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Background Information on Mental Illness

OUTLINE

- Why Physical Therapists Should Care About Mental Health Issues and Medical Complexity
- Scope of the Text
- Background Terminology for the Physical Therapist
  - General Terms
  - Diagnostic Terms
  - Signs and Symptoms
- Demographics of Selected Mental Illnesses
- The Human Movement System
  - Exploration of the Human Movement System
  - General Movement System Differences in Persons With Mental Illness
- Management of the Medically or Psychiatrically Complex Patient
  - Strategies for Patient Management
  - Counseling for Complex Patients: Opportunities and Challenges
  - The Patient’s Social Support
- Summary
- Key Points
- Review Questions
- Case Studies: First Impressions
LEARNING OBJECTIVES

• Acquire basic vocabulary related to interprofessional management of persons with psychological conditions
• Incorporate demographic and risk factor information for major mental health issues into the physical therapy patient management model (ie, a cycle of processes physical therapists follow in decision making)
• Justify skilled physical therapy intervention for persons with mental illness, based on the concept of the human movement system (ie, all parts of the body related to production and control of movement, including brain, mind, spinal cord/nerves, skin, muscles, tendons, bones, etc)
• Reflect on past and current management of patients with complex conditions

WHY PHYSICAL THERAPISTS SHOULD CARE ABOUT MENTAL HEALTH ISSUES AND MEDICAL COMPLEXITY

Mental illness turns people inwards. That’s what I reckon. It keeps us forever trapped by the pain of our own minds, in the same way that the pain of a broken leg or a cut thumb will grab your attention, holding it so tightly that your good leg or your good thumb seem to cease to exist.

—Nathan Filer

As physical therapists, we specialize in human movement and the structures and functions that allow and control it (ie, the human movement system). Thus, most therapists’ training is mainly in the movement sciences, which span musculoskeletal, neuromuscular, cardiopulmonary, and other systems. Curricula and continuing-education offerings also examine psychosocial aspects of health care, since each patient’s and therapist’s attitudes, beliefs, values, and his or her individual circumstances are increasingly recognized as contributing to the success or failure of treatment.

The relationship of psychosocial aspects and treatment programs goes both ways; evidence suggests that, as the population ages, regular physical activity can prevent many mental health “conditions that affect cognition, emotion, and behavior,” such as anxiety and depression. The physical therapist is in a key position to influence how a patient becomes more consistently physically active.

This section uses a mental-illness lens to look briefly at psychosocial aspects of patient management, including cognition, stigma, and social support structure, because mental wellness is related to physical and social wellness. Indeed, a worldwide survey found that mental illnesses—especially posttraumatic stress disorder, bipolar disorders, and major depressive disorders (MDDs)—cause significant partial disability, which is comparable to the number of sick days taken by persons with chronic physical conditions. Throughout this introductory section and the whole text, the reader should bear in mind that while mental health issues and multiple comorbidities can be obstacles to delivering the best quality physical therapy to the patient, the psychosocially informed provision of physical therapy to these patients can positively impact their lives and the course of diseases.

Although many doctor of physical therapy (DPT) programs include classes in psychosocial aspects, differential diagnosis, and patient management, the cognitive component may not be adequately addressed due to constraints on time, despite its demonstrated importance. For example, the function of community-dwelling elderly and restraint reduction in inpatient psychiatric settings depend on the patient’s cognitive status and abilities. Furthermore, clinical practice guidelines recommend non-pharmacological interventions (eg, physical therapy) for psychiatric disorders, including cognitive behavioral therapy to reduce depressive symptoms and the promotion of exercise behavior in older adults.
This chapter has laid the framework for evidence-based physical therapy for persons with psychological conditions and medical complexity. This framework includes a common vocabulary for the team of health care providers, as well as foundational concepts for effective care within the physical therapist’s scope of practice. Statistics, known risk factors, and general differences related to aspects of the human movement system, especially related to complex patient cases, flesh out the framework. With this background, the reader can build a mental scaffold to deepen knowledge of specific mental illnesses and treatment techniques or modifications that are the focus of subsequent chapters.

**Key Points**

- Psychosocially informed physical therapy positively impacts life and disease in persons with complex medical and psychiatric histories.
- Persons with mental health issues often need the motivation and support of group exercise, even a walking program.
- Even low-level “physical activity can prevent some aspects of mental illness in older people such as depression, dementia, and Alzheimer’s disease.”33
- “Physical activity interventions focused on improving mastery or self-worth, as well as physical fitness, may yield the greatest benefit in alleviating psychological distress.”41
- Complex patient management improves with a broad knowledge base, reflective discussion, care coordination, and lifelong learning.

**Review Questions**

- Based on the topics discussed in this chapter, what might be some reasons that cause you, as a physical therapist, to want or need to learn about persons with psychological conditions?
- Complete the following activities, then discuss with one or more classmates, if possible:
  - In your own words, define psychoneuroimmunology. How does that connect the study of mental health and illness to the scope of practice of a physical therapist?
  - Compare, contrast, and connect mood and affect. Does your clinical documentation (eg, paper patient cases, simulation labs, and clinical rotations) reflect distinctions between the 2?
- Review, for your own recall, the risk factors and prevalence of depressive and neurocognitive disorders.
- Define the human movement system in your own words. How does the contribution of various body systems to this system, including mental health and illness, define the physical therapist’s scope of practice?
- Refer to Figure 5-1. Given a common example of a patient with comorbid depression and dementia, how might you use information from the text about risk factors, demographics, and medical comorbidities in each of the following aspects of patient management?
  - Examination
  - Evaluation
  - Diagnosis
Case Studies: First Impressions

As you review the following case studies, you may want to consider these questions for thought or discussion:

- What standardized tests and measures (including psychiatric, for example, a depression screen) would you select for this patient? Why?
- Based on available data, what short- and long-term goals would you write for your plan of care? Consider using the acronyms SMART (specific, measurable, attainable, realistic, and timely) or ABCDE (actor, behavior, conditions, degree, and expected time frame) to guide your goal writing.
- What elements (procedures, psychosocial aspects, communication aspects, etc) would you make sure to include or omit in your plan of care for this patient? Why?
- What are your anticipated needs, if any, for consultation and referral for this patient?
- How will you transition this patient toward lasting health behavior change following discharge (e.g., recommending a YMCA membership trial)?

Case 1

A 23-year-old female college soccer player was referred to outpatient physical therapy 2 weeks after a left combined anterior and medial cruciate ligament tear. Her goal is to return to practice by the end of the semester, which is 4 weeks away.

- Social history: she lives on campus on the third floor of a dormitory without an elevator available. She is involved in extracurricular activities, including theater (backstage this semester), a student service club, and campus worship services.
- Medical/psychiatric history: GAD (diagnosed 4 years previously), attention-deficit hyperactivity disorder, and pain medication prescribed occasionally impairs concentration.
- Impairments, activity limitations, and participation restrictions found on initial interview and examination:
  - Pain rated 8/10 at times in left knee, especially after using crutches to walk between classes
  - Left knee joint inflammation that impairs positioning while sitting
  - Left quadriceps weakness (able to hold knee straight against gravity without resistance)
  - Difficulty managing stairs to dormitory with backpack due to shortness of breath
  - Slightly decreased grades in 2 classes due to sleepiness from pain medications
  - Unable to participate in soccer practice

Case 2

A 41-year-old male construction worker is starting rehabilitation through worker’s compensation for a back injury sustained in a fall from a 10-foot height through roof beams to the floor below. His goal is to return to work.

- Social history: he lives in a 2-story house with his wife, who works as a schoolteacher. Her parents assist with caring for their 2 children while both are at work. He has counseling twice per month for PTSD; finally, he reports difficulty with obtaining transportation to 25% of scheduled therapy appointments.
- Past medical and psychiatric history: recurrent lumbar disc protrusions, obesity, partial rotator cuff tear (2 years prior to current injury), PTSD from serving overseas in the military in his 20s, and a long history of taking low-dose opioid pain medications as needed.
### Quick Reference

- Possible diagnoses and their signs/symptoms:
  - GAD: constant worry, restlessness, fatigue, poor concentration, headache, nausea, or trouble falling asleep
  - Panic disorder: panic attacks in response to seemingly innocuous stimuli or situations; may include hyperventilation, heart racing, sense of impending doom, feeling of choking or smothering
  - PTSD: irritability, hypervigilance, insomnia, loneliness, anhedonia, intrusive thoughts, emotional detachment, hostility, or flashbacks
  - OCD: anxiety, depression, repetitive behavior (usually related to germs), impulsivity, hoarding, hypervigilance, compulsive behavior
  - Phobia: anxiety or panic symptoms related to a particular situation or object

- Questions to ask the patient (or friend/family member):
  - Do you often feel any of the symptoms (listed previously)?
  - Have you ever been diagnosed with one of the conditions (listed previously)? What was going on in your life around the time of that diagnosis?
  - How do you deal with your anxiety? How well does that work for you?
  - What should I know about what triggers your anxiety (or PTSD, OCD, phobia)?

- Referral options:
  - Psychiatrist for diagnosis, behavioral and pharmacological therapy
  - Support group for persons with similar conditions
  - Exercise group to capture benefits of aerobic exercise on anxiety sensitivity (after primary physician clearance for medical safety to exercise)

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### References