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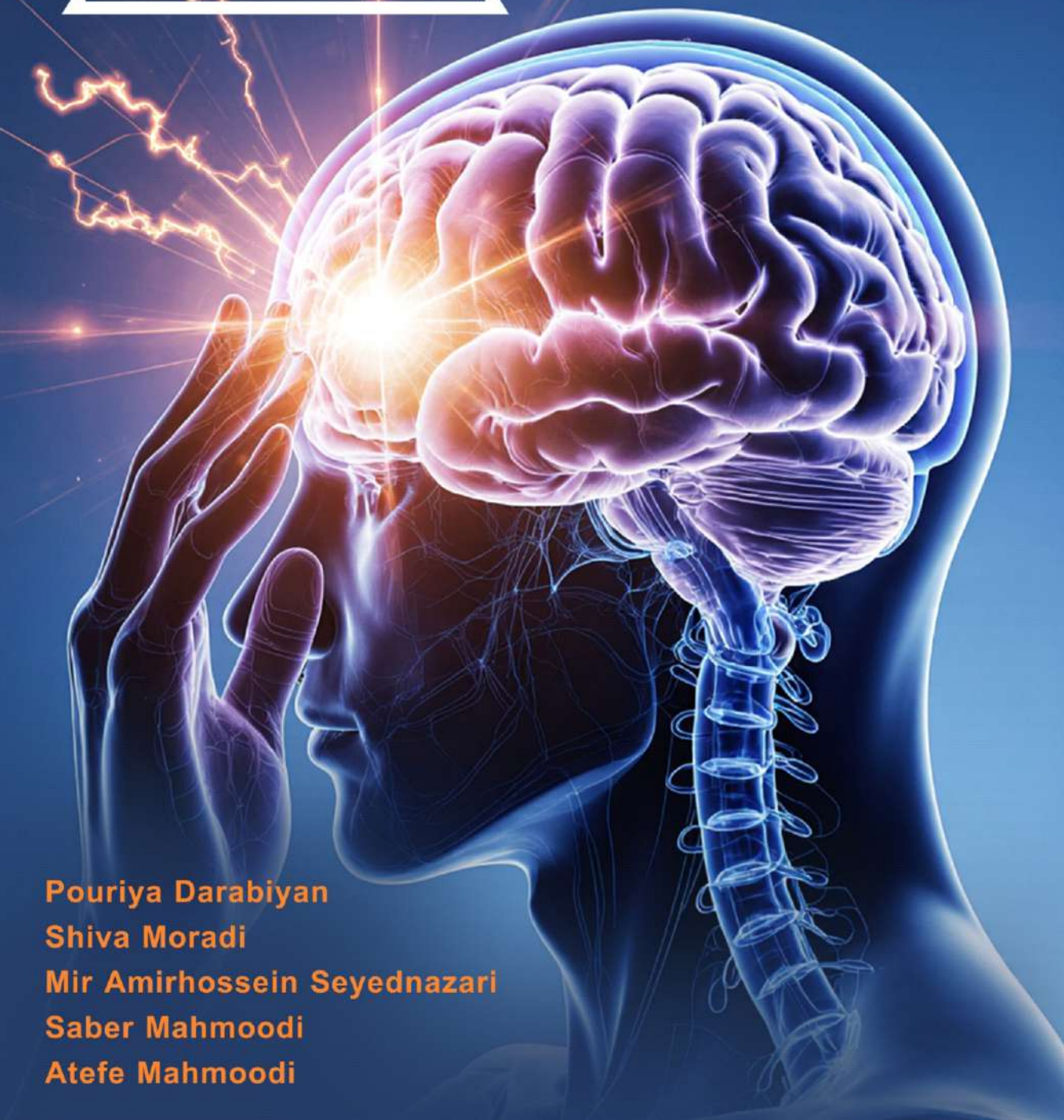
Tips for a Young Psychiatric Nurse to Perform Better



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Preface

For many years, psychotherapy has been used as one of the basic approaches in the treatment and care of neurological and mental illnesses. The last decades have seen a change of focus in the treatment of psychiatric patients – increasing attention has been paid to biological treatments. Regrettably, the nursing profession – in the context the undergraduate and graduate levels – has not been an exception for this drift, having left aside those essential frameworks in terms of an interpersonal relationship and therapeutic approach that are pivotal in the nursing care. It can be said that the beginning of the entry of nurses into the field of psychotherapy was the presentation of the theory of therapeutic communication by Dr. Hilgard Peplau. He taught effective communication with patients and also the roles of nurses in the best way. In fact, psychotherapy is a type of "planned therapeutic conversation" that is carried out to create mental health and move towards recovery. In psychotherapy, the psychotherapist must constantly think and reflect on themselves, their role in the evolutionary process created, and also the person under care. This effective therapeutic relationship develops the nurse's competencies and skills and transfers them to others. This book provides good knowledge in the process of establishing a therapeutic relationship, psychotherapy, and moving towards improving mental health for both clients and nurse therapists, so studying it will be helpful in understanding and applying more of the concepts of psychotherapy and helping to improve nurses' knowledge in this field.

Pouriya Darabiyan
Summer 2025

A Tribute to the Spirit of the National Hero, Soldier of the Homeland, Major General Pilot Mahmoud Eskandari

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Chapter 1: The History of the Psychiatric Nurse

1. What is Psychiatric Nursing?

Psychiatric nursing is a nursing specialty that involves treating people with mental illness. When a person is suffering, we work with them and their families to help them harness their own internal resources — as well as the professional resources available to them — to find a way to get better and feel better. The establishment of an empowering therapeutic relationship is the essence of psychiatric nursing.

Psychiatric nurses work with and care for people in a variety of settings. For instance, they are employed in acute inpatient settings such as Tallaght Hospital and community-oriented sector teams: day hospitals, day centers, outpatients departments, home care team. Community-based facilities and outreach community services are elements of the continuum of care. The practice of psychiatric nursing continues to change, to keep abreast of the needs of those with mental health issues and the way in which mental health care is provided.

Psychiatric nurses undergo a formal educational program (4 years degree) that prepares them with the skills and attitudes to contribute in a person-centred, empowering and culturally respectful way to the needs of the patient and family.

Nursing care and treatment are provided on a 24-hour basis and are individualized to the person. Priority for psychiatric care is based on where the person is receiving treatment — in a hospital or in the community — and how effectively they can cope with the problems at the time.

Nursing interventions will also vary based on factors like the individual's age, their "mental health wellness" or "illness," their physical health and the amount of support they receive from their family.

2. The Art of Talk Therapy

Talk is defined as “the verbal exchange of feelings, observations, opinions, or ideas”. Nurses have always talked to their patients. In 1858, in her work "Notes on Nursing," Florence Nightingale emphasized the significance of communicating with the patients in the nursing care. In the chapter “Hope and Advice for Talking,” she highlighted the fact that the words we say to a patient can cause enormous damage. False hopes and talk which causes anxiety about personal matters are not helpful in our return to health.” Have you ever wondered how nurses became psychotherapists? If these sound a lot like therapy, it’s because the formal use of talk in nursing as a psychotherapy technique started in the early 1950s, when Hildegard Peplau’s book, “Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing,” was published. This study provided the foundation for exploring nurses’ therapeutic function in mental health.

You might want to know where nurses as psychotherapists come from. The use of conversation as a formal psychotherapeutic technique for nurses began the 1950s with the publication of Hildegard Peplau’s book, “Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing”. Peplau, a true pioneer in many respects, was the first author to publish a nursing book and not have a physician coauthor. It took two years to get the book published due to the publisher's reluctance to accept a book without endorsement from a M.D.

Peplau was internationally known among national and global nursing communities for her work in psychiatric nursing, but also for professional activity in the profession. In the late 1950's she founded what would grow to be Rutgers University's first graduate program for the education of the professional nurse (RN) as the Psychiatric Clinical Nurse Specialist (CNS) program. This initiative targeted the acquisition of a postbaccalaureate nursing degree with clinical specialization in mental health.

These are some of the original wave of nurse psychotherapists to graduate from this program. They are trained in a wide range of psychotherapy methods and in the development and implementation of behavior modification programs as well as supervised practice in actual delivery of services to individuals and groups in inpatient departments. There were also many graduates who later founded private therapy practices.

Career highlights of Hildegard Peplau include a term as president of the American Nurses Association (ANA) and as ANA’s executive director. She was also a board member of the International Council of Nurses (ICN). She was awarded the Christiane Reimann Prize, the highest accolade of this organization, in 1997. Peplau passed away in 1999. You can read of her extraordinary life and her impact on psychiatric nursing in "Hildegard Peplau: Psychiatric Nurse of the Century."

The basis of her work is the interpersonal model of Harry Stack Sullivan and it was the first to articulate a nursing process that is based on a theoretical frame-work that focuses on a therapeutic relationship that facilitates patient healing. Thus a major step had been taken in the development of a formal nurse psychotherapist. First, she developed a four-phase model of the nurse–patient relationship and proposed that the conversations that take place during any phase just were therapeutic. She subsequently modified the model to be three rather than four stages by combining the identification and exploitation stages into the currently known "working stage". For the purpose of this book we will use the original model of four phases as presented above (see Figure 1.1). The following is a comprehensive analysis of what occurs (per Peplau) when a nurse interacts as the therapeutic partner with a patient.

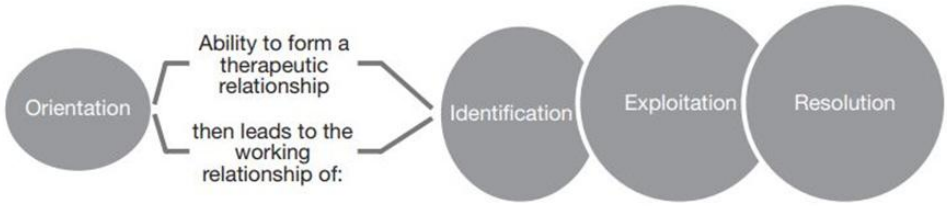

Figure 1.1 Peplau's model of interpersonal relations and formation of a therapeutic relationship.
Source: Peplau, H. E. (1952). Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing. New York, NY: G.P. Putnam

3. Orientation Phase

The first stage of the therapeutic relationship is the orientation phase. This stage starts from the moment the nurse/technician first comes into contact with the patient, that is, when the patient first contacts the service. Now the patient has made a cry for help, and the therapist emerges as an available figure. It is also important to share details of the treatment relationship during the orientation, such as the frame for the sessions, payment rates and whether sessions are structured in open-ended or time-limited ways.

The patient should make an effort to voice his needs and problems clearly and to ask and provide information. As a nurse or therapist your task is to watch and evaluate the patient, and you should be noticing what this relationship requires of you. You will be a participant observer, playing on the relationship to gather data, based on what you know about what impacts him. It is important to take into consideration the patient's past experiences, values, beliefs, culture and expectations.

In doing this early work, you are also attending to your reactions to the client and whether you can do therapeutic work together. This is a process of self-reflection, where you think about your life, where you come from, what your attitudes and values are, and how that could possibly affect the therapeutic relationship. It is that self-awareness that is a key feature of the relationship and it will be addressed in more detail in the book.

4. Identification Phase

patient relaxes more and now, they surrender to what you have to offer. This step is crucial. The capacity to surrender control and have confidence in someone else must occur before any real therapy can begin. The patient has to perceive you as a professional who can help them. On the other hand, you need to try and feel when this new relationship is established, because the patient will define his/her needs and begin to view you in the role of carer and therapist.

Once this rapport is opened, you and your patient can establish relationship-specific goals and work together to meet those needs, she adds. "Mutual" is the operative word here because goal-setting can sometimes take an unwelcome turn when a therapist sets an agenda without any regard for what the patient actually wants. Should this occur, the client will not learn to make it to the next stage in the relationship (such as empowerment and self-responsibility), and they will continue to be disempowered and depend on your validation.

5. Exploitation (Working) Phase

The bulk of the actual therapy occurs during the exploitation phase. The patient has fully engaged in the therapeutic relationship at this point and is an active, rather than a passive, participant in therapy. The term exploitation in this context means that the patient is using therapy to his or her full advantage. The phase is commonly referred to as the working phase.

The words and dialogue that you employ at this stage are very important, and rely on the patient trusting the nurse/trainer. Without this trust therapeutic objectives will be difficult to reach. We will consider some specific approaches to therapeutic conversation when we look at therapy later in the book.

The bond between the nurse or therapist and the individual by this stage is strong as the individual takes ownership of his or her own identified problems and goals. This transfer responsibility of care from the therapist to patient is what typifies this stage of change. But transitioning to responsibility is often the roughest part of the therapist-patient relationship. This phase can take weeks or months, but it is always important to begin

the process of "letting go" and preparing to foster an independent exchange / relationship for the next phase.

Psychotherapists, including nurse therapists, at times have difficulty with this process as they find the help seeker becomes more independent of them. This could suggest a boundary problem or poor counter-transference management on the part of the therapist. Though the patient will initially use the therapist as a crutch, it is the purpose of therapy to create independence.

6. Resolution Phase

Resolution dimension: after the collaboration between the nurse or therapist and the patient, and their relationship is over as the goals are achieved together. You must assess the patient's ability to make the leap over the termination. A good termination involves the patient disconnecting, knowing they can survive without you. So the individual is able to meet their needs now, they can make new goals.

It's the timing and speed of this phase that matters. Contact too early may be detrimental, leading to a relapse for the patient and the need to re-form the therapeutic alliance. You can make or break the successful resolution by your judgment as to whether the patient is ready to proceed to the next goal, or end therapy.

7. Other Nurse Psychotherapist Leaders

For further exploration of the work of Peplau and Travelbee, consult Psychiatric-"Mental Health Nursing: An Interpersonal Approach."

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Chapter 2: Discovering the Evidence

1. Clients' or Clinicians' Preference

In addition, a meta-analysis including more than 90,000 persons revealed that psychotherapy was over three times as well liked by consumers in comparison with pharmacotherapy. Psychiatrists have also noted that in the US psychotherapy is being used less and less, while drug use is increasing. A similar theme can be seen in a survey by Drew and Delaney (2009), which revealed that the majority of APPNs' time was spent providing medication management with supportive therapy, some diagnostic assessments, but no psychotherapy independent of medication management.

From our experience and current observations, this pattern continues in mental health settings. It seems that mental health agencies have taken a short-term, task-centered focus to providing care, perhaps to meet budgetary needs. This pattern has led to difficulties for academic programs in locating preceptors who are practicing to their full scope. Some programs are using two preceptors per student—one from another profession (e.g., counseling, psychology) for psychotherapy and an APPN or psychiatrist for medication and assessment. But then the scarcity of preceptors becomes an issue. Other programs are simply not separating the clinical supervision time for psychotherapy from assessments and medication management. This lack of differentiation of clinical supervision usually only provides classroom information on psychotherapy, but no clinical supervision. Is this producing graduates who are competent in psychotherapy? Likely not. Although nursing has a tradition of shifting in response to society's needs, is this pattern of narrowing the scope of practice of APPNs meeting the needs of clients or only businesses that are budget-oriented? To our knowledge, no longitudinal studies are comparing the cost-effectiveness of a task-centered versus a holistic client-centered approach to treatment. Because of this pattern of narrowing the practice of advanced practice psychiatric nursing, more APPNs are attempting to negotiate employment to allow their full scope of practice and/or start their own private practices. We have both formed our own private practices with high client satisfaction and both in-network and out-of-network insurance reimbursement, where a full scope of practice is possible.

Advanced practice psychiatric nursing is at a crossroads, and we believe that national organizations, academia, and mental health providers need a coordinated approach to providing treatment based on more than a short-term budget.

2. Psychotherapy Outcomes Research

Next, the research on the effectiveness of psychotherapy is overall strongly positive. It must be noted that there are over 100 different types of psychotherapy, and the numbers continue to expand. The types of psychotherapy range from psychoanalysis to brief manualized approaches, and the research designs range from case-centered to double-blind studies and meta-analysis. Meta-analysis is generally accepted as the most valid calculation of effectiveness because multiple studies with different designs can be combined and an effect size (ES) statistically calculated. An ES of 0.8 is considered large, 0.5 is moderate, and 0.2 is small. This is important to understand because this statistic provides information beyond a simple difference in outcome. In general, psychotherapy across a wide range of problems has been reported to have an ES ranging from 0.75 to 0.97 , and even after treatment ends, symptoms continue to improve. However, it is interesting to remember that there is no organization to review psychotherapies and to determine if there is adequate evidence from clinical trials to justify clinical use of a specific therapy, as the Food and Drug Administration (FDA) does for medications. It is also interesting to note that the ES for some antidepressants has been published by the FDA and ranges from 0.24 for Celexa, 0.26 for Prozac and Zoloft, to 0.31 for Lexapro. Although these are smaller ESs compared to psychotherapy, it has also been reported that the best recovery rates use both psychotherapy and psychopharmacotherapy. However, these studies do not identify the treatment delivery method—two separate providers or one provider. Therefore, more research about the delivery methods of treatment is needed.

3. Factors Influencing Psychotherapy Effectiveness

With these data of effectiveness firmly in place, the research question has started to move from if psychotherapy is effective to how it is effective. There has been a focus upon techniques and changes in the brain for multiple reasons, but this explanation is beyond the scope of this chapter.

Starting in the 1990s and continuing to the present, many publications and research groups have conceptualized psychotherapy as a nonlinear, dynamic, and complex process. This trend is important for practice because it helps explain features of the human change process (central to psychotherapy, of course), such as discontinuation of progress (sudden gains and losses correlated to neuronal activity), nonlinear

relationships between interventions and outcomes, variation in long-term outcomes, and the individual contributions of the therapist as well as the client. This conceptualization leads us to reexamine the common factors in psychotherapy that have been both embraced and dismissed periodically since 1936. The above-mentioned factors are not merely a package of therapeutic ingredients common to many psychotherapies. Rather they constitute a theoretical model of how change takes place in psychotherapy. There are hundreds of models that have been developed that encompass these common factors but the selection of a model does not to change our knowledge of how common factors operate to affect psychotherapy outcomes. Recent studies about the influence, of common factor, shared by the majority of psychotherapeutic models, will therefore be the subject of analysis. Recent work by Wampold (2015) examined the common factors in the contextual model as well as specific factors such as different treatments, competence of therapist, and adherence to a protocol of treatment. The common factors examined included collaboration between therapist and client, empathy, alliance, positive regard, genuineness/congruence, cultural adaptation, different therapists, and expectations. ESs were statistically calculated on all specific factors and common factors. Collaboration has an ES approaching 0.6, which is a strong effect, while empathy, alliance, positive regard, and congruence/genuineness each were approaching an ES of 0.5, which is a moderate effect. In comparison, the specific factor of treatment differences was only an ES of 0.2, which is small, and the remaining specific factors have even lower ESs. These findings indicate that the strength of common factors was about twice as important as specific factors for strong positive treatment outcomes.

Therefore, the importance of the relationship is primary and the treatment model secondary for positive outcomes. The development and dissemination of treatment models is the current focus of psychotherapy education and practice, but the themes in psychotherapy research are indicating a need for change.

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Chapter 3: Mental Illness Emergencies (Psychiatric Nursing Emergencies)

Mental health and mental illness are interrelated. A mental illness is a disorder that remains with a person for a long time, sometimes the rest of his or her life, which impacts the body and brain to an extent that he or she isn't able to handle the pain or the illness. This may occur when a person does not have a finely-tuned stress-response or doesn't have a good stress-response, and new challenges go beyond the person's ability to get back to normal. The mind is fundamentally overwhelming.

For example, the Mayo Clinic (2015) defined mental illness as "a wide range of mental health conditions —disorders that affect your mood, thinking and behavior." We all suffer from mental health problems, off and on, such as when a loved one dies — but most of us can repair ourselves thanks to our defense mechanisms, coping mechanisms and all those other things that keep most of us from going over the edge, like our social support system and our sense of spirituality.

Many of the symptoms of mental illness are also the ones we've already had when we've been stressed, anxious; when our mental health has deteriorated. This point cannot carry out daily activities any longer. Some of that signs, according to the mental illness that a particular patient has, would be:
Feeling sad or down

- Disordered thinking or problems paying attention
- Multiple fears or worries, or very strong guilt feelings
- Huge shifts in mood between highs and lows
- Avoiding wanting to be with friends or doing things
- Feeling very tired, having low energy, or having trouble sleeping

Detachment from reality (delusions), paranoia, or hallucinations
Not being able to manage day-to-day issues or stress

- Difficulty perceiving and understanding situations and people
- Alcohol or drug abuse
- Significantly changed eating behaviour
- Sex drive changes
- Rage, hostility, or unnecessary violence
- Suicidal ideation; There are times when symptoms of a mental health condition appear as physical issues, such as stomach pain, back pain, headaches, or other types of pain or aches and pains with no obvious cause.

You may not be so used to Mental Illness emergencies. We can all feel anxious, stressed, angry, and depressed at some time in our lives, but some simply go on to commit suicide, kill, act out in a way reminiscent of psychosis! It can be stressful to the attendent who is working with a patient when that particular patient acts out and causes trouble. In some cases, security precautions, anxiolytic drugs, seclusion, or even restraints will need to be employed briefly for the patient's safety. But the use of handcuffs and leg irons is, and always should be, a last resort after all other less restrictive measures have been tried.

Restraint legal documentation requirements can be intense and vary according to the purpose (medical/nonviolent vs. violent behavior). Take the time to learn the various restraint documentation requirements during orientation. Be aware that state suicide intent documentation does not always necessitate restraints and vice versa.

You must keep your priorities straight: First, yourself and your staff; Second, the patients; Third, all others in the facility. The vast majority of the mental patients are supersensitive to the "mind doctor." They do wonder much more favourably if you really hear them, respect their privacy, and give all clearly the information about anything you do or plan from the beginning.

2. Anxiety

Anxiety disorders are the most widespread mental health problem in the United States, affecting some 18 percent of the population (42.5 million people). The mean age of onset of symptoms is 11 years. Without help, many childhood anxiety disorders will persist into adulthood.

When working with someone who has an anxiety disorder, you should look for three important signs: (A) too much fear, (B) too much anxiety, and (C) bad behaviors. Anxiety is not a psychiatric disorder; in fact, it can be a wonderful motivator to get people to do things they should do on time. If anxiety is ongoing, and gets so bad it is interfering with a person's day to day life, then it is a problem. People often feel so scared and anxious that they can't work, hang out with friends, or even ask for help.

Anxiety can occur when a disruption in neurotransmitter, neuroendocrine, or neuroanatomical function in the brain shunts neuronal activity from the prefrontal cortex, the area where executive function occurs, to the limbic system, which modulates emotions. This increases likelihood of primal reactions, stalling the ability of the rational executive part of the brain to evaluate and rebalance stress responses. Through brain imaging (e.g., MRI, fMRI), researchers have discovered that individuals with anxiety, panic disorder, and PTSD have an overactive amygdala, the brain's fear centre (Martin, Ressler, Binder, & Nemeroff, 2009). It's as if someone with an anxiety disorder's brain has filed away these reactions to stimuli, and no amount of higher cognitive thinking can make them stop the bad reactions. Individuals diagnosed with generalized anxiety disorder exhibit an enlarged amygdala volume.

Changes in the amount of serotonin, a neurotransmitter in the brain, can change how people feel and act. Three theoretical models have been suggested to account for the role of serotonin in anxiety: (a) the seesaw model, (b) the amygdala model, and (c) tonically depressed basal ganglia model. A common feature in all three of these models is the failure to control serotonin with emotional arousal (anxiety) and thus the inability to inhibit the fear response. Stein and Stahl (2000) claim that models may not be explanatory with respect to the relationship between brain function and anxiety but can provide useful guidance to investigators within the domain of enquiry into mechanisms of the latter. formulation of medications aimed at alleviating the debilitating consequences of anxiety disorders.

Anxiety is a nonspecific state characterized by a general apprehension and a pervasive sense of unease that can be located along a continuum including four levels of intensity: mild, moderate, severe, and panic.
Causes: Anxiety is typically precipitated by something, although that something varies from person to person and situation to situation.

- Signs and Symptoms by Level:
  - ✓ **Mild**: Absence of muscular tension, vital signs, pin-point pupils, controlled thought and appearance.
  - ✓ **Moderate**: Typical or slightly elevated vital signs, muscle tone, excited, attention, and overall willingness to learn, solve problems, and attend, high level of energy.
  - ✓ **Severe**: Flight-or-fight response activated, tachycardia (rapid heart rate), tachypnea (rapid breathing), hypertension, sweating, urinary urgency, diarrhea, dry mouth, dilated pupils, impairment in problem-solving, sense of being overwhelmed, decrease appetite.

- ✓ **Panic**: faintness or syncope (loss of consciousness) somatic vision with sense of fainting, pallor, hyperventilation, hypertension, panic or reactivity such as panic attacks or palpitations, trembling, choking or gasping, pain, weakness, lack of coordination, chest pressure or lump in the throat, feelings of helplessness, shortness of breath, and, when extreme, changes in behavior such as anger, combativeness, withdrawal, or tears.

- Interventions: Reduce sensory stimulation, simple, repetitive communication, patient expression of feeling, simple relaxation and breathing techniques, antianxiety or analgesic medications, assess the effectiveness of medications, communicate and provide comfort and positive reinforcement to the patient.

3. Post-Traumatic Stress Disorder

The interactions of PTSD, as we know it now, have been narrow. Society may have repressed it, cloaking it in a taboo partly because it is so closely related to mental illnesses that share some of the same symptoms. (Post-traumatic stress disorder was never diagnosed then, but people back then probably had to grapple with the consequences of trauma.) Friedman (2013) suggests that 'pain and fear' from qualities associated with 'dinosaurs and saber-toothed tigers' would have generated symptoms of PTSD. The formal diagnosis of PTSD is a relatively recent phenomenon, approximately four decades old, with an official entree into the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III; American Psychiatric Association, 1980) establishing diagnostic criteria. At that time, PTSD was seen as among a group for which "a traumatic event was viewed as a catastrophic stressor that was unlike anything that the ordinary man was prepared to encounter." 'The foundation was founded on the sole basis that it was something that arose due to traumatic events and/or catastrophic events that are distinct and different, that were not part of the normal stress of life' such as divorce, death of a loved one, failing a man's family, girlfriend, wife or significant other, or not being accepted for a college.

Many attempts to explain and make sense of PTSD are based in psychology at their core. Examples of such theories include the information processing model of posttraumatic stress disorder, the emotional processing theory, and Ehlers and Clark's (2000) cognitive model. The models increased understanding of how PTSD develops and is experienced for therapists and individuals with PTSD, although the treatments and processes were also widely universal.

Prevalence refers to the number of people who actually have the disease either at a particular point in time (point prevalence) or over a specified period of time (period

prevalence). PTSD is very common — at least according to the most famous way of categorizing diseases, the DSM-5. The National Comorbidity Survey, in a large, national sample in the United States, found lifetime prevalence of PTSD to be 7.8% and higher for females (10.4%) than among males. Women often suffer from PTSD at rates that are higher than those for men, due to the fact that women are significantly more likely to be victims of domestic violence, and abuse, and rape. Twelve-month prevalence estimates ranged from 1.3% in Australia to 3.6% in the USA (Narrow et al., 2002). The disorder is highly prevalent in the posttraumatic later lifetime, most notably at subsyndromal PTSD levels. Right now, 7.7 million Americans ages 18 and up are living with PTSD. An estimated 7.8 million Americans will experience PTSD at some point in their lives. And 67 percent of people who have experienced mass violence have been found to develop PTSD — higher than the rate for people who have been through natural disasters or other traumatic events.

- Causes: This may involve military combat, rape, or both natural and man-made disasters.
- Signs and Symptoms: Common symptoms are anxiety, hyperarousal, and stress. People might have nightmares or flashbacks, complete with dissociation. Other symptoms could be outbursts of anger, more substance abuse, sleep problems, concentration challenges, unwillingness to participate in activities that remind them of the traumatic event and guilt.
- Interventions: The nurse should screen for any suicidal or homicidal ideation, assess for anxiety, listen therapeutically (without judgment), and make referrals for individual or group counseling as appropriate

4. Depression

The rate of depression among Americans over the age of 12 is about 7.6 percent, according to the Centers for Disease Control and Prevention (CDC). It is the leading "cause of disability worldwide" and the reason behind that is because in Americans between ages 15 and 44, it is the primary culprit responsible for their disability. Women are more predisposed to depression than men, and the average age of onset is 32. Those below or near the poverty line are more than twice as likely to be depressed. Serious symptoms are reported by nearly 43 percent of the depressed. And one in three people who are severely depressed receive help for their mental health.

Some of the most important signs of depression that last for at least two weeks are:

- Fatigue or claim of lacking energy
-
- Sorrow, Emptiness or Anxiousness

- Problems with sleep (difficulty in falling asleep, difficulty staying asleep, or too much sleep)
- Disinterested in activities once enjoyed
- Change in appetite (loss of appetite or overeating) leading to weight loss or gain
- Feelings of being worthless or guilty
- Psychosomatic symptoms (ie., stomach aches, headaches, muscle pains) in the absence of evident physical cause
- Cognitive effects (slow to think, forgetful; difficulty making decisions or concentrating)
- Suicidal, death or self-harm ideation

Depression is a state of sadness involving feelings of hopelessness which can affect not only mental but also physical health. Depression is fairly common after events like a divorce, or the loss of a loved one, and tends to pass with time. But clinical depression — which can be caused by chemical or hormonal imbalances in the brain — will often necessitate medication, a significant amount of therapy or both, sometimes for longer or for as long as you live.

Depressions run in families, individuals with major depression have about twice the risk of having a close relative with the condition. Personality and surroundings are also some of the reasons for depression. Neurotic people (people who complain a lot about life and are generally negativity-laden about the future) and people who are not that resilient to stress are far more prone to get depressed. Environmental foxes such as maltreatment in childhood, trauma, chronic medical illness, and enduring stress can be risk factors for the later emergence of depression.

- Causes: The reasons might be different for different persons. It can be also fselt after divorce, death of a family member, or even be a FM reaction to their living environment. But if it has hormonal or chemical causes, treatment might last longer.
- **Signs and Symptoms**: The common signs and symptoms of depression include feeling sad, low, or down in the dumps; loss of interest or pleasure in things you use to enjoy, like sex; change in weight; difficulty falling asleep or an increase in sleeping too much; feeling very tired or having little energy; feeling hopeless or helpless; having an appetite or weight change; feeling irritable; having difficulty concentrating or to settle on anything; feeling anxious; thoughts of suicide or attempting suicide.
- **Interventions**: Important interventions are to evaluate the risk of suicide, explore the patient's feelings, show a concern, and offer treatment choices. One thing to keep in mind is that it is rare that we use antidepressants in the ER, because they do not usually work in the first week or two a patient is on them.

5. Suicide

The greatest danger of depression, of course, is suicide and — as morbid as it is to say — you do need to worry about whether someone is going to kill themselves. For every 100,000 people in America, the C.D.C. says, 12.6 kill themselves. According to this, every 13 minutes someone takes their own life.

Suicide is a purposeful, self-inflicted death. Suicidal behaviors entail suicidal ideation, threat, gesture and/or attempt.

- **Causes**: Depends on the person and situation. There are however common risk factors: males; over 65; caucasian; abuse of substance/ physical / sexual / mental / emotional; depression; family history (or having previously attempted); chronically / terminally ill; psychosis; living alone; recent life change / loss; and low self-esteem.
- **Signs and symptoms:** Previous attempt(s); past verbalization of suicidal ideation; giving away loved things; writing a will; depressed/anhedonic; isolation/withdrawn.
- **Interventions**: Establish a safe room for the patient; undertakes a search of the patient and area using a security patrol; confiscate any belongings from the patient, and the area that may be misused. If doing the wound check turned up any glass, fragments are picked out at the beginning of the procedure. Documentation following hospital protocol regarding high risk or suicidal patients. One to one observation; encourage verbalization of feeling/thoughts; promote hope; get labs as prescribed for medical clearance; and have mental health eval. Here are the assessment questions.
  - Are you having thoughts about ending your life?
  - If you had a way, would you try to take your own life?
  - Have you ever had specific thoughts or plans about ending your own life?
  - Have you set a time or place?
  - What are these plans?
  - Do you have access to _____ [this method]?
  - Have you done anything or made preparations to take your own life?

6. Aggressive or Violent Behavior

This is behavior that has harmed or may result in harm to the patient or others.

- Causes: Many factors can trigger aggressive behavior, including alcohol, drugs, or long waiting times in the ED.
- **Signs and Symptoms:**
  - ✓ Loud or threatening speech
  - ✓ Yelling profanities

- ✓ Bragging about past violence
- ✓ Demanding personality
- ✓ Pacing
- ✓ Acting tense
- ✓ Clenching fists
- ✓ Slamming, pushing, or throwing objects
- ✓ Smelling of alcohol
- ✓ Other unusual behaviors

- Interventions: It can be challenging, but it's important to stay calm. You should:

Speak softly, slowly, and clearly

- **Respect the patient's personal space**
  - ✓ Provide brief and honest information
  - ✓ Be an empathetic listener
  - ✓ Encourage the patient to express their feelings
  - ✓ Involve security for a "show of force" if necessary
  - ✓ Use restraint as a last resort
  - ✓ Administer medication as ordered and when necessary
  - ✓ Document all interventions and behaviors

Remember, there are some individuals you cannot please no matter what you do. If you have tried all the strategies above, inform the person that you will find someone to assist them, and calmly walk away. Afterward, make sure to chart the person's behavior and the interventions you applied. Additionally, notify your charge nurse or supervisor if you require further assistance.

7. Psychosis

Psychosis: An extremely flawed reality perception. It is often linked to schizophrenia, which commonly involves “negative symptoms,” like trouble warming up to people and carrying on a coherent conversation.

Diagnostic and Statistical Manual of Mental Disorders (5th ed.;DSM-5;American Psychiatric Association) outlines the diagnosis of psychotic disorders on the basis of detecting aberrations in five characteristic symptom domains: (a) delusions, (b) hallucinations. (c) bizarre speech, (d) bizarre or odd motor behavior, including catatonia, and (e) negative symptoms, which are commonly accompanied by psychotic symptoms seen in schizophrenia-spectrum disorders. The psychotic symptoms associated with these phenomena are of a severity that results in distress and/or impairment in functioning. Keep in mind that the diagnostic process can be lengthy, taking months or even years because symptoms can progress gradually. About three-fourths of people with schizophrenia develop the condition between the ages of 16 and 25, and symptoms of psychosis, along with the precursor symptoms, typically first appear in the late teenage years or 20s. Erroneous beliefs are delusions: a disturbance of thought or rigid thought patterns that are contrary to reality. This inflexible tenaciousness may not be a function of anyone's culture, intelligence or religious persuasion. Delusions can vary by type (grandiose, erotomanic, jealous, somatic, persecutory, mixed, or not otherwise specified). Hallucinations are false sensory experiences. Hallucinations can include seeing things or people that aren't there, hearing voices or sounds that aren't there, smelling things that aren't there (olfactory hallucinations), feeling like someone is touching you when no one is there (tactile hallucinations) or tasting something without eating it (gustatory hallucinations). Disorganized speech is associated with communication and thinking disorder. Disorganized speech means speech gets off track a great deal, or words don't fit together in a meaningful way, or the speech is "word salad" or tangential. Thought jumping and words approximation and unclear words make speech that isn't easy to understand. Grossly disorganized is a term describing what someone looks like. If you were very disorganized, for example, you might look disheveled or wear the wrong thing for the weather (a winter coat in summer) or act inappropriately. Negative symptoms are related to having flat affect or appearance, difficulty making or maintaining eye contact or showing other levels of involvement, less body movements, less interest, less motivation, and lower social involvement.

- **Causes**: The cause of the psychosis may be unclear, but the patient must be medically ruled out. Brain injuries, imbalances in brain chemicals, losses, separations, rejections, and illicit drug use all play into the emergence of psychosis.
- **Signs & Symptoms**: Common signs and symptoms are delusions, hallucinations,ho, illusions, disorganized speech/behavior, catatonic behavior, paranoia, poverty of speech and flat effect.
- **Interventions:** Effective measures include re-orienting the patient to reality, remaining professional and calm, explaining in simple terms the nature of any non-visible noises, voices, or activities, administration of haloperidol (Haldol) if ordered, and respecting the personal boundaries of the patient.

8. Manic Behavior

Manic Behavior and Bipolar Disorder

Manic mood is an elated or irritable mood. Bipolar disorder is characterized by both episodes of mania and depression.

- **Causes**: Bipolar disorder may be caused by genetic factors and substance abuse.
- **Symptoms**: Symptoms seen in people with mania can include, but are not limited to, a feeling of being high, a grandiose sense of self, difficulty sleeping, racing thoughts, anger, lack of focus, impulsiveness, psychomotor agitation, and pressured speech (i.e. talking too much). It's hard to butt in on their conversations during these episodes.
- **Interventions**: To help someone who is in mania, the stimuli in one's environment need to be minimized. Healthcare workers should consider sending a urine drug screen and a serum lithium level if clinically indicated. Re-orienting and managing the use of a "show of force" with security personnel when behaviors are aggressive, and placing appropriate limits on manipulative or negative behavior, are also necessary. Some restraint may be needed for safety per facility policy.

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Chapter 4: Essential Practices for Psychiatry

Mental health symptoms of adults are frequently seen in primary care. Although some disorders are appropriate for initial and ongoing care by primary care practitioners, many are serious enough to require referral to a mental health professional. Practitioners with experience have the standard of care down pat in terms of how to treat clients who present with a psychiatric diagnosis and when to consult a M.D. for medication management. But, sometimes there are waits to get into a mental health treatment. There is some evidence that a coordinated care model—a model in which physical and mental health issues are dealt with in one setting—works. In this regard, instruments, symptom rating scales or clinical decision-making algorithms could be effective at assisting primary care practitioners to recognize the need for mental health care in their patients and to refer the patients as indicated.

The majority of patients on the primary care encounter probably have medical problems with high psychological or behavioral components. Meeting health-care needs of these clients can be time consuming for the provider and the resources limited. Sherman et al. (2017) provide some practical management strategies (including prompting patients to use their social supports, taking a pragmatic approach and seeing the patients more frequently, reinforcing the notion of gratitude, teaching breathing and mindfulness exercises, suggesting that the patient engage physically in some activity, and encouraging the creation of a routine).

1. Depression

Symptoms often are initially presented to the primary care physician by clients. "Depressed mood," as well as "markedly diminished interest or pleasure in, activities," must be present on either scale unless the client presents with a depressed mood and a

loss of interest has not been reported for at least two weeks. This must additionally be accompanied by four or more of the following symptoms: altered appetite, a changed sleep cycle, depressed movement or speech, fatigue, guilt or feelings of worthlessness, difficulty concentrating, and/or thoughts of death or suicide. Individuals who are suicidal or have previously attempted suicide should undergo an immediate psychological evaluation and assessment of risk by a psychiatrist or other mental health professional.

Psychotherapy works as well as antidepressants for mild-to-moderate major depression, so referral to a psychotherapist would be an option. Non-pharmacological approaches to the management of sad feelings include addressing stressors, participating in social and community supports, challenging stigma and discrimination, and treating comorbid disorders. When pharmacotherapy is also required then antidepressants may be administered at the start level dose and then the dose may be increased bit by bit until the desired therapeutic response is achieved. Clients also need to be told how long it should take to achieve the treatment's effect.

Not all pharmacologic agents are appropriate for all clients, nor are all antidepressants appropriate to initiate in all healthcare settings. It is critical that the provider is knowledgeable on appropriate first-line agents, conducts a thorough assessment of the client's symptoms and comorbid condition, severity of depressive symptoms, and overall mental health risk prior to and during the pharmacologic management of a major depressive disorder, and consults with a psychiatrist when indicated.

2. Bipolar Disorder

Besides the symptoms associated with major depressive disorder as noted above, the patient may demonstrate manic symptoms. These include having a consistently high or euphoric mood and hyperactive behavior for at least one week. To qualify as mania, the individual must also experience three or more of the following features: impaired functioning (four features are required if the mood is only irritable), inflated self-esteem or grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility, and involvement in activities that are pleasurable, but high-risk.

Experienced clinical providers usually help clients who have bipolar disorder with medication (with mood stabilizers, antipsychotic meds, or antidepressants), but generally those who have mania, should consult a mental health provider at least initially. General practitioners should be aware that some drugs can cause manic symptoms. Instances of such medications are certain antidepressants, stimulants, steroids, antiparkinsonian or dopaminergic drugs, levothyroxine, cyclosporine, and antibiotics including ciprofloxacin, gentamicin, chloroquine, and certain cancer drugs such as fluorouracil and ifosfamide.

Additionally, various co-conditions exist with bipolar disorder that are wise to learn and consider. These consist of migraines, thyroid disorder, obesity, diabetes, hypertension, heart disease, chronic obstructive pulmonary disease, human immunodeficiency virus infection, hepatitis C, sexually transmitted infections, substance abuse, and trauma. As always, a multidisciplinary approach between psychiatrists and/or psychiatric nurse practitioners, primary care providers, therapists or social workers, and other ancillary staff, to the greatest extent possible, will provide the best holistic medical care for individuals with bipolar disorder.

3. Anxiety

Generalized anxiety disorder (GAD) is among the most frequent mental disorders in primary care. GAD) - The defining detail of GAD is the experience of excessive, uncontrollable, and irrational anxiety and worry on more days than not over the previous six months. With this shared presenting symptom, clients will also demonstrate restlessness, tension, apprehensiveness, insomnia, fatigue, difficulty relaxing, poor concentration, headaches, neck and shoulder pain, and back pain.

Before deciding on a diagnosis of GAD, other possible physical causes of anxiety symptoms, such as hyperthyroidism, must be eliminated.

CBT and applied relaxation have been found to be successful in the treatment of GAD. When nondrug strategies fail, medications such as selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) may be indicated.

The skillful practitioner is aware that the client with generalized anxiety disorder typically presents with increased rates of depression, substance abuse, posttraumatic stress disorder, obsessive–compulsive disorder, and medically unexplained chronic pain, so assessment for comorbid conditions is critical. As increased cardiovascular health may be associated with this condition, screening and management are integral roles of the primary care provider.

4. Eating Disorders

Eating disorders such as anorexia nervosa, bulimia nervosa, and binge eating disorder most commonly affect white adolescent girls and young women but can affect clients of all ages and backgrounds. The primary care provider plays a key role in screening for these disorders. Once identified, a comprehensive management program involves a team approach consisting of psychiatry and other mental health experts, the primary care

provider, and a nutritionist who all play key roles in treatment. Early diagnosis and intervention are associated with improved outcomes. The assessment for and management of complications of eating disorders may be appropriate roles of the primary care provider. More significant conditions may involve inpatient management and therapies, which are beyond the scope and breadth of the primary care setting.

5. Substance Use Disorders

Although most individuals with addiction do not receive treatment, screening for substance use disorders and referral when indicated are important roles of the primary care provider.

Most primary care providers incorporate inquiry regarding smoking habits, alcohol intake, and illicit drug use. More recently, the client's health history explores vaping habits and the improper use of opioids. Time is a challenge in most primary care settings. Furthermore, providers may lack the knowledge, experience, or confidence in the management of substance use disorders.

It should be avoided by all primary care providers, who should confidently counsel clients to quit smoking. According to the 5 A's model, clinicians are invited to:

1. Inquire about smoking history, and current smoking behavior.
2. Advise all smokers to quit.
3. Evaluate the patient's motivation to quit.
4. Help them quit smoking.
5. Make provision for follow-up visits or communication.

Nicotine replacement therapy, varenicline, and bupropion are recommended for pharmacotherapy of smoking cessation in the general population. Furthermore, Park (2019) notes that various nonsmoking strategies have been effective to help clients to cease smoking. These approaches are varied and include individual and group counseling, telephone support, text messaging, web-based resources, and mobile applications.

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Chapter 5: Mental Health Complaints in Pediatric

If we want to understand psychiatric disturbances one way to do so is to look at the brain, the organ most closely associated with the biological substrates for interest. As with other organs that act as epigenetic targets for diseases, the brain is susceptible to developmental defects that impact mental processes.

The brain was an organ that could grow and develop with time, allowing to potentially learn a great deal about different psychiatric disorders through that growth. For instance, the brain is enlarged in individuals with autism, normal brain maturation is delayed in those with attention deficit hyperactivity disorder (ADHD), and brains of fetuses infected with the Zika virus do not develop well in the womb. The brain increases in size from the third week of pregnancy until the mid-20s. Embryonic tissue called the ectoderm forms the early nervous system, then becomes the developing fetal brain. Brain development relies on good physical and emotional nutrition from in utero and beyond. The brain — and many organs — continue to grow from childhood through the mid-20s. By the mid to late 20s, most individuals have achieved anatomical maturity. The brain's plasticity, or its ability to make new neurons (neurogenesis) lasts a lifetime.

1. Autism Spectrum Disorders

ASD is believed to be prevalent in about 1 in 68 kids. Boys are diagnosed more often than girls and it is more common among White children than Black or Hispanic. People with ASD typically are diagnosed by age 4, the symptoms of which can be seen as early as 2.

Signs and Symptoms

- Speech delay; no response to name being called
- Answers questions with non sequiturs

- Delayed or absence of social skills; problems understanding emotions (own or others)
- Hyperactivity, impulsivity, reactivity
- May act out violently and in a way that might hurt themselves or others
- Resistance to change; fixated interests
- Struggling with “make-believe games”
- Atypical responses to stimuli, including touch, smell, taste, noise and vision
- Odd eating and sleep habits

2. Anxiety

Anxiety Excessive fears and worries greater in chronicity, intensity, or level of distress compared to normal fears and worries that are part of development at various ages. According to the DSM-5, there are seven anxiety disorders commonly diagnosed in children. These disorders constitute generalized anxiety disorder (GAD), social anxiety, separation anxiety (over age 2), selective mutism, obsessive-compulsive disorder (OCD), phobias (including school refusal), and panic disorder.

3. Etiology

The prevalence of anxiety disorders is 8% to 9% during childhood and adolescence. In addition, a family history of anxiety is often present. In pediatrics, children manifesting an anxiety disorder often present with physical symptoms.

Epidemiology/Risk Factors

Previous trauma or abuse may play a role in causing anxiety.

Symptoms

In kids Children with anxiety disorders frequently have physical symptoms, too, but not just worry and anxiety. Such anxiety, worry, or physical symptoms either significantly interfere with the child’s daily life, or the child experiences fear or physical symptoms that are disproportionate to any risk there might be.

In order for the diagnosis of Generalized Anxiety Disorder (or GAD), besides the symptoms, there should be excessive anxiety and worry on most days for at least 6 months. This anxiety has to be tied to a specific situation, event or activity (like performing at work or school.) The individual is unable to control the worry and has at least one of the following: restlessness, fatigue, poor concentration, muscle tension, or problems sleeping.

Focused Physical Exam Signs/Findings

For children and adolescents, the best way to evaluate whether the individual has a specific anxiety disorder is by interviewing the child and the child's parents in person. Comprehensive enquire about the symptoms (for example frequency, duration, intensity or upset, interference) experienced by the child is also necessary. It is also necessary to ask the child what specifically he is thinking and what triggers anxious or avoidant behaviors.

A detailed history should also include a thorough developmental, medical, and family psychiatric history. A comprehensive social history will also take into account issues related to family relationships, social functioning, school performance, desired leisure time activities, drug history and sexual history (as appropriate for age).

Differentials

Anxiety can co-occur with other mental health conditions, such as ADHD. It is important to rule out other potential causes of symptoms and identify any comorbid conditions.

Treatment

Behavioral therapy includes child therapy, family therapy, or a combination of both. Cognitive behavioral therapy (CBT) has the strongest evidence to support it as the recommended first-line treatment for all anxiety disorders in children and adolescents (with or without medications). The school can also be included in the treatment plan.

For very young children, involving parents in treatment is key.

1. Mild to moderate anxiety often responds to education, supportive care, and follow-up office visits.
2. Evidence-based Behavioral therapy can involve child therapy, family therapy, or a combination of both approaches. Cognitive Behavioral Therapy (CBT) is the most well-supported treatment option for all anxiety disorders in children and adolescents, whether or not medications are used. It is also beneficial to include the school in the treatment plan.

For very young children, involving parents in the treatment process is essential.

1. Mild to moderate anxiety often responds well to education, supportive care, and follow-up office visits.

2. Evidence-based treatments, including CBT and/or selective serotonin reuptake inhibitors (SSRIs), are recommended for more severe cased therapies include CBT and/or a selective serotonin reuptake inhibitor.

Inhibitors (SSRI) are effective for moderate to severe anxiety disorders.

4. Prevention

While anxiety and depression cannot be avoided, the American Academy of child and Adolescent Psychiatry (AACAP) recommends that doctors screen for behavioral and mental health problems in children just like they do for hearing, vision and overall development.

Patient/Family Education

Patient and family education sheets can be found on the AACAP.org website.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is generally recognized as the most common neurobehavioral disorder of childhood. ADD is no longer part of the nomenclature. Instead, there are subtypes: ADHD, primarily inattentive type; ADHD, primarily hyperactive/impulsive type; and ADHD, combined type. AAP guidelines have now been expanded to cover ages 4 to 18 years. ADHD is a chronic condition that affects multiple domains of a child's functioning, including academic performance, adaptive skills, peer relationships, and family dynamics.

5. Etiology/Epidemiology

The estimated prevalence of children with ADHD is around 8% in school-age children with boys more likely than girls to receive the diagnosis, some of which may be related to presentation. While the exact etiology of ADHD is not known, it is believed to involve catecholamine metabolism in the cerebral cortex. In addition, there is a genetic component to ADHD, which is supported by twin studies.

Symptoms

ADHD is characterized by two core symptoms: hyperactivity/impulsivity and inattention. Other symptoms to look for include low frustration tolerance, emotional impulsivity, and executive functioning weaknesses, including planning, working memory, and abstract reasoning.

Focused Physical Exam/Findings

ADHD is generally considered the most common neurobehavioral condition in childhood. ADD is no longer the term used and ADHD is now classified into subtypes: predominantly inattentive type, predominantly hyperactive/impulsive type and combined type. The AAP has also revised its guidance to include young people 4 to 18 years old. Attention-Deficit/Hyperactivity Disorder is a persistent condition affecting multiple areas of a child's life such as school achievement, adaptive skills, peers, and family.

Lab Tests/Diagnostics

There are no specific lab tests for ADHD, but organic causes of learning difficulties, such as iron deficiency anemia, should be ruled out.

For the diagnosis of ADHD, a patient should have symptoms that are problematic

in at least two settings: symptoms should be present before the age of 12 years, for at

least 6 months, and impair function in academic, social, and/or extracurricular activities. Furthermore, symptoms exceed expected developmental expectations for the age of the child, and symptoms cannot be explained by other mental health disorders.

In children aged 17 years and less, at least 6 symptoms of either hyperactivity and impulsivity or inattention are needed for a diagnosis of the DSM-5 ADHD. In those 17 and over (or adults), the presence of at least 5 symptoms of hyperactivity and impulse or inattention is necessary in order to be diagnosed. The Conners Comprehensive Behavior Rating Scales and ADHD Rating Scale IV are examined for use in 4-year-old preschool children. The Vanderbilt rating scales are the most used and validated for children 6-years of age and older (although they may be valid for children younger than this).

Psychometric (neuropsychological or psychoeducational) testing is not necessary in

the routine evaluation for ADHD but can be useful in excluding other disorders or confirming a diagnosis, particularly when multiple comorbidities present. Other neurodiagnostic testing (EEG, MRI) is not indicated.

Differentials

Developmental: autism, learning disability Emotional/behavioral: anxiety, depression, conduct disorder, oppositional defiant disorder (ODD), posttraumatic stress disorder (PTSD) Physical: seizures (absence in particular), sleep disorders (obstructive sleep apnea [OSA]), substance abuse.

ADHD Treatment

ADHD treatment can be approached in a few ways; research has shown that the combination of therapy and pharmaceutical intervention tends to be most effective. The child's past medical history, age, symptom presentation, and family preferences all play important roles in the way management is approached.

As a very broad overview, these are the major nonpharmaceutical and pharmaceutical interventions that are typically recommended:

Nonpharmaceutical Interventions

- Cognitive behavioral therapy for the child
- Parent training for behavioral management
- Classroom accommodations (504 Plan, or IEP if child qualifies through school evaluation)
- Examples of accommodations include extended time for testing/assignments, reduced homework demands, the ability to keep study materials in class, and access to notes from the teacher. Pharmaceutical

Interventions

Nonstimulant medications—these tend to be more beneficial for children who are more hyperactive and are not as helpful for focus:

✓ Guanfacine (Intuniv), atomoxetine (Strattera), clonidine (Kapvay)

Stimulant medications:

✓ Methylphenidate and derivatives: Ritalin, Metadate CD, Concerta, Focalin/Focalin XR, Quillivant, Daytrana Patch

✓ Amphetamine and derivatives: Adderall/Adderall XR, Vyvanse

✓ Medication Considerations

Currently, there is no way to predict which medication will be most effective for a patient. Pharmacogenetic tools are not recommended due to a lack of sufficient testing and reliability. The type of ADHD (hyperactive, inattentive, or combination) does not impact stimulant choice.

Before starting a stimulant medication, it is important to ensure there is no significantly increased risk for cardiac problems in the child. To do this:

- Gather the patient's medical history.
- Gather family history for sudden death, cardiovascular symptoms, Wolff – Parkinson–White syndrome, hypertrophic cardiomyopathy, and long QT syndrome.

- If any risk factors are present, an EKG should be done, and if the EKG is abnormal, then a referral to a cardiologist should be made before starting medication.
- The risk versus benefit of medication use should be considered and discussed with the family. Common side effects should be reviewed and are outlined in the following:

Common Side Effects of Stimulants

- Decreased appetite
- Abdominal pain
- Headaches
- Sleep disturbance (most commonly difficulty falling asleep)
- Mood change/irritability
- Growth velocity changes are minimal—studies have shown diminished growth of 1 to 2 cm from predicted adult height
- Mild increase in heart rate and blood pressure, typically not clinically significant, but these measurements should be monitored
- Rare: hallucinations or other psychotic symptoms

Side Effects of Nonstimulants

- Guanfacine (Intuniv) and clonidine (Kapvay)
  - ✓ Common: decreased Heart Rate (HR) and Blood Pressure (BP), fatigue, dry mouth, dizziness, irritability, headache, abdominal pain
  - ✓ Medications should be tapered when discontinued to avoid rebound hypertension
- Atomoxetine (Strattera)
  - ✓ Common: increased HR and BP, fatigue, gastrointestinal upset, decreased appetite
  - ✓ The Food and Drug Administration (FDA) black-box warning for suicidal thoughts
  - ✓ Growth delays in the first 1 to 2 years of treatment, with return to expected measurements after 2 to 3 years of treatment
  - ✓ Rare: hepatitis

Medications

The stimulant medications are broken up into two major groups: methylphenidate (Ritalin) and amphetamine (Adderall). Within these two categories, there are multiple

different options. In general, amphetamine agents are slightly more effective, but methylphenidates are better tolerated.

A combination of stimulants and nonstimulants can be used for 24-hour coverage while optimizing focus at school. Short-acting doses may be added to long-acting forms to provide adequate coverage for the afternoon/evening (often called a booster dose).

6. What if a Child Cannot Swallow Pills?

The following medications come in a capsule that can be opened/sprinkled:

- Focalin XR
- Ritalin LA
- Metadate CD
- Adderall XR

The following medications are available in liquid/chewable/patch form:

- Quillivant XR (liquid)
- Methylin solution (liquid)
- Methylin chewable
- Daytrana Patch

Therapies that are not proven effective by research at this point, although anecdotal evidence exists:

- Omega 3/fish oil
- Diet modifications
- Cannabidiol (CBD) oil
- EEG biofeedback
- Mindfulness
- Supportive counseling
- Cognitive training
- External trigeminal nerve stimulation

Follow-Up

A close follow-up 1-2 weeks after initiation of a new medication or change in dose is advisable. To the extent possible, doses could be adjusted every 1 to 2 weeks if needed and, if you and your family agree, this can be done by phone. A follow-up visit 2–3 months following commencement of medication can then be arranged. After a stable

dose of medications is achieved, follow-up is recommended every 3-6 months depending on the response of the patient and any comorbid conditions.

Regardless of the chosen treatment (whether pharmacological or non-pharmacological), ongoing monitoring of ADHD symptoms, potential side effects of the medication, and its impact on daily functioning is essential.

Low mood and Depression

Etiology

Low mood, or dysthymia, is common among adolescents aged 11 to 19 years. Estimates indicate that 10 to 14% of adolescents experience a mental health issue that affects their daily functioning, with anxiety and depression being the most prevalent conditions. The prevalence of diagnosed depressive disorders ranges from 1% to 6%. Unipolar major depression, also known as major depressive disorder, is characterized by one or more major depressive episodes without any history of manic or hypomanic episodes. The severity of depression is typically classified as mild, moderate, or severe. Mild to moderate depression is indicated by a score of less than 20 points on the Patient Health Questionnaire (PHQ-9), which consists of nine self-report items, while severe depression is indicated by a score greater than 20 points.

Epidemiology/Risk Factors

Some personality factors including low self-esteem and excessive dependency, self-criticism and pessimism

- A stressful or traumatic life event (e.g., physical or sexual abuse)
- Blood relatives who suffered from depression, manic-depressive illness, alcoholism or suicide
- Lesbian, gay, bisexual, or transgender status
- Comorbidity with other mental health issues (Anxiety disorder, eating disorders, posttraumatic stress disorder)
- Serious and/or chronic illnesses such as cancer, stroke, chronic pain and heart disease

Focused PE Signs /Findings

While children may not verbalize feeling depressed, they may exhibit irritability, temper tantrums, and mood lability, and/or become easily frustrated, whereas adolescents may exhibit hypersomnia, decreased appetite, and weight loss.

Differentials

Unipolar major depression should be differentiated from low mood disorder. Depressed children and adolescents must be evaluated for suicide risk. In addition, depression in the pediatric patient is commonly a precursor to bipolar disorder. Other conditions on the differential can also be comorbid symptoms and include ADHD, anxiety, posttraumatic stress disorder, substance abuse disorder, and sleep disorders. The history should help to differentiate comorbid symptoms of depression from depression or low mood.

Treatment

Following screening for, and identification and assessment of, low mood or depression, APCs should provide general initial management. Standard treatment options for pediatric depression include psychotherapy, pharmacotherapy, or a combination of the two. For children with acute depression or moderate to severe depression, pharmacotherapy plus psychotherapy is initial treatment approach, typically an SSRI (i.e., fluoxetine) plus CBT. Once pharmacotherapy is initiated, treatment should be

continued for the next 6 to 12 months before being discontinued. It is reasonable to treat

with pharmacotherapy alone if other mental health services such as CBT are not available or the patient declines this intervention. Furthermore, adolescents with mild depression

can be managed with active support, and symptom monitoring may involve a referral to a mental healthcare specialist. Pharmacotherapy may be associated with adverse events, including an increased risk of suicidal thoughts or behaviors.

Prevention

There is no way to prevent depression; however, steps can be taken to help prevent depressive symptoms, such as controlling stress and encouraging patients and families to get treatment at the earliest sign of a problem.

Follow-Up/Patient/Family Education

Depression in kids and teens can be treated safely and effectively. Symptoms can ease with psychological treatments and medication, allowing young people to succeed in school and gain self-confidence.

Although there is no conclusive evidence that antidepressants cause suicidal thoughts or actions in children and teenagers, it is known that untreated depression can result in suicidal thoughts and behaviors.

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Chapter 6: Nursing Interventions for Early-Stage Dementia

1. Characteristics of early-stage Dementia

People often believe that anyone in the early stages of dementia cannot possibly have the condition because their understanding of dementia is limited to its later stages. To improve the quality of life for those of us living with dementia, we must change public perception as soon as possible. We don't begin at the final stage; some of us take a long time to progress to that point.

Early-stage dementia, particularly Alzheimer's type, is characterized by gradual changes that both the person with dementia and those close to them may notice.

- Impaired short-term memory for names, events, appointments, and other information
- Difficulty performing familiar tasks in social or work situations
- Difficulty recalling information that was just read or heard
- Frequently misplacing or losing important objects
- Diminished ability to plan or organize tasks

If significant personality or behavioral changes also occur during the early stage, the type of dementia may be Lewy body, or frontotemporal. If the changes occur episodically with periodic improvements, the type of dementia may be vascular. When dementia is a non-Alzheimer's type, the person's memory and other cognitive characteristics may not be affected during the early stage. Because of the difficulty in distinguishing between types of dementia during the early stage, obtain information about the onset and progression of various characteristics for the diagnostic process.

Assessment issues and related nursing strategies

In the words of a person with dementia:
I have to cover up, you know. Well, so I am in a conversation with somebody and I have to say to somebody, I have lost the plot totally or something got upset or something. I have to find some excuse for not ‘ sticking it.

Some people with dementia are very aware of the early stages and realises what is happening, while others know little about their illness. Some patients may be frank to speak about their dementia, on the other hand, some patients may emphatically express that I do not have any brain disease, even after shown clear proofs.

Individuals in the early stages of dementia might not want to be evaluated but this perspective shouldn’t derail conversations about it. Rather, think of it in the same way one might recommend evaluating other areas of functioning. Advise patients, family members, or caregivers to evaluate the patient for changes in mood, behavior, and personality. Stress the fact that a complete evaluation may find that there are issues that can be treated, to potentially improve or reverse these changes.

2. Cultural Considerations

In recent years, dementia has become a global health priority—a phenomenon largely attributable to the rapid and ongoing increase in the older adult population worldwide. Thus, dementia is now recognized as a “global health priority of our age”. Within a cross-cultural context, recognize that the term dementia is a Western construct, as is the designation of what is considered normal and abnormal aging.
Examples of cultural variations related to the perception of dementia:

- Manifestations of what is considered “mental illness” as shameful; these changes are likely to be ignored, denied, or covered up.
- Memory impairment and other cognitive changes may be considered normal and acceptable signs of aging; there is no need to consider medical evaluation or treatment.
- In China, people with dementia may face ridicule and isolation and be referred to in terms such as “stupid, demented elderly”.

3. Safe and Independent Operation

Most participants with early-stage dementia lived alone or with a spouse, partner, or relative, and might need some supervision or occasional help for complex activities.

Typical safety issues in this level are driving, cooking, and correct handling of money and drugs. Although they usually aren't a large issue early in the dementia process, they can become more troublesome as the dementia becomes more advanced.

While inpatient settings have limited capacity to intervene in home-related safety, these hazards can be considered in discharge planning. Nurses in acute care settings, such as ED, must consider if cognitive impairment has contributed to the presenting problem. For example, if one is in the early stages of dementia, they may not be able to safely manage medications which could result in medical emergency.

In community settings, nurses can be in a position to recognise risks to safe functioning and share strategies to minimise these risks. Questions about safety can be evaluated by inquiring about difficulty performing activities of daily living and interviewing family members or caregivers.

4. Quality of Life Issues

Early stage dementia participants expressed a desire to be acknowledged as themselves and to have help from health care practitioners to increase their ability to cope. In recent years, local chapters of the Alzheimer's Association, which are in every community, have paid more attention to the needs of those with early-stage dementia. Early stage dementia patients should attend support and educational groups (in person or on the internet) as part of their continuing care or discharge plans.

One person living with dementia explained their experience in this manner: "It was just people who have been diagnosed with Alzheimer's. Some are further along than others, but I'm OK with it. We appreciate and respect one another. We laugh, chat, have coffee and do nice things together."

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Chapter 7: Moderate-Stage Dementia

1. Characteristics of Middle-Stage Dementia

In the words of a person with dementia:
"I am afraid I don't have a very positive message. In fact, I am really suffering due to the effects of dementia. I experience a growing distance between myself and my relatives. They go on with their lives while I struggle to keep up with them. I understand that this distance is one of the consequences of dementia, but it makes me very sad."
Reisberg's (1986) widely used scale for the Functional Assessment of Alzheimer's Disease (FAST) describes the characteristics of moderate and moderately severe dementia as follows:

- Obvious cognitive deficits (e.g., disorientation, significant short-term memory impairment)
- Difficulty remembering the names of familiar people
- Inability to manage complex daily tasks without supervision or assistance
- Gradual loss of the ability to perform activities of daily living (dressing, bathing, toileting)
- Development of urinary incontinence
- Development of bowel incontinence

These changes typically develop slowly over several years, although they may occur more rapidly in the event of significant medical events, such as a stroke or major surgery. Additionally, a major change in support, such as the loss of a significant caregiver, can trigger a rapid decline in functioning. In such cases, the individual may appear to move quickly from the early to the moderate stage of dementia, even though the underlying dementia pathology may actually be stable.

2. Common Problems During Middle-Stage Dementia

In the mild dementia stage, the individual with dementia must adjust to the growing reliance on others for help with day-to-day activities, as must their caregivers. Questions about living situations frequently come up for people with dementia when they lack a care partner. For patients who live with a spouse or family member, concerns usually revolve around how to help those caregivers, how to bring in resources from the outside.

These scenarios often involve trade-offs between autonomy and safety, as well as between self-determination and the need to give others decision making responsibility. This can be particularly difficult if the individual with dementia does not have the insight or ability to make decisions for themselves regarding safety and reasonableness. Nursing Times.net During this period, family carers and nursing professionals may turn to nursing professionals for advice.

3. Assessment Issues and Related Nursing Actions

Cognitive abilities

- Use cognitive assessment tools (e.g., mini-mental status examination)
- Refer for geriatric assessment; assess memory, decision-making, and other cognitive functions during all interactions.
- Document all findings

Emotional aspects

- Use a screening tool for depression.
- Ask about feelings and coping skills related to dementia.
- Ask about spiritual/religious needs.

Ability to call for help

- Assess ability to use call light.
- Assess or ask care partners about the ability to initiate phone calls unassisted.
- Assess the ability to learn about the emergency call system. Personal care activities
- Assess grooming, bathing, oral care, and nail care.
- Refer for occupational therapy if appropriate.

Mobility

- Assess balance, walking, and transferring.
- Observe the person’s interactions with the environment.
- Refer for physical therapy if appropriate.

Bowel and bladder control

- Assess for ongoing or intermittent urinary or fecal incontinence.

- Refer for evaluations as indicated (including checking for urinary tract infection).
- Assess for constipation or fecal impaction.
- Assess factors that increase the risk for incontinence (e.g., inaccessibility of toileting facility, relying on others for assistance).

Social supports

- Ask about changes in social contacts (e.g., are there enjoyable activities that you no longer do?).
- Ask about transportation limitations.

4. Cultural Considerations

Family and societal expectations, often strongly influenced by cultural norms, play an influential role in decisions about care for the person with dementia. For example, in many cultures, families expect daughters will assume full caregiving roles and sons will provide financial support. In addition, expectations may be influenced by family caregiving history. For instance, conflict may arise if a widowed mother expects to move in with her daughter's family because her mother moved in with her family after her mother developed dementia. Nurses can help alleviate stress associated with decision-making about care by suggesting referrals, as discussed in the subsequent section.

References to Help with Decision Making

Nurses may not always have the necessary skills or time to help make decisions regarding the care of individuals with dementia. However, they can refer families to social workers for assistance. Additionally, nurses can encourage families to explore a variety of caregiving resources and living arrangements, such as assisted living facilities, senior apartments with additional services, and specialized dementia care facilities.

It is also important to provide contact information for the following resources to assist families in making these decisions:

- Geriatric Assessment Programs: These offer comprehensive multidisciplinary assessments and recommendations.
- Geriatric Care Managers: They provide initial and ongoing assistance with decisions about appropriate care.
- Alzheimer's Association Information Hotline: This offers advice about local resources for families.
- Eldercare Locator: This is a helpful tool for finding appropriate local resources.

5. Safe and Independent Operation

Implement strategies to promote safe and independent functioning, for example, by modifying environments and teaching families about interventions.
Nursing Actions to Promote Safe and Independent Functioning

Vision

- Plan for annual eye examinations
- Keep eyeglasses clean
- Provide optimal lighting
- Ensure use of magnifying aids
-

Hearing

- Plan for hearing evaluation.
- Ensure use of hearing aid or amplifying device.
- Assist as necessary with hearing aid care, insertion, and secure storage.
- Employ good communication techniques.

Memory and cognition

- Provide accurate information on the orientation board.
- Ensure visibility of clocks and calendars.
- Place photos and other reminders of family and caring relationships in visible locations.

Personal care

- Provide reminders and assist as necessary, but allow as much independence as possible.
- Arrange for manicures, pedicures, and podiatry.
- Arrange personal care items in a visible and uncluttered place in the order in which they are used.
- Leave a toothbrush with toothpaste on it on the sink.

Mobility

- Ensure use of assistive devices as recommended.
- Arrange for physical therapy.
- Encourage participation in group exercise programs (including tai chi).
- Provide individual assistance for safety.

Bowel and bladder control

- Devise an individualized toileting plan for maximum independence but with minimal risk for incontinence.
- Offer interventions to prevent constipation.

General safety and functioning

- Provide visual cues to designate important places (e.g., toilet, refrigerator).
- Provide simple cues for operating thermostats, appliances, radios, televisions, and so forth.

Usual environment

- Keep the environment simple and uncluttered.
- Keep medications, cleaning solutions, and any poisonous chemicals in inaccessible places.

Wayfinding difficulties

- Enroll in a protective program, such as the Safe Return program sponsored by the Alzheimer's Association.
- Teach about the importance of carrying identification.

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Chapter 8: Roles of Nurses in Specific Care Settings

Older adults with dementia, compared with those without dementia are at higher risk for hospitalization and emergency department (ED) use. Research suggests that dementia patients are at increased risk for adverse outcomes during hospitalisation, such as delirium, iatrogenic complications, and cognitive and functional decline. Dementia is a prevalent diagnosis, but it is not necessarily recorded in the chart if it is not the presenting complaint on hospital admission.

Dementia usually develops slowly and can be accelerated by a medical problem or changes in a person's daily schedule. For some, hospitalization can be a "straw that breaks the camel's back," prompting inquiries about whether dementia might be a diagnosis. In this context, problems related to the evaluation of changes in mental status should be addressed. If you are concerned that a patient has undiagnosed dementia, use the family questionnaire or the patient behavior assessment tool in Resources at the end of this chapter. The information below applies to caring for patients with dementia in the institutional setting, across the continuum of care, including the emergency department (ED), acute care, and rehabilitation.

1. Obtaining Accurate Information

"As nurses, we care for people with dementia who are admitted to emergency departments with altered mental status or to be treated for injuries sustained in falls. Regrettably, the history of the patient's normal functioning and mental status basis is frequently inappreciable to nonexistent. Also, the exact information is lacking for medications and medical diagnosis.

A further difficulty arises when patients have moderate dementia or expressive aphasia and the SSx they report are not those referred for recording in the RDT. For example they may face difficulty articulating their symptoms using the operative language or use

terminology that does not properly reflect the localization of their pain. They may not be reliable in answering questions about pain or other symptoms with a “yes” or “no.” You've even compromised their mental status by having them in a strange new place and new state of mind and it's difficult to pin point what the actual problem is.

It’s in these situations you need to soak up as much information as you can from the person with dementia, and then verify that information with someone who can corroborate it or add to what you know. A few effective ways to get information for assessment when you are caring for an individual with dementia include:

1. Check for any form of identification, such as a medical alert bracelet, necklace, or wallet card, that includes a toll-free number to call for medical history and contact information. When you call the toll-free number, inquire about how recently this information was updated.

2. Reach out to the person’s care partners to request information.

3. If the individual came from a nursing facility, call and ask to speak with a staff member who is familiar with the patient. Request details about the person's baseline functioning and mental status, current medications, and a comprehensive description of the reason for the evaluation.

4. Ask care partners to bring all containers of currently and recently used medications, including non-prescription products.

5. Contact the person’s pharmacy to obtain information about current and recently prescribed medications.

6. Review any available electronic medical records in your facility.

2. Identifying Elder Abuse

Also watch for subtle signs of elder abuse or self-neglect, not just so-called telltale signs like bruises or unexplained injuries but also malnutrition and medication mismanagement.

Nursing strategies for identifying elder abuse are as follows:

- If malnutrition is a concern, you might consider having a serum albumin level drawn.

- If a person is brought to the emergency department (ED) because he is lost and does not know his way home, with a medical diagnosis of dementia, consideration should be given to the fact that there is likely some type of neglect of this elderly person.
- Pay attention to the interactions between the patient and any caregivers in the room and be on the look out for signs of abusive relationship.

3. Resources Within Hospitals

Many hospitals in recent years have initiated programs to accommodate the specific needs of patients with dementia. Take advantage of any resources provided by your own institution with which you should be familiar. Two such prominent programs that are being adopted in US hospitals are Acute Care for the Elderly (ACE) units52 and the Nurses Improving Care for Healthsystem Elders (NICHE) program established by the Hartford Institute for Geriatric Nursing.

ACE units are dedicated hospital units with multi-disciplinary approaches to prevent and manage complex geriatric syndromes. This model consists of: patient-centric care, interprofessional team care, frequent re-evaluations, early discharge planning, and specific structural environment. Nurses who work in a hospital that has an ACE unit can seek consultations on the nursing care of patients with dementia or a consultation for transfer of the patient to the ACE unit.

The Gereiatric Resource Nurse, a trained nurse consultant/good practice model, is pivotal to the NICHE model, focusing on complex geriatric issues, often within patients with dementia. By 2020, more than 700 U.S. hospitals provided NICHE care. Nurses within NICHE hospitals may consult these nurses to develop individualized care plans for their patients with dementia.

If they do not have access to specialist resources or services nurses should be able to make recommendations and refer for assessments and interventions to appropriate professional colleagues:

- Geriatric Clinical Nurse Specialist or Geriatric Resource Nurse: For help, advice and care planning help.
- Geropsychiatrist/ Neurologist/ Geriatrician: For mental status assessment and management recommendations.
- Social Worker: For conversations with care partners and assistance with discharge planning and instruction on supportive services available in the community, such as the Alzheimer's Association.
- Speech Therapists: For cognitive therapies and evaluations for chewing, swallowing and safe feeding.

- Occupational Therapist: This therapist will assist with the goal to maximize safety and independence with daily activities to include driving rehabilitation.
- Physical Therapist: Help you stay active safely and prevent falls or too much disability.
- Pastoral Care: For assistance with spiritual care.

This structured approach can enhance collaboration among professionals and ensure comprehensive care for patients.

Transition in Care

As soon as a patient with dementia is admitted to any short-term care facility (e.g., acute care, EDs, rehabilitation or skilled care facility), initiate discharge planning. At a minimum, before discharge, provide the following patient education information both verbally and in writing: diagnosis, medications, referrals, and all follow-up appointments. Even for people with early-stage dementia, ensure that at least one caregiver also receives this information and has an opportunity to ask questions. When patients are transferred within institutional settings or taken to another unit for tests, it is helpful to have a family member or familiar staff person accompany the patient and ensure that appropriate information is communicated verbally to supplement the information in the chart and to provide continuity and comfort to the person with dementia.

3. Considerations for Specialized Care and Rehabilitation Centers

Skilled nursing care is typically the kind of medically necessary care that patients require on a daily or intermittent basis, and which can be provided only by a registered nurse in a Medicare-certified inpatient facility or home health care agency. Because SNF services are generally of limited duration and are subject to stringent criteria, individuals with dementia are frequently deemed ineligible for services prior to readiness for discharge as determined by themselves, their caregivers, and clinicians.

In these circumstances, nurses providing care to demented patients in the home or facility setting, who must perform reliably at an advanced level of nursing practice, must prepare defensively for the next level of care. One viable approach can be to provide appropriate discharges that refer to the existing medical social work services under the skilled care protocol. And much of what is needed for people who are no longer technically in need of skilled care is not covered by health insurance. But long-term care insurance does cover a few of these services for the small fraction of people who buy the policies. A medical social worker can assist a family in pivoting through a maze of resources and will offer guidance on obtaining financial assistance for services they require.

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Chapter 9: Triage

Today it is no longer an uncommon situation for a patient with a psychiatric emergency to be treated at an emergency department. Healthcare professionals need to know more about this category of patients and to be properly equipped to deal with them, as they may present with atypical behaviour and appearance. So, for example, a patient might have an antenna on their head that they think protects them from aliens. It is of vital importance to be kind and polite, and not to make moking remarks to these patients. Professionality is important in setting a positive tone for interaction with the psychiatrically ill.

- The patient reports either intentionally or accidentally ingesting something harmful
- The patient arrives with a weapon in their possession
- The patient expresses thoughts of wanting to die or harm themselves or other.
- The patient indicates that they have a specific plan to cause harm to themselves
- The patient's speech is disorganized

1. Worst-case Scenarios

Danger to others, manic behavior, overdose, psychotic episode, suicide.

Generic Questions

1. What can we assist you with today?
2. Has anything unusual occurred recently (e.g., trauma, noncompliance with medication)?
3. Are you taking any new medications?
4. Do you have any history of:
   - ✓ A traumatic loss or exposure
   - ✓ Illness or injury

- ✓ Secondary impacts (e.g., job loss, homelessness, financial stress)?

5. Are you experiencing thoughts of harming yourself or others?
6. Is there a plan in place to harm yourself or others?
7. What are your sleeping habits like (e.g., waking frequently during the night, insomnia)?

Generic Assessment

1. Evaluate appearance (e.g., grooming).
2. Assess affect, speech, and behavior.
3. Conduct a suicide risk assessment; refer to https://tinyurl.com/ y9pa87au for clinical practice guidelines on identifying patients at risk for suicide.

Generic Interventions

1. Ensure the safety of patients (e.g., being alone in a bathroom can be a safety concern), staff, and others.
2. Remove any items that could potentially harm the patient (e.g., belts, shoelaces, cords), and provide a gown promptly to secure personal belongings (e.g., home medications).
3. Offer emotional support.
4. Maintain patient safety by having someone monitor them (e.g., security personnel or a sitter).

2. Interventions

1. Safety First

- Maintain safety for staff, patient, and others.
- Position yourself with an exit nearby; keep dangerous objects out of reach.

2. Environmental Modifications

- Remove belts, shoelaces, cords, and sharp objects.
- Secure personal belongings, including medications.
- Assign a sitter, staff monitor, or security if risk is high.

3. De-escalation Techniques

- Use calm, respectful communication.
- Avoid confrontation or belittling comments.
- Give clear, simple instructions.
- Allow space and avoid overcrowding the patient.
- Acknowledge the patient's distress ("I can see you're upset") to build trust.

4. Emotional Support

- Show compassion and respect.
- Normalize the patient's help-seeking behavior.
- Encourage safe expression of feelings.

5. Medical & Psychiatric Management

- Address overdose or medical instability immediately.
- Obtain psychiatric consultation early.
- Administer medications (e.g., benzodiazepines, antipsychotics) only if indicated and under supervision.

6. Safety Precautions

- Never leave high-risk patients unsupervised (e.g., in a bathroom or locked room alone).
- Keep security nearby for agitated or violent individuals.
- Use physical restraints only as a last resort and according to hospital policy.
- Ensure continuous monitoring of suicidal patients.

7 Documentation

Thorough documentation is critical:

- Presenting symptoms and patient statements (use direct quotes when possible).
- Suicide risk assessment and safety plan.
- Interventions (what was removed, who monitored, medications administered).
- Staff involved and referrals made.
- Patient's response to interventions.

Collaboration & Follow-Up

- Involve psychiatric services early for comprehensive care.
- Communicate with family/support systems (with consent).
- Arrange safe discharge planning: crisis hotline numbers, follow-up appointments, community resources.
- Provide education about warning signs and when to return to the ED.

3. Key Principles

Compassionate Care: Treat patients with dignity, regardless of their mental state.
Professional Boundaries: Maintain calm authority while showing empathy.
Multidisciplinary Approach: Collaboration between emergency staff, psychiatry, security, and social services ensures safe, holistic care.

Ongoing Training: Staff should receive regular training in de-escalation, suicide prevention, and trauma-informed care.

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Chapter 10: Managing Environmental, Billing, and Political Issues as a Nurse Psychotherapist

1. Establishing Clear Boundaries and Expectations from the Beginning

To land a contract outside of our private practice, we realized that small was the best approach. We commonly outreached contracts to local mental health clinics in which we (often) equally divided our time between medication management and individual psychotherapy (allowing about 8 hours per week for each). Occasionally, we were able to get contracts that closely resembled our private practice setting where we could see patients for a full hour with therapists in the next office, coutesy calling them and getting their perspective of each patient as well as medication management (should it be appropriate).

This model is important, because it provides the context for our work. Let's also not forget that most ARPNs get reimbursed by private insurance and Medicare /Medicaid at a higher rate to social workers and counselors, which in turn allows us to argue for a higher wages. For example, the most updated current procedural terminology (CPT) codes for billing (in addition to the most recent Medicaid rates) can be accessed at: https://medicaid.ms.gov/wp-content/uploads/2014/03/ MentalHealthPsychiatry.pdf.

These rates will give you a rough idea of what to charge for your services and what you can bill for in this population. Remember that rates will be different for Medicare and private insurance. You may also choose to become a strictly fee-for-service, out-of-network provider, not taking any insurance but providing an invoice that allows the client to submit a bill toward his or her out-of-network benefits.

We found that having a working understanding of these codes and services and what they could recoup for the agency gave us a clear advantage when discussing terms of the contract and salary. Most mental health agencies will want to hire you as a 1099 contract employee. This is fine as long as you understand what this means.

As a 1099 contractor versus a W-2 employee, you are paid a flat salary with no withholdings and no benefits. Therefore, you must manage your own local/state/federal and Social Security taxes. You can do this yourself with software such as QuickBooks, or if you're not inclined to do this, an accountant can handle it for you. Some of the reimbursement rates will vary from state to state, so you will need to know these for your state beforehand.

2. The Collegial Relationship

Once you're there, it's important to network (or build relationships with other therapist colleagues). Many do not realize that psychiatric APRNs are trained and interested in psychotherapy. The fact that you are in that position is likely to be met with a cocktail of intrigue, indifference and possibly even wariness, as some may see you as a free radical in their professional domain.

A graduate psychiatric APRN student shared that at her clinical site a psychologist approached her and said, "Why don't you just stay in your own lane?" Mindsets like this can widely differ from place to place, so it is very important to be mentally prepared for such encounters.

Think about how the medical profession reacted when advanced practice nurses started prescribing meds, or how the whole RN gunnery community felt when LPNs started passing meds and starting IVs. As the newcomer, you will also be tasked with making connections with other therapists on a personal level, one therapist at a time, and building their trust over time.

First, you will need to demonstrate that you know your stuff. Most of today's mental health workforce has been trained and educated in cognitive behavioral therapy (CBT). If you can converse about this at least as a starting point, then you have a foot in the door. Second, we would also suggest making sure you are included in any meetings, such as treatment teams or case reviews, and that your contributions are not exclusively medication-related but also of the psychodynamic/ therapeutic aspects of the case. Lastly, the proof is in the pudding, as they say. Word spreads fast among the clientele regarding a clinician's skill level. Once patients start reporting their experience with you in this capacity, and assuming it's a positive one, your standing as a new member in the psychotherapist club at this clinic will begin to solidify.

3. The Practice Space

I hope with that overview, you now have a better sense of how to become a therapist so in part three, I want to talk about one of the most overlooked, overlooked and necessary

things about therapy, which is, where does therapy happen? This is the space where your clients will get to know you, trust you, drop their walls, and tell you everything. It is where they will cry, laugh and celebrate with you.

What kind of environment do you want to create that promotes these emotionally laden exchanges? There are therapists who believe that they need to show you their shingle so that you have faith in their credibility. And others see this as cockiness and putting up a wall between themselves and their client. Think about how you would like to set up the furniture. What's the preferred sitting behind a desk with the client sitting across from you? (Hint: this is not recommended!)

Also consider the lighting. Do you use gentle incandescent lights or harsh fluorescents? What are the main colors and is the client going to see them? Which smells will waft through, and what will you do with noise? And lastly, how will you manage interruptions and prevent people from knocking on your door?

This is a true story; Jeffrey had accepted a temporary 3-month contract job at a clinic in southern Ohio a few years ago. Upon arrival the first day, he was shown to an office space that was actually a storeroom with furniture piled up all over, and he was to work from a laptop computer and phone with two chairs and a small desk. When he questioned this, the office manager seemed perplexed; after all, was he not there to just see patients and refill their meds? Jeffrey just smiled and politely requested more appropriate surroundings. Jeffrey's private practice was located in a professional office building at the heart of the city's business community. He intentionally designed the environment in collaboration with the building owner to achieve an open, casual, warm, and homey feel—distinctly avoiding the typical appearance of a medical office. The walls and carpet were painted in tan, earthy colors to enhance this atmosphere.

In the far corner, a modular couch and a swivel chair were set up to evoke a living room atmosphere, and a table and chairs filled the other. Clients were kept comfortable with cold fresh iced coffee and iced tea while they waited, and a small kitchen nook provided even more iced beverage options. There was a lot of green and things growing which made them feel welcomed more by the vibe than the actual decor.

The waiting room was intended to be barrier free as the receptionist was centrally located in an island for open communication with clients. The clinicians' offices, one of them was a partner at the time, were at opposite ends of the suite. And it's not like they were professionally styled to not look so relaxed, so homey. All the offices had big comfy sofas and chairs and a small, adequate desk. Laptops were stationed at every desk, and The waiting room was made open-plan, with the receptionist situated at an island in the middle to engage directly with clients. The clinicians' offices, who were partners at the time, were located at the ends of the suite. They were decorated from the professionals to look and feel relaxed and homey. Each office had couches so plush you lose your

keys, comfortable chairs and a diminutive working desk. Each office had a laptop, there were no paper records. Through thoughtful design and usage of space, and thanks to an all-around comfortable environment, the tiny team have managed to cultivate a chilled-out, intimate-feeling space for clients.

4. Charging for What You Do?

You might decide that you even want to open your own office and your own practice, as I suggested before. One problem is setting up the office space, but then there's the more perplexing problem of how to charge for your services. This can be uncomfortable at first, as nurses have not traditionally billed their time. So let's be real: it's time to let go of that stigma!

You will even discover how to establish and manage your own practice -- and see how to address questions of reimbursement -- in the books Managing Your Practice: A Guide for Advanced Practice Nurses and Developing a Private Practice in Psychiatric Mental Health Nursing. (The latter is out of print, but well worth tracking down in the used/secondary market.)

We will talk about the significance of taking care of yourself in the next chapters. But I'll say right now: It's crucial to create a positive healing environment but you must also be able to recognize when the environment becomes too dysfunctional or toxic, meaning it's time to leave. Self-care is also essential for preventing burnout and compassion fatigue as a therapist.

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