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Using health psychology to help patients: common health mental disorders and psychological distress

Elizabeth Barley and Victoria Lawson BJN 2016

Abstract This article provides an overview of how health psychology can be used by nurses to help patients suffering from common mental disorders and psychological distress. Psychological difficulties are common and are associated with poor outcomes, especially when comorbid with physical health conditions. Psychological difficulties are also associated with unhealthy behaviours such as smoking which also result in poor outcomes for patients. Consideration of their patients' psychological status is therefore important for all nurses providing holistic care. Awareness of the symptoms of psychological distress, good communication skills and simple screening instruments and can be used by nurses to assess patients' mental state. The cognitive and behavioural factors associated with depression and anxiety are also highlighted.

Common mental health disorders (CMD) include depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder (NICE, 2011a). As the term suggests, these disorders are not unusual in the general population. The most commonly occurring CMD is 'mixed anxiety and depressive disorder' with a prevalence of 9% (McManus et al, 2009). Lifetime prevalence estimates for all CMDs suggest that 25% of the population will experience a CMD some point (Kessler et al, 2005). Nurses in any field are therefore likely to encounter patients with CMDs. In this article, we discuss why it is important for nurses to understand how to detect and manage CMDs, and how knowledge of health psychology can help (Barley, 2016).

Why all nurses should consider CMDs

People with long term physical conditions have higher rates of depression and/or anxiety compared to the general population (Moussavi et al, 2007; Steptoe 2007). Having a comorbid mental health problem is associated with worse physical outcomes, greater disability, and higher rates of death (Benton et al, 2007). For instance, coronary heart disease (CHD) patients who are also depressed are twice as likely to have a further coronary event (odds ratio 2.0) and nearly three times more likely to die (odds ratio 2.6) than people who are not depressed (Barth et al, 2004; van Melle et al, 2004; Stafford et al, 2007). Nurses in all fields must therefore be able to assess both their patients' mental and their physical health needs if they are to be competent to deliver holistic care, i.e. to treat the 'whole person' (Nursing and Midwifery Council, 2015).

So why do CMD's have such an impact on physical health conditions? A range of explanations is possible, including psychological, behavioural, and physiological factors. For example, in CHD potential biological pathways may include higher cardiovascular stress reactivity, reduced heart rate variability, reduced heart rate recovery, dysfunctional hypothalamic-pituitary-adrenal axis, greater cortisol reactivity to stress, increased awakening and daytime cortisol levels, increased inflammatory mediators and increased platelet reactivity. However, behaviours such as cigarette smoking, physical activity, and alcohol intake are also important. In a large prospective study of healthy adults (N = 6,576), the association between psychological distress and CHD risk was mostly explained by behavioural processes, with pathophysiological factors only accounting for only a modest amount of the variance (Hamer et al, 2008). Therefore, addressing behavioural factors as a maintaining

mechanism for poor health is key, and nurses can use the information in this series of articles to help patients to do so.

Effective care is clearly not possible without a holistic consideration of mental health. Diagnosis of CMDs are made by mental health professionals but nurses should identify patients at risk. This is important because patients may not ask directly for help due to embarrassment, stigma, lack of knowledge or worries about treatments. This may especially be the case in people with existing physical health problems, who may consider mood problems as 'to be expected' and may not understand that treatment is available (Simmonds et al, 2013). Older people or people of some ethnicities may be particularly likely to feel that feelings of low or anxious mood are a sign of weakness and avoid seeking help (Burroughs et al, 2006). Furthermore, the risk of suicide must be considered. Psychiatric disorders are present in around 90% of people who die by suicide (Cavanagh et al 2003) and more than half of all suicides occur in people who meet the criteria for depression diagnosis (Hawton and van Heeringen, 2009). CMDs are therefore common, have serious consequences, are associated with poor outcomes, and are not always easy to identify. Nurses must be vigilant to the very real possibility of a patient experiencing a mental health problem, and confident in screening for them.

Screening for CMDs

When considering if a patient maybe experiencing a CMD good communication skills will help build the trust necessary for the patient to disclose any difficulties. It is also important for nurses to display empathy, and explore the patient's expectations and preferences, both as part of an assessment and of ongoing support (Maguire and Pitceathly, 2002). Communication skills include the ability to detect symptoms of CMDs which may be expressed in behaviour and body language as well as words (Box 1). Many of these symptoms are part of our normal experience; it is their intensity, duration and the extent to which they impair function that differentiates CMD.

Box 1: DSM V* Symptoms of depression:

Low mood
Loss of interest and pleasure or loss of energy number
Significant weight loss or gain
Physical agitation
Fatigue or loss of energy
Significant distress or impairment
Feelings of worthlessness or excessive guilt
Reduced concentration
Indecisiveness

DSM V Symptoms of anxiety:

Excessive worry
Angst
Irritability
Fear
Difficulty concentrating
Increased startle
Hypervigilance
Compulsions
Obsessions
Restlessness
Muscle tension
Shortness of breath

Sleep disturbance
Easily fatigued
Palpitations
Choking

*CMD diagnoses in the UK are made using criteria set out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association 2013). An alternative system, which is also widely used, is The ICD-10 classification of mental and behaviour disorders produced World Health Organization (2016).

As can be seen in Box 1, many of the diagnosable symptoms of a CMD may appear to be physical symptoms but are also symptoms of anxiety and depression. It is important to keep this in mind when screening for CMD.

Anyone may experience CMDs but predictors include past history of CMD, low socioeconomic status, alcohol misuse and female gender (Kessler et al, 2005; McManus et al, 2009). Women may be more likely to experience depression symptoms during the perinatal period, though the relative incidence of diagnosed depression during this period compared with the general population of women at non-childbearing times is unclear (NICE, 2007; Gavin et al, 2005). The potential consequences of maternal mental health problems are serious, however, and nurses should be alert to this.

Knowing how to identify a potential CMD can be daunting but there is a number of easy to administer, widely used validated questionnaires instruments that nurses can use to screen for depression or anxiety symptoms. For example:

- Patient Hospital Questionnaire 9 items, for depression (Kroenke et al, 2001)
- Generalised Anxiety Disorder 7 items (Spitzer et al, 2006)
- Beck Depression Inventory (BDI) (Beck et al, 1996)
- Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1993)

Perhaps the simplest screen for depression is the PHQ-2 or 'Whooley questions' detailed in Box 2 and consists of two items concerning the core features of depression (Whooley et al, 1997). It can be administered as a questionnaire but is also easily used verbally as part of a consultation.

PHQ2: Whooley questions (for depression)
"1) During the past month, have you often been bothered by feeling down, depressed, or hopeless?
2) During the past month, have you often been bothered by little interest or pleasure in doing things?"

A positive response to either or both questions is an indication of possible depression.

Use of these two items provides correct identification in 95% of people who have depression but a significant number of people (57%) will be falsely identified as depressed (Whooley et al, 1997). Therefore follow up with a longer instrument may be useful. Additionally, if a nurse's clinical judgement suggests depression is likely, the free-to-use PHQ-9 administered as a questionnaire (and that includes the Whooley questions), may be more useful. Longer instruments will also be more effective at determining symptom severity or monitoring changes over time (Kroenke et al, 2001)

For anxiety a similar two item screen exists, see Box 3:

Box 3: Generalised Anxiety Disorder Assessment 2 (GAD-2; Spitzer et al, 2006)

"Over the past 2 weeks, how often have you been bothered by:
1) Feeling nervous, anxious or on edge?
2) Not being able to stop or control worrying?"

There is a choice of 4 response options: Not at all, several days, more than half the days, or nearly every day. Overall scores of 3 or more may indicate an anxiety disorder.

The GAD-2 has been found to work almost as well in detecting anxiety disorders as the GAD-7; sensitivity is good for generalised anxiety disorder, panic disorder, social anxiety disorder and, to a slightly lesser extent, PTSD (Kroenke et al, 2007). However, the GAD-7 provides more detailed information about the nature of anxiety.

Patients who screen positive should be referred for specialist assessment and diagnosis by a mental health professional. A diagnosis of depression requires at least one key symptom of low mood, loss of interest and pleasure or loss of energy to be present plus other symptoms from Box 1. Symptoms should have been present for at least 2 weeks in sufficient severity for most of every day for a diagnosis to be made.

For anxiety, DSM V lists a range of disorders, the most common being Generalized Anxiety Disorder (American Psychiatric Association, 2013) but is characterised by excessive worry associated with heightened tension (NICE 2011b). Other anxiety symptoms from Box 1 may also be present but anxiety disorder is not diagnosed unless symptoms have been present for at least 6 months and cause clinically significant distress or impairment in social, occupational or other functioning (NICE 2011b). It is increasingly recognised however, that even symptoms of CMD which do not meet diagnostic criteria, are debilitating, associated with poor outcome and may develop into a disorder (Rodriguez et al, 2012). There are behavioural and cognitive factors which contribute to symptoms. Understanding of these is useful for nurses when helping patients to manage psychological distress.

1) *Behavioural factors in depression and anxiety*

Behaviours, including cigarette smoking , excessive alcohol (which has a depressive effect), physical inactivity, over-eating and being obese have been found to be associated with CMD diagnosis and symptoms (National Obesity Observatory 2011 ; Royal College of Physicians, 2013; Smith et al, 2013). The direction of cause and effect is unclear but if the individual stops or reduces the unhealthy behaviour, mood may improve (Hamer et al, 2008). For instance, many smokers use smoking as a coping strategy, believing it improves mood thus perpetuating smoking behaviour (Ferguson et al 2005). Smoking can reduce feelings of irritability in the short term, however, a recent systematic review of 26 studies demonstrated that stopping smoking is actually significantly associated with reduced depression, anxiety, stress, improved mood and quality of life compared with continuing to smoke (Taylor et al, 2014).

Similarly, a Cochrane review of 39 studies found that exercise was more effective than no treatment for improving depressive symptoms and similarly as effective as pharmacological or psychological therapy (Cooney et al, 2013). In obesity, mediating factors for mental health problems include low self-esteem, stigma, dieting and weight cycling, medication, functional impairment and lack of social support (National Obesity Observatory, 2011).

Psychological models have also explored how social support is important (Cohen et al, 2000). The 'buffering hypothesis' suggests that social relationships provide resources, including information, emotional support, and tangible help that promote healthy responses to stressful events. Social support can also facilitate healthier behaviours such as exercise, healthy eating, not smoking and treatment adherence, through 'role modelling' or social norms. Review evidence in older people suggests that it is not the amount of support which is important, but the individual's level of satisfaction with it (Schwarzbach et al, 2014). Paradoxically, CMD symptoms may both influence the perceived quality of social support and the quality of social interaction. Use of the health psychology techniques described in earlier articles in this series (for example on how to help patients make healthier choices, set goals and enhance social support) are useful to help patients' improve their mood (Barley and Lawson, 2016a; b).

2) Cognitive factors in depression and anxiety

A previous article in this series (Barley and Lawson, 2016c). described Beck's cognitive model which proposes that people may develop unhelpful ways of thinking – 'thinking errors' (Beck, 1967). Thinking errors often lead to unhelpful 'avoidance' and 'safety' behaviours. For instance, an anxious person may misinterpret symptoms of anxiety (e.g. raised heartbeat, sweaty palms, rapid breathing) as an indication that they are having a heart attack, i.e. they 'catastrophise' their symptoms (Clark, 1986). They may then start to avoid stressful situations (avoidance behaviour) and/or carry out safety behaviours (such as drinking alcohol to calm nerves or avoiding shaking hands for fear of germs) to protect them from their feelings of anxiety. These avoidance and safety behaviours help people to feel better in the short term, but in the long term only maintain irrational beliefs, unhelpful behaviours and depression or anxiety. It *may* be helpful for nurses to try to understand and then gently challenge the thought patterns which are contributing to a patient's distress and hindering them from making healthy choices. However, patients who meet diagnostic criteria for CMD are likely to need to be referred for specialist treatment.

Treatment of CMDs

Treatment for CMD usually follows a 'stepped care' approach. This is where the least intrusive, most effective intervention is provided first. If a person does not benefit from the first treatment or if they decline it, they are offered an intervention from the next step. Treatment can range from active monitoring, talking therapies, medication, right through to inpatient admission. The patient's wishes are always of paramount importance, both ethically and as engagement with treatment is essential for recovery.

Conclusion

Disorders such as depression and anxiety are common and associated with psychological distress and poor health outcomes. A distinction is made between a diagnosis of a CMD and the experience of symptoms which can nevertheless impair quality of life and overall health. CMDs and distress are associated with a range of patient characteristics and behaviours. Understanding this can help nurses to screen for and assess patients for CMDs and psychological distress. Simple screening tools are available for nurses to use. Nurses can also provide psychoeducation and employ behaviour change techniques to support patients to make healthy choices and change unhelpful thinking patterns which impact on mood. Appropriate awareness, detection and management of CMDs and distress is essential for nurses to be able to provide appropriate, holistic care.

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