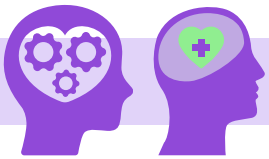

Mental Health Study Guide

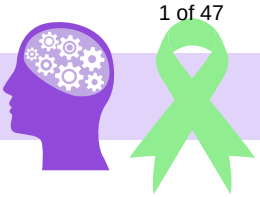

Table of Contents

Mental Health and Mental Illness

Mental Health

- State of well-being:
  - Realize his/her potential
  - Cope with normal stressors of life
  - Work productively
  - Make contribution to the community

Mental Illness

- All psychiatric disorders that have definable diagnoses
- May be seen as dysfunction in developmental, biological, psychological functioning
- The ability to think, emotions and behavior may all be affected

Mental Health - Mental Illness Continuum

Health		Illness
Well-being • Occasional stress or mild distress • No impairment	Emotional Problems • Mild to moderate distress • Mild or temporary impairment	Mental Illness • Marked distress • Moderate to disabling or chronic impairment

- Mental Health and well-being affected by:
  - Individual attributes and behaviors
    - Inborn and learned
    - Biological (e.g. prenatal exposure to alcohol)
    - Genetic *HUGE predictor of mental health*
  - Social and economic circumstances
    - Family sets stage in promoting confidence and coping skills OR opposite - instilling anxiety and feelings of inadequacy
    - Schools and peer groups - can be positive or negative
  - Environmental factors
    - Access to basic needs and commodities
    - Social and economic policies (e.g. insurance coverage)
    - Cultural norms (acceptance varies between cultures)

Poor physical health can lead to mental distress & Poor mental health can lead to physical problems

Diathesis-stress model

- Most accepted explanation for mental illness
- Diathesis - biological predisposition
- Stress - environmental stress or trauma
- Nature PLUS nurture
- Genetic vulnerability + negative environmental stress

- Resilience - the ability to secure the resources needed for well-being; able to regulate emotions and control negative thoughts
- Stigma - belief that the overall person is flawed and is socially shunned, disgraced, shamed
- Recovery - process of change; improve health and wellness; live a self-directed life; strive to reach full potential

Diagnostic and Statistical Manual (DSM)

- Developed by the American Psychiatric Association
- Dominant method of categorizing and diagnosing mental illness in the U. S.
- Identifies disorders based on specific criteria
- Classifies disorders, not people

Nursing Standardized Classification Systems

- DSM - 5
- NANDA - I
- Nursing Outcomes Classification (NOC)
- Nursing Interventions Classification (NIC)

Psychotropic Drugs, cont.

Drug Treatment for ADHD

Psychostimulants

- methylphenidate (Ritalin, Daytrana)
- dextroamphetamine (Adderall, Vyvanse)

- Mainstay of treatment for ADHD

T. Class = CNS Stimulants

Method of Action:
- Block reuptake of norepinephrine and dopamine

Indications:
- ADHD; narcolepsy

Contraindications:
- CVD; HTN (moderate to severe)
- Hyperthyroidism
- Within 14 days of stopping MAOI
- Glaucoma

Adverse effects:
- Headache, insomnia, agitation, seizures
- Palpitations, arrhythmias
- Dry mouth, N/V, wt loss, growth suppression

Interactions:
- Antacids; MAOIs; thiazides
- Caffeine; alcohol; ephedra

Black Box Warning High potential for abuse

Nonstimulants

- atomoxetine (Strattera) (T. Class = ADHD drugs)
- guanfacine (Intuniv) (T. Class = Antihypertensives)
- clonidine (Kapvay) (T. Class = Antihypertensives)

Method of Action:
- Norepinephrine reuptake inhibitor or alpha-2 adrenergic agonist

Indications:
- ADHD

Contraindications:
- Heart problems; recent MI; HTN; tachycardia
- Within 14 days of stopping MAOI

Adverse effects:
- ↓ appetite, fatigue, dizziness
- Bradycardia, severe rebound HTN, N/V

Interactions:
- Albuterol; MAOIs; many antidepressants
- Beta blockers; Ma huang; capsicum

Considerations / Patient Education

- Stimulants:
  - Instruct to give last dose 4-6 hrs before bedtime
  - Monitor children for continued physical growth and aggressive behavior
  - Monitor blood pressure
- Nonstimulants:
  - Instruct to report: SOB, chest pain
  - Monitor BP and pulse
  - Do not stop abruptly (to avoid severe rebound HTN)

Antipsychotic Drugs

- First-Generation Antipsychotics
- Second-Generation Antipsychotics

Black Box Warning Older adults with dementia: ↑ risk of death

First-Generation Antipsychotics (FGAs)

T. Class = Antipsychotics

- AKA 'Conventional' 'Typical'
- Not used as much as SGAs due to negative side effects; however cheaper than SGAs and do not cause metabolic syndrome

Method of Action:
- Block dopamine receptors

Indications:
- Delusions and hallucinations of schizophrenia

Contraindications/Interactions: See SGAs

Adverse effects:
- Many, including anticholinergic side effects (see next page); Extrapyramidal Symptoms (EPS): acute dystonic reactions, parkinsonism, akathisia, tardive dyskinesia; must monitor for involuntary movements after administering

- chloropromazine (Thorazine)
- fluphenazine (generic)
- perphenazine (generic)
- prochlorperazine (Compazine)
- trifluoperazine (generic)
- thioridazine (generic)
- thiothixene (Navane)
- haloperidol (Haldol)
- pimozide (Orap)

Anxiety and Obsessive-Compulsive Disorders, cont.

Anxiety Disorders, cont.

Selective mutism - child does not speak due to fears of negative responses or evaluations; speaks at home and around family but nowhere else

Agoraphobia

- Excessive anxiety over being in a place where escape may be difficult or embarrassing
- Avoids those places or does not go there alone
- e.g. Being home alone, riding alone in a car, bus, etc.

Generalized Anxiety Disorder

- Main symptom is excessive worry of things such as job responsibilities, finances, health of family, etc.
- Prepares immensely, puts things off, avoids, seeks continual reassurance, sleep disturbances

Obsessive-Compulsive Disorders

- Disorders that have obsessive-compulsive characteristics
- Obsessions - thoughts, impulses or images that persist, recur and cannot be dismissed
- Compulsions - ritualistic behaviors; driven to perform to ↓ anxiety or prevent calamity; temporarily relieves anxiety

- Obsessive-Compulsive Disorder
- Trichotillomania
- Body Dysmorphic Disorder
- Hoarding Disorder
- Excoriation Disorder

Obsessive-Compulsive Disorder

- Symptoms occur on a daily basis and cause marked distress, humiliation, shame
- Rituals are time-consuming and interfere w/normal routines; performance of cognitive tasks impaired
- E.g. hand-washing, counting, repeating words

Trichotillomania

- AKA hair pulling disorder
- Pulling hair off body
- Trichophagia - swallowing the hair (may be fatal if obstructs abdomen)

Body Dysmorphic Disorder

- Preoccupied with imagined defective body part
- Leads to obsessional thinking and camouflaging
- Leads to disgust/shame/depression
- High suicide risk
- Often comes from home w/abuse and neglect

Hoarding Disorder

- Accumulation of belongings with little to no value; fills every surface space; home nearly inhabitable; unsanitary/unsafe
- Often very indecisive

Excoriation Disorder

- AKA skin picking disorder
- Usually on face
- To deal with stress and to relieve anxiety
- Leads to painful sores, scars, infections

Risk Factors

- Genetics
- Neurobiological - possibly related to neurotransmitters
- Psychological:
  - Freud: repressed emotions breaking through
  - Behavioral: Learned response (classical conditioning) or modeling of parents
  - Cognitive: distortions in thoughts/perceptions

Assessment

- Must rule out another psychiatric disorder, medical condition, substance abuse
- Determine level of anxiety
- Assess for self-harm/suicidal ideation
- Good tool to use: Severity Measure for Generalized Anxiety Disorder in Adults

Neurocognitive Disorders

Neurocognitive Disorders

- Disorders in which the prominent clinical feature is a decline in cognitive functioning from a previous level

- Delirium
- Mild Neurocognitive Disorders
- Major Neurocognitive Disorders

Delirium

- Acute, cognitive disturbance, short-term; reversible
- A syndrome, not a disorder
- Common complication of hospitalization, especially in older patients
- Always due to underlying physiological cause
- Important to identify potential causes early
- Medical emergency - to prevent irreversible and serious damage

Signs and Symptoms

- **Abrupt onset - be aware of the symptoms!
- Attention problems alternating w/periods of lucidity
- Disorganized thinking and poor executive functioning (planning and problem solving)
- Time and place disorientation
- Anxious and agitated
- Conversations difficult
- Staring straight through you
- Cannot recall who s/he is
- Disorientation and confusion worse at night and early morning
- Perceptual disturbances - misinterpretation of reality;
  - Illusions - e.g. a fold in blanket looks like snake
  - Hallucinations - mostly visual
- May see reversal of sleep-wake cycle
- Moods may be either hypoactive or hyperactive; behavior and emotions erratic and fluctuating

Risk Factors

- Cognitive impairment
- Older age
- Severity of disease
- Infection
- Multiple comorbidities
- Polypharmacy
- ICU
- Fractures
- Surgery
- Stroke
- Aphasia
- Vision impairment
- Restraint use
- Change in hospital room
- Unaddressed orientation, visual or hearing issues

Treatment

- Treat underlying organic cause → if not treated, permanent brain damage may ensue
- May needs to use antipsychotics or antianxiety agents to control behavior
- Alternatively, meds may be the cause → must assess

Interventions

- *Keep pt safe while identifying cause
- *Never leave alone (include family)
- Initiate therapies to decrease cause
- Monitor neurological status ongoing
- Admin meds if needed
- Assist patient w/nutrition, elimination, hydration, hygiene needs
- Environment should be simple/clean; clocks/calendars in view
- Keep reading glasses, hearing aids nearby
- Routine maintained
- Monitor for tachycardia, sweating, flushed face, dilated pupils and ↑ BP
- Caution: pt will often wander, pull out IV lines and indwelling catheters and fall out of bed
- Approach:
  - From front and introduce self
  - Use calm voice and simple statements
  - Inform of the time and place as needed
  - Acknowledge his/her feelings
- Make sure pt has ID bracelet