Mental Health concepts are integrated throughout the curriculum, however ADN II has the most focused material. In Intro to Practical Nursing the concepts of stress, coping and adaptation are introduced. Practical Nursing I includes information on anxiety, elder abuse and dementia. In Practical Nursing II, the mental health concepts discussed are depression, substance abuse, child abuse, and eating disorders. Intro to ADN Nursing present crisis intervention. Remaining topics are then presented in ADN II.

Included in this handbook are some materials that will be given to students regarding Mental Health and some explanatory material for nursing clinical instructors. As you are all aware, even instructors and students on non-mental health areas will be caring for clients with co-morbid mental health problems, and the information can be helpful to everyone.

Mental Health Handout #1 DSM TR Multiaxial System
Mental Health Handout #2 Defense Mechanism
Mental Health Handout #3 Attitude Therapy

DSM IV Multiaxial System

<table>
<thead>
<tr>
<th>Axis</th>
<th>Description</th>
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<tr>
<td>I</td>
<td>Clinical Syndromes. Conditions not attributable to a mental disorder</td>
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<td>II</td>
<td>Personality Disorders. Specific Developmental Disorders</td>
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<td>III</td>
<td>Physical Disorders</td>
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<td>IV</td>
<td>Psychosocial Stressors</td>
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<td>Global Functioning</td>
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It is essential that clinicians have a thorough understanding of the components of the multiaxial system for it to be used effectively. What follows is a brief description of each of the axes.

Aaxes I and 11

Axes I and 11 comprise all of the mental disorders and some associated conditions. The easiest way to differentiate between these first two axes is to look first at Axis 11. Axis 11 is for recording personality disorders usually diagnosed in adults and specific developmental disorders usually diagnosed in children and adolescents. All of the other mental disorders and associated conditions are recorded on Axis 1. The two classes of disorders on Axis 11 were given their own axis because their usually
mild, stable and chronic symptomatology often is overshadowed by a more florid Axis I condition. If a person appears in an emergency room with a floridly psychotic major depression, for example, that person's underlying personality disorder may be overlooked. In addition to the other mental disorders, Axis I includes "Conditions Not Attributable to a Mental Disorder That Are (nevertheless) a Focus of Attention or Treatment. This may include Occupational Problem, Marital Problem, and Parent-Child Problem, in which the problem being evaluated, or for which clinical care is being sought, is not due to a mental problem. Finally, Axis I includes a code for "Unspecified Mental Disorder (Non-Psychotic)

Axis III

Axis III is for recording physical disorders and conditions that are important to take into account in planning treatment, or that are relevant to an understanding of the etiology or exacerbation of the mental disorder. For example, in a patient with delirium, where the delirium was caused by pneumonia; the physical disorder (Axis 111) is etiologically related to the mental syndrome (Axix 1).

Axis IV

Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and 11). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, and inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed.

Axis V

Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and predicting outcomes. The reporting of overall functioning on Axis V is done using the Global Assessment Functioning (GAF) scale. The GAF scale is particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF scale is to be rated with respect only to psychological, social, and occupational functioning, and should not include impairment due to physical or environmental limitations. The GAF scale follows on the next page.
Usefulness of DSM IV Multiaxial System to Mental Health Nursing

Provides a framework for interdisciplinary communication
Bases subsequent revisions on a series of formative evaluations
Represents progress toward a more holistic view of mind-body relations
Represents a collaborative achievement
Makes a provision for diagnostic uncertainty
Incorporates, at least in part, biological, psychological and social variables
Has achieved positive results in extensive field testing of validity and reliability
Considers adaptive strength as well as problems
Provides for a comprehensive biological-psychological-social approach
Reflects a descriptive phenomenological perspective rather than any particular psychiatric theoretical orientation.

Defense Levels and Individual Defense Mechanisms

I. High adaptive level - This level of functioning results in optimal adaptation in the handling of stressors. Examples of this level are:

   a. anticipation
   b. affiliation
   c. altruism
   d. humor
   e. self-assertion
   f. self-observation
   g. sublimation
   h. suppression
II. Compromised level of function - Defensive functioning at this level keeps potentially threatening ideas, feelings, memories, wishes, or fears out of awareness. Examples are:

   a. displacement
   b. intellectualization
   c. isolation of affect
   d. reaction formation
   e. repression
   f. undoing

III. Mid-range level of defensive function.
   A. Employed to regulate self-esteem. Examples are:

      a. devaluation
      b. idealization
      c. omnipotence

   B. This level is characterized by keeping unpleasant or unacceptable stressors, impulses, ideas, affects, or responsibility out of awareness. Examples are:

      a. denial
      b. projection
      c. rationalization

   C. Characterized by gross distortion or misattribution of the image of self or others. Examples are:

      a. autistic fantasy
b. projective identification

c. splitting of self-image or image of others

IV. Lowest level of defensive function (Maladaptive) - Characterized by defensive functioning that deals with internal or external stressors by action or withdrawal. Examples are:

a. acting out

b. apathetic withdrawal

c. help-rejecting complaining

V. Dysregulation (Ego disintegration) - Characterized by failure of defensive regulation to contain the individual's reaction to stressors, leading to pronounced break with objective reality.

a. delusional projection

b. psychotic denial

c. psychotic distortion

Glossary of Specific Defense Mechanisms and Coping Styles

**Acting out:** The individual deals with emotional conflict or internal or external stressors by actions rather than reflections or feelings. This definition is broader than the original concept of the acting out of transference feelings or wishes during psychotherapy and is intended to include behavior arising both within and outside relationship. Defensive acting out is not synonymous with "bad behavior" because it requires evidence that the behavior is related to emotional conflicts.

**Affiliation:** The individual deals with emotional conflict or internal or external stressors by turning to others for help or support. This involves sharing problems with others but does not imply trying to make someone else responsible for them.

**Altruism:** The individual deals with emotional conflict or internal or external stressors by dedication to meeting the needs of others. Unlike the self-sacrifice sometimes
characteristic of reaction formation, the individual receives gratification either vicariously or from the response of others.

**Anticipation:** The individual deals with emotional conflict or internal or external stressors by experiencing emotional reactions in advance of, or anticipating consequences of, possible future events and considering realistic, alternative responses or solutions.

**Autistic fantasy:** The individual deals with emotional conflict or internal or external stressors by excessive daydreaming as a substitute for human relationships, more effective action, or problem solving.

**Denial:** The individual deals with emotional conflict or internal or external stressors by refusing to acknowledge some painful aspect of external reality or subjective experience that would be apparent to others. The term *psychotic denial* is used when there is gross impairment in reality testing.

**Devaluation:** The individual deals with emotional conflict or internal or external stressors by attributing exaggerated negative qualities to self or others.

**Displacement:** The individual deals with emotional conflict or internal or external stressors by transferring a feeling about, or a response to, one object onto another (usually less threatening) substitute object.

**Dissociation:** The individual deals with emotional conflict or internal or external stressors with a breakdown in the usually integrated functions of consciousness, memory, perception of self or the environment, or sensory/motor behavior.

**Help-rejecting complaining:** The individual deals with emotional conflict or internal or external stressors by complaining or making repetitious requests for help that disguise covert feelings of hostility or reproach toward others, which are then expressed by rejecting the suggestions, advice, or help that others offer. The complaints or requests may involve physical or psychological symptoms or life problems.

**Humor:** The individual deals with emotional conflict or external stressors by emphasizing the amusing or ironic aspects of the conflict or stressor.

**Idealization:** The individual deals with emotional conflict or internal or external stressors by attributing exaggerated positive qualities to others.

**Intellectualization:** The individual deals with emotional conflict or internal or external stressors by the excessive use of abstract thinking or the making of generalizations to control or minimize disturbing feelings.

**Isolation of affect:** The individual deals with emotional conflict or internal or external stressors by the separation of ideas from the feelings originally associated with them.
The individual loses touch with the feelings associated with a given idea (e.g. a traumatic event) while remaining aware of the cognitive elements of it (e.g. descriptive details).

**Omnipotence:** The individual deals with emotional conflict or internal or external stressors by feeling or acting as if he or she possesses special powers or abilities and is superior to others.

**Passive aggression:** The individual deals with emotional conflict or internal or external stressors by indirectly and unassertively expressing aggression toward others. There is a facade of overt compliance masking covert resistance, resentment, or hostility. Passive aggression often occurs in response to demands for independent action or performance or the gratification of dependent wishes but may be adaptive for individuals in subordinate positions who have no other way to express assertiveness more overtly.

**Projection:** The individual deals with emotional conflict or internal or external stressors by falsely attributing to another his or her own unacceptable feelings, impulses, or thoughts.

**Projective identification:** As in projection, the individual deals with emotional conflict internal or external stressors by falsely attributing to another his or her own or unacceptable feelings, impulses, or thoughts unlike simple projection, the individual does not fully disavow what is projected. Instead, the individual remains aware of his or her own affects or impulses but misattribute them as justifiable reactions to the other person. Not infrequently, the individual induces the very feelings in others that were first mistakenly believed to be there, making it difficult to clarify who did what to whom first.

**Rationalization:** The individual deals with emotional conflict or internal or external stressors by concealing the true motivations for his or her own thoughts, actions, or feelings through the elaboration of reassuring or self-serving but incorrect explanations.

**Reaction formation:** The individual deals with emotional conflict or internal or external stressors by substituting behavior, thoughts, or feelings that are diametrically opposed to his or her own unacceptable thoughts or feelings (this usually occurs in conjunction with their repression).

**Repression:** The individual deals with emotional conflict or internal or external stressors by expelling disturbing wishes, thoughts, or experiences from conscious awareness. The feeling component may remain conscious, detached from its associated ideas.

**Self-assertion:** The individual deals with emotional conflict or stressors by expressing his or her feelings and thoughts directly in a way that is not coercive or manipulative.
**Self-observation:** The individual deals with emotional conflict or stressors by reflecting on his or her own thoughts, feelings, motivation, and behavior, and responding appropriately.

**Splitting:** The individual deals with emotional conflict or internal or external stressors by compartmentalizing opposite affect states and failing to integrate the positive and negative qualities of the self or others into cohesive images. Because ambivalent affects cannot be experienced simultaneously, more balanced views and expectations of self or others are excluded from emotional awareness. Self and object images tend to alternate between polar opposites: exclusively loving, powerful, worthy, nurturant, and kind-or exclusively bad, hateful, angry, destructive, rejecting, or worthless.

**Sublimation:** The individual deals with emotional conflict or internal or external stressors by channeling potentially maladaptive feelings or impulses into socially acceptable behavior (e.g., contact sports to channel angry impulses).

**Suppression:** The individual deals with emotional conflict or internal or external stressors by intentionally avoiding thinking about disturbing problems, wishes, feelings, or experiences.

**Undoing:** The individual deals with emotional conflict or internal or external stressors by words or behavior designed to negate or to make amends symbolically for unacceptable thoughts, feelings, or actions.

**APPROACHES FOR ATTITUDE THERAPY**

There are six different approaches that will be discussed according to behavior. Throughout each, keep using "I" or "you", rather than "we" or "let's".

1. **Indulgence - (warm, gentle, friendly)** - this approach is used with shy, timid aloof and withdrawn patients. Can also be used with autistic patients. With this approach, sitting through periods of silence is important. Don't push the patient to talk. Work slowly with them or use short frequent visits. Avoid direct questions. Plan to stay between a few minutes and several minutes. If he seems uncomfortable after a few minutes, leave and return at the designated time. Don't try to get too close too fast, this will threaten the patient and slow the whole trusting process down. Use accepting, paraphrasing, restating-and gentle inflection. Use restating when he first starts to initiate conversation. Ask the patient if he would like to participate in activities and then slowly increase the length of time. Divergence by the patient from the schedule is gracefully accepted by the nurse. More than the average flexibility is shown, but no change in their status regarding privileges and precautions. Grant harmless favors even though they may be a little inconvenient.
2. Active friendly - this approach is being warm, friendly and open with the patient. It's a give and take relationship. This can be used when the patient trusts you. The nurse initiates working interest, but is not seductive (tempt into involvement).

3. Passive friendly - this is used with the suspicious patient or the distrusting patient. This is a casual approach. Visit the patient and ask if there is anything they need. Tell them when you'll be back again. Plan to stay for short periods (2-10 minutes). They make the choice as to if you stay or leave. The nurse is available and preserves contact but does not initiate or force attention. The nurse continues to give information about ward routine, schedule, passes, privileges and is courteous.

4. Kind, firm - this in used with the acutely underactive patient. They don't have any energy to be out and going unless they are strongly encouraged by others. In general, they have a stronger ego than the schizophrenic so you can be encourage them to participate without threatening them. If they have somatic complaints, allow them extra time but then set the expectations and encourage follow through. The nurse conveys an ambiance of "I know what needs to be done and expects requests to be carried out. Consistency is very important. Requests are clear, quietly confident, but not overbearing or, commanding.

5. Calm, matter of fact - with this approach you listen and are nonjudgmental especially if they are expressing somatic complaints. Deal with this by allowing them to express their complaints and then say "OK, now I want you to go down to OT and finish the project that you started yesterday." Another time that this approach is used is when the patient is manipulative. (i.e. Adolescent asks for a request that is not appropriate. Point this out and then work on problem solving, perhaps collaboration or compromise).

This is also used with sociopath. Set expectations using a calm technique. Ritualistic behavior is another time when this approach is used. Do not call attention to this behavior, it only makes the person more insecure (increases anxiety) which increases the behavior.

Casual but not indifferent. Present but without signs of emotion to (reaction) patient's pleas, distress or maneuvers. Do not directly reassure them.

6. Watchfulness (no demand) - thorough and usually inconspicuous observation. Maintain courtesy. This needs to be utilized when the patient is in a severe panic state of anxiety or if the patient is about to lose control. Don't ask questions, no decision making by the patient. This is the time when you take over for the patient until he regains control. Keep them informed of reality and your decisions/actions. Do not allow the patient to make any decisions at this point because he is not capable of a realistic solution. DO NOT argue with this patient at this time, it will only increase their anxiety. Anticipate establishing contact with physician regarding hold or use of prn medications, QR and use of restraints prn.