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FAST FACTS for
MANAGING PATIENTS WITH A PSYCHIATRIC DISORDER
Brenda Marshall, EdD, APRN, ANEF, is a psychiatric nurse practitioner with a private practice in Oakland, New Jersey, and an associate professor of nursing at William Paterson University, Wayne, New Jersey. She is the author of *Becoming You, An Owner’s Manual for Creating Personal Happiness* and has published articles in peer-reviewed journals and as chapters in nursing and psychology textbooks. She has been recognized by multiple national organizations for her innovative teaching approaches in psychiatric nursing. Dr. Marshall is an internationally recognized speaker and a Fulbright Specialist in Mental Health. She has served on multiple national boards and been the president of the American Psychiatric Nurses Association’s New Jersey chapter. Her three decades of nursing experience, research, and certifications in psychiatric nursing, administration, addiction management, and psychotherapy have won her the respect of her colleagues in nursing, medicine, and psychology.
FAST FACTS for MANAGING PATIENTS WITH A PSYCHIATRIC DISORDER

What RNs, NPs, and New Psych Nurses Need to Know

Brenda Marshall, EdD, APRN, ANEF

With special contributions from
Benjamin Evans, DD, DNP, RN, APN
Assistant Professor Graduate Nursing and APN Track Coordinator
Felician University, Lodi, New Jersey

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Preface

Patients with psychiatric diagnoses compose some of our most vulnerable global populations, and as the number of people with mental illness continues to grow, the number of specialists and specialized treatment centers is shrinking. One in four adults and one in five children have a mental illness. Regardless of what specialty a nurse chooses in the 21st century, the likelihood of providing care to a person with a psychiatric disorder is inevitable. Nurses, advanced practice and non-advanced practice alike, will be required to:

- Assess and provide care to a person who has mental illness and a concurrent physical disorder or injury
- Work with a child who is experiencing emotional distress with or without a diagnosed psychiatric illness
- Help a patient with chronic pain, perhaps with a psychiatric diagnosis or substance use problem, learn how to live a full life managing pain and staying in recovery
- Support a family who has a loved one who is diagnosed with a mental illness or who may have committed suicide
- Counsel a couple who is expecting a baby and whose family genetic history includes a known mental illness

The specialty of psychiatric nursing follows the general nursing code of ethics and has its own specialty-oriented strategies, interventions, and scope of practice. Many of the more current collaborative research articles demonstrate that having a psychiatric nurse specialist as part of the response team in hospitals, on police forces, and in community planning can promote mental health in the community.
and decrease negative outcomes for our patients. Although as nurses we use a holistic and collaborative model, when it comes to providing care for the mentally ill, both the patient and the specialty nurse have felt the sting of stigma. As the profession of nursing meets the new demands of the Institute of Medicine’s future of nursing suggestions, we will find ourselves creating the policies that focus time, energy, and money on creating a better health care system. Part of that new health care system will be the emerging role of all nurses in dealing with the crisis of mental illness and the emergent opioid epidemic.

This book is divided into five sections:

■ **Part I: Mental Health and Mental Illness: What It Is, What It Is Not, and What Nurses Can Do** provides the nurse with general information related to psychiatric diagnosis, prevalence statistics, and theories of etiology. It reviews the basic environmental safety guidelines and discusses ethics in caring for the mentally ill. Finally, it presents the importance of the therapeutic alliance in providing trauma-informed care in a safe environment.

■ **Part II: Presentation of Psychiatric Disorders** identifies, and provides brief examination of, seven specific disorder categories that nurses may need for providing safe care to patients on any floor and admitted for any reason, including a psychiatric disorder. These categories include pediatrics and neurodevelopmental disorders, thought disorders (psychosis and the schizophrenia spectrum), mood disorders, anxiety disorders, obsessive compulsive disorder (OCD) and related disorders, trauma and stress, and neurocognitive and neurodegenerative disorders.

■ **Part III: Medical Diagnosis and Mental Illness: Symptom Sharing** examines three specific groups of medical diagnoses in which the signs and symptoms of the medical diagnosis share symptoms with a psychiatric diagnosis. Misidentification of these symptoms as purely psychiatric can lead to incorrect treatment of the patient’s condition.

■ **Part IV: Addictive Disorders** investigates substance use disorders and dual diagnosis (the existence of a substance use disorder with a psychiatric disorder).

■ **Part V: Psychiatric/Mental Health Issues: Clinical Setting Challenges** focuses on what the nurse may encounter with patients who have a psychiatric disorder, but who have been admitted to, or are being treated for, a separate medical issue. It closes with suggestions for practice for all nurses in different subspecialties who may be dealing with patients with mental illness.
Every chapter begins with learning objectives. Tables and “Fast Facts in the Spotlight” boxes highlight important factors, adding further information for a fuller understanding of each topic. “Spotlight on the Unit” mini-vignettes present case situations for discussion, focusing on instances in which evidence-based practice meets ethical dilemmas. Each chapter includes references, website resources, and further reading recommendations specific to the chapter topic for those interested in delving deeper.

This Fast Facts book is designed for the nonpsychiatric nurse, advanced practice nurse, and the nurse with a psychiatric specialization who want to keep current and share information with others. Fast Facts About Managing Patients With a Psychiatric Disorder can serve as an evidence-based, user-friendly resource that will help all nurses provide excellent care to patients with and without a mental illness.

Brenda Marshall
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Share

Fast Facts for Managing Patients with a Psychiatric Disorder: What RNs, NPs, and New Psych Nurses Need to Know
Thought Disorders: Psychosis and the Schizophrenia Spectrum

In this chapter, you will learn:

- Statistics related to psychosis and schizophrenia spectrum
- How to recognize the signs and symptoms of psychosis, schizophrenia, and thought disorders
- Prevalent specific thought disorders
- Evaluation of presenting symptoms in patients with thought disorders
- Common medications and therapeutic strategies used to treat thought disorders
- Nursing diagnoses and the *International Classification of Diseases and Related Health Problems*, 10th revision (ICD-10) classifications for thought disorders

**STATISTICS**

The National Institute of Mental Health (NIMH) statistics on thought disorders (psychosis and schizophrenia spectrum) indicate that about 3% of people living in the United States have a psychotic experience, with 100,000 new (first experience) psychotic events occurring each year in adolescents and young adults (NIMH, 2015). Schizophrenia affects about 1% of U.S. adults (NIMH, n.d.). Schizophrenia spectrum disorders, while not as common, are very disabling and have a
significant impact on the individual, family, and community. Although children can be diagnosed with schizophrenia, the average age of onset for symptoms is 16 to 30 years.

Risk factors for schizophrenia identified by the NIMH include:

- Genetic predisposition
- Virus exposure
- Prenatal malnutrition and other in-utero events affecting brain chemistry and structure

Psychosocial factors may be another risk factor. These include but are not limited to perinatal exposure to viruses, inadequate maternal nutrition, and problems during the birthing process (NIMH, 2016).

**RECOGNIZING SIGNS AND SYMPTOMS OF SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS**

**Thought Disorders**

Schizophrenia spectrum disorders present a constellation of symptoms and are characterized by a lack of insight. They are strongly associated with neurocognitive disorders and genetic etiology. The duration of symptoms is important in differentiating among this group of disorders. For example, patients with schizophreniform disorder and schizophrenia may present with the same symptoms; however, in schizophrenia, symptoms have lasted for at least 6 months with 1 month of active symptoms, whereas in schizophreniform disorder, symptoms have lasted 1 to 6 months without significant functional decline (Sadock & Sadock, 2008).

**Characteristic Signs**

The main characteristic signs of schizophrenia spectrum and psychotic diseases are:

- **Delusions**: Thoughts or beliefs, generally irrational, that are held despite evidence to the contrary
- **Hallucinations**: Experiencing something that is not present, which can affect all senses
- **Disorganized speech**: Jumping from one topic to another without any identifiable connection, sometimes called “word salad,” which might include inappropriate repetition of words being said (echolalia)
Disorganized behavior: Unpredictable behaviors that interfere with normal ability to engage in productive, and even basic self-care

Characteristic Symptoms

These characteristics have been identified in three categories: (a) positive symptoms, (b) negative symptoms, and (c) cognitive symptoms. Each of these categories exists on a continuum from mild to severe and should be evaluated related to the presentation and the chronicity of the disorder.

Positive Symptoms

The positive symptoms are those most commonly associated with schizophrenia spectrum disorders. Patients with positive symptoms present the classic picture of the person who lives outside of reality. They often demonstrate delusional thinking, identify or complain of hallucinations (auditory and visual), have bizarre or unusual thought patterns, and may be engaged in body movements that appear unusual or reflect emotional agitation.

Negative Symptoms

These symptoms are indications of emotional shutdown. The patient may appear expressionless and speak with a flat tone of voice, reflecting a sense of anhedonia (lack of pleasure in life), lack of desire to engage in activities of daily living, and even a lack of desire to talk. These symptoms may be read by family members as depression rather than symptoms of schizophrenia.

Fast Facts in the Spotlight

For a patient to be diagnosed with a thought disorder, specific milestones or social/cognitive deficits must be present and quantified. These include social/occupational dysfunction, specified duration of symptoms, and exclusion of other psychiatric and medical diagnosis that could have the same presentation. Unless you are a nurse practitioner, you should not be providing a medical/psychiatric diagnosis for the patient. Your relationship with and keen observation of your patient, however, will be invaluable.
Cognitive Symptoms

These symptoms indicate the patient’s reduced ability to access specific executive brain functioning. The patient experiencing these symptoms may have difficulty remembering things, understanding commands or information, or making decisions.

Evaluating Presenting Symptoms

When a patient presents with signs and symptoms of a thought disorder, it is important to look at certain aspects of the presentation. For example, tempo or acute onset of symptoms can help distinguish schizophrenia spectrum disorder from acute head trauma, delirium, a drug side effect, an infection, or a neurological disorder. Another important aspect in correctly identifying whether the disordered thought and behavioral presentation are characteristic of psychosis is to look at the prior history of the patient, the existence of other psychiatric disorders that might have psychotic features, or any other preexisting brain disorders (e.g., Alzheimer’s disease or multiple sclerosis).

Think about the individual in front of you: his or her age, sex, education, socioeconomic and educational status, and cultural norms. If possible, elicit a family history of mental illness, vascular disorders, infections and inflammatory diseases, recent travel, nutrition, and sleep patterns.

Many patients will not be comfortable sharing information about drug or alcohol use if they believe they will be judged or punished for use. It is imperative that the patient understand the need for honesty and feel safe and comfortable sharing his or her substance use history. Withdrawal from medications (legal and illegal), as well as use of certain drugs, can mimic a psychotic event. In all situations, maintaining a safe environment, open airway, and access to emergency interventions can be lifesaving.

Schizophrenic patients present the nurse with specific needs for care. Multiple nursing diagnoses, which specifically reflect the unique and specific needs of the patient, can address symptoms of each of the types of thought disorders.

PREVALENT SPECIFIC THOUGHT DISORDERS

Schizophreniform disorders are categorized for purposes of diagnosis as mild, moderate, or severe, depending on a number of factors
including intensity of presenting symptoms. The characteristics and deficits previously identified are evaluated for severity, and it is noted how many of these symptoms are presented by the patient. ICD-10 guidelines for differentiating these disorders follow.

ICD-10 Definitions

- **Schizophrenia**—A spectrum of mental disorders where a person’s ability to perceive reality is affected. This disorder affects the capacity to understand and provide social/emotional responses that would be considered acceptable. People experiencing symptoms of schizophrenia might have auditory, tactile, visual, olfactory, and taste disturbances; hearing, seeing feeling, smelling, and tasting things that are not real. The person’s ability for social/emotional communication can also be affected, presenting as an inability to respond with proper, intelligible speech patterns (disorganized speech) or with appropriate emotional or social behaviors. These symptoms often can lead to the person’s withdrawal from society. The disorder is chronic, and severe, usually starting in the late teens or early 20s with unusual thoughts and perceptions as well as hallucinations. The duration of this disorder is at least 6 months.

- **Schizoaffective disorder**—This disorder includes two sets of symptoms. The person will have the symptoms of a mood disorder, like bipolar disorder, and also of schizophrenia during the active portion of the disorder. When the patient is not experiencing the symptoms of the mood disorder, the symptoms of the psychosis, inclusive of hallucinations and delusions persist.

- **Schizophreniform disorder**—This disorder has a different duration from the diagnosis of schizophrenia, in that the diagnosis includes a duration between 1 and 6 months. This disorder is less debilitating in its impact on functioning in daily living, including job and social/emotional arenas.

- **Delusional disorder**—Delusions are untrue beliefs that are held despite evidence to the contrary. A person with a delusional disorder must hold the delusion for over a month, and not be diagnosed with schizophrenia or a mood disorder. The delusion that is held is not one that substantially interferes with the person’s ability to carry on activities of daily living.
This disorder is chronic and can be identified in both psychotic and nonpsychotic patients, with presenting symptoms of delusions of jealousy, persecution and paranoia.

- **Brief psychotic disorder**—This disorder presents as schizophrenia, with the symptoms of hallucinations, delusions, and impairment in thoughts and communication, but it resolves in less than one month.

- **Catatonia**—This disorder causes a disturbance in mobility, reflected in the person’s loss of control over physical movement or posture. This may be represented by loss of (or excessive) motor activity, an inability to speak (mutism), an engagement in intense negative attitudes or speech, and the mirroring of words (echolalia) or movements (echopraxia).

### COMMON MEDICATIONS USED TO TREAT PSYCHOTIC DISORDERS

Antipsychotic medications are central to the treatment of patients with psychotic disorders. Any one of a number of first- and second-generation agents may be prescribed, depending on the severity of the patient’s symptoms.

#### First-Generation Antipsychotics (Neuroleptics)

All antipsychotic drugs are associated with significant side effects. First-generation antipsychotics have a high likelihood of causing cognitive slowing or impairment, and movement disorders that include extrapyramidal side effects and tardive dyskinesia. Commonly used drugs in this class are:

- Haloperidol (Haldol)
- Loxapine (Loxitane)
- Chlorpromazine (Thorazine)
- Thioridazine (Mellaril)

#### Second-Generation Antipsychotics

Second-generation antipsychotics, too, have a high likelihood of causing cognitive slowing or impairment and metabolic syndrome. Commonly used drugs in this class are:
Aripiprazole (Abilify)  
Clozapine (Clozaril)  
Ziprasidone (Geodon)  
Risperidone (Risperdal)  
Quetiapine (Seroquel)  
Olanzapine (Zyprexa)

THERAPEUTIC AND ENVIRONMENTAL STRATEGIES USED TO TREAT THOUGHT DISORDERS

Psychosocial Interventions

- **Cognitive behavioral therapy (CBT)** works by using thoughts and behaviors on emotions. It is a solution-focused therapy that increases the patient’s ability to cope.
- **Cognitive remediation therapy** can be helpful in improving attention, working memory, and executive functioning.
- **Psychoeducation** increases illness awareness, self-management skills, habit regularity, and recognition of early warning signs of relapse (Colom, 2014).
- **Psychodynamic therapy** examines past problems and unresolved struggles and the impact those experiences are having on the person’s present experience.

Client-Centered, Supportive, and Insight-Oriented Psychotherapy

- **Behavior modification**: Desired behaviors are reinforced using a reward system (e.g., token economy).
- **Family intervention**: The family meets together to identify needs, acquire skills to deal with the disorder, provide support to family members, and provide ongoing psychoeducation.

MATCHING NURSING DIAGNOSIS AND MEDICAL DIAGNOSIS

Table 5.1 correlates nursing diagnoses with the ICD-10 codes for thought disorders.
Table 5.1
Nursing Diagnoses and ICD-10 Nomenclature for Thought Disorders

<table>
<thead>
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<th>ICD-10 codes</th>
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<td>Social isolation</td>
<td>Delusional disorder (F22)</td>
</tr>
<tr>
<td>Sensory and perceptual alterations related to hallucinations</td>
<td>Brief psychotic disorder (F23)</td>
</tr>
<tr>
<td>Impaired verbal communication</td>
<td>Schizophreniform disorder (F20.81)</td>
</tr>
<tr>
<td>Ineffective individual coping</td>
<td>Schizoaffective disorder, bipolar type (F25.0)</td>
</tr>
<tr>
<td>Risk for violence</td>
<td>Schizoaffective disorder, depressive type (F25.1)</td>
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<tr>
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<td>Schizophrenia (F20.9)</td>
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Sources: Herdman & NANDA (2012); ICD10Data.com (n.d.).

SPOTLIGHT ON THE UNIT: ADOLESCENT BOY ON ORTHOPEDIC FLOOR AFTER A BIKING INJURY

A patient on your floor, Patrick, is calling for the nurse; his leg has just been casted after a fracture to his tibia. His mother comes to the nursing station stating that her son is talking “in tongues” and she believes that he must have been given some drug for his pain that has made him act “crazy.” You check the chart and see that he has not requested any medications, nor has he been given any. You go to the room and find his father there, watching TV. Patrick, speaking in a loud voice and staring at the upper corner of the room, says “It doesn’t matter what you think, XANDIDO, I will not follow your command!” He looks frightened. His father continues to watch TV. You ask, “Patrick, who are you talking to?” His father responds, “Ignore him. He does this to upset us. Like there are other people in the room . . . he’s been worse lately, though.”

- What are the possible problems you are facing?
- What is the differential diagnosis?
- What kinds of evaluations do you think Patrick needs?
- Whom do you think you should call for a referral and evaluation?
- What possible safety issues might you have to consider?
Further Reading


References


Anxiety Disorders

In this chapter, you will learn:

- Statistics related to anxiety disorders
- Neurobiology of anxiety
- How to recognize the signs and symptoms of anxiety disorders
- Prevalent specific anxiety disorders
- Evaluation of presenting symptoms in patients with anxiety disorders
- Common medications and therapeutic strategies used to treat anxiety disorders
- Nursing diagnoses and the International Classification of Diseases and Related Health Problems, 10th revision (ICD-10) classifications for anxiety disorders

STATISTICS

The most common of all mental illnesses, anxiety disorders affect approximately 18% of the U.S. population (more than 40 million people). The average age of symptom presentation is 11 years. A number of the anxiety disorders, if not treated in childhood, will persist into adulthood (see Figure 7.1). Anxiety disorder is more common in females (2:1 ratio; American Psychiatric Association, 2013).

It is not unusual for people with anxiety disorder to have other comorbid mental illnesses. Almost 50% of those diagnosed with an anxiety disorder are also diagnosed with depression. Anxiety disorders
are not outcomes of other physiological illnesses or substance use, although anxiety may be a common symptom of those other disorders. The National Institute of Mental Health (NIMH) identifies several types of anxiety disorders, including generalized anxiety disorder, panic disorder, and social anxiety disorder.

**OVERVIEW OF ANXIETY DISORDERS**

There are three significant features to observe for when working with a person diagnosed with an anxiety disorder: (a) excessive fear, (b) overwhelming anxiety, and (c) maladaptive behaviors. Anxiety itself is not a psychiatric diagnosis; in fact, it can be very helpful in motivating people to get things done on time. A problem occurs when anxiety becomes persistent and so excessive that daily living is affected. Individuals often feel so overwhelmed by the fear and anxiety that they are unable to work, socialize, or even seek help.

Another word that is often used interchangeably with anxiety is “phobia.” Phobias are irrational fears that are specific to a situation (e.g., heights or closed spaces) or objects (e.g., needles or bacteria). Although this chapter focuses on anxiety, rather than the multiple...
phobias, some of the behavioral components that individuals with anxiety disorders develop to help reduce the anxiety produced by a phobia (e.g., excessive hand washing) are discussed.

**Fast Facts in the Spotlight**

Anxiety is not pathological unless it interferes with the ability to carry out activities of daily living. It is identified with excessive worries and fears. When experienced in our daily lives, anxiety can be an appropriate response, helping us evaluate immediate threats or long-term consequences. Whereas fear is our short-term response to a specific perceived threat, anxiety is the response we have after an event or in anticipation of it. All anxiety disorders share symptoms of co-existing anxiety and fear.

**NEUROBIOLOGY OF ANXIETY**

Anxiety can result when a neurotransmitter, neuroendocrine, or neuroanatomical disruption in the brain shifts the neuronal activation from the prefrontal cortex, where most executive functioning occurs, to the emotion-regulating limbic system. This increases the likelihood of more visceral responses, denying the ability of the rational executive branch of the brain to evaluate and mitigate stress responses. Neuroimaging, using magnetic resonance imaging (MRI) and functional magnetic imaging (fMRI), has identified hyper-responsiveness to stimuli in the amygdala (the fear center of the brain) in patients diagnosed with anxiety, panic disorder, and posttraumatic stress disorder (Martin, Ressler, Binder, & Nemeroff, 2009). It appears that the brain of a person with an anxiety disorder has encoded the person’s responses to stimuli, which block the ability of the higher cognitive part of the brain to repress the negative responses. Patients with generalized anxiety disorder have been found to have increased amygdala volume.

If a person is unable to access the prefrontal cortex because of severe, persistent anxiety, it is as though he or she has been emotionally hijacked. During those times, the patient cannot relax, self-soothe, or process any environmental cues being provided. These patients are in a state of total emotional dysfunction.
Serotonin and Anxiety

Changes in the levels of serotonin, a neurotransmitter in the brain, influence both mood and behavior. Three models have been theorized to explain the link between serotonin and anxiety: (a) the seesaw model, (b) the amygdala model, and (c) the basal ganglia model (Stein & Stahl, 2000). In all three models, the inability to regulate serotonin during anxiety is a central feature, resulting in an inability to mitigate the fear response. Stein and Stahl (2000) emphasize that the intricacies and complexities of anxiety and brain function cannot be easily explained by models; however, these models provide some guidance for researchers developing medications to mitigate the debilitating effects of anxiety disorders.

RECOGNIZING SIGNS AND SYMPTOMS OF ANXIETY DISORDERS

The presenting symptoms of anxiety disorders are sweating, trembling, chest pain, shortness of breath, and heart palpitations. Patients may say that it feels as though nothing is real, express a fear of dying, and be hypervigilant, seeking a way to escape. Frequently patients experience tingling in the limbs, become flushed, or complain of chills. Their ability to respond to everyday questions may be affected, and their response to the possibility of environmental danger heightened. A patient may have had insomnia in the preceding days, have some difficulty swallowing because of dry mouth, have numbness in the hands or feet, or be very fidgety.

Fast Facts in the Spotlight

Anxiety may be associated with heart disease and risk factors for heart attack (McCann, n.d.). People with anxiety disorders may experience tachycardia, hypertension, and decreased heart rate variability. Because 50% of people with depression also have an anxiety disorder, and depression has been linked to coronary heart disease, it is important to examine the patient with anxiety for any heart problems.
**Prevalent Specific Anxiety Disorders**

**Specific Phobias**

Specific phobias are defined as persistent fear of objects or situations that result in immediate extreme anxiety. Behavioral alterations reflect a desire to avoid the object or situation at all costs, demonstrating an uncontrollable, irrational response. This response has a negative effect on other areas of living, such as employment, social attachments, and activities of daily living. Children and adolescents may react with varying degrees of freezing, crying, acting out, or holding onto the caregiver.

**Social Anxiety Disorder**

Social anxiety disorder is diagnosed when an individual demonstrates a persistent (for at least 6 months) extreme fear of being negatively evaluated by others in social situations. The fear extends to worrying about engaging in actions that will be humiliating. The individual attempts to change behaviors to avoid the social situations completely; if that is not possible, he or she is forced to experience them while feeling an overwhelming sense of anxiety and worry. Onset of symptoms is usually between the ages of 8 and 15 years. Children and adolescents experience this disorder with peers and in adult social situations, and they may respond by throwing tantrums and refusing to participate in activities.

**Generalized Anxiety Disorder**

In adults, generalized anxiety disorder is defined as excessive and persistent worrying and feelings of anxiety over a period of 6 months or more, such that the level of worry and anxiety has significantly interfered with work, socializing, or daily functioning. The ongoing experience results in a sense of fatigue, difficulty concentrating, disturbances in sleep patterns, and muscle tension. The mean age of onset for generalized anxiety disorder is about 30 years.

**Panic Disorder**

Panic disorder is an intense, paralyzing apprehension accompanied by a sense of impending doom, which produces physical effects such as shortness of breath, a sense of choking, chest pain, and palpitations.
These symptoms occur without warning and not in response to any specific known environmental or emotional stimuli. A panic attack is usually of short duration, but in rare instances it may be prolonged. Patients who have panic disorder are often apprehensive about the possibility of experiencing an attack and frequently alter their behavior in an attempt to avoid one. These patients have an increased rate of suicide.

**Anxiety Symptoms Secondary to an Existing Medical Condition**

Medical conditions that may be an underlying cause of panic or anxiety in a patient include:

- **Endocrine disorders**: Hyperthyroidism, hypoglycemia, and hyperadrenocortisolism
- **Respiratory disorders**: Asthma, chronic obstructive pulmonary disease, pneumonia
- **Cardiovascular disorders**: Emboli, atrial fibrillation, congestive heart failure
- **Neurological disorders**: Seizure disorder, neoplasms, encephalitis
- **Vitamin deficiencies**: Vitamin B₁₂ deficiency

**Anxiety Secondary to Substance Use**

This category applies when a patient presents with anxiety that is secondary to use of or withdrawal from a substance, and the excessive anxiety experienced is the factor having the impact on functioning.

**Postpartum Anxiety**

Although postpartum depression is a well-known disorder affecting new mothers, women may also develop postpartum anxiety, which is an apprehension of death and danger after childbirth, leading to specific avoidance-prone behaviors that are disabling or interfere with activities of daily living.

**MEDICATIONS USED TO TREAT ANXIETY DISORDERS**

Many different medications are available for the treatment of anxiety disorders. Categories of medications are listed in Table 7.1.
### Table 7.1

**Categories of Medications Commonly Used for Anxiety Disorders**

<table>
<thead>
<tr>
<th>Category</th>
<th>Generic name</th>
<th>Brand name(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td>alprazolam</td>
<td>Xanax</td>
</tr>
<tr>
<td></td>
<td>clonazepam</td>
<td>Klonopin</td>
</tr>
<tr>
<td></td>
<td>diazepam</td>
<td>Valium</td>
</tr>
<tr>
<td></td>
<td>lorazepam</td>
<td>Ativan</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>metoprolol</td>
<td>Lopressor</td>
</tr>
<tr>
<td></td>
<td>metoprolol LX</td>
<td>Toprol-LX</td>
</tr>
<tr>
<td></td>
<td>propranolol</td>
<td>Inderal</td>
</tr>
<tr>
<td></td>
<td>atenolol</td>
<td>Tenormin</td>
</tr>
<tr>
<td>Tricyclic antidepressants (TCAs)</td>
<td>doxepin</td>
<td>Sinequan</td>
</tr>
<tr>
<td></td>
<td>clomipramine HCl</td>
<td>Anafranil</td>
</tr>
<tr>
<td></td>
<td>imipramine</td>
<td>Tofranil</td>
</tr>
<tr>
<td>Other antidepressants</td>
<td>bupropion</td>
<td>Wellbutrin</td>
</tr>
<tr>
<td></td>
<td>amitriptyline (tricyclic)</td>
<td>Amitid, Amitril, Elavil, Pameler</td>
</tr>
<tr>
<td></td>
<td>nortriptyline (tricyclic)</td>
<td></td>
</tr>
<tr>
<td>Monoamine oxidase inhibitors (MAOIs)</td>
<td>isocarboxazid</td>
<td>Marplan</td>
</tr>
<tr>
<td></td>
<td>phenelzine</td>
<td>Nardil</td>
</tr>
<tr>
<td></td>
<td>tranylcypromine</td>
<td>Parnate</td>
</tr>
<tr>
<td></td>
<td>selegiline</td>
<td>Emsam</td>
</tr>
<tr>
<td>Selective serotonin reuptake inhibitors (SSRIs)</td>
<td>sertraline</td>
<td>Zoloft</td>
</tr>
<tr>
<td></td>
<td>fluoxetine</td>
<td>Prozac</td>
</tr>
<tr>
<td></td>
<td>escitalopram</td>
<td>Lexapro</td>
</tr>
<tr>
<td></td>
<td>citalopram</td>
<td>Celexa</td>
</tr>
<tr>
<td></td>
<td>paroxetine</td>
<td>Paxil</td>
</tr>
<tr>
<td></td>
<td>fluvoxamine</td>
<td>Luvox</td>
</tr>
<tr>
<td>Serotonin–norepinephrine reuptake inhibitors (SNRIs)</td>
<td>desvenlafaxine</td>
<td>Pristiq</td>
</tr>
<tr>
<td></td>
<td>duloxetine</td>
<td>Cymbalta</td>
</tr>
<tr>
<td></td>
<td>venlafaxine</td>
<td>Effexor XR</td>
</tr>
<tr>
<td>Mild tranquilizers</td>
<td>buspirone</td>
<td>BuSpar</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>quetiapine</td>
<td>Seroquel</td>
</tr>
</tbody>
</table>
Therapeutic and Environmental Strategies Used to Treat Anxiety Disorders

Psychosocial Interventions and Psychotherapy

Several different psychotherapies have been demonstrated to be effective in treating anxiety disorders.

- **Cognitive behavioral therapy (CBT)** is often used in conjunction with pharmacotherapy with good effect.
- **Exposure therapy** is a form of CBT in which the person is exposed to the feared solution, allowing the brain to adapt to the experience of anxiety during the introduction of the stimuli. There are four general variations of exposure therapy: (a) in vivo (direct confrontation of the fear object), (b) imaginal (imagining the feared object), (c) virtual (digital reconstruction of the feared object; e.g., online driving of a car in virtual traffic), and (d) interoceptive (creating a physical sensation and learning how to deal with it; e.g., tachycardia after exercising). Pacing of the exposure therapy is also important. Interventions can be paced as graded exposure (starts with mild experiences and progresses to more difficult ones), flooding (starts with the hardest experience), or systematic desensitization (often combined with relaxation so that the focus of fear becomes associated with relaxing).
- **Sensorimotor psychotherapy** is a form of somatic therapy that uses therapeutic interactivity to facilitate regulation of a client’s dysregulated emotional response. It is a body-based talk therapy that involves mindfulness, collaboration, and client self-awareness of body sensations.

Therapeutic Techniques

Nurses without formal training in these therapeutic techniques can rely on therapeutic alliance skills to support the person with an anxiety disorder.

- “Listen, believe, empathize”: Anxiety is a brain disorder. Your patient has come for help. Listen with respect and believe that what your patient is telling you is real to the patient. Ask your patient what has worked in the past to reduce the anxiety. If possible, incorporate the patient’s suggestions into the care plan.
Reduce environmental stimuli: Where possible, reduce the noise, lights, and normal commotion that are common in many areas of patient treatment centers. Ask the patient if the changes you are making are reducing the sense of worry.

MATCHING NURSING DIAGNOSIS AND MEDICAL DIAGNOSIS

Table 7.2 correlates nursing diagnoses with the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) codes for anxiety disorders.

**Table 7.2**

<table>
<thead>
<tr>
<th>Nursing diagnoses</th>
<th>ICD-10 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Anxiety disorder, unspecified (F41.9)</td>
</tr>
<tr>
<td>Fear</td>
<td>Generalized anxiety (F41.1)</td>
</tr>
<tr>
<td>Real or perceived threat of (1) death,</td>
<td>Panic disorder (F41.0)</td>
</tr>
<tr>
<td>(2) self-concept</td>
<td>(Each anxiety disorder has its own ICD-10 code)</td>
</tr>
<tr>
<td>Ineffective coping</td>
<td></td>
</tr>
<tr>
<td>Ineffective impulse control</td>
<td></td>
</tr>
</tbody>
</table>

Sources: Herdman & NANDA (2012); ICD10Data.com (n.d.).

- **SPOTLIGHT ON THE UNIT: WOMAN WITH PANIC DISORDER IN THE POSTANESTHESIA CARE UNIT (PACU)**

Mrs. Z is a middle-aged woman who was admitted this morning for foot surgery. When she met with you before surgery, she reported that she was a highly anxious person and had been taking clonazepam (Klonopin), 1 mg three times a day, for the past 20 years. Some days she took the medication only in the morning and at night, skipping the midday dose. She has not taken any pills since 9 p.m. the night before.

(continued)
As she is awakening from anesthesia in the PACU, she starts to fidget with the sheets. She calls out “Nurse! Nurse! Oh my God, I think I’m going to die!” You notice that her blood pressure is going up. Whereas it had been 110/70 mm Hg on admission and 110/82 post-operatively, it is now 150/90. Her pulse is 92 bpm and her respirations are very rapid and shallow at 26/min. As you approach the bed, she is crying and shaking, and tells you she is so scared that her chest hurts and she can’t breathe. The pulse oximetry reading is 98%.

■ What are the possible problems you are facing?
■ What differential diagnosis might you consider?
■ What are the nursing diagnoses?
■ Whom should you call to assess Mrs. Z in the PACU?
■ What are your thoughts about the needs of this patient, during hospitalization and after?
■ What kind of hand-off report might you need to give to the floor nurses?
■ What do you do next?

Further Reading


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References


