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Contact Hours: **3**

Understanding Mental Illness for All Healthcare Professionals

Integrating Physical and Mental Health Care

By Judith Swan, MSN, BSN, ADN

LEARNING OUTCOME AND OBJECTIVES: Upon completion of this course, you will have increased your knowledge of recognizing and responding to signs, symptoms, and behaviors of mental health disorders in patients being seen for physical health conditions. Specific learning objectives to address potential knowledge gaps include:

- Identify concerns healthcare professionals express about caring for patients with physical health conditions who also exhibit mental disorders.
- Summarize primary mental health disorders, including their signs, symptoms, patient behaviors, and treatment modalities.
- Describe effective strategies for responding to and caring for patients with mental disorders.

INTRODUCTION

Acute care settings are complex environments offering a range of challenges for healthcare staff. These challenges are exacerbated when patients present with a comorbid mental illness. Close to one billion people worldwide have some form of mental illness, including 51.5 million in the United States. Of these, 36 million are estimated to be hospitalized each year. Nearly 1 in 3 people with a long-term physical health condition also has a mental health condition (Monaghan & Cos, 2021; Perry & Dilks, 2022).

These numbers make it easy to see that no matter what the role or setting, healthcare professionals will encounter patients who exhibit signs, symptoms, and behaviors indicating mental illness, and will be involved in the provision of care for both physical and mental illness.

Healthcare clinicians are expected to provide holistic care involving the whole person, which includes physical, mental, spiritual, and social needs, and is rooted in the understanding that all of these aspects affect overall health. Being unwell in one aspect affects the others. This means that the responsibility for providing mental health care needs to be shared across the multidisciplinary workforce, requiring skilled clinicians to deliver both physical and mental health services in diverse clinical settings.

Physical and mental health education, training, and services, however, have historically functioned independently from each other, and as a result those caring for patients with physical disorders report a lack of training and feeling inadequately prepared to care for their patients' mental health care needs. In addition, they report a lack of access to appropriate training and support in the workplace (McInnes et al., 2022)

CHALLENGES FOR INTEGRATION OF PHYSICAL AND MENTAL HEALTH CARE

Frustrations reported by staff related to caring for patients experiencing mental illness seem to arise from knowledge gaps or skill deficits, and mostly relate to ineffective therapeutic interaction, leaving the caregivers with feelings of inadequacy and professional dissatisfaction.

Nonpsychiatric healthcare professionals often report having to struggle to provide care for patients with mental illness, without having the sort of specialized training that is standard for those who work in psychiatric facilities, such as:

- De-escalation
- Communication skills
- Suicide prevention
- Addressing potential violence and aggression
- Maintaining a safe environment

In addition, negative attitudes toward mental illness by healthcare professionals have been reported. These attitudes can have adverse consequences for people with mental illness from delays in seeking care to decreased quality of care provided.

Stigma in Healthcare

One of the most significant challenges for the integration of physical and mental health care is stigma. Stigma is disempowering. Historically, people with mental illness have experienced

discrimination in healthcare settings. Stigma undermines health by preventing access to critical health-promoting resources and acting as a destructive stressor leading to harmful affective, cognitive, behavioral, and physiological responses among individuals. In healthcare settings, provider stigma compromises access to diagnosis, treatment, and successful health outcomes.

Nonpsychiatric professionals identify negative attitudes, fear, and even hostility toward patients with mental illness. These patients are commonly misperceived to be dangerous, unpredictable, uncooperative, and frightening. Self-stigma, the process of internalizing these negative stereotypes and applying them to oneself, can also lead to lower rates of willingness to disclose one's psychiatric history and may prevent seeking healthcare altogether.

Clinician inexperience in caring for patients with mental illness can contribute to delays and misdiagnoses. Implicit bias may occur when a patient's physical symptoms are ascribed to mental illness, which can lead to delays in referrals and initiation of treatment (Ollila, 2021; Earnshaw et al., 2022).

MENTAL HEALTH MYTHS VS. FACTS	
Myth	**Fact**
Children do not experience mental health problems.	Even very young children may show early warning signs of mental health concerns. Half of all individuals with mental health disorders show the first signs before the person turns 14 years old.
People with mental health issues are violent, unpredictable, and dangerous.	The vast majority of those with mental health problems are no more likely to be violent than anyone else. Only 3% to 5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population.
People with mental health issues, even those who are managing their illness, cannot tolerate the stress of holding down a job.	People with mental health problems are just as productive as other employees. Employers who hire people with mental health problems report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees.
Mental health problems are caused by a personality weakness or character flaws, and the individual can snap out of it if they try hard enough.	Mental health problems have nothing to do with being lazy or weak, and many people need help to get better. Many factors contribute to mental health problems, such as genes, physical illness, injury, brain chemistry, life experiences such as trauma or a history of abuse, or family history of mental health problems.

There is no hope for people with mental illness.	Studies show that people with mental health problems get better and many recover completely.
Therapy and self-help are a waste of time.	Treatment for mental health problems varies depending on the individual and could include medication, therapy, or both.
(MentalHealth.gov, 2022)	

DEPRESSIVE DISORDERS

Depressive disorders are characterized by a depressed mood that is severe enough or persistent enough to interfere with function and may presents as an absence of interest or pleasure (anhedonia), a loss of energy, feelings of guilt or low self-esteem, altered cognition, altered appetite, and disturbed sleep.

Depressive disorders can develop at any age. However, they most often occur in a person's mid-teens, 20s, or 30s. Patients with depressive disorders make up as many as 30% of those cared for in primary care settings.

It is important to be aware that certain physical disorders can be the cause of a depressive disorder. These can include:

- Thyroid disease
- Adrenal gland disorder
- Malignant or benign brain tumors
- Stroke
- AIDS
- Parkinson's disease
- Multiple sclerosis

Depression may also be caused as a side effect of:

- Medications (corticosteroids, some beta blockers, interferon)
- Recreational drugs

Depression may weaken the immune system and cause increased susceptibility to illness. Individuals with depressive disorders also have increased risk for cardiovascular disorders, myocardial infarction, and stroke, thought to be due to elevated inflammatory cytokines and factors that increase blood clotting, and to decreased heart rate variability. In addition, depression can mimic medical illness (Coryell, 2022; MHA, 2022a; NIMH, 2022).

Signs and Symptoms of a Depressive Disorder

Subjective clues that an individual is experiencing depression include:

- Verbalization of inability to cope or request help
- Sleep disturbance and fatigue
- Abuse of chemical agents
- Reports of muscular or emotional tension or unexplained aches and pains
- Persistent sadness or anxious mood
- Preoccupation with thoughts of death

Objective clues may include:

- Inability to concentrate or lack of ability to focus or stay focused
- Lack of goal-directed behavior
- Inadequate decision-making and problem-solving
- Inability to meet role expectations or basic needs
- Destructive behaviors toward the self, reckless behaviors
- Expressed loss of interest in all activities and loss of motivation
- Irritability, short-temperedness, or being obstinately silent
- Expressions of being hopeless, helpless, or worthless
- Disturbed sleep patterns, including insomnia, frequent awakening during the night, sleeping more than normal
- Appetite changes, either binge eating or loss of appetite resulting in considerable weight loss or gain
  (Mayo Clinic, 2022; Tabangcora, 2022a)

SCREENING FOR DEPRESSION

Patients who present with signs and symptoms of depression should be screened. One depression screening tool that is accurate and easily administered is the **Patient Health Questionnaire-2**, also called the **Two-Question Screen,** used for adolescents, adults, and older adults. It consists of two questions:

1. During the past two weeks, have you often been bothered by feeling down, depressed, or hopeless?

2. During the past two weeks, have you often been bothered by having little interest or pleasure in doing things?

Responses may be dichotomous (yes/no), or scaled (0 to 3).

0 = No, not at all
1 = Yes, several days
2 = Yes, more than half the days
3 = Yes, nearly every day

A single "yes" response or a score ≥3 (out of a possible score of 0 to 6) indicates possible clinically significant depression. If positive, the test should be followed up with a more detailed screening (Williams & Nieuwsma, 2022).

Treatment for Depressive Disorders

Evidence-based treatment for depression includes the use of specific psychological therapies and/or pharmacologic agents. Patients who are being treated for a medical condition may have been taking an antidepressant medication or may be started on an antidepressant following screening and diagnosis while in a medical setting. It is important for clinicians to become aware of the contraindications, cautions, and side effects for these medications. Common types of antidepressants and examples include:

- Tricyclics: amitriptyline, doxepin, imipramine (Tofranil), nortriptyline (Pamelor)
- Monoamine oxidase inhibitors (MAOIs): isocarboxazid (Marplan), phenelzine (Nardil)
- Selective serotonin reuptake inhibitors (SSRIs): citalopram (Celexa), fluoxetine (Prozac)
- Serotonin norepinephrine reuptake inhibitors (SNRIs): venlafaxine (Effexor) (Tabangcora, 2022b)

How to Respond to and Care for a Patient with Signs and Symptoms of Depression

Current recommendations are to manage depression as a chronic condition. This requires follow-up of symptoms, side effects of medications, treatment compliance, and treatment modification as necessary to achieve the best outcome.

Patients who present with the signs and symptoms of depression should be carefully assessed for warning signs of suicide. **Indications of suicidal thinking** may include:

- A clear or covert statement indicating that the patient may be considering suicide
- Previous suicide or self-harm attempts
- Saying good-byes (e.g., "I won't need any more appointments.")

- Preoccupation with death or lack of concern about personal safety

(Hildah, 2022)

Nursing management for a hospitalized patient with comorbid depressive disorder includes:

- Monitoring the environment for safety
- Engaging the patient in a therapeutic relationship
- Using empathy when communicating with the patient
- Encouraging self-care and offering direction if depression is severe
- Using sleep hygiene measures to encourage sleep
- Assisting patient to set realistic goals for the day and reviewing goal attainment
- Reviewing and evaluating the patient's coping strategies and support systems
- Monitoring eating and encouraging nutritional intake
- Monitoring medications for effectiveness and side effects
- Including family in care if the patient wishes
(Shand et al., 2022)

The central element of responding to the patient is the development of a quality **therapeutic relationship.** A therapeutic relationship requires exceptional communication skills, which include:

- Trust: Critical to the relationship and requiring continual effort to maintain it
- Respect: Recognizing each individual has inherent dignity, worth, and uniqueness
- Professional intimacy: Providing physical care while being privy to the patient's psychological, spiritual, and social history
- Empathy: Understanding, validating, and confirming what the healthcare experience means to the patient
- Power: Recognizing the unequal power relationship and not abusing it
(CNO, 2020)

CASE

A Patient with Signs of Depression
Yolanda, a physical therapist, is making her fourth visit to Loren, a male patient who lives in Forest Park, an assisted-living facility. Loren is 78 years old and recovering from a stroke affecting his left side. He has been progressing well, and normally greets Yolanda with a smile, but today he simply opens the door for her without any greeting.

During the treatment session, Yolanda notes that Loren seems distracted and not his usual self. He appears to be tired and out of sorts. She begins a conversation with Loren in order to learn more about his condition.

Yolanda: "You don't seem to be your usual self today."
Loren: "Well, I'm kind of tired is all."

Yolanda: "Are you not sleeping well?"
Loren: "Oh, I don't know. Things get to me."

Yolanda: "You've been through a lot lately. Perhaps this is affecting your sleep."
Loren: "Oh, dear. I can't sleep at all lately."

Yolanda: "Tell me more about that."
Loren: "Well, I wake up during the wee hours of the morning and just can't get back to sleep."

Yolanda: "What do you think about when you're trying to get back to sleep?"
Loren: "Oh, I just lay awake, turn this way and that way, and think of all the mistakes I've made in my life."

Yolanda: "That sounds very distressing."
Loren: "Yes, it is."

Yolanda: "Tell me …"

Discussion

Yolanda recognizes that sleep disturbances, especially early morning awakenings, are a major physical symptom of a depressive disorder and that Loren's negative ruminations are also a problem. Her next step will be to inquire about other signs and symptoms of depression (e.g., changes in appetite, feelings of hopelessness, etc.) and then to inform Loren's primary care provider about her findings. Yolanda will also watch for any indicators of suicidal thinking. This is especially important with older male patients like Loren who have comorbid health problems, since they have the highest rate of suicide.

BIPOLAR DISORDER

Bipolar disorder is a life-long mood disorder that causes intense shifts in mood (from mania to depression), energy levels, thinking patterns, and behavior. These shifts can last for hours, days, weeks, or months and interrupt the person's ability to perform day-to-day tasks. Bipolar disorder affects approximately 5.7 million adult Americans every year, or about 2.6% of the U.S. population 18 and older. It is present in up to 4% of primary care patients (DBSA, 2023).

Signs and Symptoms of Bipolar Disorder

Mania is a period of abnormally elevated or irritable mood, as well as extreme changes in emotions, thoughts, energy, talkativeness, and activity level. People in this state often indulge in activities that result in physical, social, or financial harm. They often develop psychotic symptoms, including delusions and hallucinations, which can make it difficult to distinguish bipolar disorder from other psychotic disorders. Other signs and symptoms may include:

- Restlessness
- Rapid speech, racing thoughts, and poor concentration
- Distractibility
- Lack of insight
- Increased energy and less need for sleep
- Increased impulsivity and poor judgment
- Unusually high sex drive
- Feeling able to do many things at once without getting tired
- Grandiosity (claiming exaggerated and unrealistic abilities and achievements)

Depressive episodes in bipolar disorder are periods of low or depressed mood and/or loss of interest in most activities as well as other symptoms of depression, including fatigue, appetite changes, negative feelings of self-worth, and hopelessness (Cleveland Clinic, 2022a).

SCREENING FOR BIPOLAR DISORDER

The **Mood Disorder Questionnaire (MDQ)** is an effective screening instrument for bipolar disorder. It is not diagnostic, but is indicative of the existence of bipolar disorder. A positive screen must be followed by a clinical assessment (Molina Healthcare, 2021).

Treatment for Bipolar Disorder

Bipolar disorder is a complex, chronic condition that can be difficult to treat and that requires medications and psychotherapy. As a result, polypharmacy is commonplace, and many patients require multiple medications to control their symptoms effectively. It is important that clinicians become educated about the various side effects of the wide array of medications available for treatment and to be aware that the tolerability of these medications is one of the key reasons for noncompliance (Nasrallah & Kuo, 2022).

Medications prescribed for treatment of bipolar disorder include:

- Mood stabilizers
- Some anticonvulsants
- Antipsychotics
- Anxiolytics
- Antidepressants

Medical comorbidities are quite prevalent in patients with bipolar disorder due to the adverse effects of these medications. Regular monitoring of weight, glycemia, dyslipidemia, blood pressure, and liver function is necessary.

The gold standard for treating bipolar disorder is the mood stabilizer **lithium carbonate**. Lithium has a narrow range of safety, and blood tests are required before and at intervals during treatment with the drug. Clinicians should be aware that patients who are taking lithium carbonate are at risk for **lithium toxicity,** for which there is no antidote and which can cause death. It is also important for clinicians to be aware that there are 690 drugs known to interact with lithium (NAMI, 2021; Chokhawala et al., 2022; Drugs.com, 2022).

How to Respond to and Provide Care for a Patient with Signs and Symptoms of Bipolar Disorder

In contrast to patients with major depressive disorder, patients with bipolar disorder are more likely to present with racing thoughts and/or irritability when they are not depressed and are more likely to have suicidal thoughts during periods of depression. Patients with bipolar disorder should always be evaluated for suicide risk and acute or chronic psychosis.

The priority in caring for a patient with bipolar disorder is safety and the establishment of external controls. Patients with bipolar disorder experiencing a manic episode are at risk for injury and self-directed or other-directed violence. They have impaired social interactions, do not cope well, and may be unable to complete self-care (Martin, 2022a).

When involved in the care of a patient with bipolar disorder, it is true that some conduct associated with the disorder can be very difficult to contend with. However, it is necessary to remember that these behaviors are actually symptoms, the result of illness. It is also important to recognize some of the **typical reactions clinicians may have** toward persons with manic behaviors and to consider them during interactions. These can include:

- Amusement. It is easy to laugh and respond to the outrageous things a patient may say or do, but it is important to ensure that respect for the patient is maintained at all times.
- Irritation. Manic patients may be noncompliant with routines, rules, or personal healthcare. They often test limits. This can cause providers to feel irritated or even angry with such patients.

- Embarrassment. Some providers feel embarrassed at what is seen as the patient's apparent lack of control. If the behavior occurs in front of others, providers may feel embarrassed that they cannot effectively intervene.
- Discomfort. The patient can be verbally abusive and can make personally demeaning comments to and about providers.

Effective ways to respond include:

- Be patient when attempting to communicate; do not rush or pressure the patient to talk.
- Answer questions briefly, quietly, calmly, and honestly.
- Counter distractibility and poor concentration by giving the patient clear, simple, and concrete instructions.
- Attempt to educate patients about the inappropriateness of their behavior without criticizing or blaming them.
- Avoid judging the person, and do not give negative feedback.
- Avoid verbal confrontations with the person, who is likely to have a low tolerance for debate.
- Do not try to appeal to the patient using logic, as the patient is not thinking rationally.
- Encourage the patient to respect the personal space of others.
- Provide consistent limits on behaviors and verbal abuse; make sure all staff are clear about these limits and that they reinforce them.
- Encourage and support any ideas the person has that are realistic and in keeping with their healthcare regimen. It is far more effective to suggest alternative strategies rather than to forbid an action.
- Encourage the person to organize and slow thoughts and speech patterns by focusing on one topic at a time and asking questions that require brief answers only.
- If a patient's thoughts and speech become confused, cease the conversation and help to calm the patient by sitting quietly together.
- Limit the person's interactions with others as much as possible, and remove any external stimulation where possible.

Nursing interventions include:

- Providing structured solitary activities to help the patient stay focused
- Providing frequent rest periods
- Promoting rest and sleep
- Monitoring intake, output, and vital signs

- Providing supervision when eating
- Maintaining clear and consistent limits and expectations to minimize potential for manipulation of staff
- Maintaining a low level of stimuli, which helps to minimize escalation of anxiety
- If the patient is taking lithium, observing for signs of toxicity
- Monitoring for side of effects of medications
- Redirecting aggressive or violent behaviors
(Townsend, 2018; Martin, 2022a)

CASE

A Patient with Bipolar Disorder

Michael is a 34-year-old who has a diagnosis of bipolar disorder. He is seeing Nadia, an occupational therapist, to improve his ability to manage his money and communicate more effectively with family and caregivers. Today in a group session, Michael is more talkative and his speech is pressured. He makes grandiose statements about how much money he has and that he is going to be married soon to a movie star. He makes sexually inappropriate comments and gestures to one of the other patients in the group. Nadia asks Michael to go with her to a quiet corner of the room.

Nadia, speaking calmly in a neutral tone and with a low-pitched voice: "Michael, making sexual comments and gestures to other patients is not acceptable."
Michael: "Why not? She's cute and single, and so am I."

Nadia, speaking firmly: "I hear what you are saying, but it is not acceptable to make sexual comments and gestures to other patients."
Michael: "Well, how about I go ask her what she thinks?"

Nadia: "Again, Michael, this behavior is not acceptable and will not be tolerated."
Michael: "Well, if you're going to be that way about it!"

Nadia: "Michael, to remain here today, you may not make sexual comments and gestures to other patients."
Michael, giggling: "Well, I'll try to be good."

Nadia: "Thank you, Michael."

Discussion

Nadia recognizes that hypersexuality is not unusual among persons with bipolar disorder and that it should be dealt with like any other behavioral symptom. By removing Michael from the group setting (distracting him), Nadia is stopping the behavior and limiting his interactions with others. Nadia then utilizes several communication techniques when interacting with Michael, including confrontation using a nonjudgmental approach.

- She is respectful while focusing Michael on his behavior and encouraging him to have respect for others.
- She sets boundaries in a kind, firm, and calm manner (accepting) and does not deviate from the goal of having Michael understand that his behavior is unacceptable.
- She does not argue or debate the issue.
- She does not respond to his attempts to show anger or humor.
- She does not forbid the behavior, but rather offers him the alternatives of remaining or leaving the group.

ANXIETY DISORDERS

Anxiety disorders affect 19% of the population, and because the majority of individuals with anxiety disorders will access medical care at some point in their lives, anxiety disorders are likely the most common psychiatric illnesses to be encountered by healthcare professionals (NAMI, 2022).

Anxiety disorders include

- Generalized anxiety disorder
- Panic disorder
- Social anxiety disorder
- Phobia-related disorders
- Agoraphobia
- Separation anxiety
- Selective mutism
- Posttraumatic stress disorder (PTSD)

Anxiety is an uncomfortable feeling of apprehension or dread in response to internal or external stimuli. Anxiety involves physiologic arousal (fight-or-flight) and alterations in cognitive processes (decision-making), requiring implementation of coping strategies.

Signs and Symptoms of an Anxiety Disorder

Anxiety disorders have one of the longest differential diagnosis lists of all psychiatric disorders and can be due to a wide variety of medical or psychiatric syndromes. Symptoms can also be the result of certain medications.

A patient with **generalized anxiety disorder** can present with:

- Complaints of feeling restless, wound-up, or on edge
- Being easily fatigued
- Having difficulty concentrating
- Being irritable
- Having headaches, muscle aches, stomachaches, or unexplained pains
- Difficulty controlling feelings of worry
- Having sleep problems

Patients experiencing **panic disorder** have periods of intense fear, discomfort, or sense of losing control even without clear danger or trigger. Patients with panic disorder frequently present to the emergency department with the complaint of chest pain, dyspnea, and the fear that they are experiencing a heart attack.

Others with an anxiety disorder may exhibit physical signs of anxiety such as tremor, sweaty palms, restlessness, and distractibility. Patients may also complain of other physical symptoms including:

- Tachycardia
- Tachypnea
- Dyspnea
- Diaphoresis
- Stomach cramping
- A lump in the throat or inability to swallow
- Urinary frequency
- Dry mouth
- Nausea
- Diarrhea
- Headache, neck or backaches

It is common for patients with these symptoms to present to health professionals repeatedly, with pressing but long-standing concerns that prove to be medically unexplained (Bhatt, 2019).

SCREENING FOR ANXIETY

Patients who present with signs and symptoms of an anxiety disorder without already having been diagnosed should be screened. A tool that is easy to perform as an initial screening is the **Generalized Anxiety Disorder 7-item (GAD-7)**. Although designed as a screening tool for generalized anxiety, the GAD-7 also performs well as a screening tool for three other common anxiety disorders: panic disorder, social anxiety disorder, and posttraumatic stress disorder (NHIVC, 2022).

Treatment for Anxiety Disorders

Anxiety disorders are generally treated with psychotherapy, medication, or both. The most common medications used for treatment are antidepressants, anti-anxiety medications, mild tranquilizers, and beta-blockers.

- Antidepressants (SSRIs and SNRIs) are the drugs of choice. Tricyclics are used but may cause significant adverse effects. Examples include:
    - SSRIs: citalopram (Celexa), fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft)
    - SNRIs: duloxetine (Cymbalta), venlafaxine (Effexor), desvenlafaxine (Pristiq)
    - Tricyclics: amitriptyline, amoxapine, doxepin, imipramine (Tofranil), nortriptyline (Pamelor)
- Anxiolytics include benzodiazepines and the milder tranquilizer buspirone. Benzodiazepines are used for short-term acute management. Benzodiazepines are controlled substances and have the potential for abuse, addiction, and diversion. Examples include diazepam (Valium), alprazolam (Xanax), lorazepam (Ativan), and clonazepam (Rivotril).
- Beta-blockers are used to tamp down the fight-or-flight response to control the physical symptoms of anxiety, including tachycardia and shakiness. Examples include: propranolol (Inderal), atenolol (Tenormin), and metoprolol (Lopressor).
(Chand, 2022)

How to Respond to and Care for a Patient with Signs and Symptoms of Anxiety Disorder

It can be easy to discount someone's anxiety when it is obviously out of proportion to the situation or circumstances. This can lead to minimizing or disregarding the patient's symptoms. Providers can also experience feelings of frustration when they are unable to get the panicked

person to calm down. It is important to recognize that anxiety is contagious and may be transferred from healthcare provider to patient or vice versa.

These are **effective strategies** when responding to a patient with anxiety disorders:

- Remain calm, present a calm demeanor, and speak in a soothing voice.
- If possible, move to a quiet place with minimal stimuli.
- Acknowledge what patients are experiencing but remind them that they are not in danger, they will be okay, and you are there to help.
- Speak in short, simple sentences and encourage the patient.
- Remind patients to breathe; if they are hyperventilating, have them breathe into their hands cupped over the mouth and nose or a small paper bag.
- Guide the patient through a simple, distracting physical task, such as raising the arms over the head.
- Offer PRN medications and watch for adverse side effects.
- Encourage participation in relaxation exercises such as deep breathing.
- Offer a distraction:
    - Ask the person to list five things they can see, four things they can touch, three things they can hear, two things they can smell, and one thing they can taste.
    - Talk about mundane things.

The following are **actions to be avoided** in interactions with such patients:

- Touching patients. Patients experiencing a panic attack are concerned about survival, experience serious threat to self, and usually distort intentions of those who invade their personal space.
- Telling patients experiencing a panic attack to calm down. This suggests that they have control over their symptoms and can result in increased anxiety.
- Telling patients that they have nothing to fear or be nervous about. This implies that their fear is unfounded. These patients usually already understand there is no reason to be so anxious but are unable to prevent the attack from finishing its course.
- Telling patients that their behavior is embarrassing. This can increase anxiety and feelings of shame.
- Telling patients they are overreacting. Minimizing can be discouraging, increase the patient's discomfort, and make it even harder for them to calm down.

When the level of anxiety has been reduced, it can be useful to explore with patients the possible reasons the anxiety occurred so that they can learn to interrupt escalating anxiety in the future (Townsend, 2018; Vera, 2022).

CASE

A Patient Having a Panic Attack

Andrew is a visiting nurse caring for Rhiddhi's grandmother, who is recovering from a surgical procedure. Andrew arrives at her home to change her dressings. When he has finished, Rhiddhi, who is 31 years old, enters the room. Andrew notices that Rhiddhi is quite short of breath and appears pale and frightened. He asks her how she is feeling, and she says she is feeling dizzy, her heart is pounding, and she can't breathe. She says she is having a panic attack and that she's had them before. Andrew walks with her to the sofa.

Andrew says to her, "Rhiddhi, come sit down on the sofa with me. You're having a panic attack, and it will be over soon. You're safe here. You'll get through this."

Andrew continues, speaking slowly and in a soothing voice: "You are doing a great job, Rhiddhi. You'll be okay. I'm here to help you. I'll stay with you. I'm okay staying here with you."

Andrew begins to model slow breathing. He breathes in through his nose for a count of 4 seconds and out through his mouth for 8 seconds and says, "Rhiddhi, look at me. I'm breathing slowly. Follow my breathing."

When Rhiddhi's breathing has begun to slow down, Andrew asks her to focus on a physical task: "Good, Rhiddhi. Now raise your arms over your head like this."

Rhiddhi raises her arms. Andrew then says, "Okay, now put them in your lap." They both lower their arms.

Andrew asks her to repeat the movement. "Let's do that again." Rhiddhi responds by following along with Andrew. Andrew says, "Good, Rhiddhi. Now raise both arms over your head. Like this."

As they raise and lower their arms, Andrew asks, "Have you been to the new supermarket yet?" Rhiddhi, becoming calmer, replies, "No, not yet."

"Well, it's really quite beautiful," replies Andrew.

Discussion

Andrew recognizes that Rhiddhi is experiencing serious physical symptoms, but when she tells him she is experiencing a panic attack, which she has had before, it allows him to change his initial reaction from her physical symptoms to focus instead on her psychological symptoms. He begins by staying calm and speaking quietly while guiding her to a comfortable place. Andrew verbally encourages Rhiddi and reassures her that she is safe and that he will remain with her.

Andrew asks her to focus on performing slow breathing, and when she makes an effort to do so, he instructs her to perform a physical task in order to distract her from her symptoms. As she follows along, he attempts to distract her further by discussing a mundane matter (the supermarket).

At no point during his intervention does Andrew tell Rhiddi there are no grounds for her fear (accepting). He does not minimize her symptoms, shame her in any way, or tell her to calm down.

PSYCHOTIC DISORDERS

A psychotic disorder involves a loss of contact with reality. Psychotic disorders are rare, affecting just 1% of the population, and often begin in the individual's late teens to early 30s (Mercy, 2023).

Psychotic disorders include:

- Schizophrenia
- Schizoaffective disorder
- Schizophreniform disorder
- Brief psychotic disorder
- Delusional disorder
- Shared psychotic disorder (also called *folie à deux*)

Psychotic disorders, primary or medically related, are defined by abnormalities in one of the following domains:

- **Delusions:** Fixed false beliefs for which the person lacks insight, even in the face of evidence that proves contrary to their validity
- **Hallucinations:** Perceived experiences (auditory, visual, tactile) in the absence of external stimuli
- **Disorganized thoughts:** Speech and communication patterns that may include:
    - Loose associations: Sequences of unrelated or loosely related ideas
    - Circumstantial thought: Inability to give a direct answer to a question without excessive unnecessary detail
    - Tangential thought: Drifting from a topic never to return to the original point
    - Word salad: unintelligible or incoherent jumble of words
    - Neologisms: Made up words or phrases

    - Perseveration: Repetition of words and statements
- **Disorganized behavior**: Bizarre or inappropriate behavior, actions, or gestures that may include:
    - Faulty goal-directed activity that leads to a decline in daily functioning
    - Inappropriate and/or unpredictable impulse control
    - Socially inappropriate, nonsensical actions
    - Catatonic behavior: Decrease in reactivity to the external environment
- **Negative symptoms**: Withdrawal and absence of interest in everyday social interactions that may include:
    - Decrease or loss in normal functioning (which can be confused with depressive disorders)
    - Inexpressive or emotional blunting, with "flat affect"
    - Simplistic or prosodic speech patterns along with alogia (poverty of speech)
    - Psychomotor retardation
    - Lack of energy
    - Loss of interest, concentration, and pleasure in formerly pleasure activities (anhedonia)

(Calabrese et al., 2022)

SCREENING FOR PSYCHOTIC DISORDER

Quick screening questions for psychotic symptoms in patients include:

- "Have you had any strange or odd experiences lately that you cannot explain?"
- "Do you ever hear things that other people cannot hear, such as noises or the voices of other people whispering or talking?"
- "Do you ever have visions or see things that other people cannot see?"
- "Do you ever feel that people are bothering you or trying to harm you?"
- "Has it ever seemed like people were talking about you or taking special notice of you?"
- "Are you afraid of anything or anyone?"

Answering yes to any of these questions indicates the need for a more detailed assessment. It is also important to obtain corroborating information from caregivers or others who are close to the patient (CAMH, 2022a).

Treatment for Psychotic Disorders

Some patients with psychosis require inpatient care. Residential and inpatient psychosis treatment facilities provide around-the-clock care for those who need more help than an outpatient program offers. Others may have a condition that can be managed at home along with outpatient psychotherapy.

ANTIPSYCHOTIC MEDICATIONS

Antipsychotic medications are universally indicated for the treatment of psychotic disorders. These medications are effective in the treatment of acute and chronic psychotic disorders and for maintenance therapy to prevent exacerbation of symptoms. These are referred to as "typical" (first-generation, conventional antipsychotics) or "atypical" (second-generation or newer antipsychotics).

The many benefits of antipsychotic medications are often negated by their many **adverse effects**. It is important for healthcare providers to be aware of the many problems that can arise in patients they are caring for who are being treated with these medications and to monitor them carefully. Side effects of antipsychotic medications may include:

- Extrapyramidal symptoms: Drug-induced movement disorders, including akathisia, dystonia, dyskinesia, akinesia, Parkinsonism, tardive dyskinesia
- Neuroleptic malignant syndrome: One of the most dangerous adverse effects of antipsychotics; a medical emergency often requiring intensive care that manifests with fever, autonomic instability, rigidity, and altered mental status
- Neutropenia/agranulocytosis: Most commonly a side effect of clozapine (Clozaril) that causes reduction of infection-fighting neutrophils, and the more serious form, agranulocytosis; both of which increase susceptibility to infection and require monitoring of granulocyte counts
- Excessive production of saliva (sialorrhea): A side effect common for those treated with clozapine and that can result in aspiration pneumonia
- Metabolic syndrome: A significant issue that increases the risk of adverse health outcomes; requires those taking an atypical antipsychotic to have weight, glucose levels, and lipid levels monitored regularly
- Cardiovascular events: QT interval prolongation and sudden death
- Cholestatic jaundice: Psychiatric drug-induced hepatic injury
- Orthostatic hypotension: A risk factor for all antipsychotics, requiring blood pressure monitoring to prevent dizziness, syncope, falls, and worsening of angina
- Anticholinergic side effects: Dry mouth, constipation, blurred vision, increased pupil size, tachycardia, and urinary incontinence

- Prolactin elevation: A side effect that can lead to sexual dysfunction, galactorrhea, and gynecomastia
(Freudenreich & McEvoy, 2023; Wijdicks, 2022; Jibson, 2022)

THERAPY INTERVENTIONS

While medications are central in the treatment of psychotic disorders, therapy can also be essential. Types of therapy may include:

- Cognitive Behavioral Therapy (CBT): An approach that helps patients monitor and analyze thought processes more closely, make rational connections, and recognize when symptoms are arising; also helps strengthen reality testing skills
- Acceptance and Commitment Therapy (ACT): Assists in understanding that it is counterproductive to try to control painful emotions or psychological experiences and that suppression of these feelings ultimately leads to more distress; teaches alternatives to change the way one thinks, including mindful behavior, attention to personal values, and commitment to action
- Cognitive Enhancement Therapy (CET): A recovery phase intervention that uses a combination of medicines, computer-based exercises, and group therapy to treat psychotic disorders
(Hairston, 2022)

How to Respond to and Care for a Patient with Signs and Symptoms of a Psychotic Disorder

HALLUCINATION

A patient with a psychotic disorder may present with **signs** of hallucinating, which can include:

- Evidence of intently listening when there is nothing to hear
- Wild eye movements
- Talking to persons who are not present
- Inappropriate facial expressions
- Increased signs of fear and/or agitation
- Preoccupation or being unaware of surroundings
- Isolating and using radio or TV to drown out the “voices”

Responding to and interacting effectively with a patient who is hallucinating requires the healthcare professional to:

- React calmly and quickly with reassuring words. Speak slowly, clearly, and keep sentences simple, as the person may have difficulty concentrating.
- Ask the patient directly if they are hallucinating.
- Do not respond as if the hallucinations are real (e.g., do not say, "Hey, you voices, stop telling her these things!").
- Do not argue with the patient or deny the patient's experience, but do suggest your own perceptions.
- Be alert for signs of increasing fear, anxiety, or agitation; the patient may act upon command hallucinations.
- Use touch only after asking permission to do so; some psychotic patients are prone to react negatively.
- Acknowledge the feelings behind the hallucination and try to find out what it means to the person.
- Use distraction. Hallucinations often subside in well-lit areas where others are present. Try to distract with music, conversation, or other enjoyable activity.
- Modify the environment by turning off the television or radio or turning on lights to reduce shadows.
- Help with reality testing by comparing the patient's perceptions with those of others.
- Stay with hallucinating patients and direct them to tell the voices to go away; repeat often in a matter-of-fact manner. The patient can learn to push the voices aside when given repeated instructions to do so.
- Monitor medication compliance as well as physical health; be certain antipsychotic medications are being prescribed.
- If voices are telling the patient to harm self or others, follow unit protocol (in an inpatient environment) or notify physician, police, or facility administration (in an outpatient environment) and evaluate for need for hospitalization.
(Townsend, 2018; Martin, 2022b)

CASE

A Patient Who Is Hallucinating

Michaela is 20 years old and was admitted for treatment of an asthma exacerbation. She was recently diagnosed with schizophrenia and is currently on an antipsychotic medication. The nursing staff have noticed and reported that Michaela frequently has been seen to be watching something moving about the room, talking, and laughing at something unseen and unheard by any of them.

This morning when Sharon entered the room, she found Michaela looking frightened, crying, and talking to someone who wasn't there. She approached her bed slowly and spoke softly.

Sharon: "Michaela, don't worry, I'm here and will protect you. What are you seeing now?"

Michaela: “Him! Can’t you see him?”

Sharon: “No, Michaela, I don’t see anyone. Is he speaking to you?”
Michaela: “Yes, yes! Can’t you hear him?”

Sharon: “I don’t see or hear anything, but I can see you are very upset about this.”
Michaela: “Yes, it’s awful!”

Sharon: “What is he saying to you?”
Michaela: “He’s telling me I’m a terrible person and should die!”

Sharon: “I know this must be very scary for you. Michaela, is it all right if I hold your hand?”
Michaela: “Yes.”

Sharon (taking Michaela’s hand): “Let’s get out of bed and take a walk down to the dayroom to talk to some other people.”

Sharon (while walking to the dayroom): “It doesn’t appear that your roommate has been seeing or hearing the same things you are.”

Discussion

Sharon became aware that Michaela was exhibiting signs of hallucinating. Because Michaela was obviously frightened, Sharon reacted calmly and reassured the patient that she was safe and not alone. To be certain of her observation, Sharon then asked Michaela if she was seeing and hearing things and encouraged a description of her perceptions. When Michaela replied that she was seeing someone, Sharon acknowledged how upset Michaela must be.

Sharon did not tell the patient that her hallucination was not true, since to Michaela the hallucinations seemed quite real. Instead, she told Michaela that she herself was not seeing or hearing things, thereby avoiding an argument about what was or was not true. Sharon asked the patient to describe what was happening and again attempted to reassure her by asking if she could touch her.

In order to distract Michaela from her hallucinations, Sharon then suggested they leave the room and go to a place where there were others. She also began a conversation to help Michaela test reality by suggesting that her perception of what is real is not the same as that compared to her roommate.

Sharon will also report and document this incident, since it will assist in determining the effectiveness of the medication Michaela has recently been started on.

DELUSIONS

Patients with psychotic disorders may show signs that they are experiencing delusions, or fixed false beliefs. Delusions are **based on a theme**, including:

- Erotomania: The belief that someone is in love with them, usually someone important or famous, which can contribute to stalking behaviors
- Grandiosity: An overinflated sense of worth, power, knowledge, or identity, or the belief that they have a special talent or made a great discovery
- Jealousy: The belief that a spouse or sexual partner is unfaithful
- Magical thinking: The belief that their thoughts or behaviors have control over specific situations or people
- Persecutory: The belief that they or someone close to them is being mistreated, spied upon, or planning to harm them; may include repeated complaints to legal authorities
- Reference: The view that all events occurring in the environment refer to oneself
- Somatic: The belief that they have a physical defect or medical problem
- Mixed: A combination of two or more types listed above
(Casarella, 2020)

Responding to and interacting with a person who is experiencing a delusion requires an understanding that the delusion cannot be challenged and that the patient cannot be dissuaded despite evidence to the contrary. **Effective measures** include:

- Present reality concisely and briefly and do not challenge illogical thinking or try to convince the patient that the delusion is false.
- Use touch cautiously, particularly if thoughts reveal ideas of persecution, since patients who are suspicious may misinterpret touch as either sexual in nature or threatening and respond with aggression.
- Recognize the delusion as the patient's perception, which can help with understanding the patient's underlying feelings.
- Try to distract from the delusion by focusing on reality-based activities.
- Explain and try to be sure the patient understands procedures prior to carrying them out.
- Show empathy to convey caring, interest, and acceptance of the patient.
(Martin, 2022b; Townsend, 2018)

CASE

A Patient with Delusions

Yuan is 25 years old and has been admitted for treatment of septicemia. He had stepped on a nail four weeks prior to admission and attempted to treat the wound by soaking his foot in hot water. A piece of the nail had remained embedded in his foot and was surgically removed two days ago. Today during wound treatment, he begins speaking with his nurse, Julian:

Yuan: "I'm infested with these awful parasites. They're crawling all around inside me."
Julian: "That's quite interesting. How did this start?"

Yuan: "When I was soaking my foot, a bug fell into the water, and before I could get it out, the water became infested with the parasites the bug was carrying."
Julian: "What happened after that?"

Yuan: "The parasites got into the wound, and now they're crawling around inside of me, and I haven't been well since."
Julian: "Well, that is quite interesting. Let's get you set up now to eat. The breakfast trays are on their way."

Discussion

Julian considered that Yuan may be having a somatic delusion. While he could have responded that Yuan does indeed have parasites (bacteria) in his body that are making him sick, instead, he first encouraged the patient to describe the perception. Yuan's story confirmed that his belief was a delusion. Therefore, Julian chose distraction as a good response in this situation.

PERSONALITY DISORDERS

A personality disorder is a way of thinking, feeling, or behaving that deviates from the expectations of the prevailing culture and causes distress or problems functioning. Types of personality disorders include:

- Borderline personality disorder
- Obsessive-compulsive personality disorder
- Histrionic personality disorder
- Dependent personality disorder
- Narcissistic personality disorder
- Paranoid personality disorder
- Schizoid personality disorder

- Schizotypal personality disorder

Obsessive-compulsive personality disorder (OCPD) is the most prevalent, with rates around 5% of the general population. Borderline personality disorder (BPD) prevalence is estimated to be 1.6% in the general population. Personality disorders are highly comorbid with other mental health disorders, substance abuse, and medical problems such as sleep disturbance, chronic pain, and obesity (Feldman, 2021; Chapman et al., 2022).

Core features of personality disorders include:

- Interpersonal difficulties: Stormy relationships, especially with people to whom they are close to
- Affective dysregulation: Affective lability, excessive anger, and efforts to avoid abandonment
- Behavior dysregulation: Impulsivity, suicidality, and self-injurious behaviors (Skodol, 2022)

SCREENING FOR PERSONALITY DISORDERS

While there are no specific tests that can diagnose personality disorders, there are screening instruments that can assist in identifying them. For example, a screening tool for assessing for borderline personality disorder is the **McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD),** a 10-item measure based on the DSM-5 diagnostic criteria. It is useful for detecting individuals who may have borderline personality features and is very effective in detecting possible BPD in people who are seeking treatment or who have a history of treatment for mental health problems. However, it is not known whether it is good at detecting BPD in the general public (CAMH, 2022b).

Treatment Modalities for Personality Disorders

Treatment can be problematic, as people with personality disorders tend to externalize, seeing their problems as "out there" and not within themselves. They rarely see themselves or their behavior as problematic and tend to blame others for any failure or missteps. Various forms of **psychotherapy** are the first-line treatments for personality disorders, along with symptom-targeted medication treatment. Medications may include mood stabilizers, antipsychotics, and antidepressants (Skodol, 2022).

Common Symptomatic Behaviors among Persons with Borderline Personality Disorder

Patients who have this particular personality disorder have always been present in medical settings and most often are described as "hard to care for" or "difficult." Interactions with

patients who have this disorder can make most healthcare providers feel mentally exhausted. Patients may display **various behaviors** that are suggestive, but not diagnostic, of BPD. These may include:

- Aggressive or disruptive behavior: Refusing treatment, angry outbursts out of proportion to the situation, demandingness, or intimidation
- Intentional sabotage of medical care: Making medical situations worse, such as preventing wounds from healing, which may function as a means to cause self-injury
- Excessive healthcare utilization: Seeing a great number of primary care physicians, taking more prescription medications, and being more frequently referred to specialists
- Alcohol and substance misuse, including abuse of prescription medications
- Multiple somatic complaints in an attempt to elicit caring responses from others
- Chronic pain syndromes, thought to be related to the inability to self-regulate
- Sexual impulsivity: Greater sexual preoccupation, greater number of sexual partners, and broader range of sexual experience, which may manifest in higher rates of sexually transmitted infections
- Black-white thinking, meaning others are either 100% for them or 100% against, or "all good" or "all bad" (referred to as ***splitting***)
  (Skodol, 2022)

How to Respond to and Care for a Patient with Borderline Personality Disorder Signs and Symptoms

The following are some important principles to keep in mind when responding to and caring for patients who have borderline personality disorder:

- Set explicit guidelines and boundaries for expected behaviors on their part, as well as what the patient can expect from the healthcare provider, and expect the patient to test these limits repeatedly.
- Ensure that patients are fully aware they will be held responsible for their behaviors, and that when limits or policies are not followed, consequences will be enforced in a matter-of-fact, nonjudgmental manner.
- Be clear as to the facility policies and the consequences if policies/limits are not adhered to.
- Approach the patient in a consistent manner in all interactions, being aware that exceptions encourage a manipulative behavioral response.
- Monitor one's own thoughts and feelings constantly regarding responses to the patient, as strong and intense countertransference reactions (emotional entanglement with the patient) can occur.

- Refrain from sharing personal information with the patient, which can open up areas for manipulation.
- Be aware that flattery is an attempt to make a caregiver feel special and can pit one staff member against another, which can undermine the patient's need for limits.
- Reiterate boundaries if the patient becomes seductive.
- Be alert to the prospect of the patient engaging in "splitting" behavior among staff, making one the "good guy" and another the "bad guy."
- Help to minimize manipulations by developing a clear and concrete written plan of care for all staff to follow.
- Remain neutral and calm and avoid power struggles if the patient becomes hostile or projects blame onto others.
- Recognize that acting out behaviors often stem from underlying feelings of anger, fear, shame, insecurity, or loneliness.
- Remain neutral but firm when patients with a personality disorder attempt to instill guilt if they do not get what they want.
- Be aware that reinforcing positive behaviors might increase the likelihood of repetition, and ignoring negative behaviors (when feasible) deprives the patient of negative attention.
- Assess for self-mutilating or suicidal thoughts or behaviors.
- Observe for mood changes, as many patients with BPD suffer profound depression, sudden mood changes, increased withdrawal, and unreasonable paranoia.
  (Martin, 2022c; Belleza, 2021)

CASE

A Patient with Borderline Personality Disorder

Thaddeus is a 27-year-old patient with paraplegia and a history of borderline personality disorder who has been receiving physical therapy from the therapist Sheri. One day, Thaddeus angrily approached Ahmed, the rehab director, and complained that Sheri was being unfair and treating him badly. He insisted that Ahmed assign him to another therapist. Ahmed listened respectfully and responded by telling Thaddeus that he could not do that but that Thaddeus could bring his concerns directly to Sheri. It seemed that this was not the response Thaddeus wanted, and he left disgruntled.

Later, Ahmed approached Sheri to let her know that Thaddeus had come to him and angrily complained about her. Thaddeus didn't say why he was angry and upset but asked to be seen by another therapist. Sheri replied that she had no inkling at all that there was anything wrong between Thaddeus and herself. He was responding well to therapy and was always pleasant. She began to feel angry herself now and said, "I didn't do anything wrong. I don't understand!"

Ahmed listened and then replied, "I think Thaddeus is upset about something, cannot tell you about it, and is going behind your back to me. This may be an example of splitting behavior due to his BPD history." He told Sheri that he had informed Thaddeus to bring up any problems directly with her.

At Thaddeus's next appointment, Sheri brought up what Ahmed had told her and asked him to talk to her about what was bothering him.

Sheri: "Thaddeus, tell me what happened that made you go to Ahmed and tell him you were upset with me."

Thaddeus: "I bet you're angry with me for doing that."
Sheri: "No, I'm not angry. I just want to know how I can help you. What has happened that made you feel upset and angry?"

Thaddeus: "Well, last week you told me I wasn't working hard enough and would never get better."
Sheri: "I disagree."

Thaddeus: "You're saying you didn't tell me that?"
Sheri (based on the element of truth): "It is true that I said we needed to add a new exercise."

Thaddeus: "But you said I wasn't working hard enough."
Sheri: "I disagree. Now, let's move on to do some more work today."

Discussion

When Thaddeus went to Ahmed with a complaint about Sheri, Ahmed listened but did not respond and "rescue" Thaddeus, as Thaddeus was likely expecting him to do. Instead, Ahmed directed Thaddeus back to Sheri to discuss his concerns.

When Ahmed described this interaction to Sheri, she was confused, concerned, and then upset with herself, wondering what she had done to make Thaddeus angry. But when Ahmed suggested that Thaddeus may be engaging in splitting behavior due to his BPD diagnosis, making Sheri the "persecutor" (all bad) and Ahmed the "rescuer" (all good), she considered this possibility and stopped taking Thaddeus's complaints personally.

When Sheri next met with Thaddeus, she directly confronted the issue, denied being angry, did not attempt to defend herself, remained detached, acknowledged the element of truth in what Thaddeus said, and distracted him to bring him back to the task.

SUBSTANCE USE DISORDERS

Substance use disorders may be suspected from the history obtained from the patient or family, or be the recognition of signs of intoxication or withdrawal. A person can have more than one substance use disorder at a time. Substances of abuse include:

- Alcohol
- Caffeine
- Cannabis
- Hallucinogens (PCP and LSD)
- Hypnotics, sedatives, anxiolytics
- Inhalants (nitrites, paint thinners, aerosol sprays, gases)
- Prescription and nonprescription opioids (codeine, oxycodone, heroin)
- Prescription and nonprescription stimulants (Adderall, cocaine, methamphetamine)
- Tobacco/nicotine

Signs and Symptoms of Substance Use Intoxication and Withdrawal

Each substance with the potential for intoxication and withdrawal has signs and symptoms that are unique. If not medically managed, withdrawal from certain substances, such as alcohol and benzodiazepines, can be quite severe and, in some rare cases, lethal.

ALCOHOL

Signs and symptoms of alcohol **intoxication** include:

- Disinhibition of sexual or aggressive impulses
- Mood lability
- Impaired judgment
- Impaired social or occupational functioning
- Slurred speech
- Incoordination
- Unsteady gait
- Nystagmus (rapid, involuntary movement of the eyes)
- Flushed face

Following reduction or cessation in heavy or prolonged use (several days or longer), these **withdrawal symptoms** may appear:

- Coarse tremor of hands, tongue, or eyelids
- Nausea or vomiting
- Tachycardia
- Diaphoresis
- Elevated blood pressure
- Anxiety
- Depressed mood or irritability
- Transient hallucinations or illusions (misperceptions or misinterpretations of the environment)
- Headache
- Insomnia
- Seizures

A complicated withdrawal may progress to **delirium**:

- Difficulty sustaining and shifting attention
- Distractibility
- Disorganized thinking
- Rambling, irrelevant, pressured, or incoherent speech
- Flight of ideas
- Impaired reasoning or goal-directed behavior
- Disorientation to time and place
- Impaired recent memory
- Illusions
- Hallucinations
- Fluctuating psychomotor activity
- Emotional instability

A small number of individuals will have the serious form of withdrawal called ***delirium tremens (DTs)***. DTs may appear suddenly and is evidenced by:

- Seizures

- Fever
- Severe confusion
- Agitation
- Hallucinations

DTs can be fatal without swift medical intervention, making alcohol withdrawal safest when monitored around the clock by medical professionals (Townsend, 2018; Sharp, 2022).

OPIOIDS

These drugs desensitize the person to both psychological and physiological pain and induce a sense of euphoria. Following the initial euphoria, signs and symptoms of opioid **intoxication** include:

- Apathy
- Dysphoria
- Psychomotor agitation or retardation
- Impaired judgment
- Pupillary constriction
- Pupillary dilatation due to anoxia from severe overdose
- Drowsiness
- Slurred speech
- Impaired attention or memory

Severe opioid intoxication can lead to respiratory depression, coma, and death.

Signs and symptoms of **withdrawal** from opioids include:

- Dysphoric mood
- Nervousness or anxiety
- Nausea or vomiting
- Flu-like symptoms
- Muscle aches and pains
- Abdominal cramping
- Teary eyes
- Rhinorrhea

- Dilated pupils
- Piloerector (goose bumps)
- Diaphoresis
- Diarrhea
- Yawning
- Fever
- Insomnia
(Sharp, 2022)

COCAINE

Signs and symptoms of cocaine **intoxication** include:

- Excitability
- Dilated pupils
- Rhinorrhea
- Weight loss
- Mood swings
- Epistaxis (nosebleeds)
- Talkative habits
- Changes in sleeping and eating patterns

Signs and symptoms of cocaine **withdrawal** include:

- Agitation and restless behavior
- Anxiety
- Irritability
- Paranoia
- Depressed mood
- Fatigue
- Problems with concentration
- Increased appetite
- Vivid and unpleasant dreams
- Lethargy or ongoing tiredness
(Sharp, 2022; Borke, 2021)

BENZODIAZEPINES

Signs and symptoms of benzodiazepine **intoxication** include:

- Diaphoresis
- Shallow respirations
- Slurred speech
- Impaired coordination
- Nausea and vomiting
- Complaints of dizziness
- Weakness
- Poor judgment or thinking
- Blurred vision
- Drowsiness
- Mood changes

Signs and symptoms of benzodiazepine **withdrawal** include:

- Sleep disturbances
- Increased tension
- Anxiety
- Panic attacks
- Difficulty concentrating
- Diaphoresis
- Heart arrhythmias
- Headache
- Muscle stiffness or discomfort
- Mild to moderate changes in perception
- Cravings
- Hand tremors

Less common and more **severe symptoms** can occur as well, which include:

- Hallucinations
- Seizures
- Psychosis or psychotic reactions
- Increased risk of suicidal ideation
  (AAC, 2022)

SCREENING FOR SUBSTANCE USE DISORDERS

There are several **screening tools** available for both alcohol and substance use in adults, such as:

- NIDA Drug Use Screening Tool, also known as the NIDA Quick Screen
- DAST-10 (Drug Abuse Screen Test), designed for both adults and older youth
  (NIH, 2021)

Treatment Modalities for Substance Use Disorders

Treatments for substance abuse disorders are highly individualized, and one individual may require different types of treatment at different times. Treatment often requires continuing care to be effective, as substance use disorder is a chronic condition with potential for both recovery and relapse. The three main forms of treatment include:

- Detoxification
- Cognitive and behavioral therapies
- Medication-assisted therapies
  (Cleveland Clinic, 2022b)

How to Respond to and Care for a Patient with Signs and Symptoms of Substance Use Disorder

Substance use is common among patients in all healthcare settings and is known to have a substantial impact on health. It is a challenge to address drug use disorders and to detect problematic use. Studies have shown that patients tend to deny or underreport substance use, and those with substance use disorders may not report any problems at all. Therefore, it is important to determine the presence of signs and symptoms that may indicate substance use problems in order to identify patients in need of comprehensive screening, intervention, and referral (Krause, 2021).

Common presentations of disorders due to substance use may include:

- Appearing affected by alcohol or other substances (e.g., odor of alcohol, slurred speech, sedated or erratic behavior
- Signs of recent drug use (recent injection marks, skin infections)
- Deterioration of social functioning (e.g., difficulties at home or work, unkempt appearance)
- Signs of chronic liver disease (jaundiced skin and eyes, palpable and tender liver edge, ascites, spider-like blood vessels on the surface of the skin, and altered mental status)
- Problems with balance, walking, coordinating movements, and nystagmus
- Dilated pupils, disordered thinking, aggression, and elevated blood pressure in patients who may be using a stimulant
- Patients who make repeated requests for psychoactive medications, including analgesics
- Presence of infections associated with intravenous drug use (HIV/AIDS, hepatitis C)

When a patient presents with signs and symptoms of substance use withdrawal, a calm and supportive environment should be provided. Nurses should monitor the patient's status and administer needed therapy as ordered. Following withdrawal:

1. **Ask:** Ask one or more questions related to drug use. When a patient answers no to drug use, probe gently, perhaps by asking, "Not even when you were in high school or college?"

2. **Advise:** Provide medical advice about the patient's drug use. Recommend quitting before problems (or more problems) develop. Medically supervised detoxification may be advised for discontinuing the use of some drugs. If patients appear ashamed or embarrassed, state that this is a health-related medical recommendation and is not meant to judge or stigmatize them.

3. **Assess:** Assess how willing a patient is to change their behavior after hearing the clinician's advice. Acknowledge ambivalence about changing behavior. State concerns about specific ways that the drug of choice may affect the person's health or personal life. If the patient becomes upset or argumentative, do not argue. Give the patient time unless the condition is life-threatening.

4. **Arrange:** Arrange for a referral for further assessment and treatment if appropriate. If the patient resists referral, explore the concerns.
(NIDA, n.d.)

CASE

A Patient Withdrawing from Substance Use

Patrick, an accountant, had been admitted to the surgical unit following a laparoscopic appendectomy. During the evening he was stable and had good pain relief. Later, Yin, the night nurse, made rounds and found him to be sleeping soundly. A short while later she ran to his room because he was yelling. When Yin arrived at the bedside, Patrick was awake and told her he had had a terrible nightmare. He was sweating profusely and was quite shaken and jittery. She reassured him that he was safe. He then stated that he was very hungry.

Yin took the patient's vital signs. His pulse rate was 65, despite his bad dream, and everything else was within normal limits. She did a brief physical examination and found no abnormalities. Yin told him she would get him something to eat from the unit kitchen. On her way back to his room, Yin checked his history and physical and nursing assessment for comorbid medical or mental conditions and found no mention of alcohol or drugs.

Yin sat down next to the bed while the patient ate. He began to speak with her.

Patrick: "Geez, I never have nightmares. Not like that anyhow."
Yin: "Tell me how you're feeling right now, Patrick."

Patrick: "I've got a slight headache, and I'm really feeling down in the dumps."
Yin: "You're feeling depressed?"

Patrick: "Yeah, and I don't have a clue why I should be."
Yin: "Is anything else bothering you?"

Patrick: "Well, yeah, as a matter of fact, I feel totally worn out."
Yin: "You feel fatigued."

Patrick: "Yeah, I do."

Yin began to wonder if these could be signs of a stimulant withdrawal, and so she began a short screening conversation:

Yin: "Patrick, I need to ask you an important question. Do you use any recreational drugs?"
Patrick: "No! Never!"

Yin: "Have you ever used any drugs?"
Patrick (hesitatingly): "No."

Yin (smiling): "Not even when you were younger?"
Patrick: "Well, yeah. I've done that."

Yin: "What type of drug have you used?"
Patrick: "Oh, a little coke now and then."

Yin: "When did you last use this drug?"
Patrick: "Gee … I don't remember."

Yin: "Have you by any chance used this recently?"
Patrick: "Yeah, I guess so."

Yin: "When was the last time you used cocaine?"
Patrick (looking ashamed): "Well … yesterday after work."

Yin nods encouragingly.

Patrick: "I suppose you think that's awful."
Yin: "No, Patrick, I don't think that's awful. I'm only concerned about your well-being."

Patrick: "Okay. Thanks."
Yin: "Can you tell me how often you use cocaine?"

Patrick: "Oh, not too often."
Yin: "Tell me what you mean by 'not too often.'"

Patrick (pausing): "Actually, I use it every day."
Yin: "Patrick, I'm concerned that you may be experiencing some withdrawal symptoms, and I want to call your doctor to find out what he wants me to do to help you out. I'll be right back to talk with you."

Yin then contacts the physician on call and informs him that Patrick may be going through withdrawal from cocaine.

Discussion

Yin suspected that the signs and symptoms Patrick was experiencing may be indications of withdrawal from a stimulant. These included his jitteriness, an unpleasant dream, slowed heart rate despite his bad dream, increased appetite, and feeling depressed and fatigued. She found that his record did not show any indication of substance use, and so she gently eased into the topic in a nonjudgmental manner, recognizing that people often diminish or deny their use of drugs and alcohol. Her nonthreatening approach allowed Patrick to overcome his concern about her judging him, and he eventually acknowledged his use of cocaine. Following this acknowledgment, Yin reassured him that she was concerned only with his well-being and would be there to help him.

EATING DISORDERS

Eating disorders are serious medical illnesses characterized by abnormal eating behaviors, maladaptive efforts to control body shape or weight, and disturbances in perceived body shape or size. These disorders can affect a person's physical and mental health and can even be life-threatening.

Common types of eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder. Eating disorders are among the deadliest mental illnesses—second only to opioid overdose—due to medical conditions and complications. Suicide is the second leading cause of death for people diagnosed with these disorders (ANAD, 2021; NIMH, 2021).

Signs and Symptoms Eating Disorders

Anorexia nervosa involves avoiding food, severely restricting food, or eating very small quantities of only certain foods. Even when people are dangerously underweight, they see themselves as overweight. There are two subtypes of anorexia nervosa:

- Restrictive: Severe restrictions on the amount and type of food consumed
- Binge-purge: Severe restrictions on the amount and type of food consumed together with binge eating and purging behaviors (e.g., vomiting, laxative and diuretic use)
(NIMH, 2021)

Common signs and symptoms of anorexia that develop over time include:

- Muscle wasting and weakness
- Dry skin
- Hypercarotenemia (yellowish skin)
- Lanugo (fine downy hair over the body to help retain body heat)
- Amenorrhea
- Bradycardia
- Bradypnea
- Hypotension
- Enlarged salivary glands and eroded dental enamel resulting from purging
- Dehydration and electrolyte imbalance
- Severe constipation
- Lowered internal body temperature resulting in feeling cold

- Lethargy, sluggishness
(NIMH, 2021)

Bulimia nervosa is characterized by recurrent episodes of binge-eating unusually large amounts of food accompanied by the feeling of lack of control. People with bulimia nervosa, unlike those with anorexia nervosa, may maintain a normal weight or be overweight.

Common signs and symptoms of bulimia nervosa include:

- Chronically inflamed and sore throat
- Swollen salivary glands of the neck and jaw
- Worn tooth enamel with increasingly sensitive and decaying teeth related to stomach acid exposure from vomiting
- Scarring or calluses of the knuckles from using fingers to induce vomiting
- Esophagitis and other GI problems
- Intestinal discomfort and irritation from laxative abuse
- Severe dehydration
- Electrolyte imbalance
(NIMH, 2021)

People with **binge eating disorder** lose control over their eating but do not purge, exercise excessively, or fast. As a result, they are most often overweight or obese. Binge-eating disorder is the most common eating disorder in the United States.
It is extremely difficult to detect binge-eating disorder, as most signs and symptoms do not present to others. Although these patients eat large amounts of food and eat rapidly, they eat normally when around others. They are often of normal weight or obese and may go on diets to try to lose weight.

Persons with binge-disorder who are obese often present with the following:

- Hypertension
- Hyperlipidemia, particularly elevated triglyceride and cholesterol levels
- Hyperglycemia
- Osteoarthritis due to trauma to weight-bearing joints
- Angina or respiratory insufficiency related to increased workload
(NIMH, 2021)

Other eating disorders include:

- Avoidant/restrictive food intake disorder (ARFID): Limiting the amount or types of foods consumed and failing to meet nutritional or energy needs; without distress about body shape, size, or fatness; more than just a "picky eater"
- Diabulimia: Deliberate insulin restriction in people with type 1 diabetes for purposes of controlling weight; increases the risks for retinopathy, neuropathy, and diabetic ketoacidosis, thereby increasing the mortality risk threefold
- Pica: Repeated eating of nonfood substances
- Rumination disorder: Repeated regurgitation to rechew, reswallow, or spit out what has been eaten

SCREENING FOR EATING DISORDERS

A number of screening instruments have been developed to identify patients with eating disorders. Some are long and not ideally suited for screening in a primary care setting, but shorter instruments have been developed that may help identify patients who need further evaluation.

SCOFF is a clinician-administered 5-question screening that asks:

1. Do you make yourself **sick** because you feel uncomfortably full?
2. Do you worry you have lost **control** over how much you eat?
3. Have you recently lost more than **one** stone (14 pounds) in a three-month period?
4. Do you believe yourself to be **fat** when others say you are too thin?
5. Would you say that **food** dominates your life?

(Feltner et al., 2022)

Treatment Modalities for Eating Disorders

The foundation for the treatment of eating disorders includes:

- Adequate nutrition
- Reducing excessive exercise
- Discontinuing purging behaviors

Treatment and therapy may include:

- Medical care and monitoring

- Individual, family, or group psychotherapy
- Nutritional counseling
- Weight restoration and monitoring
- Medications, including antidepressants, antipsychotics, mood stabilizers
  (NIMH, 2021)

Inpatient hospitalization is required for medical instability. Some patients may require **medical refeeding**, which carries the risk of developing "refeeding syndrome." This syndrome can occur when patients that have been starved begin to eat again, causing changes in metabolism and dangerous shift in fluids and electrolytes in the body, resulting in compromised cardiovascular status, respiratory failure, seizures, and even death (ACUTE, 2020).

Responding to and Caring for the Patient with Signs and Symptoms of an Eating Disorder

A patient with an eating disorder may not be easy to identify, and patients may not be forthcoming because of the secrecy and shame that go hand-in-hand with eating disorders. The stereotype of an underweight person makes it easier to identify an eating disorder, but it must be remembered that patients of normal weight or those who are obese also may have an eating disorder.

Many medical conditions can **mimic** eating disorders, including:

- Chronic infectious disease
- Malabsorptive disorders
- Malignant conditions
- Immune deficiency
- Endocrine disorders
  (StatPearls, 2021)

Patients in primary care often are not diagnosed with eating disorders most probably due to the fact that they present with apparently unrelated physical or psychiatric complaints. It is important for healthcare providers in outpatient and inpatient settings to know the signs and symptoms of the disorders, as early intervention produces the best outcomes. The following are factors to keep in mind when working with patients with eating disorders:

- Be nonjudgmental. Because there is stigma surrounding eating disorders, patients are often reluctant to discuss them; they are embarrassed and ashamed and are very successful at hiding their behaviors.
- Develop a therapeutic relationship, allowing the patient to verbalize feelings related to food and weight gain.

- Promote constructive self-talk, such as complimenting the patient on other positive qualities unrelated to appearance or highlighting features they say they like about themselves.
- Monitor for changes in vital signs, height, and weight.
- If hospitalized, monitor meals and snacks and record amounts eaten.
- Refer to a dietitian for meal planning to promote weight restoration or maintenance, considering the patient's specific eating disorder history and what behaviors they engage in, such as purging.
- Monitor nutritional status, electrolyte balance, and activity.
- Be watchful for diuretic/laxative use.
- Determine anxiety level when discussing food and weight, and how willing the patient is to follow a nutritional regimen.
- Provide education related to normal growth of the body and the role of fat in the protection of the body.
- Establish patient-centered or patient-driven goals together with the patient to ensure the patient maintains awareness, practices healthy coping techniques, and adopts a positive body image.
- Remain vigilant regarding suicidal ideation.
- If the patient is hospitalized for medical refeeding, monitor closely for signs and symptoms of refeeding syndrome.
  (Dugan 2022; Quann, 2022)

CASE

A Patient with an Eating Disorder

Grace is a 20-year-old female college student who has come to the clinic with the chief complaint of abdominal pain and constant constipation. She says she has been using over-the-counter laxatives, but they "don't work." While taking her health history, the intake nurse, Helen, notes that Grace looks thin, pale, and tired, and she reports being a bit moody.

Helen: "You look a bit tired."
Grace: "Oh, yes. I am. I'm so stressed out. I have my college finals next week."

Helen: "I see. What else is concerning you, Grace?"
Grace: "My periods have been a bit erratic lately."

Helen: "Erratic?"
Grace: "Yeah. Some months I miss my period. I get scared I might be pregnant."

Helen: "Have you lost any weight lately, Grace?"
Grace: "Yeah, I've lost a couple of pounds, but I think that's because of the stress of my finals."

Helen: "Do you think your diet might have anything to do with your constipation?"
Grace: "Oh, I don't think so. I'm very careful with my diet. I have allergies to meat and dairy, so now I only eat organic vegetables."

Helen: "Grace, does how much you weigh affect how you think and feel about yourself?"
Grace: "Well, of course. Nobody wants to be fat and ugly. I'd die if I was fat."

Helen: "Do you feel fat and ugly?"
Grace: "Well, I am, aren't I?"

Helen: "So, are you happy with how you eat and with what you eat?"
Grace: "I try to watch what I eat very carefully. I'm quite picky and don't like a lot of stuff."

Using Grace's complaint of erratic menstrual periods, along with the two questions "Have you lost any weight lately?" and "Does how much you weigh affect how you think and feel about yourself?", Helen has validated that Grace may have an eating disorder. She will discuss this with the physician, and further screening and treatment recommendations should follow.

Discussion

Helen was alerted to the possibility of an eating disorder by Grace's appearance, her complaints of abdominal pain and constant constipation, her use of over-the-counter laxatives that "don't work," and her complaints of being under stress. A big red flag went up when Grace talked about her erratic menstrual cycles and her recent weight loss.

As Helen continued to interview Grace, she understood that patients with eating disorders often complain of many food allergies and restrict their eating to one food group (in this case, only vegetables). To further clarify her suspicion that Grace has an eating disorder, Helen asked questions that involved Grace's perceptions about weight, her self-image, and her approach to eating. Helen is now in a position to refer Grace for further assessment and intervention. Throughout the interaction, Helen used active listening skills, encouraged description of perception, and restatement.

CONCLUSION

Providers who do not work in the mental health arena often do not consider that mental health issues may contribute to their patients' physical problems and that their physical problems may contribute to their mental health problems. Therefore, healthcare providers in every setting must become aware of the significance of mental health disorders among their patient populations and learn to understand and respond to them effectively.

Many in the general public as well as in the healthcare professions also have opinions and attitudes that stigmatize patients with mental illness, thus preventing patients (and healthcare professionals themselves) from speaking out and seeking help or treatment for their mental health issues.

It is often said that working with patients who have mental health disorders is "not my domain." But mental health is everyone's domain. Mental illness is all around, and healthcare providers must make it a priority to learn about them and about ways in which to communicate and help patients have a better quality of life. That is what ensuring quality healthcare means.

RESOURCES

American Addiction Centers
https://americanaddictioncenters.org

American Psychiatric Association
https://www.psychiatry.org

Mental Health America
https://www.mhanational.org

National Alliance on Mental Illness
https://www.nami.org

National Association of Anorexia Nervosa and Associated Diseases
https://anad.org

National Eating Disorders Association
https://www.nationaleatingdisorders.org

National Institute of Mental Health
https://www.nimh.nih.gov

National Institute on Drug Abuse
https://nida.nih.gov/

Self-Screening (Anxiety and Depression Association of America)
https://adaa.org/find-help/treatment-help/self-screening

Substance Abuse and Mental Health Services Administration
https://www.samhsa.gov

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TEST

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1. Which statement is a common "myth" regarding people with mental health problems compared to people without mental health problems?

a. People with mental illness experience discrimination and stigma in healthcare settings.
b. People with mental health issues are more likely to be violent and dangerous.
c. People with mental health problems are just as productive on the job as other employees.
d. People with mental illness often get better and recover completely.

2. Which action **best** describes the central element in responding to a patient with depression?

a. Using understanding and sympathy
b. Using power carefully
c. Making judgments about the patient's thinking
d. Developing a therapeutic relationship

3. Which medication used for the treatment of bipolar disorder has a high risk of toxicity?

a. Diazepam
b. Lithium
c. Valproic acid
d. Risperidone

4. In which way would a clinician respond to a patient demonstrating symptoms or behaviors of bipolar disorder?

a. Appeal to the patient using logic in an attempt to change a behavior
b. Tell the patient they are forbidden to behave and say things that are inappropriate
c. Provide consistent limits on the patient's inappropriate and abusive behaviors
d. Encourage the patient to focus on more than one topic at a time

5. Which strategy is effective when responding to a patient with an anxiety disorder?

a. Tell the patient to calm down
b. Minimize the patient's overreaction
c. Tell the patient there is nothing to be fearful of
d. Offer a distraction by talking about mundane things

6. Which side effect of antipsychotic medications is considered a medical emergency?

a. Neuroleptic malignant syndrome
b. Orthostatic hypotension
c. Sedation
d. Neutropenia

7. Which action would a clinician take when responding to a patient who is having a delusion?

a. Do not challenge the delusion directly
b. Explain to the patient that their thought is false
c. Gently touch the patient to offer reassurance
d. Avoid distracting the patient

8. Which action would the clinician take when communicating with a patient who is experiencing a borderline personality disorder?

a. Recognize the patient is not responsible for their behaviors
b. Expect the patient to test limits repeatedly
c. Ignore threats of self-mutilation
d. Take sides when the patient complains about another staff person

9. Which finding is considered a serious and possibly fatal form of withdrawal from alcohol?

a. Anxiety and tachycardia
b. Rambling and incoherent speech
c. Delirium tremens
d. Elevated blood pressure

10. Which treatment poses a serious risk to patients who are severely malnourished because of an eating disorder?

a. Taking medications such as mood stabilizers
b. Medical refeeding
c. Discontinuation of purging
d. Weight restoration and monitoring