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Practice Matters: Red Flags in Adults with Mental Illnesses

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Mental illness and religion have a long-established association (Lakeman, 2013). When people are experiencing the challenges of mental illnesses, they may relate symptoms to religious affiliated causes such as sin or messages from God (American Psychiatric Association Foundation and the Mental Health and Faith community, 2016). Faith Community Nurses (FNCs) have common beliefs, principles, ethics, and a level of trust with their population making them well-positioned to positively impact parishioners (Anaebere & DeLilly, 2012). FCNs provide support for people's spiritual needs and nursing care. FCNs can encounter parishioners with mental illnesses such as schizophrenia, mood disorders, and post-traumatic stress disorder in their communities. This makes FCNs a vital and approachable resource for parishioners when seeking advisement and assistance regarding their mental healthcare.

Red flags in adults with mental illnesses are predominately found in people with schizophrenia, depression, bipolar disorder, and post-traumatic stress disorder (PTSD) (American Psychiatric Association [APA], 2013). In this article, we define *red flags* as suicidal idealization, mania, and psychosis, which if not promptly assessed and referred for treatment may result in serious harm or death. The epidemiology and pathophysiology of schizophrenia, mood disorders, and post-traumatic stress disorder will be discussed in this article, along with red flags that may occur in adults with mental illnesses. This article will then discuss FCNs' screening strategies to identify red flags, potential community referral sources, and lifestyle recommendations for adults with mental illnesses.

Epidemiology

Schizophrenia

Schizophrenia affects 21 million people worldwide (World Health Organization [WHO], 2016) and 2.4 million people in the United States (U.S.) (National Alliance on Mental Illness [NAMI], 2016). Schizophrenia occurs more often in men than women and approximately one-third of people affected will attempt suicide in their lifetime (Centers for Disease Control and Prevention [CDC], 2013). People with schizophrenia have a higher mortality rate when compared to the general population (Saha, Chant, & McGrath, 2007). Suicide is a leading cause of death in people with schizophrenia (Pompili et al., 2007).

Mood Disorders

Mood disorders consist of major depressive disorder (MDD) and bipolar disorder (APA, 2013). Since MDD affects a wide age group, all nationalities, and/or cultures, it is the most common mental illness (Kessler & Bromet, 2013). MDD impacts approximately 350 million people worldwide (WHO, 2016) and about 16 million adults in the U.S. (NAMI, 2016). Women are at a 70% higher risk of developing MDD than men (NAMI, 2016). The WHO (2016) estimates that about 800,000 people die annually from suicide related to MDD. Bipolar disorder affects around 60 million people worldwide (WHO, 2016) and 6 million people in the U.S. (NAMI, 2016). Bipolar disorder affects women slightly more than men (CDC, 2013). Rates of suicide among people with bipolar disorder are increased as much as 20-30% when compared to the general population (Pompili et al., 2013).

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) can affect adults of any age (APA, 2013). PTSD affects approximately 8 million adults in the U.S. (U.S. Department

of Veteran Affairs, 2016). Worldwide, PTSD statistics are lacking due to inconsistent methods of reporting. Women are more likely than men to develop PTSD (U.S. Department of Veteran Affairs, 2016). PTSD is also associated with an increased incidence of suicide when compared to the general population (Sareen et al., 2005).

Pathophysiology

Schizophrenia

Advanced neuroimaging techniques have revealed evidence of structural brain abnormalities in people with schizophrenia (Takahashi, 2014). Cerebral ventricular enlargement often exhibits cognitive impairments and negative symptoms associated with schizophrenia, which include inappropriate affect, anhedonia or loss of interest or pleasure, inattention, and poor decision-making. Also, changes in the temporal lobe areas may contribute to the production of positive symptoms of schizophrenia. These symptoms include hallucinations, delusions, and thought disorders. Therefore, people with mental illness tend to have poor responses to treatment (Takahashi, 2014).

Mood Disorders

Mood disorders stem from interplay between susceptible genes and environmental influences (Takahashi, 2014). Depressive episodes in mood disorders may occur or recur suddenly or gradually and last for weeks or months. MDD is the most common mood disorder and the leading cause of disability in the U.S. and throughout the world. Symptoms associated with MDD include anhedonia, sleep disturbances, fatigue, poor concentration, thoughts of death or suicide, and feelings of hopelessness or worthlessness (Takahashi, 2014).

Bipolar disorder involves extreme mood swings from episodes of depression to mania (Videbeck, 2014). The first manic episode generally occurs in the teens, twenties, or thirties, with episodes beginning suddenly with rapid escalation of symptoms. During the manic phase, people are euphoric, grandiose, energetic, and sleepless. They display poor judgment, and have rapid thoughts, actions, and speech (Videbeck, 2014).

Post-Traumatic Stress Disorder

People that suffer with mental illnesses such as depression or anxiety disorders and those who lack social support systems may be more sensitive to the effects of traumatic stress (Takahashi, 2014). People exposed to terrifying or life-threatening events may develop symptoms of PTSD. People experiencing PTSD symptoms often have flashbacks, where they relive traumatic event(s) and/or may report having nightmares or night terrors. These symptoms can interfere with sleep patterns, which may affect decision-making skills and lead to increased irritability and poor impulse control. In addition, people may display emotional numbing or detachment from others. They may also avoid activities that lead to recollection of thoughts, feelings or connection to places or people related to the trauma (Takahashi, 2014).

Red Flags

People with mental illnesses should receive timely evaluations and treatments. However, when timely evaluations and treatments are not sought or available, people can experience red flags such as suicidal idealization, mania, and/or psychosis. A relapse in mental health treatment such as discontinuing medications and/or comorbid substance use can also result in red flags. Therefore, early screening of people with mental illnesses for red flags are important to prevent injury and/or death.

Suicidal idealization

Suicidal idealization is defined as thoughts and/or plans to end one's life (CDC, 2015). Suicidal idealization ranges from a person wishing to never wake up, thinking others would be better off without him or her, transient and recurring thoughts of ending it all, and/or developing a specific suicide plan (APA, 2013). A person who has obtained the means for committing the suicidal act (gun, rope, pills, knife, etc.) and chosen the time and location for the act has imminent suicidal intent. Thoughts leading a person to suicidal idealization may include his or her perceived inability to overcome the feeling of hopelessness, end the painful mental and/or physical state(s), inability to imagine future happiness, and difficulty overcoming the feeling of being a burden to others. The risk of suicidal idealization increases with the onset of serious mental and/or medical illnesses (APA, 2013).

Risk factors for suicide include feelings of hopelessness, unemployment, post-psychotic episode, and following hospitalization (APA, 2013). A previous suicide attempt and prolonged depressive state are associated with an increased risk of suicide idealizations. People with bipolar disorder in depressed or hypomanic state have a higher risk of suicide attempts. People in hypomanic states often have increased energy and are able to follow through with suicidal plans as the person's distorted view of reality impairs all areas of his or her life (APA, 2013).

Some people experience command hallucinations (APA, 2013). *Command hallucinations* occur when people hear voices or see visions that tell them to harm themselves (APA, 2013). People with command hallucinations are at greater risk for acting on their suicidal idealization (Wong et al., 2013).

Screening strategies. Screening every person for suicidal idealization is important. Research has shown that asking about suicidal idealization does not initiate or encourage suicide (Dazzi, Gribble, Wessley, & Fear, 2014). Literature shows that near one-half of suicide victims have had contact with a healthcare provider within one month of the act (Luoma, Martin, & Pearson, 2002). Therefore, it is important for FCN's to ask people about their suicidal idealizations. FCNs should begin by asking if the person has had thoughts of harming himself/herself (see Table 1). If the answer is yes, this screen is considered positive and the FCN needs to obtain specific information about the person's plan by asking the following questions. How do you plan to do to harm yourself? When and where do you plan to harm yourself? Have you attempted to harm yourself in the past? Past suicide attempts increase the risk of current suicide completion (Substance Abuse and Mental Health Services Administration [SAMSHA], 2015b). A positive screen for current suicidal idealization requires an urgent referral for mental healthcare.

Mania

Symptoms of mania include a person's mood that is euphoric or irritable (APA, 2013). A person exhibiting a euphoric mood can be described as being in a state of exaggerated happiness where he or she feels unrestricted by societal norms. The person in a state of mania has increased energy levels and self-confidence engaging in multiple purposeless tasks that are outside his or her norm. During the time of increased energy levels, the person sleeps less than three hours a night and does not feel that he or she needs sleep. The person's speech is rapid and pressed to talk. The person appears distracted as his or her mind is constantly shifting from one subject to another and often focusing on unconnected thoughts and/or activities. A person in a manic phase may become energetically involved in sexual and monetary activities that have negative consequences to his

or her personal, social, and financial stability. The person's disturbance in mood impairs all areas of his or her life (APA, 2013).

Screening strategies. FCNs are likely to encounter people in the depressed or hypomanic phases of bipolar disorder (SAMSHA, 2015a). Screening is important to determine current manic or hypomanic episodes along with past episodes that may have been missed in the healthcare system. The FCN assesses the person for a high energy level, rapid speech, flight of thought process, and sleep patterns. Asking the person the following questions can assess sleep patterns (see Table 1). Have you ever slept less than three hours a night and felt that you did not need sleep? How many nights in a row did you not need sleep? What did you do during the time that you did not sleep? The person in a manic state will have slept less than three hours a night for several days in a row and feel like he or she has had enough sleep. During the time that the person does not sleep, he or she will be engaging in busy activities (APA, 2013). A positive screen for current mania requires an urgent referral to mental healthcare, while a positive screen for past-undocumented mania requires the FCN to notify the person's primary care provider and/or psychiatric-mental health provider.

Psychosis

Primary symptoms of psychosis include delusions and hallucinations (APA, 2013). *Delusions* are false fixed beliefs where the person is going to be persecuted or harmed by an outside force, subtle communications are referred or directed towards the person's mind, and/or the person believes that he or she has been given grandiose abilities in the areas of prosperity or celebrity. In contrast, *hallucinations* are false perceptions experienced as stimuli outside the body. Hallucinations can be auditory and/or visual. Auditory hallucinations are voices

perceived outside of the person's thoughts, while visual hallucinations are images perceived in the current setting (APA, 2013).

Screening strategies. Asking the person if he or she feels like others are trying to harm him or her, read or communicate with his or her mind, and/or that he or she has been given special abilities can assess for delusions. FCNs need to discuss these beliefs with the person. These beliefs do not change even when evidence is presented to the contrary. Asking a person if he or she sees or hears things that no one else can see or hear is a good assessment question for the presence of hallucinations (see Table 1). Does the person experience these visual and/or auditory sensations during the day, night, or both? Sensations experienced during the nighttime only are more likely to be associated with active imagination rather than hallucinations.

Table 1

Interview Questions to Determine if Red Flags for Mental Illnesses are Present

Red Flags	Interview Questions
Suicidal idealization	Have you had thoughts about harming yourself? What do you plan to do to harm yourself? When do you plan to harm yourself?
Mania	Have you ever slept less than three hours a night and feel that you did not need sleep? How many nights in a row did you not need sleep? What did you do during the time that you did not sleep?

Psychosis	Do you ever see or hear things that only your can see or hear? Do you see or hear something during the day, night, or both?

Red Flags Require Urgent Referral

A person with mental illness who exhibits current red flags should be immediately referred to psychiatric services. Continuous monitoring of the person is critical until transfer is complete to prevent the person harming himself or herself. Verbal report to the psychiatric-mental health provider should include the person's name, age, current mental health conditions, medications, allergies, and presence of suicidal idealization, mania, and/or psychosis. Discuss with the psychiatric-mental health provider about arranging transportation for the person to the mental health facility. Once transportation arrives, the person's care is transferred from the FCN to the mental health transporter.

FCNs should plan ahead by developing a list of urgent psychiatric-mental health referral sources in their areas of practice. Options for urgent referrals may be the local emergency department, crisis mental health center, and/or suicide hotline. For people with mental illnesses who are not currently exhibiting red flags, FCNs are well-positioned to provide lifestyle recommendations.

Lifestyle Recommendations

The American Heart Association recommends healthy lifestyles for all adults (American Heart Association [AHA], 2016). These recommendations include exercise, proper nutrition, and smoking cessation (AHA, 2016). People with mental illnesses are also advised to follow these recommendations.

Medication side-effects and disease progression can place people with mental illnesses at higher risk for medical comorbidities. (Shrivastava & Johnson, 2010).

Exercise is one component of a healthy lifestyle that can help reduce the risk of obesity and depressive symptoms (Walsh, 2011). Stress can negatively impact diet, sleep, and lifestyle choices such as tobacco or alcohol use; while exercise can have positive effects on the body by reducing stress (Jackson, 2013). In a study by Vancampfort et al. (2013), patients with schizophrenia demonstrated less depressive symptoms with regular exercise when compared to those with less exercise. In another study, positive links between exercise and MDD have been evidenced, as exercise lessens depressive symptoms (Pollock, 2001). The AHA (2016) recommends that adults have 150 minutes of moderate physical activity each week. This activity can be broken down into small time increments, such as 10-minute activity sessions, to achieve 150 minutes weekly.

Proper nutrition such as skinless fish and poultry, fruits, vegetables including legumes, whole grain foods, low-fat dairy, and nuts are recommended (AHA, 2016). The use of alcohol or tobacco is not advised for people with mental illnesses due to interactions with medications and/or worsening the disease progression (Crocq, 2003). People living a health lifestyle can benefit from improved mental health and overall well-being (Walsh, 2011).

Conclusion

People with mental illnesses can develop red flags that require timely assessments. FCNs are readily accessible to people with mental illnesses and can screen for red flags of suicidal idealization, mania, and psychosis. Timely screenings for red flags with appropriate referrals have the ability to reduce serious injury or death in this population, while educating people with mental

illnesses about lifestyle recommendations has the ability improve people's overall mental health and well-being. FCNs preparing to screen for red flags of mental illnesses should develop local urgent referral sources in their practice area. FCNs not only provide spiritual support, but also can link the parishioner with necessary mental health resources and/or referrals.

Mental Health Resources for the FCN

Table 2

Mental Health Resources

Resources	Links
American Heart Association's Diet and Lifestyle Recommendations	http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/Nutrition/The-American-Heart-Associations-Diet-and-Lifestyle-Recommendations_UCM_305855_Article.jsp#.VytA7oSDFBe
American Psychiatric Association - Mental Health: A Guide for Faith Leaders	https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership
World Health Organization – Preventing Suicide: A Global Imperative	http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

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