

State-approved Curriculum Nurse Aide I Training Program

MODULE U Mental Health and Mental Illness

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NC DEPARTMENT OF **HEALTH AND HUMAN SERVICES**

Division of Health Service Regulation



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HUMAN SERVICES**



North Carolina Department of Health and Human Services
Division of Health Service Regulation
North Carolina Education and Credentialing Section

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Module U – Mental Health and Mental Illness

Definition List

Anxiety - a feeling of worry, nervousness, or unease; fear characterized by behavioral disturbances.

Bipolar disorder - a condition in which an individual has mood swings and changes in energy levels including the ability to function. The mood swings can alternate from extreme activity (a manic episode) to periods of deep depression (a depressive episode).

De-escalate – to reduce the intensity of (a conflict or potentially violent situation); to (cause to) become less dangerous or difficult.

Delusion – fixed, false conviction in something not real or shared by other people.

Delusional Disorder – firmly held false beliefs (delusions) that persist for at least one month without other symptoms of psychosis; having false beliefs involving real-life situations.

Depression – persistent feelings of sadness and/or a loss of interest in activities once enjoyed. Major depression is diagnosed when persistently low or depressed mood, decreased interest in pleasurable activities, feelings of guilt or worthlessness, lack of energy, poor concentration, appetite changes, psychomotor retardation or agitation, sleep disturbances or suicidal thoughts present.

Disorder – a group of symptoms involving abnormal behaviors or physiological conditions, persistent or intense distress; or a disruption of physiological functioning.

Dysthymia – milder, but long-lasting form of depression; persistent depressive disorder.

Generalized anxiety disorder - anxiety and worry in the absence of an imminent event.

Loneliness - a subjective feeling of a lack of connection to other people and a desire for more satisfying relationships.

Mental Health - an ability to cope with and adjust to everyday stresses in ways society accepts.

Mental Illness – includes a wide range of disorders including thinking, emotion and/or behavior; a disturbance in the ability to cope or adjust to stress; impaired behavior and function either short-lived or long term.

Obsessive-compulsive disorder – a long-lasting disorder in which a person experiences uncontrollable and recurring (obsession), engages in repetitive behaviors (compulsions) or both.

Panic Disorder – frequent and unexpected sudden wave of fear or discomfort or a sense of losing control even when there is no clear danger or trigger.

Phobia – an uncontrollable, irrational, and persistent fear of a specific object, situation, or activity.

Post-Traumatic Stress Disorder (PTSD) – a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event. PTSD is characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations.

Psychosis – a collection of symptoms that affect the mind, where there has been some loss of contact with reality.

Psychotic Disorders – severe mental health disorders causing abnormal thinking and perceptions.

Psychotic disorder due to another medical condition – a medical condition that causes hallucinations and/or delusions. The condition can result from a traumatic brain injury or dementia.

Psychotherapy- talk therapy.

Schizoaffective Disorder – characterized by delusions, hallucinations, disorganized thoughts and speech, unusual behavior, and withdrawal.

Schizophrenia – a severe mental health disorder interfering with an individual's ability to interact with others, make decisions, think normally, and communicate clearly. A mental illness characterized by delusions, hallucinations, disorganized thoughts and speech, unusual behavior, and withdrawal.

Social Isolation – having objectively few social relationships and infrequent social contact

Social Anxiety Disorder – chronic condition in which social interactions cause irrational fear, anxiety, self-consciousness, and embarrassment.

Substance/medication induced psychotic disorder – certain drugs, including not only illicit drugs such as hallucinogens and stimulants but also prescribed medications such as steroids and antiepileptic drugs, can trigger short-term or long-term symptoms of psychosis.

Module U – Mental Health and Mental Illness	
(S-1) Title Slide (S-2) Objectives <ol style="list-style-type: none"> 1. Discuss the risk factors of social isolation and loneliness for the older adult 2. Describe the most common mental health illnesses for older adults 3. Identify symptoms of mental illness in the older adult 4. Explain the role of the nurse aide in the de-escalation of the resident who is agitated. 	
Content	Notes
(S-3) Mental Health and the Older Adult <ul style="list-style-type: none"> • Older adults may experience life changes impacting their mental health • An increasing percentage of older adults, experience feelings of grief, social isolation, or loneliness • Persistent feelings related to loss may lead to a clinical diagnosis of mental illness • Researchers indicate older adults are more likely to <ul style="list-style-type: none"> — Live alone — Lose a family member or friend — Suffer from a chronic illness or hearing loss — Risk factors for social isolation and/or loneliness <ul style="list-style-type: none"> ○ High blood pressure ○ Heart disease ○ Obesity ○ Weakened immune system ○ Anxiety ○ Depression ○ Cognitive decline ○ Alzheimer’s disease ○ Death 	
(S-4) Causes of and Mental Illness Contributing factors: <ul style="list-style-type: none"> • Physical factors include illness, disability, aging, substance abuse, and chemical imbalances • Psychosocial including interpersonal or family relationships • Genetics include inherited traits • Stressors include the inability to cope with life’s challenges and past traumatic experiences 	
(S-5) Symptoms of Mental Illness for the Older Adult <ul style="list-style-type: none"> • Noticeable changes in mood, energy level, or appetite 	

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<ul style="list-style-type: none"> — Difficulty sleeping or sleeping too much — Feeling restless or on edge — Anger, irritability, or aggressiveness — Sadness or hopelessness — Feeling down or having trouble feeling positive emotions — Increased worry of feeling stressed — Ongoing headaches, digestive issues, or pain • Seeing, hearing, and feeling things that other people do not see, hear, or feel <ul style="list-style-type: none"> — Engaging in thinking or behavior that is concerning to others — Obsessive thinking or compulsive behavior • Thoughts of death or suicide <ul style="list-style-type: none"> — Suicide attempts • Misuse of alcohol or drugs 	
<p>(S-6) Most Common Mental Health Illness for Older Adult</p> <ul style="list-style-type: none"> • Mood Disorder • Anxiety Disorder • Psychotic Disorder • World Health Organization (WHO) states in 2019, 1 in every 8 people were experiencing a mental health illness • WHO also stated in 2020, due to COVID-19 there was almost a 30% increase in people diagnosed with anxiety and major depressive disorders in just one year 	
<p>(S-7) Mood Disorders (Refer to Definition List)</p> <ul style="list-style-type: none"> • Major Depression • Dysthymia • Bipolar Disorder 	
<p>(S-8) Mood Disorders and the Older Adult</p> <ul style="list-style-type: none"> • Feelings of sadness, anxiety, or emptiness • A persistent sense of hopelessness, guilt, worthlessness, or helplessness • Loss of interest in previously enjoyable activities • Decreased energy and increased fatigue • Changes in eating and/or sleeping patterns • Thoughts about death or suicide or suicide attempts • Depression is not an automatic symptom of the aging process. However, older adults have a higher risk of experiencing a mood disorder due to specific unique factors: 	

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<ul style="list-style-type: none"> — Life changes – moving into a retirement community, inability to care for self, and losing family and friends to death — Chronic pain due to lack of mobility — Substance abuse such as alcohol or drugs — Financial stress due to overwhelming medical costs, lack of spousal income, and lack of retirement savings — Lack of social community — Family history of depression may also be a risk factor — Sense a lack of purpose • Depression in older adults is often referred to as geriatric depression 	
(S-9) Anxiety Disorders (Refer to Definition List) <ul style="list-style-type: none"> • Generalized Anxiety disorder • Obsessive Compulsive Disorder • Panic Disorder • Post Traumatic Stress Disorder • Social Anxiety Disorder 	
(S-10) Anxiety and the Older Adult <ul style="list-style-type: none"> • Anxiety disorders are frequently related to <ul style="list-style-type: none"> — Traumatic events such as a fall or acute illness — Multiple medical conditions — Concern for physical problems — Use of numerous prescribed medications • Symptoms of anxiety may include headaches, back pain, or a rapid heartbeat 	
(S-11) Psychotic Disorders (Refer to Definition List) <ul style="list-style-type: none"> • Schizophrenia • Schizoaffective Disorder • Delusional Disorder • Substance/medication induced psychotic disorder 	
(S-12) Psychotic Disorders and the Older Adult (1) <ul style="list-style-type: none"> • Psychotic disorders can be highly distressing, impacting a resident's quality of life • Residents with a psychotic disorder often lose touch with reality and may experience symptoms like delusions and hallucinations • The disorder is often managed with medication and therapy • Behavioral effects of a psychotic disorder include: <ul style="list-style-type: none"> — Speak incoherently 	

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<ul style="list-style-type: none"> — Erratic or odd behaviors — Agitation — Restlessness — Apathy — Withdrawal — Lack of emotional expressions — Lack of self-care 	
<p>(S-13) Psychotic Disorders and the Older Adult (2)</p> <ul style="list-style-type: none"> • Refusal of care by nursing staff • Resident may refuse to eat, bathe, shower, and change clothes • Refusal of medical treatment • Resident may refuse medications leading to infections, injuries, or a significant change in condition • Suicidal thoughts or attempts 	
<p>(S-14) Treatment for Mental Illness</p> <ul style="list-style-type: none"> • Treatment depends on the mental health diagnosis, the severity, and what works best in the condition of the older adult • Medication and psychotherapy (talk therapy) in combination may work best depending on symptoms • A team approach is appropriate to make sure psychiatric, medical, and social needs are met, especially with psychotic disorders • The treatment team may include primary care doctor, nurse practitioner, physician assistant, psychiatrist, psychotherapist, pharmacist, social worker, and family members • Medications may include: <ul style="list-style-type: none"> — Antidepressants, which treat depression and long-term anxiety — Anti-anxiety medications, which treat anxiety disorders, such as generalized anxiety disorder or panic disorder — Antipsychotic medications treat psychotic symptoms like hallucinations and delusions. — Mood stabilizers which treat bipolar disorder, schizoaffective disorder 	
<p>(S-15) Mental Health and the Older Adult- Nurse Aide's Role</p> <ul style="list-style-type: none"> • Observe changes in resident's mental health • Recognize inappropriate behavior • Report observations to the nurse • Document observations 	

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<ul style="list-style-type: none"> • Participate in de-escalation 	
<p>(S-16) De-escalation of an Agitated Resident (Refer to Definition List)</p> <ul style="list-style-type: none"> • Supportive day-to-day relationships are the heart of de-escalation • Know what is normal for the resident • Be aware of specific triggers for the resident • The primary objective in de-escalation is to reduce the level and intensity of the resident's behavior • If de-escalation is not working, the nurse aide should STOP and calmly call for help • Trust your instincts 	
<p>(S-17) Mental Health and the Older Adult- Nurse Aide's Role</p> <ul style="list-style-type: none"> • Control the environment <ul style="list-style-type: none"> — Stand with feet shoulder length apart and to the dominant side of the resident; keep a distance of 6 feet — Move others out of harm's way — Remove objects that could harm — Watch client without touching — Keep client safe • Look for meaning of the behavior <ul style="list-style-type: none"> — Address feelings, not just words — Observe body language and facial expression • Check for underlying causes <ul style="list-style-type: none"> — Physical or medical conditions (pain, infection, hunger, medications) — Social or emotional triggers (resident may have been startled, another staff member in a bad mood that was sensed by the resident, recent loss, feeling threatened) — Environmental conditions (loud and hectic area, too hot/cold, change in preferred schedule, change in roommate, peers not tolerated by the resident) • Respond in the resident's reality <ul style="list-style-type: none"> — Redirect by drawing attention to another subject — Explore triggers of the resident's behavior • Engage in resident's story <ul style="list-style-type: none"> — For example, if a resident is upset about spouse who passed away years ago not coming to pick them up on that day, reply by commenting the resident must really care about their spouse and ask them to talk about the spouse) 	

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(S-18) Nurse Aide's Awareness of Self Behaviors in De-escalation

- Behavior- Appear calm, centered, and self-assured even if this not the case. Anxiety can make residents feel anxious and unsafe which can escalate aggression
- Posture- Always be at the same eye level. Encourage the resident to be seated, but if they need to stand, stand up also. Keep a relaxed and alert posture. Avoid aggressive stances
- Position self for safety- Never turn your back for any reason. Maintain your distance from the resident by at least two arms lengths. Place hands in front of your body in an open and relaxed position. This stance appears non-threatening and positions hands for blocking if need arises.
- Body movement and language- Body movements indicate anxiety and will tend to increase agitation. Minimize excessive gesturing, pacing, fidgeting, or weight shifting. Avoid crossed arms, hands in pockets, or arms behind back. Avoid pointing or shaking finger. Refrain from touching although some touching is generally culturally appropriate and usual in setting. Residents with cognitive disorders who become agitated may misinterpret the physical contact as hostile and threatening.
- Facial expression- Maintain neutral facial expression. A calm, attentive expression reduces hostility
- Eye contact- Maintain limited eye contact. Loss of eye contact may be interpreted as expression of fear, lack of interest or regard, or rejection. Excessive eye contact may be interpreted as a threat or challenge. Do not stare at resident.
- Attitude- Refrain from becoming defensive when comments or insults are directed toward you. Comments are not about you. Nurse aides should not defend self or anyone else from insults, curses, or misconceptions about roles or behaviors. Be respectful when firmly setting limits or calling for help. An agitated resident may be sensitive to feeling shamed and disrespected; the resident should be treated with dignity and respect.
- Tone- Use low monotonous tone of voice. Refrain from the normal tendency to have a high-pitched, tight voice when a situation is escalated. Refrain from getting loud or trying to yell over screaming resident; wait until the resident takes a breath, then talk. Speak calmly at an average volume.

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<ul style="list-style-type: none"> • Responses- Respond selectively. Answer only informational questions. Be honest. Lying to a resident to calm them may lead to future escalation if they become aware of the dishonesty. Do not volunteer information which may further upset a resident • Reasoning- If directed by the interdisciplinary care plan, explain limits and rules in authoritative, firm, but respectful tone. Give choices, where possible. Suggest alternative behaviors where appropriate. Do not analyze or interpret how a resident is feeling. Refrain from arguing or convincing. • Seek guidance from the nurse with residents who also have dementia because they have difficulty processing information. 	
(S-19) Points to Remember <ul style="list-style-type: none"> • All behavior has meaning. Identifying the meaning behind the behavior is key • Each resident diagnosed with a mental illness is different from other residents with same diagnosis <ul style="list-style-type: none"> — Recognize that a resident with a mental illness is an individual • Residents with a mental health disorder are more than the mental health diagnosis 	
(S-20) Points to Remember <ul style="list-style-type: none"> • The interdisciplinary care plan should identify specific interventions • Healthcare professionals should acknowledge a resident with a mental illness as an individual with a unique background and often challenging life experiences • Nurse aides can successfully handle situations when a resident is stressed and agitated by using proper communication skills <ul style="list-style-type: none"> — A resident with mental health diagnoses and dementia, the resident may not be doing things on purpose — Utilizing effective communication skills with a resident on a daily basis will enhance interactions and build trust 	
(S-21) Points to Remember <ul style="list-style-type: none"> • A resident with a mental illness may display behaviors beyond their control • When unusual or inappropriate behavior escalates safety concerns should be the primary focus for the resident and others • An important tool is de-escalation 	

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<ul style="list-style-type: none"> • Great day-to-day relationships are at the heart of de-escalation <ul style="list-style-type: none"> – The resident may be a danger to self and others – The interdisciplinary care plan will include specific details about resident’s condition and any special approaches to use when working with resident 	