ENTRY-LEVEL FAMILY NURSE PRACTITIONERS: PSYCHIATRIC KNOWLEDGE IS COLLABORATION

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# Table of Contents

Abstract ...............................................................................................................................................5

Overview .............................................................................................................................................6

Purpose ...............................................................................................................................................7

Importance of Issue ..............................................................................................................................7

Literature Search Techniques ..............................................................................................................9

Overview of FNP Mental Health Diagnoses and Management ..........................................................10

Anxiety Disorders ..............................................................................................................................10

Selective Mutism ...............................................................................................................................11

  Treatment of Selective Mutism ........................................................................................................13

Separation Anxiety Disorder ...............................................................................................................13

  Treatment of Separation Anxiety Disorder ....................................................................................15

Specific Phobia .....................................................................................................................................15

  Treatment of Specific Phobia ...........................................................................................................17

Social anxiety disorder .......................................................................................................................18

  Treatment of Social Anxiety Disorder ............................................................................................19

Panic Disorder .....................................................................................................................................20

  Treatment of Panic Disorder ...........................................................................................................22

Agoraphobia .........................................................................................................................................23

  Treatment of Agoraphobia ................................................................................................................24

Generalized anxiety disorder .............................................................................................................24

  Treatment of Generalized anxiety disorder .....................................................................................25

Suicide and Anxiety Disorders ..........................................................................................................26
Depressive disorders

Disruptive Mood Dysregulation Disorder

Treatment of Disruptive Mood Dysregulation Disorder

Major Depressive Disorder

Persistent Depressive Disorder (dysthymia)

Treatment of MDD and PDD

Nurse Practitioner Role

Psychiatric Nurse Practitioner Role

Entry-level FNPs and Caring for Mental Illness

Primary Care, FNPs and Psychiatric NPs

Collaboration for Mental Health

Barriers to Collaboration

Discussion

Increasing Education

Implications for Practice for Entry-level FNPs

Implications for Further Research

Conclusion

References

Appendix A - DSM-V Diagnostic Criteria for Selective Mutism

Appendix B - DSM-V Diagnostic Criteria for Separation Anxiety Disorder

Appendix C - DSM-V Diagnostic Criteria for Specific Phobia

Appendix D - DSM-V Diagnostic Criteria for Social Anxiety Disorder

Appendix E - DSM-V Diagnostic Criteria for Panic Disorder
Appendix F - DSM-V Diagnostic Criteria for Agoraphobia…………………………………..…66
Appendix G - DSM-V Diagnostic Criteria for Generalized Anxiety Disorder………………67
Appendix H - DSM-V Diagnostic Criteria for DMDD………………………………………….68
Appendix I - DSM-V Diagnostic Criteria for Major Depressive Disorder………………….69
Appendix J – Patient Health Questionnaire (PHQ-9)……………………………………………70
Appendix K – How to Score the PHQ-9…………………………………………………………71
Appendix L - DSM-V Diagnostic Criteria for Persistent Depressive Disorder…………….72
Appendix M - Poster……………………………………………………………………………73
Abstract

Family nurse practitioners (FNPs) in British Columbia (BC) are trained in the care of young infants to elderly patients in all aspects of their healthcare. BC has three specialties available for NPs to practice in: family, pediatric, and adult. Currently, U.S. registered psychiatric NPs applying for registration in Canada/BC are not recognized as either a psychiatric NP or an NP due to regulations set by the College of Registered Nurses of British Columbia (CRNBC) and other provincial regulatory bodies. At the entry level of practice, BC NPs have full scope to care for a variety of mental illnesses including depression, anxiety, obsessive-compulsive disorder and substance use disorder, (CRNBC, 2015). Entry-level FNPs should acknowledge that psychiatric care is a large part of their practice and needs more attention than their current education may provide them. The best way to reduce the gap between psychiatric knowledge and physical health knowledge is interprofessional health care team collaboration (Hert et al., 2011; HFMH, 2006; McNeil, 2000; Thielke et al., 2007; Roberts et al., 2009). A professional poster was created with the intended purpose of providing entry-level NPs with a visual representation of some of the concerns experienced by family NPs, with some suggested strategies when providing health care to individuals with mental health issues.

Keywords: depression, anxiety, psychiatric nurse practitioner, family nurse practitioner, collaboration
**Overview**

FNPs in BC are trained in the care of young infants to elderly patients in all aspects of their healthcare. This includes mental health conditions within the primary care setting such as anxiety, depression, obsessive-compulsive disorder and substance use disorder (CRNBC, 2015). Entry-level FNPs can also provide continuing care of (monitor and prescribe) and consult with physicians in the care of patients with attention deficit disorder, post-traumatic stress disorder, autistic spectrum disorder and fetal alcohol spectrum disorder (CRNBC, 2011). Although there is specialty care provided for mental illness, FNPs need to be prepared to both diagnose and properly refer patients to psychiatric specialties when required.

According to the Canadian Mental Health Association, 20% of all Canadians will experience mental illness in their lifetime (2015). In the year 2007/2008, 21.8% of British Columbians (15.6% men, 27.9 % women) had a diagnosis of depression or anxiety (Fang, Kmetic & McCarney, 2010). According to these statistics, all entry-level FNPs regardless of their practice setting or specialty will care for individuals with mental illness.

BC has three NP specialty streams, which are family, pediatric and adult (CRNBC, 2005) Presently, there are no masters prepared psychiatric NP programs in BC. However, in the U.S. there are specific psychiatric NPs programs educating NPs to work independently with psychiatric patients and manage their care. NPs who have received licensure as a psychiatric NP in the US are not recognized as either a psychiatric NP or an NP in BC.

This literature review will discuss the diagnosis and treatment of various depressive and anxiety disorders that FNPs in BC diagnose and manage independently. The FNP role in Canada and the role of the U.S. psychiatric NP will be investigated and reviewed. This review will investigate the entry-level FNP perspective in regards to their understanding of mental health
diagnosis and management and what strategies are implemented by these new FNPs to build collaborative relationships in an effort to increase knowledge and care for patients with mental illness in primary care settings.

**Purpose**

Mental illness requires a multifaceted, multidisciplinary approach regardless of the severity of the mental illness. Entry-level FNPs may not feel confident in diagnosing and treating the many mental illness disorders they will encounter in clinical practice (Koren et al., 2015). This literature review will summarize the diagnosis, risk factors and treatment of depression and anxiety disorders that FNPs are required to treat in primary care. This review will investigate the psychiatric NP role in United States where it is well established. Although this role is not yet implemented in Canada, knowledge of the competencies required for the psychiatric NP will help to identify the further educational requirements needed for Canadian FNPs in order to meet the needs of mental illness patients. This review will also investigate interprofessional collaborative efforts to treat patients with mental illness in primary care.

**Importance of this issue**

Mental illness is a common health problem for Canadians. In 2009/2010, about 14.4% of Canadians (5 million) 1 year of age or older had a mental health illness and received healthcare for it (Government of Canada, 2015). The most commonly seen mental illnesses in Canada are anxiety disorders and depressive disorders (Fang, Kmetic & McCarney, 2010). Anxiety and depression are very important to identify and treat in primary care to reduce the risk of patients developing comorbid mental health disorders. Anxiety disorders have a high likelihood of suicide attempts if left untreated (Nepon et al., 2010). Similarly, thoughts of suicide and suicide attempts are common in patients with depressive disorders (APA, 2013). FNPs scope of practice
includes the diagnosis and management of specific mental illnesses including anxiety, depression, obsessive-compulsive disorder and substance use disorder (CRNBC, 2015). The public and other healthcare providers may not understand the role of the FNP in health care or understand FNP responsibilities in mental health care. The FNP role has been present in Canada for over 50 years but has only been in BC since 2005. The lack of exposure to NPs by the public and physicians (especially in BC) is another barrier than entry level FNPs must overcome while learning to practice.

Although NPs have been practicing in Canada since the 1960s, role identification has been an ongoing issue (Sangster-Gormley et al., 2010). NPs are not commonly placed into generalist positions making the NP role difficult for the public and other healthcare providers to identify (Keough et al., 2011). Interestingly, FNPs in BC are often employed in specialty clinics that serve patients with mental illnesses yet they do not feel prepared to practice in these settings. The psychiatric NP role developed in the 1990s in the U.S. to address these concerns and since the implementation of this specialty role there has been a significant reduction in mental illness comorbidities in primary care (Bjorklund, 2003). Koren et al. (2015) found that entry-level FNPs felt least prepared to care for patients with mental illness but overall felt well prepared to treat patients overall based on their entry-level education. Psychiatric NPs receive training in the treatment of psychiatric illness but are not as prepared to treat patients with chronic disease (Bjorklund, 2009; Lumby, 2007; WHO, 2003). Since most psychiatric patients have multiple chronic illnesses it would seem logical that a generalist FNP would be the most appropriate primary care practitioner to work in collaboration with other healthcare professionals for follow up and treatment of those comorbidities (Hert et al., 2011; Jones et al., 2004; Roberts et al., 2009; Stanley & Laugharne, 2014).
Many authors have concluded that collaboration in healthcare is the key to entry-level FNPs providing safe, competent care for patients with mental illness (Hert et al., 2011; HFMH, 2006; McNeil, 2000; Thielke et al., 2007; Roberts et al., 2009). FNPs who work in collaboration with other health professionals will have better success in effective diagnosis and long-term treatment of patients with mental illness. Collaboration between physicians, FNPs, dietitians, social workers and mental health workers can have a vital role in the assistance of mental health care. Using one profession to tackle a complex mental health illness will not result in long-term benefit (Hert et al., 2011; Roberts et al., 2009; Thielke et al., 2007). FNPs can use interprofessional health care collaboration to better understand the complex care required to effectively treat patients with mental illness. Entry-level FNPs can feel confident that their care is more effective when collaborating between their colleagues and other health professionals (Hert et al., 2011; HFMH, 2006; McNeil, 2000; Thielke et al., 2007; Roberts et al., 2009). FNPs can act as champions for change in mental healthcare. Evidence supports that the treatment of mental illness is most effective when an FNP or any other health practitioner refuses to work alone.

**Literature Search Techniques**

This literature search was conducted from a variety of databases that include: EBSCOhost Databases, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Academic Search Complete and PubMed. All searches had the criteria of being peer reviewed and between the years 2000-present. Search headings included the following and multiple combinations of the following: Family Nurse Practitioner, Nurse Practitioner, Primary care provider, education, nursing, graduate, mental illness, anxiety disorder, specific phobia, selective mutism, social anxiety disorder, panic attack, panic disorder, agoraphobia, generalized anxiety
Entry-Level FNPs: Psychiatric Knowledge is Collaboration

Disorder, suicide, depressive disorder, depression disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, dysthymia, premenstrual dysphoric disorder, obsessive compulsive disorder, physical health problems and older adults. In addition, online resources were used including Statistics Canada, Government of Canada, Canadian Registered Nurses of British Columbia, Canadian Community Health Survey (2002), Primary Care Medicine: Office Evaluation and Management of the Adult Patient (2009) and treatment guidelines were obtained from the Doctors of BC treatment guidelines (BC Guidelines) and “Up To Date” an online evidence-based clinical decision support tool.

**Overview of FNP Mental Health Diagnoses and Management**

FNPs are responsible for the diagnosis and management of anxiety, depression, obsessive-compulsive disorder and substance abuse disorder (CRNBC, 2011). FNPs are also responsible for continuing care and consulting with physicians on patients with attention deficit disorder, post-traumatic stress disorder, autistic spectrum disorder and fetal alcohol spectrum disorder (CRNBC, 2011). Anxiety disorders and depressive disorders are the most common disorders seen in primary care in Canada (Fang, Kmetic & McCarney, 2010). Since this is likely what FNPs will be seeing in their practice, these disorders are included in a more comprehensive manner for clarification and understanding.

**Anxiety Disorders**

Anxiety is an unpleasant experience involving excessive amounts of fear often accompanied by various physiological autonomic responses (Goroll & Mulley, 2009). Instead of having a normal anxiety in response to specific events, individuals with an anxiety disorder have an excessive amount of worry and apprehension that will interfere with their everyday lives (Government of Canada, 2006). The 2002 Mental Health and Well-being Survey found that
approximately one in eight Canadian adults have had one type of anxiety disorder in their lifetime (Statistics Canada, 2002). FNPs are a primary care contact for individuals who may be exhibiting symptoms of anxiety thus emphasizing the importance for FNPs to understand diagnostic criteria and treatment options available for anxiety.

Anxiety includes a variety of disorders classified by the DSM-V: selective mutism, separation anxiety disorder, specific phobia, social anxiety disorder, panic disorder, panic attack, agoraphobia, generalized anxiety disorder, substance/medication-induced anxiety disorder, anxiety disorder due to another condition, other specific disruptive, impulse-control and conduct disorder and unspecified anxiety disorder (American Psychiatric Association, 2013). Each disorder is differentiated from one another due to what specific trigger induces fear, anxiety, panic or avoidance as well as specific cognitive dysfunctions (APA, 2013). Generally, in order to receive a diagnosis of anxiety a patient needs to exhibit symptoms of anxiety lasting greater than six months (APA, 2013).

The DSM-V encourages judgment to decide if more or less time is required for diagnosis (APA, 2013). It is important for FNPs to recognize the unique presentation of each anxiety disorder in order to effectively treat and manage anxiety conditions. Selective Mutism, Separation Anxiety Disorder, Specific Phobia, Social Anxiety Disorder, Panic Disorder, Agoraphobia and Generalized Anxiety Disorder will be discussed in detail to increase clarification and summarize treatment options specific to these anxiety disorders.

**Selective Mutism.** Selective Mutism (SM) is a condition where a person is persistently unable to speak in social situations while having no concern of speaking in other situations (APA, 2013). This condition can occur both in adulthood and childhood but is more commonly
seen in children (APA, 2013). This is an extremely rare diagnosis of anxiety frequently overlapping the diagnosis of social anxiety (APA, 2013).

The epidemiology of SM occurs in about 0.02-1% of the population in the United States (APA, 2013). SM is usually diagnosed before the age of five and in many cases children will overcome the disorder naturally without intervention but social anxiety will usually remain (APA, 2013).

Risk factors for SM include child neuroticism and a parental history of shyness, social isolation and social anxiety (APA, 2013). Parents who are overprotective or controlling over their children’s behaviour may also be a risk factor for their child developing SM (APA, 2013). There may or may not be a genetic predisposition to SM if a first-degree relative has social anxiety disorder (APA, 2013). It is important to FNPs to complete a full assessment on both the child and the parents to complete a thorough symptom analysis as well as contributing factors, which may be causing the child to exhibit symptoms of SM.

Diagnosis of SM, along with all other psychiatric disorders is decided according to the DSM-V criteria. It is important for healthcare professionals to distinguish SM from other diagnoses including communication disorders (language development, speech and sound disorder, stuttering, social communication disorder), neurodevelopmental disorders (autism spectrum disorder), schizophrenia or other psychotic disorder, or intellectual disability (APA, 2013). Although SM is a rare diagnosis, it is an important differential when completing a developmental examination on a child. After all communication disorders, neurodevelopmental disorder or psychiatric disorders have been ruled out by a psychiatrist, a diagnosis SM may be determined.
Cunningham et al. (2004) completed a study on 104 children (54 with SM and 54 without Selective Mutism). The children with SM had a higher level of anxiety, higher levels of obsessive-compulsive disorder (OCD) and lower social assertiveness than the children without SM (Cunningham et al., 2004). Cunningham et al. (2004) found that there were no differences in children with SM than children without SM in academic performance in school, victimization or bullying. Study results demonstrated that although children with SM may have difficulty with social situations in the future, they would likely not have any long-term effects with effective treatment and therapy.

**Treatment of Selective Mutism.** SM is primarily a childhood anxiety disorder and treatment will be focused on this age category. Due to the risk of reduced peer relationships and school performance, SM should be treated effectively and followed up regularly (Glazier et al., 2015). Without treatment, there is a risk that a child could develop future comorbidities including obsessive-compulsive disorder, depression, substance abuse and suicidal thoughts/attempt (Glazier et al., 2015). The most effective therapy for SM (in the mild to moderate category) is cognitive behavioural therapy (CBT). In severe cases of SM (child not attending school, unable to speak in any social situations and failure to CBT) a trial of pharmacological therapy may chosen under the supervision of a psychiatrist. Pharmacological therapy is not recommended for children or adolescents in the treatment of anxiety disorders, as there are no clear benefits to pharmacological therapy (BC Guidelines, 2010; Glazier et al., 2015). If an anxiolytic medication is chosen for adolescents, the medication is usually a half or quarter of the adult dose initially and gradually increased based on the child’s response to the medication (BC Guidelines, 2010).

**Separation Anxiety Disorder.** The main feature of separation anxiety disorder is an unrealistic and excessive anxiety state when being separated or anticipating separation from an
attachment figure (APA, 2013). Individuals with this disorder also have a persistent fear of their attachment figures being harmed from illness, accidents or other circumstances resulting in death (APA, 2013). These symptoms must occur for at least 4 weeks in children and 6 months in adults and cause a significant impairment in their social functioning, schoolwork or other important areas of functioning (APA, 2013). Further DSM-V diagnostic Criteria for separation anxiety disorder is in Appendix B.

In the United States, the prevalence of separation anxiety disorder is about 4 percent for children, 0.9-1.9% in adults and 1.6% in adolescents (APA, 2013). It is listed as the most prevalent anxiety disorder in children under the age of twelve (APA, 2013).

Risk factors for the development of separation anxiety disorder include the loss of a loved one, change in schools, death of a pet, parental divorce, moving to a new neighbourhood, immigration, or in young adulthood could be moving out of a parent’s home, having a new relationship or having a child (APA, 2013). There may also be hereditary component making it imperative to complete a full family history assessment. Parents who are overly protective of their children may also have separation anxiety disorder.

There are many other differentials to consider with separation anxiety including psychotic disorders, depressive disorders, posttraumatic stress disorder, social anxiety disorder, generalized anxiety disorder, panic disorder personality disorders and agoraphobia (APA, 2013). Separation anxiety may also occur with the above differentials often being the contributor or result of the listed differentials (APA, 2013).

Lewinsohn et al. (2008) found an increased risk of developing a mental illness in individuals that had been diagnosed with separation anxiety disorder before the age of nineteen. The most common mental illness identified was panic disorder but depression was also a
common occurrence (Lewinsohn et al., 2008). This is a good example of how untreated psychiatric disorders such as separation anxiety contribute to reduced functioning as an adult. Lewinsohn et al. (2008) found 73.5% of all children treated for separation anxiety continued on to developed a type of mental illness during their young adulthood. Providing evidence that not only would a child require treatment for separation anxiety disorder but also continued psychotherapy for reducing their chances of developing future panic disorder or depression.

**Treatment of Separation Anxiety Disorder.** The most effective therapy for Social Anxiety Disorder is CBT. Pharmacological therapy is not recommended for children or adolescents in the treatment of anxiety disorders, as there are no clear benefits to pharmacological therapy (BC Guidelines, 2010; Glazier et al., 2015). In severe cases of social anxiety disorder a referral to a psychiatrist may assist in both the treatment of the disorder as well as identify other comorbid psychiatric disorders, which may be perpetuating the symptoms. With all anxiety disorders in children, parents should also be assessed for anxiety symptoms as well as the home situation in order to explore further modifiable causative factors.

**Specific Phobia.** Specific Phobia (SP) is related to a specific fear towards an object or situation that in most cases will provoke an immediate anxiety and fear response (APA, 2013). The symptomatic responses to phobias are variable. A person with an animal phobia, situational phobia or natural environment phobia will usually show sympathetic nervous system response (fight or flight response). Individuals with a phobia of a phlebotomy or blood injection or blood injury will typically have a vasovagal response (APA, 2013). Seventy five percent of people with SP have more than one phobia. Most individuals with SP have an average of about three phobias (APA, 2013). In most cases, individuals are unable to explain the exact reason why they have a SP or what originally brought on the phobia itself (APA, 2013). The onset of phobias is usually
in childhood (ages seven to eleven) and will come and go as the child grows and matures (APA, 2013). If SP persist into adulthood, however, it is unlikely that they will go into remission (APA, 2013). Adults can develop SP but they are usually linked to a traumatic event such as a phobia of flying due to experiencing a plane crash. DSM-V diagnostic criteria for SP is located in Appendix C.

Excessive fears are common in young children, are generally related to their developmental age, and therefore these children should not be diagnosed with SP (APA, 2013). In order to have a diagnosis of SP it is important for the FNP to both measure the grade of impairment and if the fear response is appropriate to their developmental age (APA, 2013). Any parent with concerns of their child exhibiting excessive fears towards a stimulus will need to be both reassured of their child’s developmental age characteristics as well as understand when their child’s phobia becomes abnormal.

SP is one of the most common disorders experienced by adults and is usually exhibited by signs and symptoms of medical conditions rather than symptoms of a specific phobia (APA, 2013). FNPs need to be aware of patients presenting with fear and anxiety to be thoroughly assessed for anxiety disorders. Older adults that experience SP are more likely to experience a lower quality of life and may contribute to a reduction in neurocognitive functioning (APA, 2013). Without effective treatment for SP, older adults will not experience their lives to their full potentials. In fact, adults are up to 60% more likely to attempt to commit suicide if they have a specific phobia (APA, 2013). By acknowledging SP as contributor to a reduction in adult overall health and well being, an FNP should be well aware of both the diagnostic criteria as well as treatment options available to these patients.
Other differential diagnoses that FNPs need to be aware of when diagnosing a specific phobia are agoraphobia, social anxiety disorder, separation anxiety disorder, panic disorder, obsessive-compulsive disorder, eating disorder and other psychotic disorders (APA, 2013). Although rarely seen in the clinical setting as a primary diagnosis, FNPs need to be aware of other somatic symptoms that may develop that are directly related to a specific phobia in the presence of anxiety.

_Treatment of Specific Phobia._ The first-line treatment of SP in adults and children is CBT including exposure to the phobia (Glazier et al., 2015; McCabe & Swinson, 2016). A psychologist or therapist that specifically is trained in the treatment of specific phobias is best to perform the CBT with exposure therapy. There are many different types of exposure therapies including In Vivo, imaginal and virtual reality (McCabe & Swinson, 2016). The most effective exposure therapy is In Vivo, where the patient is exposed to their fear in a real world situation (McCabe & Swinson, 2016). Imaginal confronts the fear situation by examining it with imagery and virtual reality uses computer simulation. There are also other types of therapy that a psychologist or therapist may use depending on the situation as well as the financial capabilities available to the patient (for example: needing to take a flight to reduce phobia of flying).

The use of pharmacological therapy for SP is only used when effective CBT is not available or despite CBT there is no change in the anxiety and fear response to the stimulus and the patient prefers medication to CBT (McCabe & Swinson, 2016). Because clinical trial evidence does no support the use of pharmacological therapy in the treatment of SP they should only be used as a last-resort. In cases where the patient is exposed to the phobia on a regular basis and the phobia is not avoidable, pharmacological therapy is an option (Swinson & McCabe, 2016).
First-line pharmacotherapy for specific phobias is benzodiazepines. Other pharmacological options may be the addition of a Selective Serotonin Reuptake Inhibitor (SSRI) if the use of benzodiazepines are ineffective and exposure to the phobia is frequent (Swinson & McCabe, 2016). Currently, under the federal Controlled Drugs and Substances Act and Regulations, it is outside the scope of practice for FNPs to prescribe benzodiazepines. If a patient has already been prescribed a benzodiazepine for their SP, it would be important for the FNP to ensure the patient understands to use the medication thirty minutes before their exposure to the phobia stimulus and to not consume any drugs or alcohol in combination with the benzodiazepine due to the risk of sedation and confusion.

**Social anxiety disorder.** Social anxiety disorder is a condition where the individual will either fear or completely avoid all social performance situations like public speaking, parties or conversations where they may have a chance of being humiliated or embarrassed (Government of Canada, 2006). Non-social situations such as performance in school, interactions with family members and solitary work performance are not effected by social anxiety disorder (APA, 2013).

Some typical features of social anxiety disorder include being shy or withdrawn and will not typically disclose personal information. They are very commonly self-medicating with either alcohol or other substances before attending social gatherings and typically will blush in response to being spoken to or having to speak during a social gathering (APA, 2013). Diagnostic criteria from the DSM-V for social anxiety are included in Appendix D.

According to the Canadian Community Health Survey (out of the 4.7% of Canadians that met the diagnostic criteria for anxiety) three percent of Canadians aged 15 years or older reported symptoms of social anxiety in the last twelve months and one out of ten adults had
reported symptoms that met the criteria for anxiety disorder in their lifetime (Statistics Canada, 2002).

Risk factors for social anxiety disorder include childhood maltreatment, behavioural inhibition, fear of negative evaluation and having a parent or relative with social anxiety disorder (APA, 2013). An individual with a first-degree relative with social anxiety disorder have a two to six greater chance of developing the disorder (APA, 2013). Males with social anxiety tend to fear dating, are disobedient towards authority, use substances such as alcohol or drugs to relieve symptoms of the disorder whereas females have comorbid disorders such as bipolar, depression or generalized anxiety (APA, 2013).

Social anxiety can affect schoolwork and school attendance, employment, marriage and relationships and quality of life. Despite these impairments and many more, only 50% of people with social anxiety ever seek help for it (APA, 2013). Knowing the overall impact social anxiety has on a person’s quality of life, it is imperative for FNPs to diagnose and treat social anxiety effectively.

**Treatment of Social Anxiety Disorder.** Treatment of social anxiety disorder in adults includes both pharmacological treatments and CBT. The use of pharmacological treatments in children has show poor efficacy in randomized trials and is not recommended for use in children (BC Guidelines, 2010; Glazier et al., 2015). CBT therapies are best offered through a psychologist or trained therapist. CBT strategies include exposure therapy, cognitive restructuring and psychoeducation (Hofmann, 2016). These therapies can be offered both on a one-to-one basis but are also invaluable as group sessions. Psychoeducation involves challenging the patients to understand and identify the thoughts and environments that contribute to their social anxiety. Exposure therapy will then apply information learned from the psychoeducation
to situations they are anxious about and challenge their thinking in those situations.

Pharmacological therapy for adults includes the use of selective SSRIs, serotonin norepinephrine reuptake inhibitors (SNRIs) and monoamine oxidase inhibitors (MOIs) (Stein, 2016). SSRIs are the most commonly used, researched and effective pharmacological therapy for social anxiety disorder (Stein, 2016). Regardless of the choice of pharmacological therapy, the FNP needs to be aware of the side effects and adverse reactions of each medication. Anti-depressant medications used in the treatment of anxiety disorders with patients that have a history of suicidal thoughts or a family history of suicide need to be used very carefully. These patients are at an even greater risk of suicide thoughts or suicide when beginning a new antidepressant medication (Simon, 2016). Other pharmacological therapy includes the use of beta-adrenergic blockers (only with performance anxiety) and benzodiazepines. Benzodiazepines have been shown to have good efficacy in the treatment of social anxiety disorder but also have a high risk of sedation and abuse potential (Stein, 2016). Combination therapies of SSRIs or SNRIs with a benzodiazepine have also show effectiveness in treatment of social anxiety disorders that are resistant to monotherapy and CBT. Again, FNPs are not currently licensed to prescribe a benzodiazepine and this patient would need to be referred to a physician or psychiatrist. It is important to emphasize that adolescents with remitting episodes of anxiety are at a high risk of developing a chronic anxiety disorder (BC Guidelines, 2010).

**Panic disorder.** Panic disorder is diagnosed when an individual has repeated (more than one) and unexplained panic attacks that are subsequently followed by a one month period of fear over having repeated attacks, concern of how the attacks affect themselves and others around them or have a complete change in their behavior that can be directly related back to the attacks (Government of Canada, 2006). Out of the 4.7% of Canadians that met the diagnostic criteria for
anxiety, 1.6% of Canadians aged 15 years or older reported a panic attack in the last 12 months and over 3.7% met the criteria for panic disorder in their lifetime (Government of Canada, 2006). The age of onset of a panic disorder is around 20-25 with only a small number of cases being reported in children (APA, 2013). Adults above the age of 45 rarely report a panic disorder without a previous history of panic disorder (APA, 2013). The DSM-V diagnostic criteria for panic disorder are included in Appendix E.

Frequency of panic attacks is quite variable. Some individuals experience one panic attack per week for many months, others have daily attacks with periods of no attacks for many weeks or months and some individuals have about one to two panic attacks per month over many years (APA, 2013). Panic attacks may occur at night or during the day. Approximately 50% have at least one episode of nocturnal panic attacks (APA, 2013). Individuals with panic disorder often believe their panic attacks are the result of other underlying medical disorders such as thinking they are having a myocardial infarction or a sore throat means they have throat cancer. This is important for FNPs to recognize as these individuals may present to the clinic with medical complaints but may actually be experiencing a panic disorder. Therefore it is important to include panic disorder in the differentials when patients with these complaints present to the clinic.

Risk factors for the development of panic disorder include a predisposition towards negativity, sensitivity towards anxiety symptoms (such as believing that they are having more severe illness-induced symptoms in the presence of anxiety), reports of childhood sexual or physical abuse and smoking (APA, 2013). Most people that have panic disorder report significant recent and past history life events and stressors that have contributed to the development of the panic attacks (APA, 2013). A diagnosis of panic disorder or having a panic
attack in the last twelve months is associated with a higher rate of suicide attempts and suicide ideation (APA, 2013). Parents who have an anxiety disorder have an increased risk of having children with anxiety disorders. FNPs can use this knowledge to encourage parents with anxiety disorders to seek treatment for themselves so they may better care for their children and reduce their children’s risk of developing panic disorder or any other anxiety type disorder.

**Treatment of Panic Disorder.** Like other anxiety disorders, panic disorder in adults is treated with a combination of CBT and pharmacotherapy. Panic disorder treatment is only referred to adults in this case due to the majority of cases being in adults over the age of twenty (APA, 2013). CBT specific to panic disorders includes the use of education, breathing retraining, muscle relaxation, cognitive restructuring, exposure, and relapse prevention (Craske, 2016). These CBT techniques focus on treating the symptoms of panic disorder including panic attacks, anxiety about panic attacks and avoidance of situations that cause anxiety and panic attacks from occurring (Craske, 2016). Although these techniques are best performed by a trained psychologist or therapist, FNPs can continue some of the techniques that are taught in CBT sessions including breathing techniques, muscle relaxation and education.

Pharmacological therapy for panic disorder includes the use of SSRIs, SNRIs, tricyclic antidepressants (TCADs), MOAIs and benzodiazepines (Roy-Byrne, 2016). The choice of antidepressant therapy varies based on the side effects of the medication and patient history. The use of benzodiazepines (as stated earlier FNPs are currently not licensed to prescribe benzodiazepines) should be used carefully as there is a high risk of sedation and abuse potential. SSRIs are the first-line therapy for panic disorder and have been proven to reduce the amount of panic attacks, severity of attacks and anxiety and the amount of phobia avoidance (Roy-Byrne,
Combinations of benzodiazepines and anti-depressants have limited evidence-based efficacy and should only be used as a last resort for panic disorder (Roy-Byrne, 2016).

**Agoraphobia.** Agoraphobia is anxiety related to being in situations or places where escape may be difficult or access to help is not easily achievable if panic symptoms occur (Government of Canada, 2006). Fear of leaving the home alone, being in crowds or standing in lines, being on bridges and traveling on busses, trains, automobiles or planes are typical characteristics of Agoraphobia (Government of Canada, 2006). Severity of agoraphobia varies with severe cases of individuals not able to leave their home and being completely dependent on others for their activities of daily living (APA, 2013). DSM-V diagnostic criteria for agoraphobia is located in Appendix F.

Out of the 4.7% of Canadians over the age of fifteen that met the diagnostic criteria for anxiety in the last twelve months, 0.7% had agoraphobia. Out of the one in ten adults that met the criteria for having anxiety disorders in their lifetime, 1.5% had agoraphobia (Government of Canada, 2006). Panic attacks and panic disorder are very common with individuals that have agoraphobia (APA, 2013). Agoraphobia is persistent and chronic in most cases and can result in the development of secondary disorders such as major depressive disorder, persistent depressive disorder and substance use disorders (APA, 2013).

Risk for the development of agoraphobia includes traumatic childhood events, other trauma related to being jumped or assaulted and having a first-degree relative with agoraphobia (APA, 2013). According to the DSM-V, there is a 61% chance of developing agoraphobia if a first-degree relative has the disorder (APA, 2013). It is common for a patient to initially present with another anxiety-type disorder and then develop agoraphobia making it very important to effectively treat the anxiety disorder before the symptoms persist into agoraphobia.
**Treatment of Agoraphobia.** Agoraphobia should also be treated similarly to other anxiety disorders with a combination of CBT and pharmacotherapy. Due to the symptoms of agoraphobia attacks being similar to panic disorder, treatment is essentially the same (McCabe, 2016). SSRIs would be used as a first-line pharmacological therapy and CBT would concentrate on developing education as well as breathing and muscle techniques to reduce the panic associated with agoraphobia. Refer to panic disorder treatment for further information on how to treat agoraphobia.

**Generalized anxiety disorder.** Generalized anxiety disorder (GAD) includes excessive worrying and anxiety over life events and social situations for at least six months or more with other symptoms including lethargy and concentration problems (Government of Canada, 2006). An individual with GAD will experience more days with anxiety and worry than days without it (APA, 2013). People with anxiety will present with other features including muscle tension, sweating, nausea and diarrhea and are less likely to present with shortness of breath or dizziness that are more common with panic disorder (APA, 2013). GAD is one of the most broad anxiety diagnoses categories and one of the most common. GAD affects approximately three percent of Canadians each year (Statistics Canada, 2015).

A typical patient with GAD will express general anxiety and nervousness that has been occurring throughout their lives. The anxiety and nervousness may have been shown as a predisposition to getting anxious in situations or events that is a part of their personality and will have come and gone over the years (APA, 2013). Although mostly seen in adulthood, this disorder can occur in childhood. FNPs must be careful to rule out all other types of anxiety before concluding a diagnosis of GAD (APA, 2013). A stressful life event may cause the initial onset of symptoms to develop but it would be difficult to find a specific factor that initially
started the GAD as this anxiety disorder develops slowly over the course of many years. DSM-V diagnostic criteria for GAD are included in Appendix G.

Individuals with a first-degree relative with GAD are at a higher risk of developing GAD. One third of GAD development is genetic (APA, 2013). If a person has neuroticism and behavioural inhibition they are also at a higher risk of developing GAD (APA, 2013). About one third of all individuals with GAD are female (Statistics Canada, 2015). Men and women will present differently in clinical settings with men presenting with more substance abuse issues and women presenting with depression (APA, 2013).

GAD, due to chronicity, can result in the development of neurocognitive decline. Gualtieri & Morgan (2008) found that patients with GAD did markedly poor compared to controls in the categories of memory, psychomotor speed, reaction times, complex attention and cognitive flexibility. The results of this study showed a substantial difference in the cognitive scores of patients with GAD regardless of treatment. Neurocognitive functioning declines when a patient exhibits long-standing symptoms of anxiety re-enforcing the need for early identification, prevention and treatment strategies by FNPs treating patients with anxiety disorders in general.

**Treatment of Generalized Anxiety Disorder.** Treatment of GAD includes a combination of both CBT and pharmacotherapy. Techniques of CBT for GAD are similar to the treatment of panic disorder and agoraphobia and include patient education, self-monitoring, relaxation training, cognitive restructuring, imagery exposure, exposure to anxiety provoking situations, and relapse prevention (Bystritsky, 2016). The most effective therapy for GAD includes a combination of both CBT and pharmacotherapy.
First-line pharmacotherapy for GAD includes SSRIs and SNRIs. The use of SSRIs or SNRIs is usually dependent on the side effects of the medication, drug interactions and patient history (Bystritsky, 2016). SSRIs have shown to be the most effective in treatment of GAD and should be trialed first before changing to an SNRI (Bystritsky, 2016). Second line pharmacotherapy for GAD includes the use of tricyclic antidepressants, benzodiazepines, and certain anticonvulsants. The use of benzodiazepines in GAD has shown good efficacy in reducing the somatic symptoms and expressive symptoms of GAD (Bystritsky, 2016). Reasons for avoiding the use of benzodiazepines in the treatment of GAD include over-sedation and drug abuse potential (Bystritsky, 2016). The use of tricyclic antidepressants and muscles relaxants can also be used in the treatment of GAD with evidence of efficacy in cases that are not responding to first-line therapies (Bystritsky, 2016). Combination therapy with first-line and second-line therapies have also show good efficacy in the treatment of resistant GAD to first-line therapies and CBT (Bystritsky, 2016).

**Suicide and Anxiety Disorders**

Persistent anxiety disorders are linked with suicide attempts and suicide. Without effective screening and treatment plans the outcome can result in death for some patients suffering with anxiety. Nepon et al. (2010) studied the association between suicide attempts and anxiety disorders. Specifically Nepon et al. (2010) looked at panic disorder, agoraphobia, social phobia, generalized anxiety disorder and posttraumatic stress disorder. The results showed that 70% of those participants reporting a lifetime history of suicide attempts had an anxiety disorder (Nepon et al., 2010). The most likely disorders to result in a suicide attempt were panic disorder and posttraumatic stress disorder (Nepon et al., 2010). This emphasizes the importance for FNPs to assess suicidal ideation in any client with anxiety disorders with every face-to-face encounter.
Depressive disorders

Depression is a very common disorder with has a prevalence rate of about 5.8 percent in men and 9.5% in women (Goroll & Mulley, 2009). Depression contributes to morbidity and mortality and is a high risk factor for the development of coronary vascular disease (Goroll & Mulley, 2009). According to the World Health Report (2004), MDD is one of the leading causes of reduced quality of life and quantity of life in years (WHO, 2004). MDD results in a reduction in quality of life and life expectancy by 4.5%. When compared to other top contributors to a reduction in quality of life and life expectancy: 3.9% for ischemic heart disease, 3.3% for strokes, 5.1% for cancers and 5.7% for HIV/AIDS (WHO, 2004).

With early detection and management depression is a treatable disease. Unwanted future outcomes can be avoided with effective screening and diagnosis. Similar to anxiety disorders, patients with depression often present with somatic symptom complaints (primarily fatigue and trouble sleeping) rather than the depression itself (Goroll & Mulley, 2009; Schulz & Arora, 2015). It is important to be knowledgeable about depressive disorders because patients will likely not seek help directly from psychiatrists but instead visit their primary care practitioner making physicians and FNPs their first point of contact with the health care system. Because depression can result in both suicide attempts and suicide, it is very important for FNPs to know how to recognize, diagnose and treat depressive disorders in their practice (Schulz & Arora, 2015).

Goals of depressive disorder treatment should be focused on the reduction of symptoms as well as prevention of a relapse of the disorder (Schulz & Arora, 2015).

There are several depressive disorders listed by the DSM-V: disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive
disorder due to another medical condition, other specified depressive disorder and unspecified depressive disorder (APA, 2013). Bipolar disorder is no longer characterized as a depressive disorder under the DSM-V. Characteristics that are shared by all these disorders include feeling sad, having an empty or irritable mood along with somatic and neurocognitive functional changes resulting in a reduction in quality of life and ability to function normally (APA, 2013). Of the several depressive disorders, disruptive mood dysregulation disorder, major depressive disorder and persistent depressive disorder (dysthymia) will be discussed in further detail.

**Disruptive Mood Dysregulation Disorder.** Disruptive mood dysregulation disorder (DMDD) is a childhood disorder diagnosed in children under the age of twelve (APA, 2013). DMDD is characterized by chronic, severe irritability and episodes of behaviour that are extreme in nature and very frequently observed (APA, 2013). DMDD is a new diagnosis that was added to the DSM-V in response to children who were being over-diagnosed with bi-polar disorder. Bi-polar and related disorders are now completely separated from depressive disorders and classified separately (APA, 2013). It is important for FNPs to recognize that a child exhibiting symptoms of DMDD must not have symptoms of bi-polar or related disorders to receive a full diagnosis of DMDD. A psychiatrist should assess children with DMDD or symptoms that resemble DMDD if the FNP is not familiar with the diagnosis or treatment of this new disorder. DSM-V diagnostic criteria for DMDD are located in Appendix H.

Due to how new DMDD is, prevalence rates are unclear but the initial reports from mental health pediatric clinics states a high frequency of DMDD patients (APA, 2013). Onset of this disorder is generally before the age of ten and no younger than six years old. About half of all children that present with symptoms of DMDD will continue to have persistent symptoms for one year or later (APA, 2013). Children that present with symptoms of DMDD also have
comorbid conditions of attention deficit hyperactive disorder, anxiety disorders and some with major depressive disorder (APA, 2013). It is uncommon to have DMDD without comorbidities. It is recommended that all children with chronic irritability should be assessed for symptoms of severe aggression and suicidal behaviours (APA, 2013).

Risk factors for the development of DMDD include a history of chronic irritability and disobedience (APA, 2013). There are not identified genetic and physiological links that are directly related to DMDD. A thorough history of a child’s behavioural patterns is an important part in developing a risk assessment for both DMDD as well as other comorbid psychiatric disorders.

Children that have DMDD will likely have difficulty in school activities, studies and relationships with their peers (APA, 2013). The frequencies of outbursts and aggressive behaviours are likely to have a history of frequent hospitalizations and psychiatric evaluations (APA, 2013). Entry-level FNPs need to be aware of the trauma that a DMDD child may have experienced in hospital and keep this in mind when treating them. It is important for the FNP to be clear on the treatment plan for the patient and have open communication with both the family and psychiatrists to help both the child with DMDD and the family. It is common for families to suffer difficulties in their relationships due to having a child with DMDD (APA, 2013).

**Treatment of Disruptive Mood Dysregulation Disorder.** Treatment of DMDD would be treated similarly to any pediatric depressive disorder. DMDD treatment includes a combination of psychosocial therapy and pharmacological therapy (Bonin & Moreland, 2016). Psychosocial therapy includes CBT, interpersonal therapy for adolescents (IPT-A), family therapy, dynamic therapy, group therapy, and supportive therapy (Bonin & Moreland, 2016). The goals of psychosocial therapy are to educate the families about the disorder, manage stress in the home
and increase relationships with one another to foster a healthy happy home environment (Bonin & Moreland, 2016). Goals for the patients include coping skills to deal with symptoms of DMDD or depression, improvement in social skills and increase self-confidence (Bonin & Moreland, 2016). The most effective psychosocial therapies are CBT and IPT-A. It is important for the FNP to ensure the psychologist, therapist, psychiatrist, professional counselor or social worker has training in CBT and IPT-A before referring to these specialties.

Pharmacotherapy includes the use of SSRIs but dosages and monitoring are quite different than the adult population. Entry-levelFNPs and other healthcare professionals should always consult with a psychiatrist before attempting to add an SSRI or any pharmacotherapy to a pediatric patient with a depressive disorder (BC Guidelines, 2013). Before even referring to a psychiatriesthreads with pharmacotherapy, there are recommendations specific to the pediatric population. Firstly, a psychiatrist will need to have diagnosed the DMDD officially (Bonin & Moreland, 2016). Next, the parents would need to be involved in thorough discussions to both weigh the risks and benefits of using medications for the treatment of DMDD. After beginning a medication, frequent follow up (weekly or bi-weekly) needs occur to encourage a strong relationship with both the child and the family (Bonin & Moreland, 2016). Both the prescriber and family must commit to close monitoring of the patient if the choice of medication therapy is selected. Finally, all risks and benefits must be thoroughly explained to the parents and family if medication therapy is chosen (Bonin & Moreland, 2016). With these principles, medication therapy for pediatric patients with DMDD as well as any depressive disorder can be used effectively and safely in primary care.

**Major Depressive Disorder.** Major Depressive Disorder (MDD) is a serious form of depression affecting many Canadians and the population worldwide. According to the Mental
Health and Well-being Survey (2002) 6.6% of Canadian men and 13.9% of Canadian women over the age of fifteen met the criteria for MDD during their lifetime (Statistics Canada, 2002). MDD is accompanied by a variety of neurovegetative symptoms. These neurovegetative symptoms include appetite disturbance, sleep disturbance, psychomotor retardation or agitation, anhedonia, loss of energy, feelings of worthlessness or guilt, decreased concentration and suicidal thoughts (APA, 2013).

In order to receive a diagnosis of MDD, a patient must have at least four or more of these neurovegetative symptoms for a minimum of two weeks (APA, 2013). The neurovegetative symptoms relate very closely to SIGECAPS (sleep, interest, guilt/worthlessness, energy, cognition, appetite, psychomotor agitation/retardation, suicide) FNPs and other primary care practitioners use in their practice when evaluating patients with depression (BC Guidelines, 2015). An FNF completing a SIGECAPS assessment with each patient presenting with depressive symptoms is completing a thorough assessment and providing diagnostic evidence of depression. The DSM-V diagnostic criteria for MDD are located in Appendix I. Other diagnostic tools include using the PHQ-9 to identify the severity of the depressive disorder (BC Guidelines, 2015). This tool (including scoring criteria) is included in Appendix J and K.

Risk factors for the development of MDD include individuals that have neuroticism and adverse childhood events (each adverse event contributes to even higher likelihood of developing MDD). If an individual has a first-degree relative with MDD, they are at a two to four times greater risk of developing MDD than the general population (APA, 2013). Statistics state a 40% heritability rate for MDD stating neuroticism being the most responsible heritable trait for the development of MDD (APA, 2013). The development of a chronic disease also is linked to
MDD with cardiovascular disease, diabetes and morbid obesity having the highest risk factors for developing MDD (APA, 2013).

MDD is a persistent disorder with multiple relapses and remissions (Government of Canada, 2006). Individuals are less likely to recover from MDD with multiple MDD episodes and there is a significantly less probability to recover if the MDD episode was severe (Government of Canada, 2006). Since most patients with one MDD have multiple MDD episodes, it is important for FNPs to complete depression screening in any patient who had a previous episode of MDD. Family members are also affected by MDD and an individual with MDD will contribute to a higher rate in depression and anxiety symptoms in family members (Government of Canada, 2006). Emphasizing the importance to treat the patient for depression, screen the family for depression and have the family well involved in the patient’s care plan.

Thoughts of death, suicidal ideation, or suicide attempts are common in MDD (APA, 2013). In order to reduce risk factors for suicide attempts or thoughts of suicide, patients need to be effectively diagnosed and each MDD symptom treated. One of the most common reported symptoms in depression is sleep disturbance (APA, 2013). Agargun et al. (2006) investigated the relationship between insomnia and nightmares and suicide in patients with depressive symptoms. Agargun et al. (2006) found increases in suicide attempts in MDD patients with higher rates of nightmares and insomnia. Nightmares were also more common among patients with depressive symptoms than those without (Agargun et al, 2006). Insomnia and depression are related to suicide attempts in patients with depressive symptoms and this need to be addressed in primary care. This continues to emphasize the importance of not only using the SIGECAPS as a diagnostic tool but also as a red flag for patients who are having symptoms of sleep deprivation and nightmares.
If a patient presents to an FNP with somatic complaints, it is imperative that they screen the patient for major depressive disorder (APA, 2013). Somatic complaints are a common occurrence for patients who are experiencing major depressive disorder and after a thorough medical investigation should be examined for depression. Many scientific studies that show specific neurotransmitters responsible for the somatic complaints associated with depression (Chakraborty et al., 2010). Depression causes a reduction in serotonin and norepinephrine, and because these neurotransmitters are responsible for determining either to increase or decrease pain, it is likely this is the cause for the somatic symptoms in depression (Chakraborty et al., 2010). Entry-level FNPs need to listen to their patient’s somatic complaints because they are a good indicator of major depressive symptoms and also are a guide for how well they are managing their depressive symptoms. It may be important for patients to have acknowledgement that their somatic complaints are actual physical representations of how their body is responding to their depressive symptoms.

**Persistent Depressive Disorder (dysthymia).** Persistent Depressive Disorder (also referred to as dysthymia) is a form of depression that is chronic in nature and persists for two years or more in adults and at least one year for children (Goroll & Mulley, 2009; APA, 2013). Patients with persistent depressive disorder (PDD) will typically present with feelings of depression that have occurred over their lifetime, and in many cases, will refer to those feelings as normal and part of their personality (Goroll & Mulley, 2009). The symptoms of PDD are characterized by six criteria according to the DSM-V: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions and feelings of hopelessness (APA, 2013). An individual will persistently need to have at least two of the six criteria to be diagnosed with PDD (APA, 2013). These six criteria are
similar to the criteria for MDD but are less severe in nature and patients will need less of the six
criteria to be diagnosed with PDD. A patient with PDD can also have repeated episodes of MDD
and should be diagnosed with both PDD and MDD during these episodes of MDD (APA, 2013).
If a patient has MDD for greater than two years and continues to have more MDD symptom
criteria than PDD criteria, they should still be diagnosed with both MDD and PDD. DSM-V
diagnostic criteria for PDD are located in Appendix L.

According to the 2002 Canadian Community Health Survey, 0.3% (0.3% men, 0.4%
women) of study participants had met the criteria for PDD (Statistics Canada, 2002). Women
were also found to be two to three times more likely than men to develop dysthymic disorder. In
the United States, the prevalence rate for PDD is 0.5% (APA, 2013). Beekman et al. (2004)
conducted a large study of individuals (age 55-85) over a ten-year period to assess the clinical
features, risk factors, prevalence and prognosis of PDD in older adults in the community.
Beekman et al. (2004) found a lifetime prevalence of PDD to be 4.6%. The reasoning for the low
percentage of PDD reported by the CCHS and the DSM-V may have to do with how PDD is
both diagnosed by the FNP and how the patient presents to their FNP.

Sansone and Sansone (2009) describe many factors that may contribute to the
underdiagnosis of PDD in primary care. PDD has symptoms that are less severe and often less
recognizable by both the patient and primary care provider (Sansone & Sansone, 2009). Often
patients with PDD will have adapted many methods to mask their symptoms in the presence of
family and social situations (Sansone & Sansone, 2009). Patients with PDD have persevered for
two years or greater with these symptoms of depression and family may likely attribute their
abnormal behaviour as normal. Sansone and Sansone (2009) also found that PDD will unlikely
present itself as purely PDD and likely the patient will present with another psychiatric disorder
such as MDD or anxiety disorders. These disorders have much more pronounced symptoms that are easily recognized and treated with PDD going unnoticed and untreated. Similarly to both anxiety disorders and MDD, PDD will often present with somatic complaints rather than PDD symptoms (Sansone & Sansone, 2009).

If a patient presents with somatic complaints and has PDD it would be a very difficult for the FNP to determine the patient has PDD and not an underlying medical condition due to the mild symptoms associated with PDD. FNPs and other practitioners may misdiagnose PDD because patients think that the day-to-day difficulties they have been living with for many years are purely a part of their own personality (Sansone & Sansone, 2009). This article emphasizes the need to complete a full SIGECAPS assessment with all patients presenting with somatic complaints that are not explained through initial medical diagnostics. It is also important to assess and treat patients for MDD but consider they may have a coexisting diagnosis of PDD.

Risk factors for the development of PDD include increased levels of neuroticism, the presences of an anxiety disorder, recurrent MDD episodes, parental loss or separation from parents, and having a first-degree relative with MDD or PDD (APA, 2013). Differentials to consider for PDD include MDD, psychotic disorders, depressive or bipolar and related disorder due to another medical condition, Substance/medication-induced depressive or bipolar disorder and Personality disorders (APA, 2013).

Effective diagnosis and treatment of PDD is important due to the increased risk of developing a secondary psychiatric disorder over time (APA, 2013). Beekman et al. (2004) found patients with chronic PDD having a poor prognosis, which was further compromised in those individuals that had MDD along with PDD. Early diagnosis and treatment is vital to increasing a patient’s quality of life.
**Treatment of MDD and PDD.** PDD may (in some cases) be referred to as a resistive type of depression, however, in a large number of individuals, PDD symptoms are minor and do not alert clinicians or family members of their cardinal signs and will likely have not received initial treatment for their symptoms (APA, 2013). For this reason, PDD and MDD treatment options are discussed together. Initial treatment for MDD and PDD is a combination of both pharmacotherapy and psychotherapy. Combination therapy has been shown to be the most effective therapy in the treatment of these disorders (Simon & Ciechanowski, 2016). Medication combinations are usually chosen based on patient specific responses, side effects and drug interactions. Not one single medication has been given more superiority over another (Simon & Ciechanowski, 2016). Antidepressant medications for MDD and PDD include SSRIs, SNRIs, MOIs and tricyclic antidepressants (Simone & Ciechanowski, 2016; BC Guidelines, 2013). Drugs are chosen based on comorbid illnesses, frequency of administration, drug interactions, symptoms of depression, side effects, patient preferences, cost, patient response to the medication and the family (Simon & Ciechanowski, 2016). The most common side effects of antidepressant medications are diarrhea, nausea and vomiting, sexual dysfunction, somnolence and weight gain (Simon & Ciechanowski, 2016). Each specific medication will have a higher likelihood of the above side effects and can be changed based on those unwanted effects.

All practitioners should allow a period of six to twelve weeks of antidepressant therapy before making a clinical decision of symptom reduction (Simon & Ciechanowski, 2016). If there is a less than 25% reduction in symptoms from baseline after 4-6 weeks, more vigorous treatment options can be offered (Simon & Ciechanowski, 2016). Initially, all practitioners should increase the dosage of the antidepressant mediation and if that does not work to change the antidepressant medication from an SSRI to SNRI or MAOI or tricyclic antidepressant. If
there are repeated failures of these changes to medications, it is best for the FNP to then consult with a psychiatrist for further treatment options. Because of the high risk of suicide with patients that exhibit MDD or PDD in the long-term, this consultation would be urgent. Psychiatrists may use multiple drug classes and adjunctive drugs and/or electroconvulsive therapy as a treatment option for these resistive-type patients (Thase & Connolly, 2016).

Self-care is very important in the treatment of depressive disorder. Healthy management includes exercising regularly, eating regularly, good sleeping patterns, avoidance of substance use, stress management, doing one pleasurable task each day and keeping a mood diary (BC Guidelines, 2013). A patient that applies these lifestyle techniques will have better management of their illness in the present and prevent relapses in the future.

Psychotherapy is a very important part in the treatment of MDD and PDD (BC Guidelines, 2013). Psychotherapy is just as effective as the use of anti-depressant medications and in conjunction with anti-depressant medication can have more effect for some patient populations (BC Guidelines, 2013). Types of Psychotherapy options include CBT, interpersonal psychotherapy (IPT), behavioural activation, family and couples therapy, problem solving therapy, psychodynamic psychotherapy and supportive therapy (Simon & Ciechanowski, 2016). A trained therapist or psychologist best performs these options. Ways that an FNP can help patients with MDD or PDD are having frequent follow-ups (every 2 weeks) and encourage patients to engage in activities that will be beneficial for their mental health as discussed earlier in self-care management. Because psychotherapy is primarily completed by a psychologist or therapist it would be important for the FNP to know what psychologists/therapists are available in their area and get to know which ones are appropriate for each individual patient. This would
be difficult for an entry-level FNP, but they could start off with acknowledging a couple of psychologists in the area and working from there.

The number of anxiety and depressive disorders that FNPs are responsible for diagnosing and managing in the primary care setting can be quite overwhelming. However, the number of depression and anxiety disorders diagnosed in Canada is high, so FNPs need to be prepared and have the knowledge and confidence in treating these disorders regardless of their practice environment.

**Nurse Practitioner Role**

NPs have been practicing globally since the 1960’s. In Canada, NPs have been practicing since 1967 starting in Northern Communities (Sangster-Gormley et al., 2010). Throughout the development and education of the NP role there continues to be discourse in NP role development and implementation (Sangster-Gormley et al., 2010). Currently in Canada, there are NPs working in primary healthcare, long-term care and acute care settings. As the role of the NP is new and evolving it is vital for all investors in healthcare (patients, public, policy makers, governments, and healthcare professionals) to have some understanding of how an NP functions within the healthcare team (Sangster-Gormley et al., 2010). Although the NP role has been identified in Canada since the 1960’s, NP integration into all provinces has been a slower process than other areas in the world. This may be due to the geographical location of NPs being located in northern communities in Canada. The slow integration of the NP role has been a large contributor to NP role confusion.

NP role confusion exists in the United States where the NP role has been implemented since the early 1960’s (Keough et al., 2011). Keough et al. (2011) found the greatest contributor to NP role confusion was that unlike other professions such as physicians, physiotherapists,
pharmacists and psychologists, NPs enter their profession into a specific population that they are educated to care for. By not being a generalist, the role of the NP maintains confusion among the public, physicians and other healthcare providers (Keough et al., 2011). Increasing awareness of the NP role to other healthcare providers is an important part of the evolution of the NP role, but may not be the most influential one.

Arguably, the most influential population to encourage integration of the NP role is the public. Increasing public awareness greatly impacts NP role integration by reducing barriers to NP role acceptance (Witt & Pleog, 2005; Donald et al., 2010). The public can advocate positive changes to the health care system by lobbying the government for greater accessibility to NPs (Witt & Pleog, 2005). Although lobbying the government may take many years of struggle and consistency, it has a more upstream approach towards NP role acceptance (Witt & Pleog, 2005; Donald et al., 2010). Since the 1960’s, more resources, opportunities and educational programs for NPs have been added in Canada showing slow, but steady progress in NP role development and clarification (Sangster-Gormley, 2013). With further advancement from the government, NP roles can be further clarified and therefore more accepted.

All NPs complete four years of a Bachelors of Science in Nursing, minimum of two years of practice as a registered nurse and two years of NP education (along with subsequent examinations that are province specific) in order to be certified as an NP in Canada. At the end of their education, all NPs are qualified to treat a variety of patients within either an acute care setting, primary care setting or long-term care facility. All NPs are involved in both traditional and non-traditional medicine providing health promotion, education, pharmacological, diagnostic and counseling services to patients (Keough et al., 2011).
Psychiatric Nurse Practitioner Role

Although not currently a role in Canada, the United States has advanced Psychiatric nursing from psychiatric clinical nurse specialists to masters educated Psychiatric NPs. Advanced Psychiatric mental health nursing has been in existence since the 1950s and the addition of the masters educated psychiatric NP role has been occurring since the 1990’s (Bjorklund, 2003; Weiss & Talley, 2009). The new role of Psychiatric NP allowed greater autonomy in psychiatric nursing (when compared to psychiatric clinical nurse specialists (PMHCNS) roles) and prescriptive authority (Weiss & Talley, 2009). There are two examinations that a psychiatric NP can take created by the American Nurses Certification Center (ANCC): Adult Psychiatric NP and Family Psychiatric NP (Weiss & Talley, 2009).

One of the reasons why the Psychiatric NP role was developed was to amalgam the roles of the PMHCNS and Adult NP (Bjorklund, 2003). Role definition, similar to Adult, Pediatric and FNPs, has been a struggle for Psychiatric NPs to develop (Bjorklund, 2003). Weiss and Talley (2009) conducted a study that found a large overlap between Psychiatric NPs and PMHCNS roles (including similarity of almost all duties and responsibilities). PMHCNS have been practicing with certification since the 1970s and with evolution of their role advancing in treatment of advanced psychiatric illnesses and prescriptive authority (Weiss and Talley, 2009; Bjorklund, 2003). PMHCNS and Psychiatric NPs treat acute and chronic mental health illnesses and prescribe psychotropic medications (National Panel for Psychiatric Mental Health NP Competencies, 2003). FNPs, Adult NPs and Pediatric NPs do not have prescriptive authority for the types of medications that Psychiatric NPs are allowed to prescribe (CRNBC, 2011).

Caldwell, Pirem & Torre (2011) created a survey of New Jersey advanced practice nurses (both PMHCNS and Psychiatric NPs) and found that advanced practice nurses (APNs) most
commonly treated Schizophrenia, Bipolar Disorder and Major Depressive Disorder. Substance use disorder, posttraumatic stress disorder and generalized anxiety disorder were the other most commonly seen disorders from APNs in their survey (Caldwell, Piren & Torre, 2011). These disorders differ from the FNPs scope of practice, which includes GAD, depression (major depression managed by a physician and continued by FNP), obsessive-compulsive disorder and substance abuse disorder (CRNBC, 2011). Psychotropic medications are not included in the FNPs scope of practice but are included in the practice of both PMHCNS and Psychiatric NPs in the United States. Psychiatric APNs also reported cardiovascular disease, diabetes, obesity, endocrine disorders and seizures as the most frequently seen medical disorders (Caldwell, Piren & Torre, 2011). Psychiatric NPs receive education on how to manage Psychiatric illnesses and common medical problems but must know how and when to refer patients to further medical professionals if they have more complex medical disorders (Psychiatric-Mental Health Nurse Practitioner Competencies, 2003).

The development of the Psychiatric-Mental Health Nurse Practitioner Competencies (2003) was created by the National Organization of Nurse Practitioner Faculties in Washington DC. This document outlines competencies required from entry-level Psychiatric NPs. The document was created in order to create further understanding of the role and responsibilities of Psychiatric NPs and provide guidance for entry-level psychiatric NPs as they grow into their new roles (Psychiatric-Mental Health Nurse Practitioner Competencies, 2003). The competencies include health promotion, health protection, disease prevention and treatment of mental illness as well as physical illnesses related to the client’s mental health issue.

The Psychiatric NP role in the United States closed a gap between the need for further Psychiatric care of patients in communities that both the psychiatrists and Family/Adult NPs
could not fill. The addition of the Psychiatric NP role in the United States, although continues to be difficult to separate from the PMHCNS role, is an important piece in the mental health care of patients with both acute psychiatric illnesses and chronic psychiatric illnesses.

**Entry-level FNPs and Caring for Mental Illness**

Entry-level FNPs are responsible for the identification and treatment of a variety of psychiatric disorders as described in detail above. An interesting question is if all entry-level FNPs feel ready to begin treating and diagnosing patients with mental illnesses. Koren et al. (2015) found that upon completion of the Ontario NP program, all entry level NPs felt prepared to practice, but not confident in caring for patients with multiple health issues. The NPs in this study indicated the practice area they were least prepared for was mental health (Koren et al., 2015). All entry-level NPs in this study felt less equipped to handle the complexity of a patient with mental illness. Although the NPs in this study felt least prepared to care for patients with mental illness, 72% felt prepared for entry level to practice as an NP (Koren et al., 2015). All entry-level NPs may feel least prepared for the care of mental health patients, but overall, feel safe and competent to care for their patients with support and mentorship around them.

Sangster-Gormley et al. (2013) conducted a study of the NP (Adult NP, FNP and Pediatric NP) role implementation in British Columbia in 2009. Although the participants in this study consisted of only sixteen people, there were only two hundred registered NPs in BC at that time (NPs started practicing in British Columbia in 2005). The data was collected from the perspectives of entry-level NPs and how they adjusted to their new roles and expectations (Sangster-Gormley et al., 2013). Most of the NPs in the study had a clear idea of what was expected from the health authority who hired them, but did not expect to have knowledge on how to increase patient access to healthcare and improve of patient outcomes generally
Entry-Level FNPs: Psychiatric Knowledge is Collaboration

(Sangster-Gormley et al., 2013). NP frustration came from a lack of clear expectations from the interdisciplinary team who did not provide role clarification for entry-level NPs (Sangster-Gormley et al., 2013). The most successful NPs were those who were able to express their role and responsibilities to the interdisciplinary team.

In reference to mental health, NPs were not well accepted into the mental health field immediately and it took a while for not only the health care team to accept the NP but the patients to trust NPs in this particular setting (Sangster-Gormley et al., 2013). Although FNPs are more likely to see mental illness in a primary care setting, it is important to note that patients with any mental illness may have difficulty trusting a new health care professional like an NP to care for their mental illness. This study stressed the importance for all NPs to provide role clarification for not only their interdisciplinary team but the patients they are treating and responsible for.

**Primary Care, FNPs and Psychiatric NPs**

Mental illnesses, and particularly anxiety and depressive disorders, are seen frequently in the primary care setting (Goroll & Mulley, 2009; Government of Canada, 2006; Statistics Canada, 2002). Although they are a frequent occurrence in health care, the question remains if they are effectively treated and diagnosed in primary care. Bjorklund (2003) believes that patients with mental illness are the least cared for and supported in health care. The creation of the Psychiatric NP role in the 1990s in the United States arguably provides a closure in the gap between primary health care knowledge and psychiatric mental health care (Bjorklund, 2003). The emphasis on mental illness as a specialty is apparent as well as the emphasis that all entry-level FNPs are not prepared to care for patients with mental illness. Bjorklund (2003) found that
family physicians as well as adult NPs and FNPs were under-diagnosing and treating patients with mental illness indicating that this is not just an issue with FNPs and Adult NPs.

Bjorklund (2003) suggests that all NPs need to have certification as a Psychiatric NP, FNP and Adult NP. All NPs without dual certification as both a FNP and Psychiatric NP and continues to provide care to patients with psychiatric illness (even under the supervision of a psychiatrist), are arguably not practicing within their scope of practice (Bjorklund, 2003). Although Bjorklund (2003) is referring specifically to patients with psychiatric illnesses out of scope that are currently being treated and with ongoing psychiatric illness, this mental health care does apply to many FNPs in BC. According to the Koren et al. (2015) study, approximately 20% of all Ontario NP graduates were working in rural communities that were located more than fifty kilometers away from any specialty. Many FNPs are working in BC in rural communities that have less access to psychiatric services and need to care for these patients with mental illness regardless of their certification. The concern about safety of these patients in the care of FNPs as opposed to psychiatric NPs is not clear. What is clear is that FNPs are going to be working with psychiatric patients regardless of their specialty or geographical location.

Although psychiatric NPs are well trained in case management and treatment of patients with mental illness, psychiatric NPs are less prepared to treat patients with underlying chronic disease and illnesses unrelated to their mental illness (Bjorklund, 2009; Lumby, 2007; WHO, 2003). Patients that have mental illness have many risk factors increasing their likelihood of developing one or more chronic illness contributing to a higher mortality rate than the normal population (Hert et al., 2011; Jones et al., 2004; Roberts et al., 2009; Stanley & Laugharne, 2014). Lumby (2007) discusses a variety of chronic health concerns in the mental illness population that far exceed the statistics of the general population. Risk factors for developing
chronic illness include cognitive impairment, lifestyle choices (smoking) and sense of hopelessness (Lumby, 2007). Obesity is listed as the greatest physical health concern in this population according to numerous resources (Jones et al, 2004; Lumby, 2007; WHO, 2003). Psychiatric NPs need to be prepared to both manage and refer patients to other practitioners for their physical health in order to reduce mortality of this population. Without this knowledge, the psychiatric NP is also at a disadvantage in the treatment of their patients.

**Collaboration for Mental Health**

It is more likely that someone exhibiting symptoms of mental illness will initially seek help from their FNP or primary care practitioner. Similarly, psychiatric patients that have developed a relationship with their psychiatric practitioner will discuss their physical health problems with them rather than going to their family physician (Roberts et al., 2009). Roberts et al. (2009) used an integrated mental health model to increase nursing student awareness of the benefits of combined mental health and physical health care within an interdisciplinary health team. The model that Roberts et al. (2009) used is derived from The Hogg Foundation for Mental Health (HFMH). The HFMH (2006) created an Integrated Mental Health Model to provide holistic care to patients with mental illness and chronic physical health problems. This model uses collaboration between psychiatric clinical nurse specialists and psychiatrists and psychologists along side FNPs and other primary care practitioners (HFMH, 2006). It has shown great success in multiple programs across the United States in the treatment and ongoing care of patients with mental illness (HFMH, 2006).

This type of collaboration between mental health care and physical health care is not a new idea. Many sources agree that the best approach towards mental health and physical health care is collaboration between the two (Hert et al., 2011; HFMH, 2006; McNeil, 2000; Roberts et
al., 2009; Thielke et al., 2007). Unlike mental health care, physical health care focuses on episodic health challenges that can be diagnosed, treated and followed up generally in a linear fashion. Mental health uses a multidisciplinary approach to caring for patients including group care and case management that is seldom used in primary care (Thielke et al., 2007). Primary care use of general screening tools and collocated care will increase mental health diagnosis but shows repeated failure in the clinical outcomes of these patients (Thielke et al., 2007).

Thielke et al. (2007) state that the main reason why primary care systems do not work as well in the treatment of mental health concerns is that they are not set up to treat mental health disorders. Efficient collaborative care of mental illness uses a case manager to both follow up and regularly treat the patient based on the primary care practitioners guidelines, as well as a systematic follow up and tracking of patient outcomes (Thielke et al., 2007). Thielke et al. (2007) discovered that repeated literature (thirty-five controlled trials) continues to support collaborative care over usual care in the treatment of mental illness. Although collaborative mental health and physical health care seems to be the key to holistic treatment, is difficult to implement due to many barriers.

**Barriers to Collaboration**

The barriers that exist are multiple and have mainly to do with the primary functioning of each health care environment. Primary care delivery systems and mental health delivery systems not only function differently but also operate under different cultures (HFMH, 2006; Thielke et al., 2007). Attempting to change either culture would be a difficult and lengthy process. Primary care units operate primarily on objective findings and data and mental health units operate and treat based on subjective data (Theike et al., 2007). The financial costs to the primary care unit would be substantial due to the length of time needed to acquire subjective data from clients that
usually is only billed as a one problem visit (HFMH, 2006). This would require a change in the entire operation of the health unit perhaps requiring more staff and trained professionals to allocate towards the treatment of subjective complaints. In order for a collaborative unit to truly work at its peak effectiveness there needs to be a consistent sharing of information across provider systems (HFMH, 2006). This would require not only a change in the health unit, but also a change in every health authority across the province/state/country.

Though these barriers exist, it is important for entry-level FNPs to advocate for more collaboration in primary care with patients that have mental illness. Advocacy can be in the form of effective knowledge of the resources available to an entry-level FNP wherever they find employment. Unutzer et al. (2002) used an intervention tool to implement collaborative primary care in the treatment of older adults with depression. The participants included 1801 men and women over the age of 60 who had MDD, dysthymic disorder or a mix of the two. The study involved providing educational videotapes and booklets about depression if they screened positive, along with an optional visit with a depression care manager at the clinic (Unutzer et al., 2002). The care managers were either a nurse or a psychologist who had specialized training in depression. The results of this study showed that almost half (45%) of all intervention patients had a 50% reduction in depressive symptoms from baseline compared with 19% in patients that received the usual plan of care at the clinic (Unutzer et al., 2002).

The main difference between the intervention patients and the usual care patients was their access to a care manager for the entire twelve-month period the study was conducted. This shows that increased appointments and access to health care for patients with mental illness will contribute to a reduction in symptoms. As described earlier, a reduction in depressive symptoms has been shown to increase the overall quality of life of individuals (Goroll & Mulley, 2009;
Government of Canada 2006; Schulz & Auora, 2015; WHO, 2003). Entry-level FNPs may be at an advantage in achieving care management of their patients if they are able to schedule more time with patients that have mental illness concerns and more frequent follow up regardless if the patients is being seen for their mental illness by a psychiatrist or specialist.

**Discussion**

**Increasing Education**

Currently there are no psychiatric NP roles or education offered in British Columbia but there are many ways that Entry-level FNPs can increase their knowledge on mental illness. For instance, continuing medical education (CME) conferences are offered both online and in person in multiple locations across Canada and in the United States. One method of continuing education for Entry-level FNPs is to attend conferences offered by Pri-Med Canada or complete live or online courses through their website. Pri-Med Canada offers education for pharmacists, physicians and FNPs in areas covering everything from allergies and immunology, to cardiology, to psychiatry and women’s health (Pri-Med Canada, 2016). Other areas for entry-level FNPs to obtain continuing education in mental health include multiple resources that are listed below:

- mdBriefCase: [https://www.mdbriefcase.com/default.aspx?](https://www.mdbriefcase.com/default.aspx?)
- Canadian Primary Care updates: [http://www.mycmeupdates.ca](http://www.mycmeupdates.ca)
- University of British Columbia Faculty of Medicine Online CME: [http://ubccpd.ca/courses](http://ubccpd.ca/courses)
- Canadian Nurses Association: [https://www.nurseone.ca/en](https://www.nurseone.ca/en)
Other ways that Entry-level FNPs can increase their knowledge of mental illness is by networking with other FNPs. The most opportunistic way of networking with FNPs is by joining the British Columbia Nurse Practitioner Association (BCNPA). The BCNPA is an independent organization that is non-profit and is the voice for NPs in BC. Access to information regarding continuing education is only one area that the BCNPA works on. The BCNPA is a resource for all NPs in BC to use for understanding their role in healthcare. The BCNPA can work with FNPs to increase their understanding of mental illness in primary care and provide a voice for entry-level FNPs.

**Implications for Practice for Entry-level FNPs**

Entry-level FNPs need to be well aware of their large capacity to continually learn and adapt to situations they will be exposed to in the future. Collaboration efforts are a key component to providing mental health care and physical care for all patients. Primary care is at an advantage with the addition of FNPs to primary care. Patients are at the center of all healthcare systems and should be considered first before making any changes to healthcare. Whether a patient receives care from an FNP, Adult NP, Pediatric NP or physician, they should rest assured the care will be holistic and complete. Mundinger et al. (2000) conducted a study of 1316 patients randomized to be treated by either an NP or physician. The study results showed no difference between the satisfaction from patients or the health status of patients treated by either an NP or physician (Mundinger et al., 2000). Although the study results were completed over a short six-month period, the results were statistically significant and show that the quality of care provided by NPs is similar to the care of physicians. Conlon (2010) completed a study on the comparison of patients receiving care for diabetes control from physicians or NPs. Conlon (2010) found the interventions chosen by the group of NPs were as equal and in some cases more
beneficial for patients receiving care for their diabetes. Although this study does not reflect mental health care, it does apply to how entry-level NPs are well equipped to deal with any specialty. All NPs are providing fantastic care to patients and deliver similar patient outcomes when compared to the care a patient receives from a physician.

The best way for patients to receive an increase in quality of care is for both physicians and FNPs to work together collaboratively. As stated earlier, the most effective way to partner mental health and physical health care is through collaboration between the two (Hert et al., 2011; HFMH, 2006; McNeil, 2000; Roberts et al., 2009; Thielke et al., 2007). This collaboration requires effort from both physicians and NPs to work together. Roots & MacDonald (2014) studied the addition of NPs to rural general practitioner practices in Canada. Roots and MacDonald (2014) found that NPs have a profound effect on care delivery, access to healthcare, comprehensive care, and increases in collaboration within the health units and job satisfaction from the physicians. All NPs have a profound effect on the outcomes of patient delivery systems due to the amount of time they can spend with the patients and level of expertise they bring.

**Implications for Further Research**

Utilization of resources in a health care unit including the use of an on-site counselor and case manager is a way to implement collaborative care. If this seems impossible to implement in smaller communities, an entry-level FNP can increase access to health care by providing more frequent follow up and longer appointments with patients diagnosed with a mental illness. Dual education as both a psychiatric NP and FNP may not be the answer towards comprehensive mental health care but as described by experiences in the US, does provide further education and preparedness for FNPs when dealing with mental illness in acute settings and in patients with more complex psychiatric illnesses. The best way for entry-level FNPs to be prepared to care for
mental illness is to continually increase their knowledge, work in a supportive collaborative practice and most of all treat the patient from the patient’s perspective. If the patient requires more follow up and attention, it would be up to the FNP to provide care in that manner.

If an entry-level FNP struggles with the diagnosis, treatment and/or management of mental illness there are a variety of education courses and primary care conferences that can help provide continuing education. Much like an FNP would increase their education in hypertension or diabetes care if they were taking care of a large population with those illnesses, an FNP would need to be well educated in mental illness to continue safe, competent care of their patients.

Interprofessional collaboration when providing mental health and physical care is the most effective method to increase patient access to mental health care and to reduce poor outcomes due to untreated mental illness. Physicians and all NPs will need to continue to work together to support patients in the management of mental health care.

Conclusion

Mental illness requires a multifaceted, multidisciplinary approach regardless of the severity of the mental illness. Entry-level FNPs are required to treat and manage depression, anxiety, obsessive-compulsive disorder and substance abuse disorder but are not alone in the treatment of those disorders. All NPs, regardless of their education (family, adult, pediatric or psychiatric) are responsible for the care of patients with mental illness. Requiring all NPs to obtain a psychiatric specialty in order to care for patients with mental illness may not be the answer to the insecurities entry-level FNPs experience when working with mental health patients. The answer may be in professional development activities and working in an interprofessional collaborative setting supported by expert colleagues. In any care provided by a health care professional, it is important to always revolve care around their patient’s individual
needs. The future of FNPs in psychiatric roles may be undetermined, but the determination of all FNPs in primary care is overwhelmingly apparent.
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Appendix A - DSM-V Diagnostic Criteria for Selective Mutism

Selective Mutism

Diagnostic Criteria 312.23 (F94.0)

A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
B. The disturbance interferes with educational or occupational achievement or with social communication.
C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
E. The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.
Appendix B - DSM-V Diagnostic Criteria for Separation Anxiety Disorder

### Separation Anxiety Disorder

<table>
<thead>
<tr>
<th>Diagnostic Criteria</th>
<th>309.21 (F93.0)</th>
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<tbody>
<tr>
<td>A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:</td>
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<tr>
<td>1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.</td>
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<td>2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.</td>
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<td>3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.</td>
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<td>4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.</td>
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<td>5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.</td>
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<td>6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.</td>
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<td>7. Repeated nightmares involving the theme of separation.</td>
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<td>8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.</td>
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<tr>
<td>B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.</td>
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<tr>
<td>C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.</td>
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<tr>
<td>D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder.</td>
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</table>
Appendix C - DSM-V Diagnostic Criteria for Specific Phobia

### Specific Phobia

#### Diagnostic Criteria

A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

   **Note:** In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.

B. The phobic object or situation almost always provokes immediate fear or anxiety.

C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.

D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.

E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

---

**Specify if:**

Code based on the phobic stimulus:

- **300.29 (F40.218) Animal** (e.g., spiders, insects, dogs).
- **300.29 (F40.228) Natural environment** (e.g., heights, storms, water).
- **300.29 (F40.23x) Blood-injection-injury** (e.g., needles, invasive medical procedures).

   **Coding note:** Select specific ICD-10-CM code as follows: F40.230 fear of blood; F40.231 fear of injections and transfusions; F40.232 fear of other medical care; or F40.233 fear of injury.

- **300.29 (F40.248) Situational** (e.g., airplanes, elevators, enclosed places).
- **300.29 (F40.298) Other** (e.g., situations that may lead to choking or vomiting; in children, e.g., loud sounds or costumed characters).

   **Coding note:** When more than one phobic stimulus is present, code all ICD-10-CM codes that apply (e.g., for fear of snakes and flying, F40.218 specific phobia, animal, and F40.248 specific phobia, situational).
### Social Anxiety Disorder (Social Phobia)

<table>
<thead>
<tr>
<th>Diagnostic Criteria</th>
<th>300.23 (F40.10)</th>
</tr>
</thead>
</table>
| A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).  
   **Note:** In children, the anxiety must occur in peer settings and not just during interactions with adults. |
| B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others). |
| C. The social situations almost always provoke fear or anxiety.  
   **Note:** In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations. |
| D. The social situations are avoided or endured with intense fear or anxiety. |
| E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context. |
| F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more. |
| G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. |
| H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. |
| I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder. |
| J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive. |

**Specify if:**

- **Performance only:** If the fear is restricted to speaking or performing in public.
Appendix E - DSM-V Diagnostic Criteria for Panic Disorder

Panic Disorder

Diagnostic Criteria 300.01 (F41.0)

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).
Appendix F - DSM-V Diagnostic Criteria for Agoraphobia

### Agoraphobia

#### Diagnostic Criteria

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Marked fear or anxiety about two (or more) of the following five situations:</td>
</tr>
<tr>
<td></td>
<td>1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).</td>
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<td></td>
<td>2. Being in open spaces (e.g., parking lots, marketplaces, bridges).</td>
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<tr>
<td></td>
<td>3. Being in enclosed places (e.g., shops, theaters, cinemas).</td>
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<tr>
<td></td>
<td>4. Standing in line or being in a crowd.</td>
</tr>
<tr>
<td></td>
<td>5. Being outside of the home alone.</td>
</tr>
<tr>
<td>B.</td>
<td>The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence).</td>
</tr>
<tr>
<td>C.</td>
<td>The agoraphobic situations almost always provoke fear or anxiety.</td>
</tr>
<tr>
<td>D.</td>
<td>The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.</td>
</tr>
<tr>
<td>E.</td>
<td>The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.</td>
</tr>
<tr>
<td>F.</td>
<td>The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.</td>
</tr>
<tr>
<td>G.</td>
<td>The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.</td>
</tr>
<tr>
<td>H.</td>
<td>If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.</td>
</tr>
<tr>
<td>I.</td>
<td>The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder—for example, the symptoms are not confined to specific phobia, situational type; do not involve only social situations (as in social anxiety disorder); and are not related exclusively to obsessions (as in obsessive-compulsive disorder), perceived defects or flaws in physical appearance (as in body dysmorphic disorder), reminders of traumatic events (as in posttraumatic stress disorder), or fear of separation (as in separation anxiety disorder).</td>
</tr>
</tbody>
</table>

**Note:** Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual’s presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.
Appendix G - DSM-V Diagnostic Criteria for Generalized Anxiety Disorder

Generalized Anxiety Disorder

Diagnostic Criteria 300.02 (F41.1)

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
   Note: Only one item is required in children.
   1. Restlessness or feeling keyed up or on edge.
   2. Being easily fatigued.
   3. Difficulty concentrating or mind going blank.
   4. Irritability.
   5. Muscle tension.
   6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).
Disruptive Mood Dysregulation Disorder

Diagnostic Criteria 296.99 (F34.8)

A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.

B. The temper outbursts are inconsistent with developmental level.

C. The temper outbursts occur, on average, three or more times per week.

D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).

E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.

F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.

G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.

H. By history or observation, the age at onset of Criteria A–E is before 10 years.

I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomaniac episode have been met. **Note:** Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).

**Note:** This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomaniac episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.
Appendix I - DSM-V Diagnostic Criteria for Major Depressive Disorder

**Major Depressive Disorder**

**Diagnostic Criteria**

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

**Note:** Criteria A–C represent a major depressive episode.

**Note:** Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual’s history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

**Note:** This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.
### Patient Health Questionnaire (PHQ-9)

**Patient name:** ____________________________  **Date:** __________________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all (0)</th>
<th>Several days (1)</th>
<th>More than half the days (2)</th>
<th>Nearly every day (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Trouble falling/staying asleep, sleeping too much.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Feeling tired or having little energy.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. Poor appetite or overeating.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching TV.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- □ Not difficult at all
- □ Somewhat difficult
- □ Very difficult
- □ Extremely difficult

**TOTAL SCORE**          ________________

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Appendix K: How to Score the PHQ-9

Instructions – How to Score the PHQ-9

Major depressive disorder is suggested if:
- Of the 9 items, 5 or more are checked as at least ‘more than half the days’
- Either item a. or b. is positive, that is, at least ‘more than half the days’

Other depressive syndrome is suggested if:
- Of the 9 items, a., b. or c. is checked as at least ‘more than half the days’
- Either item a. or b. is positive, that is, at least ‘more than half the days’

Also, PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all=0, several days=1, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

Guide for Interpreting PHQ-9 Scores

<table>
<thead>
<tr>
<th>Score</th>
<th>Recommended Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>Normal range or full remission. The score suggests the patient may not need depression treatment.</td>
</tr>
<tr>
<td>5-9</td>
<td>Minimal depressive symptoms. Support, educate, call if worse, return in 1 month.</td>
</tr>
<tr>
<td>10-14</td>
<td>Major depression, mild severity. Use clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment. Treat with antidepressant or psychotherapy.</td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderate severity. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment.</td>
</tr>
<tr>
<td>20 or higher</td>
<td>Major depression, severe severity. Warrants treatment with antidepressant and psychotherapy, especially if not improved on monotherapy; follow frequently.</td>
</tr>
</tbody>
</table>

Functional Health Assessment

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people. Patient responses can be one of four: Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult. The last two responses suggest that the patient’s functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.
Appendix L - DSM-V Diagnostic Criteria for Persistent Depressive Disorder

**Persistent Depressive Disorder (Dysthymia)**

<table>
<thead>
<tr>
<th>Diagnostic Criteria</th>
<th>300.4 (F34.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.</td>
<td></td>
</tr>
</tbody>
</table>
| **A.** Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.  
  **Note:** In children and adolescents, mood can be irritable and duration must be at least 1 year. |
| **B.** Presence, while depressed, of two (or more) of the following:  
  1. Poor appetite or overeating.  
  2. Insomnia or hypersomnia.  
  3. Low energy or fatigue.  
  4. Low self-esteem.  
  5. Poor concentration or difficulty making decisions.  
  6. Feelings of hopelessness. |
| **C.** During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time. |
| **D.** Criteria for a major depressive disorder may be continuously present for 2 years. |
| **E.** There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder. |
| **F.** The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder. |
| **G.** The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g. hypothyroidism). |
| **H.** The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. |
Appendix M: Poster

**Poster: Entry-Level FNPs: Psychiatric Knowledge is Collaboration**

A professional poster is an effective way to present the findings of the literature reviewed in this project. This poster could be used at a BC Nurse Practitioner Association (BCNPA) conference or at the annual UBC Nursing Graduate Student Research Symposium. At both of these events, entry-level FNPs and practicing FNPs would be exposed to the issues and concerns that NPs experience when caring for individuals with mental illness. The possibility of open-ended questioning during a BCNPA conference would be welcomed to further understand the current obligations of BC FNPs as well as the possibility of future psychiatric NPs in BC.

Graduate students at UBC as well as the BCNPA members may be interested in the role that a psychiatric NP may provide in BC. The message that would be clearly emphasized to both areas would be that collaboration in any health care setting is the most effective form of mental health care. There would also be a number of resources for mental health continuing education provided to the UBC graduate students and BCNPA members. The poster highlights the abstract, method, the importance of this issue, core questions and conclusions reached upon completion of this literature review.

**Core Questions:**

* What is the responsibility required for entry-level FNPs to care for mental health illness in British Columbia?
* Are entry-level FNPs providing safe, competent care to patients with mental illness?
* Can mental health care be effectively understood and cared for by entry-level FNPs?
* What is the psychiatric NP position? Is this the answer to more successful mental health care?
Method:

* Summarize the diagnosis, risk factors and treatment of depression and anxiety disorders that entry-level FNPs are required to treat in primary care.
* Analysis of the psychiatric NP role in the United States
* Analysis of the most effective methods to treat patients with mental illness in primary care

FNPs caring for patients with mental illness

* Anxiety disorders and depressive disorders are the most common disorders seen in primary care in Canada
* Many entry-level FNPs are working in BC in rural communities that have less access to psychiatric services
* Entry-level FNPs feel least prepared to care for patient’s with mental illness

Psychiatric NPs in primary care

* Psychiatric NPs treat acute and chronic mental health illnesses and prescribe psychotropic medications
* Psychiatric NPs are less prepared to treat patients with underlying chronic disease and illnesses unrelated to their mental illness
* Patients that have mental illness have many risk factors that increase their likelihood of developing one or more chronic illness

Collaboration:

* Collaboration between mental health care and physical care is the most effective and important method to increase access for patients to mental health care and to reduce poor outcomes due to untreated mental illness.
FNPs who work in collaboration with other health professionals will have better success in effective diagnosis and long-term treatment of patients with mental illness.

The treatment of mental illness is most effective with interprofessional health care team collaboration

The need of a psychiatric NP is not a necessity, the need for mental illness continuing education and professional development is a necessity

Opportunities for FNP Continuing Education and Professional Development

- CMEList: http://www.cmelist.com/canadian-cme.htm
- Geri-EM: http://geri-em.com
- mdBriefCase: https://www.mdbriefcase.com/default.aspx?
- Canadian Primary Care updates: http://www.mycmeupdates.ca
- University of British Columbia Faculty of Medicine Online CME: http://ubccpd.ca/courses
- Canadian Nurses Association: https://www.nurseone.ca/en

Mental Illness Diagnosis and Treatment Resources

- www.bcguidelines.ca
- Diagnostic and statistical manual of mental disorders: DSM-5
- http://uptodate.com/
Abstract

FNPs in BC are trained in the care of young infants to elderly patients in all aspects of their healthcare. BC has three specializations available for NPs to practice in: family, geriatrics, and adult. Currently U.S. registered psychiatric NPs applying for registration in Canada/BC are not recognized as either a psychiatric NP or an NP in BC due to regulations set by the CRNBC and other provincial regulatory bodies. At the entry level of practice, BC NPs have full scope of care for a variety of mental illnesses including depression, anxiety, obsessive-compulsive disorder and substance use disorders. Entry-level FNPs should acknowledge that psychiatric care is a large part of their practice and needs more attention than their current education may provide them. The best way to reduce the gap between psychiatric knowledge and physical health knowledge is interprofessional health care team collaboration.

Method

- Summarize the diagnosis, risk factors and treatment of depression and anxiety disorders that entry-level FNPs are required to treat in primary care.
- Analyses of the most effective methods to treat patients with mental illness in primary care.

Importance of this issue

Mental illness as a common health problem for Canadians. In 2009/2010, about 14.4% of Canadians (6.9 million) 1 year of age or older had a mental health illness and received healthcare for it (Government of Canada, 2011). The most commonly seen mental illnesses in Canada are anxiety disorders and depressive disorders. Anxiety and depression are very important to identify and treat in primary care to reduce the risk of patients developing comorbid mental health disorders. The public and other healthcare providers may not understand the role of the FNP in health care or understand FNP responsibilities in mental health care.

Care Questions

- What is the responsibility required for entry-level FNPs to care for mental health illness in British Columbia?
- Are entry-level FNPs providing safe, competent care to patients with mental illness?
- Can mental health care be effectively understood and treated by entry-level FNPs?
- What is the psychiatric NP position? Is this the answer to more successful mental health care?

FNPs caring for patients with mental illness

- Anxiety disorders and depressive disorders are the most common disorders seen in primary care in Canada.
- Many entry-level FNPs are working in BC in rural communities that have less access to psychiatric services.
- Entry-level FNPs feel least prepared to care for patient’s with mental illness.

Psychiatric NPs in primary care

- Psychiatric NPs treat acute and chronic mental health illnesses and prescribe psychotropic medications.
- Psychiatric NPs are less prepared to treat patients with underlying chronic disease and illnesses unrelated to their mental illness.
- Psychiatric NPs have less access to psychiatric services.
- Registered psychiatric NPs are not recognized as either a psychiatric NP or an NP due to regulations set by the CRNBC and other provincial regulatory bodies.

Diagnosis

- Collaboration between mental health care and physical care is the most effective and important method to increase access for patients to mental health care and to reduce poor outcomes due to untreated mental illness.
- FNPs who work in collaboration with other health professionals will have better success in effective diagnosis and long-term treatment of patients with mental illness.
- Treatment of a mental illness is not a necessity, the need for mental illness continuing education and professional development is a necessity.

Mental Illness Diagnosis and Treatment Resources

- http://www.bcguidelines.ca
- http://geri-em.com
- http://www.canadian-nurse-association.org
- Canadian Nurse Association: https://www.nurseone.ca
- Registered psychiatric NPs are not recognized as either a psychiatric NP or an NP due to regulations set by the CRNBC and other provincial regulatory bodies.