NURS2103 Summary Notes

Glossary

Akathisia	Restlessness where the person cannot stay still
Ataxia	Lack of voluntary coordination of muscle movement
Cyclothymia	Mild depression alternating with mild manic symptoms
Egocentric	Focusing on oneself to the degree that other people's needs are beyond one's awareness
Extra pyramidal side effects	Drug-induced movement disorders
Hypomania	Elevated moos less severe than mania
Iatrogenic	An effect caused by a medication
Somatisation	Psychological process where anxiety of psychological conflict → physical complaints though no mechanism found
Stigma	A notion that mental illness is something to be avoided, hidden away or shameful
Strengths	A person's resilience, aspirations, talents and uniqueness; what a person can do and do well
Recovery	Being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues. Recovery begins as soon as a person develops mental health problems, emphasizing hope, positive mental health and wellness
Supportive environments	Inherently helpful environments that in and of themselves enable people to move towards recovery
Peer support	The provision of support to people with mental health challenges by people who have also experienced challenges with their mental health
Support worker	Non-professional mental health worker who works with people with mental illness to enable them to function well and achieve personal life goals
Avoidance behaviours	Withdrawing or turning away from occupational and/or social activities because of fear, disapproval, rejection and ridicule
Cognitions	Knowing or perceiving something; related to intellect, logic and reason, not emotions and feelings
Fear	A response to a known threat; manifests in the same way as anxiety
Hyperarousal	A state of heightened psychological alertness and physiological arousal associated with anxiety and with PTSD
Hypervigilance	A state of heightened awareness in which the person constantly scans the environment for evidence of threats
HPA axis	Hypothalamic-pituitary-adrenal axis; complex feedback mechanism involved in stress response
Stepped care	Mental HC that is staged to provide an appropriate level of intervention for the seriousness of an individual's mental illness or symptoms. Stepped care begins in primary care with stages from advice and guided self-help through to psychological intervention, medication and hospitalization.
Stressor	An environmental condition, external stimulus or event which causes stress
Trauma-informed care	Core features include safety, trustworthiness, choice, collaboration and empowerment

Topic List

Part 1: The Therapeutic Relationship

Phase 1: Introduction and Beginning

- All effective mental health care revolves around the relationship – formal or informal
  - CBT = formal psychologically driven relationship
- Relationships 'are the heart and soul of mental health care'
  - Establishment and maintenance of therapeutic relationship is incredibly important in mental health care
  - Mental health interventions, no matter how strong the associated evidence base, are likely to fail in the absence of a therapeutic relationship being established between the practitioner and the consumer

Therapeutic Relationship in Nursing

- Nurses bring personal attributes to the therapeutic relationship, as well as clinical techniques, theoretical understandings
  - Helps to provide positive emotional experience for the person living with mental illness
- Hildegard Peplau (1952) – original base on interpersonal relations in psychiatric nursing
  - Army nurse working in France during WWII – provided psychiatric nursing to those soldiers suffering from PTSD
- Changing expectations of how mental health services should be organised – models of care = collaborative
- Impact of information + communication technology (ICT) = online therapeutic relationship

Three-Phase Model

- Working (middle) phase = longest

Phase	Characteristics
Orientation (beginning) phase	Establishment of contact with the help-seeking person
Working (middle) phase	Maintenance and analysis or contact with the help-seeking person
Termination (end) phase	Termination of contact with the help-seeking person

Professional vs. Social Relationships

Characteristic	Professional Relationship	Social Relationship
Purpose	Systematic working through of troublesome thoughts, feelings and behaviours Planned evaluation (through stages)	Companionship, sharing of interests Evolves spontaneously
Role delineation	Specific roles for practitioner and help seeking person with explicit use or clinical skills and interventions	Generally not present, except for broad social norms governing the particular type of relationship (friend vs. partner)
Satisfaction of needs	The help-seeking person is encouraged to identify, develop and access ways to meet own needs more effectively Does not address personal needs of the practitioner	Mutual sharing and satisfaction of personal and interpersonal needs

Part 2: Recovery Informed Practice + Protective Empowering

Recovery as Context for Practice

- 'How will what we do assist people to live a contributing and meaningful life in their chosen community, just like every other citizen?'
- Recovery = personal journey that can only be undertaken by the person
- Care in context of recovery is:
    - Collaborative
    - Driven by the person experiencing mental health challenges
- Paradigm = distinct set of concepts or thought patterns, including theories, research methods, hypotheses and standards for what constitutes legitimate contributions to a field
- Maintaining hope + optimism = important in recovery paradigm
- Mental health issues as seen from recovery paradigm – challenges that a person can grow beyond, through assistance of culturally appropriate, trauma-informed services and natural supports in the process of the person building a full and gratifying life in the community of his or her choice
- Appropriate terms to describe people experience mental health issues
    - Consumer
    - Client
    - People who have experience of mental health challenges
- What recovery is NOT
    - Rehabilitation: is the services and technologies made available to disabled persons so they may learn to adapt to their world, whereas recovery is the lived or real-life experience as they accept and overcome the challenges of disability
    - Cure: can be in recovery but still experience mental distress
- Recovery-informed practice vs. traditional practice
    - R-I practice is focused on guiding the person to recovery on their own terms through an ongoing process
    - Traditional practice is focused on the HCP being in control and utilising a biomedical approach to attempt to cure a person so they may return to their premorbid function level
- Key principles of recovery-informed practice
    - Promoting citizenship
    - Organisational commitment
    - Supporting personally defined recovery
    - Working relationships
- Nation Framework for Recovery-oriented Mental Health Services; five practice domains and capabilities
    - Promoting culture and language of hope
    - Person-first and holistic
    - Supporting personal recovery
    - Organisational commitment and workforce development
    - Action on social inclusion and social determinants of health, mental health and wellbeing
- Suggestions to facilitate recovery-informed care
    - Promote citizenship
    - Promote social inclusion
    - Keep hope alive

Part 3: Anxiety, Trauma + Stress-Related Disorders

Anxiety, Trauma + Stress-Related Disorders

Disorder	Key Features
Panic disorder	Recurrent unexpected panic attacks, in the absence of triggers; persistent concern about additional panic attacks and/or maladaptive change in behaviour related to the attacks
Agoraphobia	Marked, unreasonable fear or anxiety about a situation; active avoidance of feared situation due to thinking that escape might be difficult or help unavailable if panic-like symptoms occur
Specific phobia	Marked unreasonable fear or anxiety about a specific object or situation, which is actively avoided (flying, heights, animals, receiving an injection, seeing blood)
Social anxiety disorder	Marked, excessive or unrealistic fear or anxiety about social situations in which there is possible exposure to or scrutiny by others; active avoidance of the feared situation
Generalised anxiety disorder	Excessive, difficult-to-control anxiety and worry (apprehensive expectation) about multiple events or activities (school/work difficulties); accompanied by symptoms such as restlessness/feeling on edge or muscle tension
Obsessive-compulsive disorder	Obsessions: recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted and that cause marked anxiety or distress Compulsions: repetitive behaviours (handwashing) or mental acts (counting) that the individual feels driven to perform to reduce the anxiety generated by the obsessions
Adjustment disorder	Development of emotional or behavioural symptoms occurring within three months of the onset of a stressor (not including normal bereavement); distress is noted to be out of proportion to the severity or intensity of the stressor
Post-traumatic stress disorder + acute stress disorder	Exposure to actual or threatened death, serious injury or sexual violation; intrusion symptoms (distressing memories or dreams, flashbacks, intense distress) and avoidance of stimuli associated with the event; negative alterations in cognitions and mood (negative beliefs and emotions, detachment), as well as marked alterations in arousal and reactivity (irritable behaviour, hypervigilance).

HPA Axis

- Hypothalamic-pituitary-adrenal axis; complex feedback mechanism involved in stress response
- Hypothalamus (CNS) → amygdala (fear) + hippocampus (memories) → risk → SNS → pituitary gland releases cortisol → emotional memories repressed → better coping in situation
- Nature vs. nurture in response to stress

Part 4: Understanding + Treating OCD

- OCD: neuropsychiatric disorder characterised by abnormal risk assessment and unrealistic fears leading to excessive avoidance
- People with OCD experience:
  - Exaggerated concerns about danger, hygiene or harm that result in persistent conscious attention to the perceived threats (obsessions)
  - Obsessions experienced as unwanted/distressing
  - Person acts/performs a behaviour to neutralize the distress/anxiety which provides temporary relief but also reinforces the behaviours → repetitive, compulsive behaviours in response to obsessions (compulsions)

Obsessions

- Recurrent + persistent thoughts, impulses or images experienced as obtrusive, and often repugnant, and that cause marked anxiety or distress
- Common obsessions:
  - Fear of germs/contamination (usually most common)
  - Aggressive thoughts or fear of harming others
  - Symmetry/need for exactness
  - Sexual or religious concerns
  - Fear of making a mistake or behaving in a socially unacceptable manner
  - Fears about safety of baby

Compulsions

- Repetitive (often ritualized) behaviours (actions) or mental acts (thoughts) a person feels driven to perform in response to an obsession or according to rules that must be rigidly applied
- These behaviours or mental acts are aimed at reducing anxiety, preventing a dreaded obsessional event or situation from happening, or make things feel 'right'
- Common compulsions:
  - Washing / cleaning
  - Checking
  - Ordering
  - Repeating
  - Counting
  - Avoidance, eg of objects or places
  - Seeking reassurance
  - Hoarding
  - Touching objects
  - Making lists

OCD in DSM-5

- OCD grouped with other disorders which have common features of obsessive preoccupation and repetitive behaviours
  - Body dysmorphic disorder
  - Hair-pulling disorder
  - Skin-picking disorder
  - Hoarding disorder
- No longer classified with anxiety disorder but is still associated with anxiety itself
  - Anxiety disorder concerns are generally more realistic rather than irrational as seen in OCD

Part 5: How the Brain Works

- Human brain evolved to be bigger than other mammals
- 100 billion neurons
- Homo sapiens = 'wise man'

Major Regions of Brain

Cerebrum

- Main part – one on each side
- Functions:
  - Conscious thought + interpretation
  - Sensory perception
  - Conscious movement (motor function)
  - Regulates limbic system – important in understanding mental illness
  - **Cognitive supercomputer**

Limbic System

- Lies underneath the cerebral hemispheres + on to of brainstem
- Functions:
  - Emotion generator
  - Motivation, fear + reward
  - **Emotional turbo charger**

Thalamus + Brainstem

- Found at base of brain
- Functions:
  - Controls subconscious vital functions (breathing, sleep)
  - Transmits sensory and motor information
  - Influences activity of other brain regions
  - **Basic engine**

Regions of Brain

- Neurons with similar functions are grouped together throughout the brain
- Brain regions act together to influence thought and behaviour
- Sections of brain divided into lobes named after the overlying bone
- Gyrus = ridge of tissue
- Sulcus = groove

Cerebrum

- Grey matter = cell bodies – outside of brain
- White matter = axon bundles – inside of brain
- Cerebral cortex w/ outer layer of grey matter contains conscious mind
- Underlying grey matter within limbic system contains subconscious mind

Prefrontal Cortex

- Receives + integrates information from many other regions of the brain and determines appropriate behaviour
- Functions:
  - Critical thinking
  - Imagination

Part 6: Mood Disorders

- Mood disorder: more intense + persistent changes than normal
    - Affects 2.1 million in Australia, or 9.7% of the population

Major Depressive Disorder

DSM-V Criteria

- Mood: depressed, irritable, angry – fluctuations
- Anhedonia: present
- Psychomotor symptoms: agitation or retardation
- Anxiety/tension: usually not present
- Suicidal ideation: recurrent thoughts of death of SI, attempt or planning
- Appetite changes: significant increase or decrease in appetite or weight
- Insomnia/hypersomnia: present
- Low energy/fatigue: present
- Poor concentration: present
- Low self-esteem: usually not present
- Negative cognitions: worthlessness or excessive guilt
- Frequency of symptoms: nearly every day
- Duration of symptoms: > 2 weeks

> "Tailoring care to the individual in the context of an effective working relationship is the foundation upon which the proper application of any treatment relies." – Malhi et al., 2015

Features

- Appearance + behaviour
    - Change of physical appearance
    - Lack of motivation
    - Slow movement → psychomotor retardation
    - Fidgeting/pacing → psychomotor agitation
- Mood + affect
    - Miserable + hopeless → NOT just 'sad'
    - Sleep disturbance → initial (trouble getting to sleep) or middle/terminal (waking up too soon)
    - Hypersomnia = increase sleep during the day
    - Mood = worse in the morning + causes social withdrawal
- Thinking + speech
    - Increased egocentricity
    - Thinking of self + world as gloomy and negative → catastrophising + guilt
    - Poor concentration + memory
    - Present = unhappy
    - Past = guilt
    - Future = hopeless, grim → suicidal ideation/self-harm
- Perception
    - Delusions + hallucinations focusing on guilt + worthlessness
    - Nihilistic themes
- Biological symptoms
    - Sleep disturbances

Epidemiology

- 1 in 10 patients in primary care present with depressive symptoms

Part 7: Therapeutic Interventions

CBT

Definition

- Focuses on identifying + countering cognitive distortions (automatic negative thoughts), assumptions + core beliefs; encouraging more **realistic** thinking, coping mechanisms + emotions
  - Goal = target unrealistic thinking + challenge person to become more rational
- 'Modify dysfunctional cognitions and related behaviours that are presumed to maintain depression. Amongst evidence-based psychological therapies, CBT is most widely researched treatment for depression and is recommended by all international guidelines.'
- Structure:
  - Conducted over 16-20 sessions
  - Premise: interrelationship between thoughts, feelings, behaviour, biology + environment
  - Therapeutic relationship in CBT = collaborative
  - Treatment in depression, anxiety + learning disabilities

Setting

- Conducted individually or in groups – e-therapies
- Delivered over 10-16 sessions
- Aims for self-management, not cure – CBT therapist = coach
- Present-focused/forward focused – works on improving the present + future, not discussing past

Cognitive Theory

- Thought layers:
  - Outer layer – contains automatic thoughts (positive + negative)
  - Middle layer – contains intermediate beliefs/underlying assumptions
  - Inner layer – contains core beliefs
    - Develop during childhood resulting from experience + influence of parents, family + significant others

CBT Components

- Cognitive therapies: target cognitive processes and distortions that precipitate and sustain anxious, depressive or mentally unhealthy states
- Behavioural therapies: target behaviours; works on belief that behaviour + thoughts sustain anxiety and depressed mood, so changing behaviour and/or thought can improve anxious or depressive symptoms

CBT Components: Example

Session 1

Suitcase Analogy

- Unhelpful beliefs make suitcase too heavy
- Open suitcase to see what is inside
- Unpack suitcase
- Stocktake – what is helpful? What is unhelpful?
- Take unhelpful beliefs away

ABC Model of Emotion

- A = Activating event
- B = Belief of thought

Part 8: Schizophrenia

What is it?

- Complex, heterogeneous condition – few generalization hold true for all those who are diagnosed
- Most chronic + debilitating major mental illness
- Diagnosed on presence + duration of psychotic episodes (hallucinations, delusions) during which consumers exhibits gross through disorder and inability to test reality
    - Psychotic = out of touch with reality
- Characterized by major disturbances in:
    - Thought
    - Perception
    - Emotion
    - Cognition
- Consumers may have just one psychotic episode or multiple during a lifetime, or may have chronic or continuous psychosis
- Often begins in late adolescence or early adulthood – preceded by prodromal period of subthreshold symptoms
- Affects approx.. 1% of population
- Heredity:
    - If one parent has schizophrenia, chance of children developing it is 1 in 10
    - If both parents have, chance = 2 in 5
    - Concordance rates in identical twins = 50%
- Affects men + women in equal frequency
    - Men: starts in teens or twenties
    - Women: starts in twenties or thirties
- Suicide = leading cause of death for consumers with schizophrenia
    - Rate = 5-13%
    - 40% of people with schizophrenia attempt suicide

Symptoms

- Encompass all areas or mental function
- Include:
    - Positive
    - Negative
    - Cognitive deficits
    - Mood/affective symptoms
- All together, these symptoms make it difficult for consumers for function normally

Part 9: Psychopharmacology

Psychotropic Medications

- Produce therapeutic effect by altering communication among neurons in CNS
- Particularly effects the way NTs work at the synapse by modifying reuptake in the presynaptic or postsynaptic receptors or inhibiting enzyme activity

Type	Medication	Example
Anxiolytic	Benzodiazepines	- Chlordiazepoxide - Diazepam - Alprazolam - Lorazepam
	Azapirones Beta-adrenergic blockers	- Buspirone - Propanolol
Antidepressant	TCAs	- Amitriptyline - Trazadone
	SSRIs	- Fluoxetine - Paroxetine
	NSRIs	- Venlafaxine - Mirtazapine
	MAOIs	- Phenelzine - Tranycypromine
Mood stabilisers	Lithium	- Lithium carbonate
	Anticonvulsants	- Carbamazepine - Valproate - Topiramate - Lamotrigine
Antipsychotic Typical (traditional)	- Phenothiazine - Thioxanthene - Butyrophenones - Diphenylbutylpiperidines	- Thioridazine - Flupenthixol - Haloperidol - Pimozide
Atypical (second generation)		- Clozapine - Risperidone - Olanzapine - Quetiapine - Ziprasidone
Sedative-hypnotic	Benzodiazepines	- Temazepam - Flurazepam
	Cyclopyrrolones Imidazopyrimidines	- Zopiclone - Zolpidem

Anxiolytic

Type	Benzodiazepines
Mode of Action	Inhibits GABA receptors
Indication	Anxiety, insomnia, alcohol withdrawal, seizure disorders, psychomotor agitation
Side Effects	Drowsiness, headache, dizziness, nausea, hypotension, restlessness
Contraindication	Should not be taken with alcohol or any other CNS depressants
Interactions	May occur with alcohol, MAOIs, phenytoin, antacids and anticholinergic agents