patients with Mental Health Disorders

2.0 Contact Hours

First Published: July 7, 2011

Course Expires: November 30, 2017

Course Updated: June 10, 2014

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Acknowledgments

RN.com acknowledges the valuable contributions of ...

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Purpose

The purpose of this course is to provide nurses and other healthcare providers with guidelines to assist in the identification and care of patients with co-occurring mental and physical health disorders in the acute care setting. The course will meet this goal by providing strategies to identify potential mental health issues, improve communication, identify safety concerns, and improve outcomes for this vulnerable patient population.

Note to Design Team: On review of learner comments, it seems that the format of this course presented many technical difficulties for learners. There were several complaints about the amount of time it took to load different slides and lots of learners complained about links / interactions not working. Please consider changing the format...I think it's currently in Articulate so you may want to look into putting the course into Lectora?

There was also a complaint about the outline being incorrectly numbered. Another learner suggested that we do not use black as the background cover as it makes it more difficult to read.

Learning Objectives

After successful completion of this course, you will be able to:

1. Identify the prevalence of mental illness in the United States.
2. Describe factors that necessitate acute care hospitalization of patients with mental health conditions.
3. Discuss general patient care goals when caring for an individual with a co-occurring mental and physical health disorder.
4. Summarize behaviors observed in the acute care setting often associated with mental health and mental illness.
5. Describe how stigma or patient labeling can impact nursing care.
6. Define reflective practice and identify how it might be used to improve professional practice.

7. Define counter-transference and identify how to recognize it.
8. Identify the components of a therapeutic nurse-patient relationship.
9. Describe techniques used during active listening.
10. Define the criteria for nurse self-disclosure within a therapeutic nurse patient relationship.
11. Identify potential safety concerns when caring for patients with mental health disorders.

Introduction

Mental and substance-use disorders and illnesses seldom occur in isolation. Consequently the coordination of healthcare is essential to improved health outcomes.. Improving the quality of mental and/or substance use healthcare depends upon the effective collaboration of all mental, substance-use, general healthcare, and other human service providers in coordinating the care of their patients (IOM, 2006).

This extract is from the opening paragraph of *Improving the Quality of Healthcare for Mental and Substance-Use Conditions: Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders* (IOM, 2006). It is a report designed to address the gap between “what can” and “should be” and “what actually exists” in the care of individuals with mental health and substance abuse issues, and to identify an agenda for improving the general healthcare for these individuals.

This goal becomes more complex when individuals with mental illness experience a “physical” malady and require admission to an acute care hospital setting. The needs of patients with mental illness may challenge nurses unfamiliar with evidence-based treatment options. This course is designed to help nurses acquire and/or develop skills that will assist them in the care of mentally ill patients in the acute care setting and improve patient outcomes.

Prevalence

Mental disorders are the leading cause of disability in the United States and Canada (National Institute of Mental Health [NIMH], 2014). An estimated one in four adults, or approximately 26.2 percent of Americans ages 18 and older, suffer from a diagnosable mental disorder (NIMH, 2014).

When applied to the 2004 United States (U.S.) census results, this figure translates to 57.7 million people () (National Institute of Mental Health, 2014).

Many people suffer from more than one mental disorder at a given time. Nearly half (45 percent) of those with any mental disorder meet criteria for two or more disorders, with severity strongly related to co-morbidity.

Given these statistics, it is likely that nurses in the acute care setting will care for patients with co-occurring physical and mental health disorders.

Co-Morbidities and Identified Risk Factors

Individuals with mental illness and substance use problems are at increased risk for a substantial number of chronic general medical co-morbidities and serious chronic diseases; sometimes camouflaged as separate somatic problems including:

- Heart disease
- Asthma
- Gastrointestinal disorders
- Skin infections
- Diabetes
- Cancer
- Neurological disorders
- Acute respiratory disorders.

Lifestyle factors such as smoking, reduced personal hygiene, as well as lack of physical activity amplify the risk.

In addition, atypical antipsychotic medications used in the treatment of mental disorders increase the risk of chronic disease by promoting weight gain, obesity, hyperlipidemia, diabetes (metabolic syndrome), and gastrointestinal conditions (De Hert et al., 2011).

Co-Occurrence Substance Use Disorders & General Health Conditions

The following are descriptors of the co-occurrence of mental health illness and substance use disorders, along with other general health conditions.

Heart Attack Risk:

- One in five patients hospitalized for a heart attack suffers from major depression.
- Post heart attack depression significantly increases one's risk for death.
- Depression is a risk factor for new cardiac disease and has a detrimental impact in established cardiac disease (Pozuelo, 2009).

Depression & Anxiety:

It is not uncommon for someone with an anxiety disorder to also suffer from depression or vice versa. Nearly one-half of those diagnosed with depression are also diagnosed with an anxiety disorder. The good news is that these disorders are both treatable, separately and together (Anxiety & Depression Association of America, 2014).

Medical Conditions Associated with Mental Health Disorders:

- Comorbidity between medical and mental conditions is the rule rather than the exception. Studies have shown that more than 68 percent of adults with a mental disorder have at least one general medical disorder, and 29 percent of those with a medical disorder had a comorbid mental health condition (Druss & Walker, 2011).

Schizophrenia, Depression, & Bipolar Illness:

- A number of studies have shown that people with severe mental illness (SMI), including schizophrenia, bipolar disorder, schizoaffective disorder and major depressive disorder, have a 2-3 times higher mortality rate than the general population (De Hert et al., 2011).

Alcohol & Substance Abuse:

- Tobacco use, excessive alcohol and illicit drug consumption, lack of physical activity, and poor nutrition are responsible for much of the high rates of comorbidity, burden of illness, and early death related to chronic diseases. Persons with mental disorders are at elevated risk for each of these types of behaviors, which raises their risk of developing chronic illnesses and having poor medical outcomes once the illnesses emerge ((Druss & Walker, 2011).
- Rates of HIV infection, viral hepatitis, sexually transmitted diseases (STDs), and TB are substantially higher among persons who use drugs illicitly than among persons who do not use drugs illicitly (CDC, 2012).

Insert Reinforcement Box: Note! Co-morbid medical and mental health disorders are highly prevalent; and having one type of disorder increases the risk for developing the other type of disorder (Druss & Walker, 2011).

Factors Impeding Healthcare Services

In addition to the obvious identified risk factors, problems with access to and utilization of healthcare services often discourage individuals from seeking healthcare. This affects not only the care received, but also the timeliness of the care.

How Healthcare Providers Impede Healthcare Services	How Patients Impede Healthcare Services
Aversion	Poor treatment compliance
Poor follow up	Avoidance of providers
Lack of provider continuity	Difficulty communicating needs
Tendency to focus solely on the psychiatric, rather than physical presenting symptomology	Fear of being presented with stigmatizing comments from providers
Assume that health complaints of patients with a prior psychiatric diagnosis are psychotically rather than medically based	High pain tolerance
Failure of mental health and substance-use treatment providers to screen, assess, or address co-occurring mental or substance-use conditions or co-occurring general medical health problems	Difficulty changing lifestyle behaviors
Confidentiality and HIPAA (Health Insurance Portability and Accountability Act) laws	Lack of primary care provider

Acute Care Needs of Mental Health Patients

Impeded access to care, inadequate follow up, and a tendency to seek treatment only when the condition becomes urgent, are factors that increase the need for acute hospitalization for patients with co-morbid mental health conditions.

In addition, for individuals with co-occurring mental health and general physical disorders, patients without pre-existing mental health disorders may also become anxious, apprehensive, delirious, or psychotic due to physiological complications, medications, etc. when hospitalized.

It is not necessary to be a psychiatric nurse to care for patients with mental health needs in the acute care setting (Nadler-Moodie, 2010). Before you call the “psych” department to handle what you may consider a “difficult patient”, consider using an evidence-based approach. Reflect on how you might apply the therapeutic use of self through the development of a therapeutic relationship and therapeutic communication to ensure good patient outcomes.

The development of specialized assessment, planning, intervention, and evaluation skills could potentially improve outcomes for patients with co-morbid mental health and physical needs in the acute care setting. However, we must first address barriers to quality care, the first of which is stigmatization.

The Stigma Associated with Mental Illness

It all begins with a label. Though words are not supposed to hurt, they do.

The use of value-laden words perpetuates the stigma associated with mental illness.

Descriptors such as: “*psycho*,” “*wacko*,” “*schizo*,” “*loony tunes*,” “*crazy*,” “*he’s gone postal*,” or “*she must be off her meds*,” perpetuate the marginalization and disparate power dynamics associated with people with mental illness.

This concept, known as stigma or stigmatization, continues to generate misunderstanding, prejudice, confusion, and fear within the community and in particular, the healthcare setting.

Stigma Defined

Stigma is an attempt to label a particular group of people as less worthy of respect than others. It is a mark of shame, disgrace, or disapproval; and often results in rejection or discrimination.

The Four Behaviors of Stigma

In order to explore and examine stigma, it may help to break down into four behaviors. The four components/behaviors of stigma include:

1. Labeling someone with a condition: “*The borderline in 204 wants something for pain ... again.*”
2. Stereotyping people with that condition: “*All drunks are the same. He’ll be back within 24 hours. They all are.*”
3. Creating a division; a superior “us” group and a devalued “them” group: “*Those people are so dramatic. What could be so bad that you want to off yourself?*”
4. Discriminating against someone based on their label: “*I’m not going into that schizo’s room if I don’t have to. He’s so rude. He’ll just have to feed himself.*”

Assignment:

Explore your own thoughts and feelings in response to these typical comments and consider how these attitudes and behaviors might affect the care and safety of the patient in question.

Negative Outcomes Associated with Stigma

Stigma is often what keeps nurses and other healthcare personnel from providing the care all patients are entitled to receive.

Many individuals report that the behaviors associated with stigma are more hurtful and damaging than the illness itself. Many people are often reluctant to offer empathy and support to an individual with mental illness.

Why People Avoid Seeking Treatment

Nurses and other healthcare providers become uncomfortable and mistrustful around people with an identified mental health disorder. Yet for patients, the consequences of labeling are significant.

The Power of Stigma: Why People Do Not Seek Treatment	
Fear of being:	
	<ul style="list-style-type: none">• Labeled• Treated differently• Shamed, ignored, or ridiculed• Socially isolated

Barriers to Providing Mental Health Care

Another barrier to effective, compassionate care to consider is discerning what you believe about people with mental illness. While this process is somewhat related to reflective practice, it is singled out here to emphasize the impact our beliefs have on the care we provide patients.

Barriers to Providing Mental Health Care Assignment

Reflect on the following six statements and decide if the following statements are true or false:

1. Mental illness implies a distinction from physical illness.

2. Mental illness is not considered a legitimate medical condition.
3. Mental illness implies a weakness or laziness.
4. Mental illness suggests a moral failure.
5. Mental illness is suggestive of incompetence.
6. Mentally ill people are dangerous and unpredictable.

You would not be alone if you answered true to any of these six statements. If that is the case, reflect on your response, analyze the basis for your reaction, and evaluate how that belief may impact the care you provide to a young woman with bipolar illness in need of surgery, or an older adult with schizophrenia and acute pancreatitis.

Reflective Practice

Part of our professional practice as nurses includes the commitment to continually engage in reflective practice. Reflective practice includes *“reviewing experience from practice so that it may be described, analyzed, evaluated, and consequently, used to inform and change future practice”* (Bulman, 2004).

Reflective Practice Assignment I

Assignment
Examine your previous encounters with patients labeled as difficult or different; patients that may have had co-occurring mental health disorder.
<ul style="list-style-type: none">• How did you approach them?• What was your internal dialogue?• Were you able to provide empathetic, compassionate care to this individual?• How did you manifest that unconditional positive regard for your patient with mental illness?
Write down your responses to these questions in detail to assist you in developing your own reflective practice.

It is only when we first look to our own beliefs, values, and behaviors around the topic of mental illness that we can truly offer holistically-based services to those in our care.

Reflective Practice Assignment II

As you learn more about the biological basis for mental illness and the behaviors associated with each disorder, you will realize that many of your preconceived notions about mental illness and mentally ill people are not based on factual evidence, but rather on fear, and lack of knowledge and/or experience.

Your willingness to explore your thoughts and feelings on the subject is an essential step on the way to changing your practice and working towards providing compassionate care to all patients and their families.

The Concept of Counter-Transference

There are other potential barriers to providing compassionate, empathetic care to patients.

Not only is it incumbent on you as a nurse to continuously engage in reflective practice, it is vital that you also understand and be aware of the potential for counter-transference with your patient and their family members. Counter-transference refers to the unconscious response of the nurse to the patient. Counter-transference occurs when the nurse begins to project his or her own unresolved conflicts onto the patient.

Counter-transference is widely believed to contaminate the therapeutic relationship. For example, your patient (or an interaction with your patient) may remind you of your aunt and you begin responding to your patient, based on your relationship with your aunt.

While transference of the patient's conflicts onto the nurse is considered a healthy and normal part of the therapeutic relationship, it is the nurse's job to be aware of her own thoughts and feelings and remain neutral when interacting with the patient.

How to Recognize Counter-Transference

Has a patient really pushed your buttons, causing you to want to scream or run from the room? Counter-transference may be in play. Counter-transference may be observed in your level of involvement with the patient. It may also be detected during a hand-off by listening to the overly positive or negative descriptions of the patient.

You must recognize when counter-transference has occurred, and not allow it to inform and impede the developing nurse-patient relationship.

Recommendations for Counter-Transference

Counter-transference is a common phenomenon; however, if not recognized and managed, it can harm the therapeutic nurse-patient relationship. Guard against counter-transference by considering the following recommendations:

Awareness:

- Be aware of your physical and emotional response to patient behavior.

Negative Responses:

- Know that it is not uncommon to have “negative” responses to certain patient behaviors.

Re-defining Challenging Behavior:

- Understand the need for re-defining and/or categorizing unacceptable, frustrating, or difficult behavior.

Accept the Needs of Your Patient:

- Accept the need to discern the need your patient is attempting to meet.

Be Empathetic:

- Develop an empathetic attitude.

Seek Discussion Among Colleagues:

- Seek out your colleagues to discuss any overt response to a patient interaction. Remember, counter-transference is a normal phenomenon. Your job is to recognize it, process it with colleagues, and keep it out of patient care areas.

The Biological Context of Mental Illness (Stuart, 2009)

Like asthma, diabetes or emphysema, mental illnesses such as schizophrenia, depression, anxiety disorders and Alzheimer's disease are brain disorders, although they are classified as psychiatric disorders.

All nurses should have a working knowledge of the normal structure and function of the brain related to mental health and neuropsychiatric illness as psychiatric and neurological illness can overlap and mimic one another.

Neurotransmission is a key factor in understanding how various regions of the brain function and communicate with one another.

Understanding neurotransmission allows nurses to understand how interventions such as medications and other therapies affect the brain and in turn, affect behavior.

Abnormalities in the structure of the brain and the levels of various neurotransmitters affect the ability of the brain to communicate and may be contributing factors to neuropsychiatric disorders.

Neuroimaging techniques allow direct observation of the structure and function of the brain, assist in diagnosing brain disorders and help identify potential interventions.

Biological rhythms affect every aspect of the human body including sleep, mood, appetite, drinking, fertility, body temperature menses and lifestyle.

Psychoneuroimmunology explores the interactions among three systems; the central nervous system, the endocrine system, and the immune system, looking at the impact stress and behavior have on these interactions to determine how/when psychological and pharmacological interventions may affect these interactions.

Genetic investigations continue to demonstrate the familial and genetic factors underlying mental illness.

Personal Philosophy of Care

Again, you are asked to reflect on your own philosophy of care. Ask yourself: *“What are my beliefs about patients and families in my care?”*

Do I believe ...

- In the individual worth and needs of my patients, their families and significant others?
- That patients vary in their ability to cope with the stress of acute and chronic illness?
- That patients react to the stress of illness in their own, unique way?
- That it is important to accept the patient where they are in their recovery and treatment?
- That my focus should be about the patient rather than what I want, think, feel, or need?

These simple statements provide a starting point for you to clarify your own thoughts, feelings, and beliefs about how you view the patients in your care.

All Patients Deserve Quality Care

- **Fact:** Patient’s with mental illness also suffer with medical conditions that require admission and treatment in an acute care facility.
- **Fact:** Nurses and other healthcare providers are often “uncomfortable” and “unsure” when caring for patients with a co-occurring psychiatric disorder.
- **Fact:** Nurses can learn to care for the physical and mental health needs of patients in their care.

General Goals of Care

- Assess presenting behaviors early and frequently.
- Provide and maintain a safe environment. Remove all potentially dangerous items (Stuart, 2009).
- Intervene per plan of care using all available resources.
- Develop a follow up plan of care to prevent future difficulties.
- Utilize therapeutic communication skills while developing a therapeutic alliance with the patient.

Developing Strategies to Reduce Fear and Intimidation

Fear associated with mental illness is historically deep-rooted and largely irrational. Even in our “evolved, politically correct” society, seven out of ten people think that the cause of mental illness is personal weakness; implying blame. People who subscribe to this “weakness” theory believe if a person just puts his mind to it and works hard, he should be able to overcome the mental or emotional disorder.

Nurses are not immune to these misperceptions and often allow these unfounded concerns to affect their practice. In fearing a patient, you may engage in “avoidance” behaviors including: poor eye contact, answering the call light slowly, ignoring, or forgetting requests or spending the minimal amount of time “required” to just get the basics completed. These avoidance behaviors inhibit your ability to properly assess and react to the needs of the patients in your care.

The Tendency to Avoid

Avoidance (of a situation, person, place, or task) is often a symptom of fear, vulnerability or a knowledge deficit. Many feel that avoiding the feared stimulus will remove the need to address the problem. If you experience a feeling of fear or loathing when attempting to care for a patient, you might choose to do the minimum required of you, delegate tasks, or skip certain care all together. However, this approach, while often successful for short periods of time, is not an adaptive or productive way to provide care to people in need. Instead of avoiding, take a few minutes to reflect and determine:

- Where does this feeling come from?
- What is it based on?
- How does it impact the care I provide to my patients?
- What are the alternatives?

Acknowledge the Skills You Possess

As a nurse, you already possess the chief skills required to care for individuals with a co-occurring mental health disorder in the acute care setting. These include the ability to:

- Recognize and treat signs and symptoms associated with the potential disease process
- Commit to becoming a lifelong learner
- Apply the nursing process
- Anticipate and intervene with potential complications
- Provide compassionate, individualized care to those in need

Recognizing the Disease Process

Mental illness is a disease process often manifested in behaviors and comments that may seem out of the norm to most individuals. As a nurse, it is important for you to have knowledge of your patient's disease processes including mental health disorders. Patients with mental illness often find it difficult to get their needs met in a direct fashion and may react or respond in what appears to be an exaggerated manner.

Questions to ask:

- How do we provide care to individuals with an illness we are less familiar with?
- How do we address the needs of the patient and prioritize care without fear or judgment?
- What need is being manifested in the behavior the patient is exhibiting?

Identify the Disease Process

Each shift, nurses in the acute care setting are often faced with challenging patient care needs based on the given identified medical diagnosis and potential complications.

When confronted with a disease process or surgical intervention you are unfamiliar with, the reasonable and prudent nurse will take a few moments to look up the identified disease process to become familiar with potential signs, symptoms, patient care needs, and potential complications.

Mental illness is no different. Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning.

Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life (National Alliance for the Mentally Ill).

Mental Health Emergencies

You may associate “mental illness” solely with mental health emergencies. While it is true that you may encounter a mental health emergency, not all mental health problems are emergent in nature.

Some mental health emergencies that you may come across in the acute care setting include:

- Acute psychosis (Appendix A)
- Substance use (intoxication) and withdrawal (Appendix B)
- Suicidal behavior (Appendix C)
- Anxiety, bipolar illness, and aggression (Appendix D)

However, most situations will generally not include a true psychiatric emergency (Gilbert, 2009). Yet patients with mental illness often find it difficult to get their needs met in a direct fashion and may react or respond in what appears to be an exaggerated manner.

Assessment, Assessment, Assessment

Where do you start? The nurse starts with the nursing process which is the vehicle for applying nursing care, regardless of the nursing specialty.

The nursing process is a problem solving process that it:

- Systematic
- Cyclical
- Individualized
- Use throughout the health-illness continuum

The universal process includes:

- Assessment
- Diagnosis
- Outcome identification
- Planning
- Implementation
- Evaluation

The nursing process in the acute care setting, caring for an individual with a co-occurring medical/psychiatric diagnosis, does not abandon the nursing process. As a nurse, you will need to collect comprehensive health data that is pertinent to the patient's health or situation; including biological, psychological, sociological, behavioral, cultural, and spiritual components.

Conducting a Nursing Assessment

Completing a full history and nursing assessment will yield valuable information about the patient's current status, baseline behaviors, and needs.

A Mental Status Exam provides you with a quick summary of the patient's current psychological life and an assessment of your observations and impressions at the moment. It includes observing the patient's behaviors and describing it in an objective, non-judgmental manner. It also provides you and the physician with a baseline for future comparison (Appendix A).

Behaviors Associated with Mental Health Disorders

Unfortunately, patients with behavioral health disorders are often identified by behaviors that frequently disrupt nursing care, routines and interventions, present management difficulties, and require increased nursing resources.

Behaviors often associated with mental illness include:

- Poor impulse control
- Low frustration tolerance
- Difficulty communicating needs
- Unable to think clearly

Behaviors associated with mental health disorders often lead to challenging circumstances for medical personnel; resulting in labeling patients as difficult, different, or impossible. It is therefore necessary to not only understand the need behind the behaviors, but also develop an awareness of potential interventions including psychopharmacology, therapeutic communication, and therapeutic relationships and the role they play in the treatment of individuals with mental illness.

Presenting Signs & Symptoms

Abnormal Behaviors Associated with Schizophrenia

Below is a summary of the main presenting signs & symptoms, movements and social limitations usually seen in schitziphenic patients:

Insert Table from Appendix A here:

Alcohol Intoxification & Withdrawal

Below is a summary of the main presenting signs & symptoms of alcohol intoxication and withdrawal, and interventions to stabilize these patients:

Insert Table from Appendix B here:

Suicide Ideation

Below is a summary of the main presenting signs & symptoms often present in a patient who is contemplating suicide, and suggested interventions to prevent suicide:

Insert Table from Appendix C here:

Violence Towards Others

Below is a summary of the main presenting signs & symptoms and potential predictors of violent behavior, as well as recommended interventions:

Insert Table from Appendix D here:

Psychopharmacology

Insert table from Appendix F here

Medication Reconciliation & Collecting Collateral Information

Medication Reconciliation provides helpful information regarding the patient's medication regime including regularly scheduled medications, medication compliance, and the need for serum blood levels

Collection of collateral information from family and friends provides information about what has worked in the past, current status, and the status of support.

Non-Pharmacological Management

Development of Therapeutic Partnership/Relationship

Research suggests certain essential qualities are needed if one is to effectively help others.

Increasing self-awareness, clarification of values and beliefs, and exploration of feelings are all vital characteristics of compassionate, effective nursing care.

These qualities are necessary for all nurses if they wish to have a therapeutic impact on the patients in their care.

One of the primary tools at your disposal is the development of a therapeutic partnership or relationship with your patient. The key therapeutic device is the use of self.

Therapeutic Partnership/Relationship

The therapeutic relationship is based on:

- The humanity of the nurse and the patient
- Mutual respect
- Acceptance of differences

“The therapeutic nurse-patient relationship is a mutual learning experience and a corrective emotional experience for the patient”

(Stuart, 2009).

Nurse Self-Disclosure

In a therapeutic relationship, the nurse uses personal attitudes and clinical techniques when interacting with patients.

Therapeutic relationships are goal-oriented, patient-centered, and directed at learning, growth, healing, and good patient outcomes.

Criteria for self-disclosure includes the following:

- Model and educate
- Foster therapeutic alliance
- Validate reality
- Promote patient autonomy

(Stuart, 2009)

The literature provides significant evidence that a nurse's self-disclosure (true personal statements about the self intentionally revealed to another person) increases the likelihood of patient self-disclosure (a necessary component for a successful therapeutic outcome). However, the nurse must use self-disclosure in a mindful manner.

Self-disclosure must be appropriate, relevant, used in response to a statement made by the patient, and should have a therapeutic purpose.

Therapeutic Relationship

The nurse-patient relationship can be defined as a "helping relationship that's based on mutual trust and respect, the nurturing of faith and hope, being sensitive to self and others, and assisting with the gratification of your patient's physical, emotional, and spiritual needs through your knowledge and skill. This caring relationship develops when you and your patient come together in the moment, which results in harmony and healing" (Pullen & Mathias (2010).

The therapeutic relationship is central to all nursing practice. It may serve as the primary intervention to promote awareness, personal growth, and work through challenges in patients with mental illness. In patients with a physical issue as the primary diagnosis, the therapeutic relationship may be viewed in the background; serving as the intervention through which comfort, support, and provision of care is provided.

Regardless of the primary or co-occurring diagnoses, the therapeutic alliance is crucial to excellent patient outcomes. It is important for the nurse to establish the therapeutic relationship and begin the task of developing trust.

Core Qualities of the Therapeutic Relationship

Identified core qualities of a therapeutic relationship are:

- Trust
- Empathy
- Respect
- Authenticity
- Seeking clarity
- Active listening

Trust

The development of trust within a therapeutic relationship promotes the sharing of knowledge; giving the patient a sense of control over his/her circumstances.

"It includes being aware of the needs of the patient, attentive to those needs, and accepting and being present in the moment for them" (Hick & Bien, 2008).

Developing trust takes time, yet even brief encounters associated with the acute care setting, such as demonstrating the following examples of behavior, helps patients develop trust in the nurse.

Behaviors include:

- Introduce yourself to your patient and use her name while talking with her. A handshake at your initial meeting is often a good way to quickly establish trust and respect.
- Actively listen to your patient. Make sure you understand her concerns by restating what she has verbalized. For example, "Mrs. Smith, you mentioned that you were concerned that your bone pain won't be addressed in a timely manner?"
- Maintain eye contact. Remember, too much eye contact can be intimidating. Smile at intervals and nod your head as you and your patient engage in conversation. Speak calmly and slowly in terms that she can understand. Your voice inflection should say "I care about you."
- Maintain professional boundaries. Some patients need more therapeutic touch, such as hand-holding and hugging, than others and some patients prefer no touching. Always respect differences in cultures.

(Pullen & Mathias, 2010).

Additionally, maintaining a straightforward, non-defensive demeanor and answering any questions that the patient and/or family members have as completely as possible will help to develop a trusting relationship.

Promising to find the answers to questions in a timely fashion and letting the patient know what time you plan to complete a task (and following up with any deviations to the plan) are additional ways that the nurse can build trust in the patient.

Empathy

Empathy is the second core quality needed within the therapeutic relationship. Empathy is the ability to put oneself into another's shoes; to identify with and appreciate another's situation, feelings, and motives in order to better understand their internal experience. Many nurses confuse empathy and sympathy since the concepts both include compassion. It is important to distinguish **empathy** from **sympathy**.

Empathy implies intellectual and emotional awareness and understanding of another person's thoughts, feelings, and behaviors even though they may be distressing. Empathy emphasizes understanding.

Sympathy involves **sharing** another person's feelings, especially in sorrow or trouble through imagination identification with the other's situation. It emphasizes the sharing of another person's feelings and experiences.

Simply put ...

- **Empathy** is the act of listening and understanding someone's feelings without getting involved.
- **Sympathy** is the act of reacting when someone expresses emotions.

Empathy in Practice

Reading about “empathic listening” and actually engaging in empathic communication are quite different processes. Think about the following examples using empathic communication techniques and determine:

a) *If and when you have ever used empathy.*

b) *When you might use empathy in the future.*

- When talking with your patient, you pause to imagine how the patient might be feeling.
- When listening to your patient, you notice the presence of strong feelings or feeling tone (fear, anger, grief, disappointment) during the conversation.
- Taking the time to state your perception of the patient’s feelings: *“It sounds like you feel hurt that your son has not come to visit you.”*
- Making a comment to legitimize the patient’s feelings: *“You know, a lot of people feel afraid right before surgery.”*
- Respect the patient’s effort to cope with the predicament: *“I really appreciate your patience with this process. Sometimes, waiting is the hardest part.”*
- Offering support and partnership: *“Let’s see what we can do together to finish this treatment. I really need your help.”*

Respect

Treating people with respect and dignity is a basic tenant of compassionate caring and is listed as one of the ten rights in the 1997 Consumer Bill of Rights and Responsibilities, more commonly known as the Patient's Bill of Rights. What does it mean for a nurse to "be respectful" of a patient?

To demonstrate respect is to show esteem, regard, or honor to another person, both verbally and non-verbally (Substance Abuse and Mental Health Service Association [SAMHSA], nd). To be respectful is to be non-intrusive and humble. Respect is manifested in ways that reinforce a patient's dignity.

Respectful behaviors include:

- Using a patient's last name (unless they invite you to call them by their first name).
- Asking permission before conducting an assessment or examination.
- Making eye contact (culture specific).
- Speaking directly to the patient and/or family members.
- Answering questions accurately and promptly.
- Explaining what you are doing and why.
- Providing privacy whenever possible (e.g., closing doors or curtains when rounding).
- Asking the patient what they would like to do first, or how they prefer to have something done.
- Valuing family members as they are often the most important component of a patient's life.

Authenticity

You cannot respect a patient unless you are authentic.

The word authentic comes from the Greek word: **authentēs**: one who acts independently, **auto**: acting from within, and **hentes**: a doer.

“To be authentic, you must be aware of your own vulnerability, recognize yourself in others, and be willing to enter into mutual vulnerability. If you deny the opportunity to be vulnerable, you deny the opportunity to participate in humanness and are more likely to dehumanize others” (Daniel, 2007).

What it Means to Be Authentic

The concept of authenticity is somewhat overworked, yet underutilized. It can assist you in the development of a partnership or relationship with the patient that is patient-centered, rather than other/authority-centered.

To be authentic is to be:

- Genuine and sincere
- Truthful
- Trustworthy in intentions and commitments
- Compassionate
- Honest and to accurately represent the facts

Authenticity is characterized by realness, openness, respect, and empathetic understanding. Authenticity builds trust and elevates the quality of relationships.

It promotes cooperation in striving for a common goal; the health and wellness of the patient, as well as the uncompromised authority of the patient.

Caution!

Authenticity requires the maintenance of clear, distinct boundaries on the part of the nurse; keeping personal issues and patient issues separate. Being authentic must always remain patient-centered. While the nurse indeed has a role to play, the role does not require him/her to hide behind professional boundaries, but should rather fully engage in a therapeutic alliance.

Seeking Clarity

An interrelated component needed in the development of a therapeutic relationship includes the desire to seek clarity.

In seeking clarity you attempt to understand the patient's experience by considering the patient's perspective. When seeking clarity, you employ the use of unconditional, positive regard to build rapport and develop trust within the therapeutic relationship.

Seeking clarity is not about making assumptions or inferences as they may prove to be inaccurate. It does include the desire to gain an understanding of the experience from the patient when you are not certain. To do so, you must truly be "present." For example, you might say to the patient: "Let me see if I have this correct." This assists the patient in exploring their internal process more deeply. It also lets the patient know you truly want to understand what they are saying and determine what their needs are.

Therapeutic Communication

Therapeutic communication is a fundamental aspect of a therapeutic relationship. There are several techniques that the nurse can use to develop a therapeutic alliance with the patient such as:

- Active listening
- Authenticity
- Presence
- Respect

Therapeutic communication is communication designed to increase the self-worth of the patient while decreasing psychological distress. It implies the use of unconditional, positive regard for the patient and is performed in a caring, concerned, and empathetic manner.

Active listening is only one technique associated with therapeutic communication.

What is Therapeutic Communication?

Therapeutic communication is a process that emphasizes focused, non-judgmental interactions, allowing the individual to feel safe. It is a procedure in which the nurse consciously influences a patient or helps the client to a better understanding through verbal or nonverbal communication.

Therapeutic communication involves the use of specific strategies that encourage the patient to express feelings and ideas that convey acceptance and respect.

Illness is often fraught with setbacks, failure, loss, misery, and pain. This is true whether or not mental illness is present. As a nurse, you possess an extremely valuable tool to assist the patient in sorting through the myriad of thoughts and feelings he/she may be experiencing.

Therapeutic vs. Social Communication

An individual in an acute care setting, whether or not they also have a mental illness, has the need to process information, thoughts and feelings. However, this may be more challenging for an individual with mental illness as he may be unable to directly communicate his needs. It is incumbent on the nurse to actively initiate a therapeutic alliance using therapeutic communication.

Therapeutic communication is different from social communication as it is:

- Focused on others
- About listening rather than talking
- About encouraging the expression of thoughts and feelings

Goals of Therapeutic Communication

The goals of therapeutic communication include the deliberate use of verbal interaction to:

- Encourage self-disclosure
- Increase feelings of self-worth
- Promote increased understanding
- Encourage problem solving
- Facilitate decision making

Suggestions for Using Therapeutic Communication

When engaging in therapeutic communication, consider the following suggestions:

- Acknowledge what the patient says and how they feel, even if you don't agree.
- Paraphrase; *"If I understand you correctly, you are fearful of the outcome ... Is that what you're saying?"*
- Use short sentences and avoid long or complicated messages (rule of five: words with five or six letters in sentences five or six words long).
- Avoid arguing with the patient; especially with a patient exhibiting psychotic symptoms. For example: *"I know you believe you see spiders on the wall, but I don't see them."*

Implementation of Therapeutic Communication

- Engage the patient in the problem solving process by asking for opinions and suggestions.
- Observe incongruent messages between verbal and non-verbal messages.

- Focus on observable facts; things that can be seen, heard, felt, etc. "*You say you have trouble concentrating on what the doctor says if you take your medication before your doctor comes to see you.*"
- Use humor when appropriate to lighten the mood.
- A touch on the shoulder can be comforting to some, but anxiety-provoking to others. Know your patient and their needs.

Active Listening

Active listening is a fundamental therapeutic communication tool you can use to explore internal thoughts and feelings while building a therapeutic relationship with the patients in your care.

Active listening includes a structured method of listening and responding to patients.

Attention is focused on the patient while the nurse suspends his/her own frame of reference and judgment (maintaining clear boundaries).

Active listening is all about building rapport, understanding, and trust. It includes observing the patient's body language and behavior to provide clues to the patient's internal dialogue.

Active listening can be used in all patient interactions.

Special Note:

Be sure to use open-ended, leading, and reflective questions to expand the discussion and encourage exploration (Appendix G).

Non-Therapeutic Communication

Nurses and healthcare personnel, in their attempt to finish the myriad of tasks, treatments, and documentation for patients in their care, often become hurried, frustrated, angry, and even anxious. Add to these challenges a patient who is unable to directly communicate their needs and you have the potential for maladaptive responses by nurses.

While therapeutic communication promotes therapeutic relationships, non-therapeutic communication hinders potential relationships with patients and is not recommended.

Non-Therapeutic Communication	
Passing judgment	Sounding patronizing or sounding condescending
Starting a conversation with a confrontation	Approaching a patient with your defenses up
Taking comments personally	Using sarcasm
Offering personal advice	Prying
Generalizing	Making assumptions
Offering false reassurance	Asking why
Attempting to intimidate or discipline the patient using your "authority"	Stereotyping
Criticizing, accusing, or blaming	Changing the subject inappropriately
Showing approval or disapproval	Ignoring or avoiding

(Morse, Bottoroff, Anderson, O'Brien, & Solberg, 2006)

Types of Common Non-Therapeutic Responses

Common responses include:

- **Judgment:** *"That patient is so difficult. Let psych handle them."*
- **Anger:** *"I don't have to put up with that rude woman. She is so negative and demanding."*
- **Fear:** *"That guy is crazy. I am afraid he might hurt me."*

- **Ignorance:** *“No one is pouring the alcohol down his throat. He just needs to stop drinking.”*

Analyzing Maladaptive Responses

Critically analyzing the situation opens you up to new possibilities and improved patient outcomes. Hence, the need for self-analysis and self-awareness is a key part of the nursing experience.

Critical analysis involves the following skills:

- Identifying existing knowledge relevant to the situation
- Exploring personal feelings about the situation and the influence of these feelings on behavior
- Identifying and challenging any assumptions you may already have
- Imagining and exploring alternative course(s) of actions

Reframing Maladaptive Responses

If you find yourself becoming easily angered, frustrated or fearful of a patient, or if the outcome of a conversation/task was not what you expected, take a few minutes to stand back and reflect on the experience.

As stated previously, this process helps you to develop and learn from your practice. You may need to take time after your shift to write about the situation or ask a supervisor or colleague to process the event with you.

Words of Wisdom in Caring for Mentally Ill Individuals

In caring for patients with mental health issues, it is best for the nurse to remember the following “words of wisdom” in developing a therapeutic relationship:

- Be curious
- Embrace challenge
- Seek out creative alternative interventions
- Recognize the obvious
- Celebrate diversity
- Forgive
- Set boundaries

- Inspire hope

Infusing Recovery into Care of Mentally Ill Patients

The Institute of Medicine (2007) recommends the following actions to promote recovery and well-being in caring for all patients, but in particular those patients with mental health concerns:

- Provide care based on continuous healing relationships.
- Provide customization based on patient needs and values.
- See the patient as a source of control.
- Collaboration means sharing knowledge and the free flow of information.
- Continue to focus on cultural values.
- Use evidence based decision making.
- Promote cooperation among clinicians.
- Recognize the need for transparency.
- Anticipate and meet the needs of the patient.

Lifelong Learning

Learning about mental health and mental illness will serve to demystify common misperceptions you may have about individuals with psychiatric illnesses; removing the fear, vulnerability, and helplessness you may experience.

For example, exploring the role medication plays in the care of mentally ill (i.e., mechanism of action) will assist you in making informed decisions about the needs of your patient. It will also allow you to work with your patient to discover strategies to support them in the foreign, sometimes hostile environment of the acute care hospital.

Remember these patients are your neighbors, friends, teachers, mothers, sisters, husbands, and sons.

Conclusion

All nurses have an obligation to patients, their families and themselves to:

- Explore their beliefs regarding mental illness.
- Guard against allowing stigma to guide their practice.
- Learn about mental illness and substance use disorders.
- Develop and facilitate a therapeutic relationship/partnership.
- Engage in therapeutic communication while guarding against non-therapeutic communication.

Appendix A: Abnormal Behaviors Associated with Schizophrenia (Move to Pg. 25)

Behaviors	Movements	Socialization Inability to form cooperative and interdependent relationship with others	
		Direct	Indirect
Deterioration in appearance (dirty clothes, sloppy, unkempt appearance)	Catatonia (waxy flexibility, posturing); may require complete nursing care	Inability to communicate coherently	Low self-esteem resulting in social isolation
Poor or absent grooming	Abnormal gait (intentional stepping, staggering, walking on toes)	Loss of drive or interest	Inappropriate sexual behavior (public masturbation, inappropriate sexual advances)
Lack of personal hygiene	Facial grimacing (these are not caused by psychotropic meds and are not in the patient's control)	Deterioration of social skills	Stigma related withdrawal of friends, family members, peers
Avolition (lack of energy and drive)	Apraxia (difficulty carrying out purposeful, organized tasks, such as dressing themselves)	Poor personal hygiene	Social inappropriateness related to cognitive deficits: Loud evangelical praying, toileting in public, standing in the street trying to direct traffic, running naked in the street, dressing bizarrely, engaging in intimate conversations with strangers

Appendix A: Abnormal Behaviors Associated with Schizophrenia (cont.)

Behaviors	Movements	Socialization Inability to form cooperative and interdependent relationship with others	
		Direct	Indirect
Difficulty performing routine tasks (may need to repeat request several times)	Echopraxia (purposeless imitation of movements made by other people)	Paranoia	Social inappropriateness related to cognitive deficits: Loud evangelical praying, toileting in public, standing in the street trying to direct traffic, running naked in the street, dressing bizarrely, engaging in intimate conversations with strangers
Repetitive or stereotypical behaviors (needing to eat foods a certain way, taking three steps forward and one back, etc.)	Abnormal eye movements (difficulty following a moving target, poor eye contact, rapid eye blinking, frequent staring)		
Agitation (especially when they feel the need to perform or when attempting a task that was previously easy for them to accomplish)	Abnormal mannerisms (stopping mid-sentence to twirl fingers, looking back over the shoulder)		

Appendix B: Alcohol Intoxication and Withdrawal (Move to pg 25)

Alcohol withdrawal is common in the acute care setting. Many times, patients have not disclosed the extent of their substance use and abuse or have not been completely honest. Withdrawal symptoms may not occur for 24-72 hours after their last drink. This may come as a surprise to the nurse providing care.

Signs and Symptoms		Interventions (Rapid Stabilization)
Hypertension	Tachycardia	Monitor withdrawal symptoms using the CIWA-AR (Clinical Institute Withdrawal Assessment, Alcohol Revised) every 4 hours. Easy to administer and score.
Fever	Hand tremors	Benzodiazepines routinely given every 4-6 hours.
Nausea and vomiting	Diarrhea	Symptomatic care for nausea, vomiting, diarrhea, and elevated blood pressure.
Headache	Tonic-clonic seizures	Assess blood alcohol level.
Transient visual, tactile and auditory hallucinations	Insomnia	General nursing care: Vital signs every 4 hours, safe, quiet, non-stimulating environment, support, reassurance, education, promote good hygiene, and adequate food and fluid intake.
Delirium tremors: <ul style="list-style-type: none"> • Disorientation • Delusions • Severe agitation • Sweating • Fever Mortality is 5%-30%	Sever perspiration	Thiamine: Giving this nutrient to patients with Wernicke's Encephalopathy (WE) or Korsakoff's Psychosis to reverse many of the acute symptoms of the disease. Thiamine deficiency is most commonly caused by alcoholism (Raga et al., 1999) in developed countries. It is a common cause of Wernicke's encephalopathy (a life threatening neurological disorder) and Korsakoff's psychosis (a chronic neuropsychiatric syndrome characterized by behavioral abnormalities and memory impairments) (Victor et al., 1989). Although these patients have problems remembering old information (retrograde amnesia), it is the disturbance in acquisition

		of new information (anterograde amnesia) that is most striking (Singleton and Martin, 2001). Symptoms include mental confusion, paralysis of the nerves that move the eyes (oculomotor disturbances), and an impaired ability to coordinate movements, particularly of the lower extremities (i.e., ataxia).
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Appendix C: Suicide Ideation (Move to pg 25)

Threatening Violence Towards Self: Suicide Ideation	
<p>Being admitted to an acute care facility after a suicide attempt such as an overdose, hanging, or nonfatal gunshot wound and not medically stabilized in the emergency room. Patients must be assessed frequently as the desire to harm him/her self does not necessarily go away after an attempt. Patients may also verbalize suicidal thoughts or exhibit suicidal behaviors. One of the 2014 National Patient Safety Goals is to identify patients that may become suicidal; not only patients with a psychiatric history. It is therefore imperative that the nurse consider the potential for violence toward self if the patient verbalized the desire to harm self, or if their behavior changes.</p>	
Signs and Symptoms	Interventions
Verbalizing suicidal ideation with plan and intent to die	Assess for suicidal ideation and level of lethality (appraisal of stressors, history of psychiatric illness, psychosocial history, personality factors, family history, coping resources, recent losses, diagnostic history, alcoholism, chronic illness, mood disorders, psychosis, plan, and access.
Change in behavior (i.e., suddenly has energy, smiling, etc.)	Assess patient’s medical stability.
Giving away belongings	<p>Provide a safe environment: Search belongings in their room and remove items that the patient may use to harm him/her self. Acute care units pose a danger to patient’s expressing suicidal thoughts.</p> <p>Patients may use sheets, towels, bedclothes, or tubing to hang themselves. Patients may save medication and take a large dose at one time. Sharp items can also prove to be dangerous: Utensils, suture removal kits, pens, matches, lighters, aerosol spray cans, plastic bags, etc.</p>
Feelings of hopelessness and helplessness; failure and unworthiness	Provide 1:1 care for patients verbalizing active suicidal ideation with plan. Keep at arm’s length, even when in the bathroom. Restrict to the hallway and room.

Agitation and restlessness	Develop a therapeutic alliance using therapeutic communication techniques. Communicate caring, concern, and support.
Sleep disturbances	Administer PRN medication to reduce anxiety and agitation.
While it is out of the scope of this course to provide evidence-based guidelines for the care of the patient who is experiencing suicidal ideation in an acute care setting, it is important to introduce you to the topic and encourage you to learn more about the subject in the future.	

Appendix D: Violence Towards Others (Move to pg 25)

<p><i>“High rates of assaultive behavior have been reported in a variety of healthcare settings” (Stuart, 2009). It is important to remember that patients entering the healthcare system are often in great distress and may exhibit maladaptive coping responses. Violence can be a response to fear, and anger may result. Violence does not generally occur in isolation.</i></p>	
<p>Behavioral Signs, Symptoms, and Potential Predictors</p> <p>Most patients will exhibit behaviors that may indicate increasing inner turmoil/agitation, such as motor agitation, verbal outbursts, angry, hostile, anxious, irritable affect, changes in level of consciousness (Stuart, 2009).</p>	<p>Interventions</p> <p>The number one priority for the patient, staff, and family members is safety.</p>
<p>Predictors</p> <ul style="list-style-type: none"> • Active psychosis • Substance use disorders • History of violence • Situational or environmental factors • Perceived level of stress (cognitive, environmental, communication) 	<p>Employ the Nursing Process</p> <p>Conduct a full assessment with history and determine what has helped the patient in the past.</p> <p>Identify triggers: Something that sets off an action, process, or series of events such as fear, panic, upset, and agitation. Potential triggers: Change in routine, a phone call, touching, visitors, privacy, independence, boredom, fatigue, frustration, change in physical status, fear, confusion, pain, and environmental changes (new primary caregiver, different visitors, change in routine.)</p> <p>Elicit the cooperation and assistance of the patient and family.</p>
<p>Motor Agitation</p>	<p>Partnership and Collaboration</p>

<ul style="list-style-type: none"> • Pacing • Increase respirations • Inability to sit still • Sudden cessation of motor activity • Clenching fists • Pounding fists • Jaw tension • Rocking 	<ul style="list-style-type: none"> • Use a team approach • Do not isolate yourself with the patient • Always have an escape route • Develop a personal safety plan
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Appendix D: Violence Towards Others (cont.)

Violence Towards Others	
<p>Verbal</p> <ul style="list-style-type: none"> • Verbal threats • Swearing • Verbal demands • Loud speech • Pressured speech • Delusional verbalizations • Paranoid comments 	<p>Ensure all staff members receive specialized training (i.e., Crisis Prevention Institute, Pro-Act) and employ the policy and procedures as identified by your facility. Ensure they learn about the assault cycle and interventions for each phase of the cycle.</p>
<p>Affect</p> <ul style="list-style-type: none"> • Angry • Hostile • Anxious • Irritable • Labile • Inappropriate • Euphoric 	<p>Medication to assist patient in reducing the level of agitation and regaining self control.</p> <p>Meds might include lorazepam (Ativan) and haloperidol (Haldol), resperidone (Risperdal), olanzapine (Zyprexa), and zipasidone (Geodone).</p>
<p>Level of Consciousness</p> <ul style="list-style-type: none"> • Sudden change in mental status • Confusion • Disorientation • Inability to focus • Disorganized 	<p>Offer opportunities to self-soothe including music, show, a call to a family member or friend, holding an item of comfort, journal entry, prayer, meditation, or talking with clergy.</p> <p>Remove dangerous items from the environment.</p>

<ul style="list-style-type: none"> • Memory impairment 	<p>Employ de-escalate techniques and crisis intervention procedures, including calm room.</p> <p>Physical (mechanical) restraints for patients posing immediate threat to others.</p>
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Appendix A: Mental Health Exam

Mental Health Exam (Stuart, 2009)
<p style="text-align: center;"><u>General Description</u></p> <p>Appearance and physical characteristics Speech: Rate, volume, amount, and characteristics Motor Activity: Level of activity, type of activity, or unusual gait Interaction with Interviewer: Cooperative, hostile, guarded, defensive, suspicious, or seductive</p>
<p style="text-align: center;"><u>Emotional State</u></p> <p>Mood: A patient’s self report of the prevailing emotional state. Affect: Patient’s apparent emotional state (range, duration, intensity, appropriateness).</p>
<p style="text-align: center;"><u>Experiences</u></p> <p>Perceptions: Hallucinations (false sensory impressions or experiences) and illusions (false perceptions or false response to sensory stimulus)</p>
<p style="text-align: center;"><u>Thinking</u></p> <p>Thought Content (the what of the patient’s thinking): Delusions, ideas of reference, phobia, or thought broadcasting. Thought Process (the how of a patient’s self expression, observed through the patient’s speech): Circumstantial, flight of ideas, loose associations, tangential, or word salad.</p>
<p style="text-align: center;"><u>Sensorium and Cognition</u></p> <p>Level of Consciousness: Confused, sedated, stuporous, time, place, or person. Memory: Remote, recent, or immediate. Concentration and Calculations: Simple calculations, serial 7’s (100-7, etc.), or serial 3’s (20-3). Intelligence: Take a broad approach and identify intellectual strengths and abilities. Give a proverb and ask patient to interpret its meanings. Judgment: Making decisions that are constructive and adaptive. Insight: The patient’s understanding of the nature of one’s illness or problems.</p>

Appendix F: Psychopharmacology Move to Pg 26.

Psychopharmacology plays a significant role in the care and treatment of people with mental illness by reducing debilitating symptoms, providing sedation, and enhancing focus. The role of the nurse includes: a) patient assessment, b) coordination of treatment modalities, c) monitoring of medication effects, d) patient education, and e) development of medication maintenance program.

1. Complete and review the Reconciliation of Medication Across the Continuum of Care (ROMACC) on admission to determine current medication regime, medication compliance, medication history, etc.

2. Ensure the continuation of psychotropic medications:

- Abrupt withdrawal of SSRI's (Selective Serotonin Reuptake Inhibitors) can cause discontinuation syndrome characterized by flu-like symptoms, agitation, impaired concentration, vivid dreams, depersonalization, irritability, and suicidal thoughts (Warner, Bobo, Warner, Reid, Rachal, 2006).
- Abrupt withdrawal of benzodiazepines may replace patient in benzodiazepine withdrawal syndrome. Symptoms may include: Lack of concentration, amnesia, short-term memory impairment, speech difficulties, labile blood pressure, palpitations, aggressive behavior, agitation, hyperactivity, hysterical or inappropriate laughter, irrational rage, irritability, obsessive behavior, abdominal pains, cramps, diarrhea, bloating, constipation, cramping, dry throat, dyspepsia, usually sensitive, delirium, confusion, psychosis, disorientation, hallucinations (auditory, tactile, visual), dysphoria, excitability, paranoia, depression, suicidal thoughts, negative thinking, hopelessness, sleep disturbance, flashbacks, impaired memory, etc.

3. Be aware of the potential for serotonin syndrome with specific medication combinations (serotonergic drugs) including SSRI's, St. John's wort, SNRI's, MAOI, tryptophan, dextromethorphan. Must allow a five to six week washout period when moving from an SSRI to MAOI.

Signs and symptoms include:

- Change in mental status, agitation, confusion, restlessness, flushing
- Diaphoresis, diarrhea, lethargy
- Myoclonus, tremors
- If not discontinued, signs and symptoms may progress to hypertension, rigor, acidosis, respiratory failure, rhabdomyolysis

4. Know the therapeutic plasma levels of specific medications and request frequent serum drug levels.

Lithium:

- 1 – 1.5 mEq/L (acute mania)
- 0.6 – 1.2 mEq/L (maintenance)
- Toxic: >2 mEq/L
- Draw in the a.m. about 12 hours after last oral dose or before first a.m. dose
- Initially check every 1-2 weeks x 2 mos., then every 6 mos.
- Renal function Q6 mos.

Valporic Acid:

- 50 – 100 µg/mL
- Serum levels every 1-2 weeks, CBA and LFT every month

Carbamazepine

- 4 – 12 µg/mL
- Toxic >15 µg/mL
- Serum levels every 1-2 weeks, CBC and LFT every month

Appendix F: Psychopharmacology

5. Know the signs, symptoms, and treatment options for neuroleptic malignant syndrome (a serious and potentially fatal syndrome caused by antipsychotic medications and other medications that block dopamine receptors). Do not allow patient to become dehydrated when taking antipsychotic medications.

Signs and symptoms include:

- Fever: 103° - 105° F or greater
- Blood pressure lability
- Tachycardia: >130 bpm
- Tachypnea: >25 rpm
- Agitation
- Diaphoresis, pallor
- Muscle rigidity
- Change in mental status (stupor – coma)

Treatment:

Stop antipsychotics immediately. Request lab test: Creatinine kinase to determine injury to the muscle and CBC to determine if WBC is dramatically elevated. Supportive treatment including: Hydration cooling measures, bromocriptine, dantrolene, and lorazepam.

6. Be aware of the potential for extrapyramidal symptoms (EPS) with typical and atypical antipsychotic medications (and anti-emetic medications). EPS are generally placed in three categories:
- Dyskinesias: Movement disorders that can include repetitive, involuntary, and purposeless body and facial movement including: tongue thrusts, lip smacking, finger movements (pill rolling), eye blinking, and movements of the arms and legs.
 - Dystonias: Muscle tension disorders involving very severe, uncontrollable, and painful muscle contractions involving unusual twisting of various parts of the body, especially the neck. These include:

oculogyric crisis (upwards and outward deviation due to spasm of the eyes), torticollis (head held turned to one side), opisthotonus (painful forced extension of the neck and back), and macroglossia (tongue protrudes and feels swollen).

- Akathisia: Is an extreme form of internal/external restlessness and may include an inability to sit still or an undeniable urge to be constantly moving. It may also include an inner feeling of jitteriness or shakiness. It is extremely debilitating.

Treatment:

Administration of anticholinergic medication such as benztropine (Cogentin) or diphenhydramine (Benadryl) is generally extremely effective in reducing or eliminating EPS. Consider requesting regular order for Cogentin if patient remains on the antipsychotic medication.

Appendix F: Psychopharmacology

7. Be aware of Clozaril Patient Management System (Protocol). Clozaril is an antipsychotic medication indicated for the use of patients with a diagnosis of schizophrenia, unresponsive and intolerant to three different neuroleptics from at least two different therapeutic groups when given adequate doses for an adequate duration. Clozaril is a federally monitored medication due to the life threatening potential for agranulocytosis and leucopenia. Therefore, the following protocols must be applied:
 - Monitor WBC's, absolute neutrophil count (ANC) and differential before initiating therapy and after weekly for the first six months then biweekly, then weekly for one month after discontinuation.
 - Only one week supply available as it requires WBC, patient monitoring, and controlled distribution.
 - If WBC $<3000\text{mm}^3$ or granulocyte count $<15000\text{mm}^3$ withhold clozapine and monitor for s/s of infection.
 - Patient must be registered with the Clozarol National Registry: www.clozaril.com.

Appendix B: Active Listening

Active listening is a way of listening and responding to another person that improves mutual understanding.		
Therapeutic Communication Techniques		
<u>Technique</u>	<u>Explanation</u>	<u>Example</u>
Restating	Paraphrasing what you think the patient said	<i>"Let's see if I am clear on what you are saying ... "</i>
Summarizing	Bringing together (summarizing) the thoughts and feelings the patient is expressing.	<i>"So it sounds like what you are experiencing ... "</i>
Reflecting	Reflect (echo) the feeling tone the patient is expressing.	<i>"It really sounds like that affects you."</i>
Giving Feedback	Sharing thoughts, information, and insight. It is important to check for accuracy with the patient.	<i>"It seems like you have considered the pros and the cons of the situation ... "</i>
Probing	Ask questions to seek more meaningful information.	<i>"What do you think would happen in you ... "</i>

Validation	Acknowledge the patient's feelings while listening with empathy and openness.	<i>"I appreciate your willingness to share this painful information."</i>
Silence	Give the patient time to think. It slows down the exchange.	
Redirecting	Shift the discussion to another topic, especially if the patient is becoming anxious or agitated.	<i>"I notice you seem to be experiencing some strong feelings about this topic. Why don't we spend some time focusing on ... "</i>

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