Principles and Practice of

PSYCHIATRIC NURSING

GAIL W. STUART

TENTH EDITION

10

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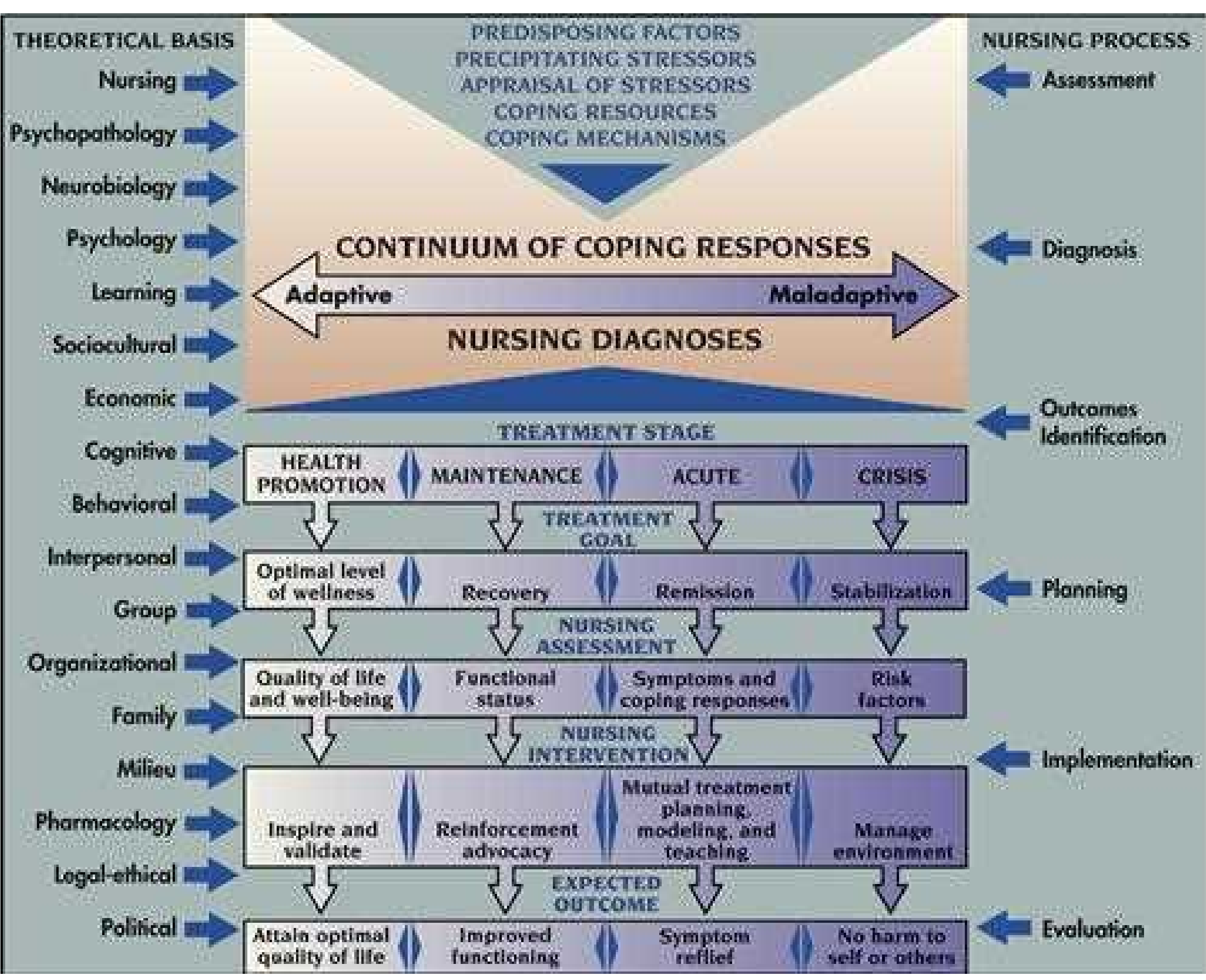
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Principles and Practice of

PSYCHIATRIC NURSING

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She is a fellow in the American Academy of Nursing, a member of Sigma Theta Tau, past president of the American College of Mental Health Administration, a distinguished practitioner in the National Academies of Practice, and a past president of the American Psychiatric Nurses Association. Her current activities include positions as president of the board of directors of the Annapolis Coalition on the Behavioral Health Workforce and a member of the board of directors of Mental Health America. She also is active internationally through consultations worldwide and was a visiting professor at King's College, Institute of Psychiatry, at the Maudsley in London. Most recently she served as an educational consultant to the Mental Health Liberia Program sponsored by the Carter Center.

Dr. Stuart's current position at the Medical University of South Carolina is dean of the College of Nursing. Before that appointment she was the director of doctoral studies and coordinator of the Psychiatric–Mental Health Nursing Graduate Program. She was previously the associate director of the Center for Health Care Research where she worked as a member of an interdisciplinary research team focusing on issues of access, resource utilization, and health care delivery systems. She also was the administrator and chief executive officer of the Institute of Psychiatry at the Medical University, where she was responsible for all clinical, fiscal, and human operations across the continuum of psychiatric care. Dr. Stuart has taught in undergraduate, graduate, and doctoral programs in nursing.

She serves on numerous academic, industry, philanthropic, and government boards, including the Advisory Council of the National Institute of Nursing Research. Dr. Stuart is a strong advocate for the specialty and is in great demand to speak and consult both nationally and internationally. She is a prolific writer and has published numerous articles, textbooks, and media productions. She has received many awards, including the American Nurses Association Distinguished Contribution to Psychiatric Nursing Award, the Psychiatric Nurse of the Year Award from the American Psychiatric Nurses Association, and the 2008 Hildegard Peplau Award from the American Nurses Association, which was awarded to Dr. Stuart in recognition of her lifetime of achievement and significant contributions to the field of psychiatric nursing. Dr. Stuart's clinical and research interests involve the study of depression, anxiety disorders, clinical outcomes, the behavioral health workforce, and health care delivery systems.

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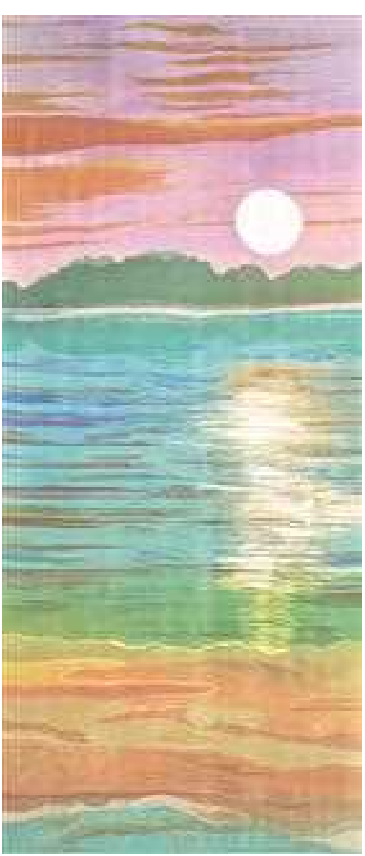
ABOUT THE ARTIST

Mary Edna Fraser observes the health of our planet transcribed onto silk using dyes in the ancient medium of batik. As satellite imagery became available, her attention began to focus on a series of images based on the surface patterns of our neighboring planets and celestial bodies. The Smithsonian National Air and Space Museum and the National Aeronautics and Space Administration have partnered with Fraser on her research. She is mapping this territory on a personal human level while astronomers view outer space scientifically. Her batiks are giant prayer flags both for individual problems and for the problems our world faces.

For more information on Mary Edna Fraser, visit www.maryedna.com.



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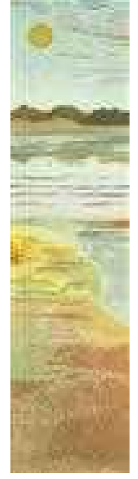

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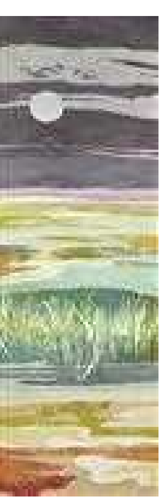

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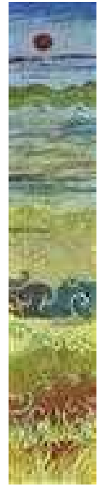

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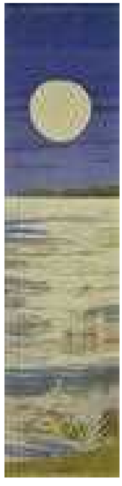

Full Moon

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PREFACE

This is the landmark 10th edition of this textbook. Such a unique milestone is important for a number of reasons. First, it attests to the quality and value of the text since it has stood the test of time. Second, it confirms the fact that each new edition has presented the most up-to-date information in a clear and compelling way, making it a most effective teaching-learning tool. Third, it reflects upon the growing importance of mental health and substance use problems in our society over the past 4 decades.

Without a doubt psychiatric care has changed radically since the first edition was published in 1979. Even more importantly, psychiatric nursing also has been transformed from custodial and supportive care to a dynamic, autonomous, and integral part of all health care.

In looking back, this textbook established many "firsts" in the field that have been adopted by other psychiatric nursing textbooks over the years. It was the first to:

- Develop the "Stuart Stress Adaptation Model" that is used consistently in each clinical chapter.
- Focus a chapter on evidence-based psychiatric nursing practice and then integrate it throughout the book.
- Include content on families as resources, caregivers and collaborators.
- Devote a chapter on mental health promotion and illness prevention.
- Present content on the Recovery Model.
- Describe behavior change interventions.
- Relate clinical exemplars from the actual practice of psychiatric nurses.

This 10th edition continues to be the true leader and standard-bearer in the field. It takes content to a new level, reflecting contemporary aspects of health care. In this edition you will find exciting new content on *motivational interviewing, traumatic brain injury, substance use screening and brief interventions (SBIRT), lateral violence in nursing, health care reform including integrated physical and mental health care, virtual mental health care, patient-centered health care homes, and care management and collaborative care models*. In addition, there are new chapters on **Policy and Advocacy in Mental Health Care** and **The Military and Their Families,** and in response to the important work of the Institute of Medicine, there are *Quality and Safety* boxes included in each clinical chapter. Finally, this text, in conjunction with the Evolve website, presents an innovative and complete educational package that goes well beyond the pages of the textbook.

STUDENT LEARNING GUIDE

Students learn in many different ways, requiring varied teaching methods, and this edition is more than print text on a static page. I am excited to present new learning tools that will help you, the student, master and then apply the content. The following list describes some of the unique learning tools that I hope you will use to your advantage:

- **NCLEX Review Questions** are provided for each chapter on the Evolve website. These will help you prepare for course examinations and for your RN licensure examination.
- **Selected text is bolded throughout the book.** This allows you to quickly access important points and the *need to know* versus *nice to know* content. Think of it as the author highlighting your reading and pointing out the most important information for you to master.
- **Learning from a Case** is presented in each clinical chapter in Unit 3. These help you think through a particular clinical situation with answers to focused questions provided at the end of each chapter.
- **Chapters in Review** are detailed summaries of content included in each chapter. If you use these as an outline, they can help you organize the wealth of material in each chapter and then allow you to come to class ready to ask questions, analyse case studies, and role play.
- **Podcasts or Audio Lecture Summaries** from the clinical chapters in Unit 3 can be downloaded to a MP3 player from the Evolve website. They highlight the important points in each of the clinical chapters in Unit Three, allowing you, the busy student, to study on the go.
- **Videos "In Their Own Words"** capture the personal stories of those living with a mental illness, giving you the opportunity to learn from actual patients and become more comfortable with encountering mental health problems in the clinical setting. They also can be accessed on the Evolve website.
- **Student Enrichment Activities** is an additional learning tool available on the Evolve website.

FACULTY TEACHING GUIDE

Instructor Resources on Evolve, available at http://evolve.elsevier.com/Stuart/, provide a wealth of material to help you make your *Psychiatric Nursing* instruction a success. In addition to all of the Student Resources, the following are provided for Faculty:

- ***TEACH for Nurses* Lesson Plans,** based on textbook chapter Learning Objectives, serve as ready-made, modifiable lesson plans and a complete roadmap to link all parts of the educational package. These concise and straightforward lesson plans can be modified or combined to meet your particular scheduling and teaching needs.

The teaching resources for instructors on Evolve also have been expanded and now include the following:

- **An updated Test Bank.** There are now more than 900 test items with the full range of testing categories including textbook page references.

- **PowerPoint Presentations** are organized by chapter. These are detailed and include customizable text and image lecture slides to enhance learning in the classroom or in Web-based course modules. Students can use the note feature in the slides to help remember your lectures.
- **Videos "In Their Own Words"** are valuable teaching-learning tools. They allow students to hear from consumers with each of the diagnoses presented in Unit Three of the textbook. This is particularly valuable for providing a personal face to the common mental health and substance use problems. Students have been most positive in their response to using these videos with the textbook.
- **Podcasts or Audio Chapter Summaries** can be downloaded to an MP3 player. These can help students who are auditory learners and reinforce important content from the clinical chapters.
- **Audience Response Questions for i>clicker and other systems** are provided with two to five multiple-answer questions per chapter to stimulate class discussion and assess student understanding of key concepts.
- **Case Studies** are included on the Evolve website. These are excellent tools for helping students apply the Stuart Stress Adaptation Model to specific clinical problems.
- **Image Collection** contained on the Evolve website provides you with additional teaching tools.

So we are now ready to begin our journey through the many moons of psychiatric and mental health nursing. Get out your telescopes, and prepare to enter a world of behaviors, thoughts, and feelings as we discover the amazing universe that resides within each one of us.

Gail Wiscarz Stuart

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UNIT 1

Principles of Psychiatric Nursing Care

CHAPTER 1

Roles and Functions of Psychiatric–Mental Health Nurses: Competent Caring

Gail W. Stuart

To be what we are, and to become what we are capable of becoming, is the only end of life.

Robert Louis Stevenson

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the evolution of psychiatric–mental health nursing roles and functions.
2. Discuss the nature of contemporary psychiatric–mental health nursing practice.
3. Analyze the factors that influence the psychiatric–mental health nurse's level of performance.
4. Critique areas of importance for psychiatric–mental health nursing's future agenda.

Nursing, or caring for the sick, has existed since the beginning of civilization. Before 1860 nursing care for those with emotional problems was mainly custodial; it focused on the patients' physical needs, such as medications, nutrition, hygiene, and ward activities. Psychiatric nurses had limited training in psychiatry, and they mostly applied the principles of medical-surgical nursing to the psychiatric setting. Psychological care consisted of kindness and tolerance toward the patients. Nursing as a profession began to emerge in the late nineteenth century, and by the twentieth century it had evolved into a specialty with unique roles and functions (Bowling, 2003) (Table 1-1).

HISTORICAL PERSPECTIVES

In 1873 Linda Richards graduated from the New England Hospital for Women and Children in Boston. She developed better nursing care in psychiatric hospitals and organized nursing services and educational programs in state mental hospitals in Illinois. She said, "It stands to reason that the mentally sick should be at least as well cared for as the physically sick" (Doona, 1984). For these activities, **Linda Richards is called the first American psychiatric nurse.** One of her most important contributions was her emphasis on assessing both the physical and the emotional needs of the patients. In this early period of nursing history, nursing education separated these two needs; nurses were taught either in the general hospital or in the psychiatric hospital. It was not until the late 1930s that nursing education recognized the importance of psychiatric knowledge in general nursing care for all illnesses (Box 1-1).

An important factor in the development of psychiatric nursing was the emergence of various somatic therapies, including insulin shock therapy (1935), psychosurgery (1936), and electroconvulsive therapy (1937). These techniques required the medical-surgical skills of nurses. Although these therapies did not help patients understand their problems, they did control behavior and make the patients more open to psychotherapy. Somatic therapies also increased the demand for improved psychological treatment for patients who did not respond. As nurses became more involved with somatic therapies, they began the struggle to define their role as psychiatric nurses. An editorial in the *American Journal of Nursing* in 1940 described the conflict between nurses and

TABLE 1-1 **EVOLUTIONARY TIMELINE IN PSYCHIATRIC NURSING**

SOCIAL ENVIRONMENT	DATE	PSYCHIATRIC NURSING
	1882	First school to prepare nurses to care for mentally ill opened at McLean Hospital in Massachusetts
American Journal of Nursing first published	1900	
Florence Nightingale died	1910	
	1913	Johns Hopkins was first school of nursing to include a course on psychiatric nursing in its curriculum
Electroconvulsive therapy developed	1937	
National Mental Health Act passed by Congress, creating National Institute of Mental Health (NIMH) and providing training funds for psychiatric nursing education	1946	
	1950	National League for Nursing (NLN) required that to be accredited schools of nursing must provide an experience in psychiatric nursing
	1952	Hildegard Peplau published ***Interpersonal Relations in Nursing***
Maxwell Jones published ***The Therapeutic Community***	1953	
Development of major tranquilizers	1954	
Community Mental Health Centers Act passed	1963	***Perspectives in Psychiatric Care*** published; ***Journal of Psychiatric Nursing and Mental Health Services*** published
	1973	***Standards of Psychiatric–Mental Health Nursing Practice*** published; certification of psychiatric–mental health nurse generalist established by American Nurses Association (ANA)
Report of the President's Commission on Mental Health	1978	
	1979	***Issues in Mental Health Nursing*** published; certification of psychiatric–mental health nurse specialists established by ANA; first edition of ***Principles and Practice of Psychiatric Nursing*** published (Stuart and Sundeen)
Nursing: A Social Policy Statement published by ANA	1980	
National Center for Nursing Research (renamed National Institute of Nursing Research [NINR]) created in National Institutes of Health (NIH)	1985	***Standards of Child and Adolescent Psychiatric and Mental Health Nursing Practice*** published by ANA
	1986	American Psychiatric Nurses Association (APNA) established
	1987	***Archives of Psychiatric Nursing*** published; ***Journal of Child and Adolescent Psychiatric and Mental Health Nursing*** published
	1988	***Standards of Addictions Nursing Practice*** published by ANA
	1990	***Standards of Psychiatric Consultation Liaison Nursing Practice*** published by ANA
Center for Mental Health Services created	1992	
	1994	Revised ***Standards of Psychiatric–Mental Health Clinical Nursing Practice*** published by ANA
Revised ***Nursing Social Policy Statement*** published by ANA	1995	***Journal of the American Psychiatric Nurses Association*** *(JAPNA)* published
Report of the Surgeon General on Mental Health	1999	Hildegard Peplau died
	2000	Revised ***Scope and Standards of Psychiatric–Mental Health Clinical Nursing Practice*** published by ANA
Report of the President's New Freedom Commission on Mental Health	2003	Certification of psychiatric–mental health nurse practitioners by ANA
Improving the Quality of Health Care for Mental and Substance-Use Conditions published by the Institute of Medicine	2006	
	2007	Revised ***Psychiatric–Mental Health Nursing Scope and Standards of Practice*** published by ANA
Patient Protection and Affordable Care Act	2010	

BOX 1-1 A NURSE SPEAKS

We do not hesitate to emphasize the need of some psychiatric training in the life of every nurse who would represent her profession on the basis of modern standards. The psychiatrically trained nurse must remember, on the other hand, that all symptoms are not of mental origin. This fact has been long recognized, so nurses trained in mental hospitals have wisely requested affiliation in general hospitals, thus avoiding the danger of overspecialization.

Does it not seem rational, therefore, that the general hospital shall guarantee its nurse an equivalent knowledge of the workings of the patient's mind as the psychiatric nurse has of the workings of his body? Modern psychology reveals the close interrelation of the two; it recognizes the ceaseless interaction of one on the other. Should we not then more consistently work toward the ideal that every hospital shall graduate nurses trained in preventive and curative methods of caring for the inevitably associated physically and mentally ill?

Annie L. Crawford, RN, BS
South Carolina Nurses' Association,
Annual Convention Presentation
October 6, 1934

physicians as nurses tried to implement what they considered appropriate care for psychiatric patients (Editorial, 1940). This conflict continued in later nursing practice (Box 1-2).

The period after World War II was one of major growth and change in psychiatric nursing. Because of the large number of military service–related psychiatric problems and the increase in treatment programs offered by the Veterans Administration, psychiatric nurses with advanced preparation were in demand. The content of psychiatric nursing had become a standard part of the generic nursing curriculum. Its principles were applied to other areas of nursing practice, including general medical, pediatric, and public health nursing. By 1947 eight graduate programs in psychiatric nursing had been started.

Role Emergence

The role of psychiatric nursing began to emerge in the early 1950s but it was not a smooth path. An article by Bennett and Eaton in the *American Journal of Psychiatry* in 1951 identified the following problems affecting psychiatric nurses:

1. Scarcity of qualified psychiatric nurses
2. Underuse of their abilities
3. The fact that "very little real psychiatric nursing is carried out in otherwise good psychiatric hospitals and units"

These psychiatrists believed that the psychiatric nurse should join mental health societies, consult with welfare agencies, work in outpatient clinics, practice preventive psychiatry, engage in research, and help educate the public. They supported the nurse's participation in individual and group psychotherapy and stated, "Despite the fact that most psychiatrists seem to ignore the role of the psychiatric nurse in psychotherapy, all nurses in psychiatric wards do psychotherapy of one kind or another by their contacts with patients" (Bennett and Eaton, 1951).

BOX 1-2 A PHYSICIAN SPEAKS

I have spent all of my professional career in close association with, and close dependency on, nurses, and like many of my faculty colleagues, I've done a lot of worrying about the relationship between medicine and nursing.

The doctors worry that nurses are trying to move away from their historical responsibilities to medicine (meaning, really, to the doctors' orders). The nurses assert that they are their own profession, responsible for their own standards, coequal colleagues with physicians, and they do not wish to become mere ward administrators or technicians.

My discovery as a patient is that the institution is held together, *glued* together, enabled to function as an organism, by the nurses and by nobody else. The nurses make it their business to know everything that is going on. They spot errors before errors can be launched. They know everything written on the chart. Most important of all, they know their patients as unique human beings, and they soon get to know the close relatives and friends. Because of this knowledge, they are quick to sense apprehensions and act on them.

The average sick person in a large hospital feels at risk of getting lost, with no identity left beyond a name and a string of numbers on a plastic wristband, in danger always of being whisked off on a litter to the wrong place to have the wrong procedure done, or worse still, *not* being whisked off at the right time. The attending physician or the house officer, on rounds and usually in a hurry, can murmur a few reassuring words on his way out the door, but it takes a confident, competent, and cheerful nurse, there all day long and in and out of the room on one chore or another through the night, to bolster one's confidence that the situation is indeed manageable and not about to get out of hand.

Knowing what I know, I am all for the nurses. If they are to continue their professional feud with the doctors, if they want their professional status enhanced and their pay increased, if they infuriate the doctors by their claims to be equal professionals, if they ask for the moon, I am on their side.

Lewis Thomas, MD
The Youngest Science,
New York, 1983, Viking Press

Critical Reasoning Do you think that the problems affecting psychiatric nurses described by Bennett and Eaton in 1951 continue to exist in the specialty today?

Also in 1951 Mellow (Mellow, 1968) wrote of the work she did with schizophrenic patients. She called these activities "nursing therapy." One year later, Tudor published a study in which she described the nurse-patient relationships she established, which were characterized by unconditional care, few demands, and anticipation of her patients' needs (Tudor, 1952). These articles were some of the earliest descriptions of the nurse-patient relationship and its therapeutic process. As nurses engaged in these kinds of activities, many questions arose: Are these activities therapeutic, or are they therapy? What is a therapeutic relationship or a one-to-one nurse-patient relationship? How does it differ from psychotherapy? These questions were addressed by Dr. Hildegard Peplau, a

BOX 1-3 INTERPERSONAL NURSING ROLES IDENTIFIED BY PEPLAU

Stranger: the role assumed by both nurse and patient when they first meet
Resource person: provides health information to a patient who has assumed the consumer role
Teacher: helps the patient grow and learn from experience with the health care system
Leader: helps the patient participate in a democratically implemented nursing process
Surrogate: assumes roles that have been assigned by the patient, based on significant past relationships, as in the psychoanalytical phenomenon of transference
Counselor: helps the patient integrate the facts and feelings associated with an episode of illness into the patient's total life experience

dynamic nursing leader whose ideas and beliefs shaped psychiatric nursing.

In 1952 Peplau published a book, *Interpersonal Relations in Nursing,* in which she described the first theoretical framework for psychiatric nursing and the specific skills, activities, and roles of psychiatric nurses. **Peplau defined nursing as a "significant, therapeutic process."** While she studied the nursing process, she observed nurses functioning in various roles, such as those listed in Box 1-3. She wrote, "Counseling in nursing has to do with helping the patient remember and to understand fully what is happening to him in the present situation, so that the experience can be integrated with rather than dissociated from other experiences in life" (Peplau, 1952).

Critical Reasoning Compare the roles of psychiatric nurses identified by Hildegard Peplau in 1952 with your observations of contemporary psychiatric nursing practice.

Two other significant developments in psychiatry in the 1950s also affected nursing's role. The first was Jones' publication of *The Therapeutic Community: A New Treatment Method in Psychiatry* in 1953. This method encouraged using the patient's social environment to provide a therapeutic experience. The basis of the **therapeutic community** was that **each patient was to be an active participant in care, become involved in the daily problems of the unit, and help solve problems, plan activities, and develop the required unit rules.** Therapeutic communities became the preferred environment for psychiatric patients. The second significant development in psychiatry in the early 1950s was the use of **psychotropic drugs.** With these drugs more patients became treatable, and fewer environmental constraints such as locked doors and straitjackets were required. Also, more personnel were needed to provide therapy, and the roles of various psychiatric clinicians were expanded, including nursing.

Evolving Functions

In 1958 the following functions of psychiatric nurses were described (Hays, 1975):

- Dealing with patients' problems of attitude, mood, and interpretation of reality

FIG 1-1 Hildegard E. Peplau. (Courtesy Hildegard E. Peplau.)

- Exploring disturbing and conflicting thoughts and feelings
- Using the patient's positive feelings toward the therapist to effect psychophysiological homeostasis
- Counseling patients in emergencies, including panic and fear
- Strengthening the well part of patients

Peplau further clarified psychiatric nursing's position and directed its future growth. In *Interpersonal Techniques: The Crux of Psychiatric Nursing,* published in 1962, **Peplau identified the heart of psychiatric nursing as the role of counselor or psychotherapist.** She clarified the differences between general practitioners, who were staff nurses working on psychiatric units, and psychiatric nurses, who were specialists and expert clinical practitioners with graduate degrees in psychiatric nursing. Thus from an undefined role involving primarily physical care, psychiatric nursing was evolving into a role of clinical competence based on interpersonal techniques and use of the nursing process. For her contributions to the specialty, **Hildegard Peplau is often called the mother of psychiatric nursing** (Figure 1-1).

In the 1960s the focus of psychiatric nursing began to shift to primary prevention and implementation of care and consultation in the community. These changes lead to a shift in the name of the specialty from "psychiatric nursing" to "psychiatric and mental health nursing." The Community Mental Health Centers Act of 1963 made federal money available to states to plan, construct, and staff community mental health centers and resulted in a growing awareness of the value of treating people in the community and preventing hospitalization whenever possible. It also encouraged the use of multidisciplinary treatment teams by combining the skills of many professions to treat illness and promote mental health. This team approach continues to be negotiated as issues of territoriality, professionalism, authority structure, consumer rights, and the use of peer counselors are still being debated.

The 1970s saw psychiatric nurses emerging as the pacesetters in specialty nursing practice. They were the first to do the following:

- Develop standards and statements on scope of practice.
- Establish generalist and specialist certification.

At this same time the nursing profession was defining caring as a core part of all nursing practice, and the contributions of psychiatric nurses were embraced by nurses of all specialty groups. Partly as a result of this broader definition of psychiatric nursing and the perceived skills of psychiatric nurses, nursing education reorganized its curriculum and began to integrate psychiatric nursing content into nonpsychiatric courses. This blending of content resulted in the second change in the name of the field in the 1970s from "psychiatric and mental health nursing" to "psychosocial nursing." Clinical rotations focusing on the psychiatric illnesses of patients in psychiatric settings were often replaced by clinical rotations integrating psychosocial aspects of the care of physically ill patients in general medical-surgical units. Unfortunately, this trend frequently did not provide students with an opportunity to care for patients with a psychiatric illness as their primary diagnosis and to learn about new information that was emerging in the field of psychiatry and the broader behavioral sciences.

Critical Reasoning It has been suggested that psychiatric nursing content can be learned by taking care of patients in medical-surgical settings because patients in these settings have depression, anxiety, and other psychiatric problems as well. How do the problems of these patients differ from those experienced by psychiatric patients? Patients in psychiatric settings have diabetes, cancer, heart disease, and other medical problems, the same as patients in medical-surgical settings. If there are no differences, explain why medical-surgical nursing content cannot be learned by taking care of psychiatric patients.

The 1980s were years of exciting scientific growth in the area of psychobiology. New focus was placed on brain-imaging techniques, neurotransmitters and neuronal receptors, and molecular genetics related to psychobiology. However, psychiatric nurses were slow in their transition from using psychodynamic models of the mind to utilizing more balanced psychobiological models of psychiatric care. Psychiatric nurses thus entered the 1990s faced with the challenge of integrating the expanding bases of neuroscience into the caring and holistic biopsychosocial practice of psychiatric nursing. By 2000 psychiatric nurses agreed that the knowledge base of the specialty is based on the integration of the biological, psychological, spiritual, social, and environmental realms of the human experience.

Critical Reasoning Compare the length of your clinical rotation in psychiatric nursing with your "clinicals" in medicine, surgery, and pediatrics. Given the high prevalence of mental health problems such as depression, anxiety, and substance abuse, do you think you have adequate education in psychiatric nursing?

CONTEMPORARY PRACTICE

Psychiatric–mental health nursing is an interpersonal process that promotes and maintains patient behavior that contributes to integrated functioning. The patient may be an individual, family, group, organization, or community. The American Nurses Association's *Psychiatric–Mental Health Nursing: Scope and Standards of Practice* (2007) defines psychiatric–mental health nursing as "a specialized area of nursing practice committed to promoting mental health through the assessment, diagnosis, and treatment of human responses to mental health problems and psychiatric disorders… [It] employs a purposeful use of self as its art and a wide range of nursing, psychosocial, and neurobiological theories and research evidence as its science."

The Center for Mental Health Services officially recognizes psychiatric nursing as one of the five core mental health disciplines. The other four disciplines are marriage and family therapy, psychiatry, psychology, and social work.

The philosophical beliefs of psychiatric–mental health nursing practice on which this text is based are described in Box 1-4. The psychiatric nurse uses knowledge from the psychosocial and biophysical sciences and theories of personality and human behavior to derive a theoretical framework on which to base nursing practice. Chapter 3 presents the Stuart Stress Adaptation Model of psychiatric nursing care that is used as the organizing framework for this text.

Nurse-Patient Partnership

Contemporary psychiatric–mental health nursing practice occurs within a social and environmental context. Thus the "nurse-patient relationship" has evolved into a "nurse-patient partnership" that expands the dimensions of the professional psychiatric nursing role. **These elements include clinical competence, consumer-family advocacy, fiscal responsibility, interprofessional collaboration, social accountability, and legal-ethical parameters** (Figure 1-2). The current practice of psychiatric–mental health nursing requires sensitivity to the social environment and the advocacy needs of consumers and their families. It includes thoughtful consideration of complex legal and ethical dilemmas that arise from a delivery system that often discriminates against those with mental illness. New models of mental health care require greater skill in interprofessional collaboration, built on the psychiatric nurse's clinical competence and professional self-assertion and balanced by a clear understanding of the costs of psychiatric care in general and psychiatric nursing care in particular. Each of these elements influences the education, research, and clinical aspects of contemporary psychiatric–mental health nursing practice.

Competent Caring

The three domains of contemporary psychiatric–mental health nursing practice are **direct care, communication,** and **management.** Within these overlapping domains the **teaching, coordinating, delegating,** and **collaborating** functions of the nursing role are expressed (Figure 1-3). Often the communication and management domains are overlooked or taken for granted when discussing the psychiatric nursing role. However, these activities are critically important and very time-consuming aspects of a nurse's role. They have become even more important in a health care system that places emphasis on efficient patient triage, care coordination, and management.

BOX 1-4 PHILOSOPHICAL BELIEFS OF PSYCHIATRIC–MENTAL HEALTH NURSING PRACTICE

- The individual has intrinsic worth and dignity, and each person is worthy of respect.
- The goal of the individual is one of growth, health, autonomy, and self-actualization.
- Every individual has the potential to change.
- Each person functions as a holistic being who acts on, interacts with, and reacts to the environment as a whole person.
- All people have common, basic human needs. These needs include physical requirements, safety, love, belonging, esteem, and self-actualization.
- All behavior of the individual is meaningful. It arises from personal needs and goals and can be understood only from the person's internal frame of reference and within the context in which it occurs.
- Behavior consists of perceptions, thoughts, feelings, and actions. From one's perceptions thoughts arise, emotions are felt, and actions are conceived. Problems may occur in any of these areas.
- Individuals vary in their coping capacities, which depend on genetics, environmental influences, nature and degree of stress, and available resources. All individuals have the potential for both health and illness.
- Illness can be a growth-producing experience for the individual.
- All people have a right to an equal opportunity for adequate health care regardless of gender, race, religion, ethics, sexual orientation, or cultural background.
- Mental health is an essential part of comprehensive health care services.
- The individual has the right to participate in decision making regarding physical and mental health.
- The person has the right to self-determination, including the decision to pursue health or illness.
- The goal of nursing care is to promote wellness, maximize functioning, and enhance self-actualization. Nursing care is based on health care needs and expected treatment outcomes mutually determined with individuals, families, groups, and communities.
- An interpersonal relationship can produce change and growth within the individual. It is the vehicle for the application of the nursing process and the attainment of the goal of nursing care.
- Above all, nurses should communicate hope in working with patients and families. Hope is a positive message of future possibility.

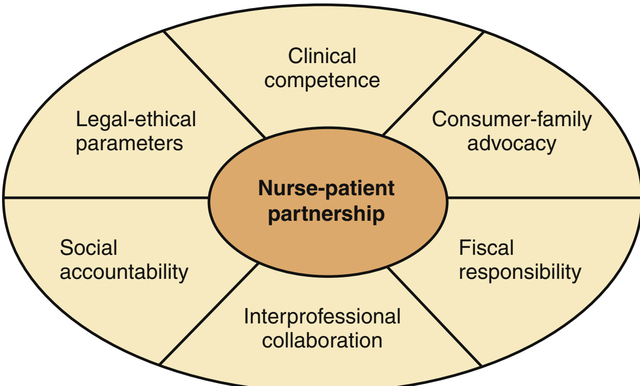


FIG 1-2 Elements of the psychiatric–mental health nursing role.

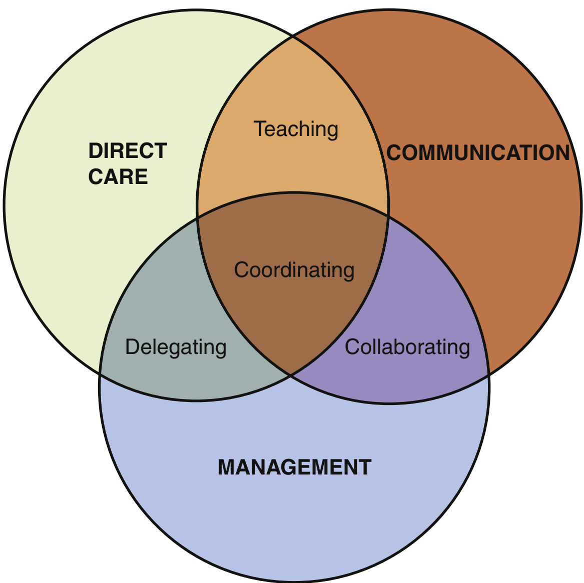


FIG 1-3 Psychiatric–mental health nursing practice.

Box 1-5 lists specific psychiatric–mental health nursing activities that reflect the current nature and scope of competent caring functions performed by psychiatric nurses. Not all nurses perform all these activities. Psychiatric nurses participate in these activities based on their education and experience. In addition, psychiatric–mental health nurses are able to do the following:

- Make culturally sensitive biopsychosocial health assessments.
- Design and implement treatment plans for patients and families with complex health problems and co-morbid conditions.
- Engage in care management activities, such as organizing, accessing, negotiating, coordinating, and integrating services and benefits for individuals and families.
- Provide a "health care map" for individuals, families, and groups to guide them to community resources for mental health, including the most appropriate providers, agencies, technologies, and social systems.
- Promote and maintain mental health and manage the effects of mental illness through teaching and counseling.
- Provide care for physically ill people with psychological problems and psychiatrically ill people with physical problems.

BOX 1-5 DOMAINS OF PSYCHIATRIC–MENTAL HEALTH NURSING PRACTICE

Direct Care Activities
Activity therapy
Advocacy
Aftercare follow-up
Behavioral treatments
Care coordination
Case consultation
Case management
Cognitive treatments
Community assessment
Community-based care
Community education
Complementary interventions
Counseling
Crisis intervention
Discharge planning
Environmental change/safety
Family interventions
Group work
Health education
Health maintenance/promotion
High-risk assessment
Holistic interventions
Home health care
Informed consent acquisition
Intake screening and evaluation
Interpreting diagnostic and laboratory tests
Medication administration
Medication education
Medication management
Mental health promotion
Mental illness prevention
Milieu therapy
Nutritional counseling
Ordering diagnostic and laboratory tests
Parent education
Patient triage
Physical assessment
Physiological treatments
Play therapy
Prescription of medications
Promotion of recovery/rehabilitation
Promotion of self-care activities
Psychobiological interventions
Psychoeducation
Psychosocial assessment
Psychotherapy
Relapse prevention
Research implementation
Social action
Social skills training
Somatic treatments
Stress management
Support of social systems
Telehealth

Communication Activities
Clinical case conferences
Development of treatment plans
Documentation of care
Forensic testimony
Interagency liaison
Peer review
Professional nurse networking
Report preparation
Staff meetings
Transcription of orders
Treatment team meetings
Verbal reports of care

Management Activities
Budgeting and resource allocation
Clinical supervision
Collaboration
Committee participation
Community action
Consultation/liaison
Contract negotiation
Coordination of services
Delegation of assignments
Grant writing
Marketing and public relations
Mediation and conflict resolution
Mentorship
Needs assessment and forecasting
Organizational governance
Outcomes management
Performance evaluations
Policy and procedure development
Practice guidelines formulation
Professional presentations
Program evaluation
Program planning
Publications
Quality improvement activities
Recruitment and retention activities
Regulatory agency activities
Risk management
Software development
Staff and student education
Staff scheduling
Strategic planning
Unit governance
Utilization review

- Manage and coordinate systems of care integrating the needs of patients, families, staff, and regulators.

Psychiatric nurses must be able to explain both the general and the specific aspects of their practice to patients, families, other professionals, administrators, and legislators. Only when such skills are identified will psychiatric nurses be able to ensure their appropriate roles, adequate compensation for the nursing care provided, and the most efficient use of scarce human resources in the delivery of mental health care.

> **Critical Reasoning** Some mental health agencies prefer to hire social workers because they have lower salaries than nurses. How would you advocate for hiring a nurse instead of a social worker based on the activities listed in Box 1-5?

LEVELS OF PERFORMANCE

Psychiatric–mental health nursing roles and activities vary widely. Individual nurses are responsible and accountable for their own practice. Four major factors—laws, qualifications, practice setting, and personal initiative—play a part in determining each nurse's role.

Laws

Laws are the primary factor affecting the level of nursing practice. **Each state has its own nurse practice act,** which regulates entry into the profession and defines the legal limits of nursing practice that must be followed by all nurses. Nurse practice acts also address aspects of advanced practice, including prescriptive authority (Byrne, 2010; Oleck at el, 2011). Nurses must be familiar with the nurse practice act of their state and define and limit their practice accordingly.

Qualifications

A nurse's qualifications include **education, certification,** and **work experience. Education has moved to a competency approach** and there are three important aspects of care in this area: the Quality and Safety Competencies (American Association of Colleges of Nursing, 2006); the *Psychiatric-Mental Health Nurse Practitioner Competencies* (National Organization of Nurse Practitioner Faculties [NONPF], 2003); and the *Essential Psychiatric, Mental Health and Substance Use Competencies for the Registered Nurse,* currently under development by the American Academy of Nursing, Psychiatric-Mental Health Substance Abuse Expert Panel. Nursing programs across the country are integrating these competencies into their curricula.

In addition, two levels of psychiatric–mental health clinical nursing practice, basic and advanced, have been identified and are eligible for **certification** (American Nurses Association, 2007):

1. **Psychiatric–Mental Health Registered Nurse (RN-PMH)—**a registered nurse who demonstrates competence, including specialized knowledge, skills, and abilities, obtained through education and experience in caring for persons with mental health issues, mental health problems, and psychiatric disorders. Psychiatric–mental health registered nurses practice in a variety of clinical settings across the continuum of care.
2. **Psychiatric–Mental Health Advanced Practice Registered Nurse (APRN-PMH)—**a licensed registered nurse who is educationally prepared at the master's or doctorate level in the specialty and holds advanced practice specialty certification from the American Nurses Credentialing Center (ANCC). The nurse's graduate level preparation is distinguished by a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and significant role autonomy. An advanced practice nurse may be either a **clinical nurse specialist (CNS)** or a **nurse practitioner (NP).**

Another qualification is the nurse's **work experience.** Although work experience does not replace education, it does provide an added and necessary dimension to the nurse's level of competence and ability to function therapeutically.

Practice Setting

Settings for psychiatric–mental health nurses include psychiatric facilities, community mental health centers, psychiatric units in general hospitals, residential facilities, and private practice. Community-based treatment settings include primary care clinics, schools, prisons, industrial settings, managed care facilities, health maintenance organizations, hospices, visiting nurse associations, home health agencies, emergency departments, nursing homes, and shelters. Treatment in a nonpsychiatric environment may be more efficient and more acceptable to patients and their families. Psychiatric nurses who obtain prescriptive authority can further expand the services they provide and deliver cost-effective psychiatric care in both inpatient and outpatient settings (Wolfe et al, 2008).

Psychiatric–mental health nurses may be employed by an organization, such as a hospital, or be self-employed in private practice. Nurses employed by an organization are paid for their services on a salaried or fee-for-service basis. Most psychiatric nurses work in hospital settings. The administrative policies of these organizations can either foster or limit the full use of the psychiatric nurse's potential. Nurses who are self-employed are paid for their services through third-party payment and direct patient fees. Some self-employed advanced practice psychiatric nurses maintain staff privileges with hospitals. The role of a nurse in any psychiatric–mental health setting depends on the following:

- Philosophy, mission, values, and goals of the treatment setting
- Definitions of mental health and mental illness that prevail in the setting
- Needs of the consumers of the mental health services
- Number of clinical staff available and the services they are able to provide
- Organizational structure and reporting relationships in the setting
- Consensus reached by the mental health care providers regarding their respective roles and responsibilities
- Resources and revenues available to offset the cost of care needed and provided
- Presence of strong nursing leadership and mentorship

A supportive environment for psychiatric nurses is one in which there is open and honest communication among staff, interprofessional respect, recognition of nurses' contributions, nursing involvement in decision making about both clinical care and the work environment, delegation of nonessential nursing tasks, opportunities for supervision and career growth into new roles and responsibilities, and the encouragement that arises from being involved in professional psychiatric nursing activities and organizations (Cleary et al, 2011).

TABLE 1-2 PSYCHIATRIC NURSING SUPPORT GROUPS

PURPOSE	RELATED ACTIVITIES
Provide practical help and professional feedback	Review clinical cases Evaluate documentation methods Analyze staff interactions and performance Develop nursing practice guidelines Discuss changes in one's role and work setting Describe successful interventions Share difficult work experiences
Exchange information and stimulate ideas	Report on conferences attended Distribute articles for reading and discussion Update on new developments in psychiatric nursing Review nursing practice legislative issues Share organizational policies and procedures

Critical Reasoning What specific characteristics would you look for in an organization to determine whether it promotes professional psychiatric nursing practice?

Personal Initiative

The personal competence and initiative of the psychiatric nurse are very important and directly relate to one's roles and activities (Alber et al, 2009). **One strategy psychiatric nurses can use to enhance their growth is to participate in a support group.** Examples of the purposes and possible activities of a professional support group are described in Table 1-2. Psychiatric nurses also benefit from networking. Networks are groups of people drawn together by common concerns to support and help one another. Networks range from informal friendships and small groups providing contacts, to larger open groups providing emotional support, to local and national organizations representing one's specialty.

Critical Reasoning What support networks do you have in your life at this time, and how do they help you? How might professional networks help you when you graduate?

PSYCHIATRIC NURSING AGENDA

Psychiatric–mental health nursing continues to grow and evolve. **More than 133,000 registered nurses are working in the psychiatric–mental health specialty in the United States** (HRSA, 2010). About 60% work in hospitals on psychiatric units (Hanrahan, 2009). **There are about 16,000 advanced practice psychiatric–mental health nurses with graduate degrees** (Hanrahan Delaney, and Merwin, 2010). Health care reform, consumer and family needs, scientific developments, economic realities, and societal expectations will shape the future roles and functions of psychiatric nurses. To best meet the challenges of the next decade, psychiatric nurses need to focus their energies on three areas: outcome evaluation, leadership skills, and political action.

Outcome Evaluation

Psychiatric–mental health nurses must identify, describe, measure, and explain the process and outcomes of the care they provide to patients, families, and communities. Outcome studies documenting the quality, cost, and effectiveness of psychiatric nursing practice are an important part of the psychiatric nursing agenda. Focusing on ways to critically evaluate the outcomes of psychiatric nursing activities is a task for every psychiatric nurse regardless of role, qualifications, or practice setting. Psychiatric nurse clinicians, educators, administrators, and researchers all must assume responsibility for answering the question, "What difference does psychiatric nurse caring make?"

Leadership Skills

Psychiatric–mental health nurses need knowledge and strategies that enable them to exercise leadership and management in their work. Such leadership has a direct impact on the care patients receive (Hughes and Bamford, 2011). It also strengthens and expands the contribution of psychiatric nursing to the larger health care system. **Psychiatric nurses should use their leadership skills and work as change agents to advocate for the mental health needs of patients, families, and communities.** Mental health consumers need adequate, humane, and socially acceptable care. Nurses can lead by joining their specialty organization. The American Psychiatric Nurses Association (APNA) is the largest organization of psychiatric nurses in the United States, representing more than 6500 registered nurses in both basic and advanced psychiatric nursing practice. It also has international members. Mental health nurses in Canada belong to the Canadian Federation of Mental Health Nurses (CFMHN). Nurses in Australia and New Zealand belong to the Australian & New Zealand College of Mental Health Nurses (ANZCMHN). Organizations such as APNA, CFMHN, and ANZCMHN also can provide informational networks to psychiatric nurses that are essential for consumer advocacy, continuing education, and effective political action.

Critical Reasoning Talk with some of the staff nurses who work in psychiatry, and ask whether they know about APNA. Are they members? If not, what would it take for them to join?

Political Action

Increasing psychiatric nurses' political awareness and skills is necessary to bring about needed changes in the mental health care delivery system (Chapter 9). To do so, **they must use their**

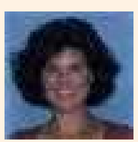
power and resources in the political arena—one of the most important targets for nursing action (Leavitt, 2009). Political action by psychiatric nurses must be respectful of others, confirming of self, and directed toward the common good.

It is essential that psychiatric–mental health nurses recognize the value and legitimacy of their own voices. Nurses must become educated in legislative and regulatory processes, get involved in political campaigns, and testify in legislative hearings. Passive acceptance of decisions made by legislators, insurers, managed care companies, and other professionals should be replaced with proactive strategies. In this way the psychiatric–mental health nursing agenda of the next decade will advance nursing's commitment to caring in a mental health delivery system that is fair, sensitive, and responsible in meeting the biopsychosocial needs of consumers, families, and communities.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Renee Koval, APRN-PMHNP



I am a child and adolescent psychiatric nurse practitioner. When people ask me, "Where do you work?" or "What kind of nurse are you?" and they hear my response, the next thing I hear is "Psychiatry! Are you crazy?" Before I can even try to explain why I love it so much, I am bombarded with opinions of how hard my job must be; questioned about how I tolerate the adolescents and not get attached to the little ones; asked if I'm afraid of the teenage boys; and challenged to defend if patients really get any help. At the end of this conversation, I am often told that they could never do what I do, and I'm never quite sure if I was criticized or complimented. I usually don't answer these questions with any sort of detail, thinking either the people weren't really interested or that their preconceived notions were not likely to change. Nonetheless, I sometimes think about what my in-depth answer would be. So, to all the people who have ever asked or thought about asking… here is my reply.

I truly love child and adolescent psychiatry! I bring a sense of order to a person's chaotic life. I have been the first to hear children's secrets that their abusers told them not to tell. I have wiped noses and dried tears. I have put bandages on unseen scratches because I'm not able to put one on a broken heart. I have been the first one to really listen to what a teenager had to say. My shoulder has been cried on when a young girl found out that she was pregnant and when a boy was told his mother just gave up her parental rights and he has to stay in the hospital a little longer until we found him a place to live. I have been screamed at, threatened, cussed at… all by a 4-year-old. I have rubbed cream on a back covered with the remnants of an angry extension cord, while being told that "It really doesn't hurt." I have been the bearer of good news, bad news, and harsh reality. I have held down patients who were out of control. I've listened to children cry in their sleep and had to relive a young girl's sexual abuse during a flashback she was having. My own emotional "buttons" have been pushed, and, at times, my patience has run thin.

Just when I wonder myself why I am doing this, in walks a small child, eyes wide with fear but dry with bravery. This little one came from a local shelter wearing oversized, stained clothes and carrying all of his worldly possessions in a brown paper bag. Suddenly my thoughts of leaving this work are replaced with a quest to show this small child that adults can be nice and that the world really isn't such a bad place to be.

But perhaps you are still asking, "Why would you want to go through all of this?" I work for the moments when a 17-year-old male who is in the throes of his first psychotic break is refusing his medicine because of his paranoia. I love it when I am able to reassure him that it will help him, that we are all here to help him. He looks at me with questioning eyes but doesn't speak. I say, "It's OK. I would never hurt you." And he takes the medicine. The next moment to live for is when he has a brief moment of clarity and tells me how scared he was but that he trusted me. I work for the moment when the big tough guy on the unit breaks down and finally tells the truth about what's bothering him and how he really feels about the fact that his father doesn't want anything to do with him. I work for the moment when a depressed patient genuinely smiles about something or an oppositional patient has a good day. I love seeing patients respond to their treatment and begin to feel better.

So do I believe we help people? Yes, I do. Sometimes patients have to return to the same dysfunctional environment, and the odds are stacked against them. I don't think they'll remember my name or what I look like, but I believe they'll remember what it felt like to have someone really listen to them and care about them—and that, for even a brief period of time, their life was peaceful and they felt hope.

CHAPTER IN REVIEW

- Psychiatric nursing emerged as a profession in the late nineteenth century, and by the twentieth century had evolved into a specialty with unique roles and functions.
- Linda Richards and Hildegard Peplau were early leaders in the specialty.
- Psychiatric nursing was influenced by the concept of the therapeutic community and the development of psychotropic drugs.
- The role of counselor or therapist was identified as the basis of psychiatric nursing practice.
- The 1980s were years of scientific growth in psychobiology.
- The current knowledge base of the specialty is based on the integration of the biological, psychological, spiritual, social, cultural, and environmental aspects of the human experience.

CHAPTER IN REVIEW—cont'd

- Psychiatric nursing is an interpersonal process that promotes and maintains behaviors that contribute to integrated functioning. The patient may be an individual, family, group, organization, or community.
- The "nurse-patient relationship" has evolved into a "nurse-patient partnership" that includes the elements of clinical competence, consumer-family advocacy, fiscal responsibility, interprofessional collaboration, social accountability, and legal-ethical parameters.
- The three primary domains of psychiatric nursing practice are direct care, communication, and management with overlapping teaching, coordinating, delegating, and collaborating functions.
- Four factors that help to determine the level of a psychiatric nurse's performance are the law, the nurse's qualifications, the practice setting, and the nurse's personal initiative.
- Psychiatric nurses work across the continuum of care in settings—from hospital based to community based with growing interest in primary care settings.
- To best meet the challenges of the next decade, psychiatric nurses need to focus their energies on outcome evaluation, leadership skills, and political action.

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CHAPTER

2

Therapeutic Nurse–Patient Relationship

Gail W. Stuart

When we treat man as he is, we make him worse than he is. When we treat him as if he already were what he potentially could be, we make him what he should be.

Johann Wolfgang von Goethe

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. State the goals of the therapeutic nurse–patient relationship.
2. Discuss six personal qualities a nurse needs to be an effective helper.
3. Describe the nurse's tasks and possible problems in the four phases of the relationship process.
4. Examine the levels of communication, the communication process, therapeutic communication techniques, and motivational interviewing.
5. Analyze how the nurse uses each of the responsive dimensions in a therapeutic relationship.
6. Analyze how the nurse uses each of the action dimensions in a therapeutic relationship.
7. Evaluate therapeutic impasses, and identify nursing interventions to deal with them.
8. Demonstrate increasing effectiveness in using therapeutic relationship skills to produce a therapeutic outcome.

The **therapeutic nurse–patient relationship** is a mutual learning experience and a corrective emotional experience for the patient. It is based on the humanity of the nurse and patient, mutual respect, and acceptance of sociocultural differences. In this relationship the nurse uses personal qualities and clinical skills in working with the patient to effect insight and behavioral change. Most importantly, the core of mental health nursing is providing hope for a better future to patients and their families (Stuart, 2010).

CHARACTERISTICS OF THE RELATIONSHIP

The goals of a therapeutic relationship are directed toward promoting the patient's growth and well-being and include the following dimensions:

- Enhanced self-realization, self-acceptance, and increased self-respect
- A clear sense of personal identity and an improved level of personal integration
- The ability to form intimate, interdependent, interpersonal relationships with a capacity to give and receive love
- Improved functioning and increased ability to satisfy needs and achieve realistic personal goals

To achieve these goals, various aspects of the patient's life experiences are explored. The nurse allows the patient to express thoughts and feelings and relates these to observed and reported behaviors, clarifying areas of conflict and anxiety. The nurse identifies and maximizes the patient's ego strengths and encourages socialization and family relatedness. Together the patient and nurse correct communication problems and

modify maladaptive behavior patterns by testing new patterns of behavior and more adaptive coping mechanisms (Wheeler, 2011). In the nurse-patient relationship, **differing values are respected.** The two communicate through a dialogue or discussion, affirming the patient's reality and worth and allowing the patient to more fully define ego identity.

Rogers (1961) summarizes the characteristics of a helping relationship that facilitate growth (Box 2-1). All nurses working with patients should ask themselves these questions because the answers will determine the progress of the relationship. The therapeutic nurse-patient relationship is complex, but evidence shows that **a strong therapeutic alliance has a positive effect on patient outcomes** (Norcross et al, 2006; Miner-Williams, 2007). This chapter examines the personal qualities of the nurse as helper, the phases of the relationship, facilitative communication, responsive and action dimensions, therapeutic impasses, and therapeutic outcomes (Figure 2-1). Each of these factors influences the nurse's effectiveness.

BOX 2-1 CHARACTERISTICS THAT FACILITATE GROWTH IN HELPING RELATIONSHIPS

- Can I behave in some way that will be perceived by the other person as trustworthy, as dependable, or as consistent in some deep sense?
- Can I be expressive enough as a person that what I am will be communicated unambiguously?
- Can I let myself experience positive attitudes toward this other person—attitudes of warmth, caring, liking, interest, and respect?
- Can I be strong enough as a person to be separate from the other?
- Am I secure enough within myself to permit the patient his separateness?
- Can I let myself enter fully into the world of his feelings and personal meaning and see these as he does?
- Can I be acceptant of each facet of the other person that he presents to me? Can I receive him as he is?
- Can I communicate this attitude? Or can I only receive him conditionally, acceptant of some aspects of his feelings and silently or openly disapproving of others?
- Can I act with sufficient sensitivity in the relationship that my behavior will not be perceived as a threat?
- Can I free him from the threat of external evaluation?
- Can I meet this other individual as a person who is in the process of ***becoming,*** or will I be bound by his past and my past?

From Rogers C: *On becoming a person,* Boston, 1961, Houghton Mifflin.

PERSONAL QUALITIES OF THE NURSE

Research suggests that some essential qualities are needed if one is to help others. These qualities are necessary for all nurses who wish to be therapeutic. They also help the nurse set goals for future growth. **The key therapeutic tool of the psychiatric nurse is the use of oneself.** Thus self-analysis is the first building block in providing quality nursing care.

> *Now, if a nurse is afraid or even ignorant of her own self, she is highly likely to be threatened by a patient's real-self expressions… A nurse who is more aware of the breadth and depth of her own real self is in a much better position to empathize with her patients and to encourage (or at least not block) their self-disclosures.*
>
> ***(Jourard, 1971)***

Awareness of Self

Effective helpers must be able to answer the question, **Who am I?** Nurses who care for the biological, psychological, and sociocultural needs of patients see a broad range of human experiences. They must learn to deal with anxiety, anger, sadness, and joy in helping patients throughout the health-illness continuum. **Self-awareness** is a key part of the psychiatric nursing experience, and the nurse's goal is to achieve authentic, open, and personal communication (LaTorre, 2005; Vandemark, 2006; Scheick, 2011). The nurse must be able to examine personal feelings, actions, and reactions. A good understanding and acceptance of self allow the nurse to acknowledge a patient's differences and uniqueness.

A holistic nursing model of self-awareness consists of four interconnected components: psychological, physical, environmental, and philosophical (Campbell, 1980):

1. The **psychological** component includes knowledge of emotions, motivations, self-concept, and personality. Being psychologically self-aware means being sensitive to feelings and outside events that affect those feelings.

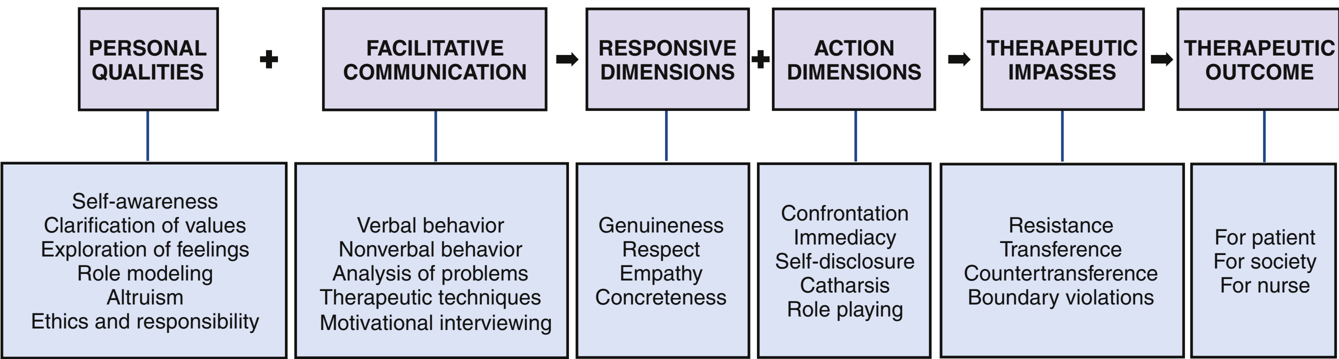


FIG 2-1 Elements affecting the nurse's ability to be therapeutic.

2. The **physical** component is the knowledge of personal and general physiology, as well as of body sensations, body image, and physical potential.
3. The **environmental** component consists of the sociocultural environment, relationships with others, and knowledge of the relationship between humans and nature.
4. The **philosophical** component is the sense of life having meaning. A personal philosophy of life and death may or may not include a spiritual being, but it does take into account responsibility to the world and the ethics of behavior.

Together these components provide a model that can be used to promote the self-awareness and self-growth of nurses and the patients for whom they care.

Increasing Self-Awareness. No one ever completely knows the inner self, as shown in the Johari window (Figure 2-2).

- Quadrant 1 is the open quadrant; it includes the behaviors, feelings, and thoughts known to the individual and others.
- Quadrant 2 is the blind quadrant; it includes all the things that others know but the individual does not know.
- Quadrant 3 is the hidden quadrant; it includes the things about the self that only the individual knows.
- Quadrant 4 is the unknown quadrant, containing aspects of the self that are unknown to the individual and to others.

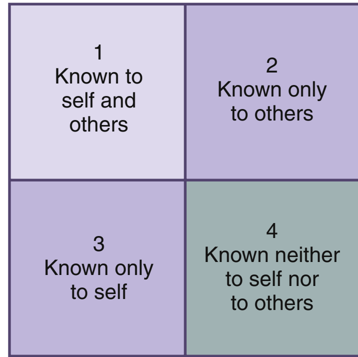


FIG 2-2 Johari window. Each quadrant, or windowpane, describes one aspect of the self.

Taken together, these quadrants represent the total self. The following three principles help explain how the self functions:

1. A change in any one quadrant affects all other quadrants.
2. The smaller quadrant 1, the poorer the communication.
3. Interpersonal learning means that a change has taken place, so quadrant 1 is larger and one or more of the other quadrants is smaller.

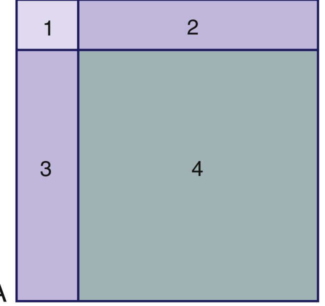
The goal of increasing self-awareness is to enlarge the area of quadrant 1 while reducing the size of the other three quadrants. To increase self-knowledge, it is necessary to **listen to the self.** This means the individual allows genuine emotions to be experienced; identifies and accepts personal needs; and moves the body in free, joyful, and spontaneous ways. It includes exploring personal thoughts, feelings, memories, and actions.

The next step in the process is to reduce the size of quadrant 2 by **listening to and learning from others.** Knowledge of self is not possible alone. As we relate to others, we broaden our perceptions of self, but such learning requires active listening and openness to the feedback others provide. The final step involves reducing the size of quadrant 3 by **self-disclosing,** or revealing to others important aspects of the self. Self-disclosure is both a sign of personality health and a means of achieving healthy personality.

Compare panels *A* and *B* of Figure 2-3. Panel *A* represents a person with little self-awareness whose behaviors and feelings are limited. Panel *B,* however, shows an individual with great openness to the world. Much of this person's potential is being developed and realized. Panel *B* represents an individual who has an increased capacity for experiences of all kinds: joy, hate, work, and love. This person also has few defenses and can interact more spontaneously and honestly with others. It is a worthy goal for the nurse to pursue.

> **Critical Reasoning** Draw your own Johari window. What changes would you like to make to any of the quadrants?

The Nurse and Self-Growth. Nurses need time to explore and define the many parts of their personalities. If their nursing experiences involve perceiving, feeling, and thinking, then nursing students should be given the time and opportunity to



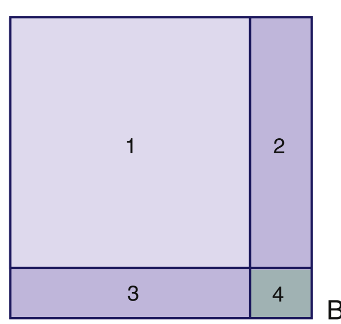


FIG 2-3 *A* and *B,* Johari windows showing varying degrees of self-awareness.

study these experiences. Authenticity in relationships must be learned, and nurses must first experience openness and authenticity in relationships with instructors and supervisors. The student and instructor can participate in a relationship that accepts and respects their individual differences. Instructors can help students by facilitating students' self-awareness, increasing their level of functioning, stimulating more self-direction, and helping them cope with stressors.

Authenticity involves being open to self-exploration of thoughts, needs, emotions, values, defenses, actions, communications, problems, and goals. Nursing students have many new experiences that provide opportunities for self-learning. The student will be faced with disease, bizarre behavior, complex problems, and even death. Feelings related to these experiences should be discussed. For example, students might enter clinical settings with high ideals and unrealistic images. Perhaps they view nurses as all-knowing, all-caring "miracle workers." During initial encounters, students may feel fearful, anxious, and inadequate, wondering how a nurse gains the necessary knowledge.

Nursing students might devalue their abilities and feel like an imposition on patients, or they may identify closely with patients and feel anger toward the impersonal system and unresponsive personnel. The feelings involved in all these situations should be identified, discussed, and analyzed. Only then can nurses resolve them in a constructive manner.

Throughout the growing process the student needs the support and guidance of a noncritical but challenging instructor. Together they can analyze the student's behavior, and the student can assess personal strengths and limitations. It is often helpful if students share these experiences with a peer group. Students can empathize, critique, and support each other while they learn more about themselves. Another effective tool is the use of a journal to express and explore one's thoughts and impressions. Finally, objective self-examination is not easy or pleasant, particularly when findings conflict with self-ideals. However, like many painful experiences, discovering self-awareness presents a challenge—that of accepting self-limitations or changing the behaviors that support them.

> **Critical Reasoning** Consider the courses you have taken as a student. How much time and emphasis were placed on developing your self-awareness as a person and a nurse?

Clarification of Values

Nurses should be able to answer the question, **What is important to me?** Awareness of one's own values helps the nurse to be honest, to better accept differences in others, and to avoid the unethical use of patients to meet personal needs. Nurses should avoid the temptation to use patients for their personal satisfaction or security. If nurses do not have personal fulfilment, they need to realize that fact. Their sources of dissatisfaction should be clarified to prevent them from interfering with the success of the nurse-patient relationship.

Value Systems. **Values** are concepts that are formed as a result of life experiences with family, friends, culture, education, work, and relaxation. The word *value* has positive connotations of worth or significance, but values also can imply negatives. If we value honesty, then it follows that we do not value dishonesty. People are likely to hold strong values related to religious beliefs, family ties, sexual preferences, other ethnic groups, and gender role beliefs. **One of the many challenges facing nurses today is the need to provide care for patients from diverse backgrounds.** Because the goals of treatment are determined greatly by beliefs and values, establishing a therapeutic relationship with patients from different backgrounds requires particular skill and sensitivity. This is discussed in Chapter 7.

Value systems provide the framework for many daily decisions and actions. By being aware of their value systems, nurses can identify situations in which value systems are in conflict. Clarification of values also provides some insurance against the tendency to project values onto other people. Many therapeutic relationships test the nurse's values. For example, a patient may describe a sexual behavior that the nurse finds unacceptable; a patient may talk about divorce, whereas the nurse may strongly believe that marriage contracts should not be broken; or a patient may be a "born-again" Christian, but the nurse may not believe in God or religion.

> **Critical Reasoning** Can a nurse empathize with and help a patient solve a problem while maintaining personal values that differ from the values of the patient? Have you ever had such an experience?

Value Clarification Process. The **value clarification process** allows individuals to discover their values by assessing, exploring, and determining what those values are and how they influence their own thoughts, attitudes, and behaviors. Value clarification does not determine what the individual's values should be or what values should be followed. Value clarification focuses only on the process of valuing, or on how people come to have the values they hold.

Seven criteria are used to determine a value. These criteria should be considered in relation to a person's strongest value and tested against the person's own definition of a value. The seven criteria are grouped into the three steps listed in Table 2-1. The three criteria of **choosing** rely on the person's **cognitive abilities;** the two criteria of **prizing** emphasize the emotional or **affective level;** and the two criteria of **acting** have a **behavioral focus.** A change takes place when certain contradictions are perceived in the person's value system. To eliminate the distress that follows such a realization, the person realigns values to coincide with the new view of self.

The Mature Valuing Process. The valuing process in the mature person is complex, and the choices are often difficult. There is no guarantee that the choice made will be

TABLE 2-1 STEPS IN THE VALUE CLARIFICATION PROCESS

CHOOSING	Freely
↓	From alternatives
	After thoughtful consideration of the consequences of each alternative
PRIZING	Cherishing, being happy with the choice
↓	Willing to affirm the choice publicly
ACTING	Doing something with the choice
	Repeatedly, in some pattern of life

self-actualizing. The valuing process in the mature person has the following characteristics (Kirschenbaum and Simon, 1973):

- It is fluid and flexible, based on the particular moment and the degree to which the moment is enhancing, enriching, and actualizing. Values are continually changing.
- The valuing experience is tied to a particular time and experience.
- Personal experience provides the value information. Although the person is open to all evidence obtained from other sources, outside evidence is not considered as important as subjective responses. The psychologically mature adult trusts and uses personal wisdom.
- In the valuing process the person is open to the immediacy of experience, trying to sense and clarify all its complex meanings. However, the immediate impact of the moment is colored by experiences from the past and thoughts about the future.

Critical Reasoning What values do you hold about health and healing?

Exploration of Feelings

Some people think that helping others requires complete objectivity and detachment. This is definitely not true. Complete objectivity and detachment describe someone who is unresponsive, unapproachable, impersonal, and self-alienated—qualities that block the establishment of a therapeutic relationship. Rather, **nurses should be open to, aware of, and in control of their feelings so that they can be used to help patients.** The feelings that nurses have serve an important purpose as barometers for feedback about themselves and their relationships with others.

In helping others, nurses have many feelings: satisfaction at seeing a patient improve, disappointment when a patient regresses, distress when a patient refuses help, and anger when a patient is demanding or manipulative. Nurses who are open to their feelings understand how they are responding to patients and how they appear to patients. The nurse's feelings are valuable clues to the patient's problems. For example, despite the patient's statement that "things are going real well," the nurse might perceive a strong sense of despair or anger. So too, nurses should be aware of the feelings they convey to the patient. Is the nurse's mood one of hopelessness or frustration? If nurses view feelings as feedback mechanisms, their effectiveness as helpers will improve.

Serving as Role Model

Formal helpers have a strong influence on those they help, and nurses function as role models for their patients. Research has shown the power of role models in molding socially adaptive, as well as maladaptive, behavior. Thus **a nurse has an obligation to model adaptive and growth-producing behavior.** If a nurse has a chaotic personal life, it will show in the nurse's work with patients, thereby decreasing the effectiveness of care. The nurse's credibility as a helper also will be questioned. The nurse may think that it is possible to separate one's personal life from one's professional life, but in caring for patients this is not possible because psychiatric nursing *is* the therapeutic use of self. This does not mean that the nurse must be a model citizen or must live a fully contented life. What it does mean is that the effective nurse has a fulfilling and satisfying personal life that is not dominated by conflict, distress, or denial, and that the nurse's approach to life conveys a sense of growing, hopefulness, and adapting.

Critical Reasoning Who have been role models in your life, and what qualities did you most admire about them?

Altruism

It is important for nurses to have an answer to the question, **Why do I want to help others?** An effective helper is interested in people and tends to help out of a love for humanity. It also is true that everyone seeks a certain amount of personal satisfaction and fulfillment from work. The goal is to maintain a balance between these two needs. Helping motives can become destructive tools in the hands of naive or zealous users.

Another danger lies in adopting an extreme view of altruism. **Altruism** is concern for the welfare of others. It does not mean that an altruistic person should not expect adequate compensation and recognition or must practice denial or self-sacrifice. Only if personal needs have been appropriately met can the nurse expect to be maximally therapeutic. Finally, a sense of altruism also can apply to changing social conditions to meet human welfare needs. One goal of all helping professionals should be to create a people-serving and growth-facilitating society. Thus a necessary role for the nurse is to work to change the larger structure and process of society in ways that will promote the individual's health and well-being.

Ethics and Responsibility

Personal beliefs about people and society can serve as guidelines for action. The *Code for Nurses with Interpretive Statements* (American Nurses Association, 2001) reflects common values regarding nurse-patient relationships and responsibilities and serves as a frame of reference for all nurses in their judgments about patient welfare and social responsibility. **Responsible ethical choice involves accountability, risk, commitment, and justice.** Related to the nurse's sense of ethics is the need to assume responsibility for one's own

behavior. This means knowing one's limitations and strengths and being accountable for them. Ethical issues related to psychiatric nursing are discussed in Chapter 8.

Critical Reasoning Recent Gallup polls have rated nurses as the most ethical of professionals. What aspects of nursing merit the public's trust?

PHASES OF THE RELATIONSHIP

A vital characteristic of the nurse-patient relationship is the sharing of behaviors, thoughts, and feelings that is based on **clear role expectations.** The support requested and provided should be within the boundaries of the nurse's role as a professional caregiver. **The elements of a therapeutic nurse-patient relationship apply to all clinical settings and can be adapted to settings in which the patient is only seen for a brief period of time** (Spiers and Wood, 2010). Nurses working in medical, surgical, obstetrical, oncological, and other specialty areas need to understand and be able to use therapeutic nurse-patient relationship skills. Four phases of the nurse-patient relationship have been identified: preinteraction phase; introductory, or orientation, phase; working phase; and termination phase. Each phase builds on the preceding one and has specific tasks.

Preinteraction Phase

Concerns of New Nurses. The preinteraction phase begins before the nurse's first contact with the patient. The nurse's initial task is one of **self-exploration.** This is no small task because psychiatric nursing clinical experience can bring both stress and challenge to the student (Happell and Gough, 2009). In the first experience of working with psychiatric patients, the nurse brings the misconceptions and prejudices of the general public, in addition to feelings and fears common to all novices (Halter, 2008; Webster, 2009) (Box 2-2). A major one is anxiety or nervousness, which is common to new experiences of any kind. Another feeling is ambivalence or uncertainty because nurses may see the need for working with these patients but feel uncertain about their ability to do so.

The informal nature of psychiatric settings may threaten the nurse's role identity. A common first reaction among students is a feeling of panic when they realize that they "can't tell the patients from the staff." It is unsettling for some students to give up their uniforms, stethoscopes, and scissors, which emphasizes that, in this nursing setting, the most important tools are the ability to communicate, empathize, and solve problems. Without a physical illness to manage, new students may feel self-conscious and hesitant about introducing themselves to a patient and starting a conversation.

Some nurses express feelings of inadequacy and fears of hurting or exploiting the patient. They worry about saying the wrong thing, which might drive the patient "over the brink." With their limited knowledge and experience, they doubt that they will be of any value. They wonder how they can help or whether they can really make a difference. Some nurses perceive the plight of psychiatric patients as hopeful; others perceive it as hopeless. A common fear of nurses is related to the stereotype of psychiatric patients being violent. Because this is the picture portrayed by the media, many nurses are afraid of being physically hurt by a patient. Other nurses fear being psychologically hurt by a patient through rejection or silence. A final fear is related to nurses' questioning their own mental health. Nurses may worry about how working with psychiatric patients might affect their own psychological struggles.

The following clinical example contains many of the feelings and fears expressed by one nursing student in the preinteraction phase of self-analysis, as reported in the notes from her journal of her psychiatric rotation.

BOX 2-2 COMMON CONCERNS OF PSYCHIATRIC NURSING STUDENTS

- Acutely self-conscious
- Afraid of being rejected by the patients
- Anxious because of the newness of the experience
- Concerned about personally overidentifying with psychiatric patients
- Doubtful of the effectiveness of skills or coping ability
- Fearful of physical danger or violence
- Insecure in therapeutic use of self
- Suspicious of psychiatric patients stereotyped as "different"
- Threatened in nursing role identity
- Uncertain about ability to make a unique contribution
- Uncomfortable about the lack of physical tasks and treatments
- Vulnerable to emotionally painful experiences
- Worried about hurting the patient psychologically

CLINICAL EXAMPLE

When first told that I would have a clinical psychiatric nursing experience, I received this information with a blank mind. Mental overload, denial, repression, or whatever it was made me hear the words but put off dealing with it. Then, when given a chance to sort through my thoughts and feelings, I thought more about what this experience would be like. Having never been personally involved with anyone who was hospitalized for a psychiatric illness, I was unable to rely on past personal experiences. I did, however, have quite a number of impressions from novels, television, and the movies.

As I thought more about it, I realized that three things scared me the most about this experience. First, I felt that the behavior of psychiatric patients is quite unpredictable. Would they get violent or aggressive without any warning? Would this aggression be directed toward me? If so, would I be hurt? Second, related to the first, is my feeling of inadequacy. I've been exposed to physically ill people and have learned how to respond to them. But not the psychiatrically ill. How can I help? What if I do or say something that

offends them? Will I have the patience to persevere? I just don't know, and my not knowing makes me even more nervous. My third fear is how seeing and being in contact with the psychiatrically ill will affect me. Although I know it's not contagious, will I begin to doubt my own stability and sanity? I mean, adolescence hasn't been easy for me, and I feel like I'm just now beginning to see things more clearly and feel better about myself. Will this experience stir up my fears and doubts, and, if so, how will I handle it? I am beginning to realize that there is a fine line between health and illness and that the psychiatric patients we'll meet have been unable to gather enough resources from within to cope with their problems. Help, reassurance, and understanding are their needs. I'm hoping I can help them… but, honestly, I'm just not sure.

Critical Reasoning What feelings, fears, and fantasies do you have about working with psychiatric patients?

Self-Assessment. Experienced nurses benefit by asking themselves the following questions:

- Do I label patients with the stereotype of a group?
- Is my need to be liked so great that I become angry or hurt when a patient is rude, hostile, or uncooperative?
- Am I afraid of the responsibility I must assume for the relationship?
- Do I cover feelings of inferiority with a front of superiority?
- Do I require sympathy, warmth, and protection so much that I become too sympathetic or too protective toward patients?
- Do I fear closeness so much that I am indifferent, rejecting, or cold?
- Do I need to feel important and keep patients dependent on me?

The nurse's self-analysis in the preinteraction phase is a necessary task. To be effective, nurses should have a reasonably stable self-concept and an adequate amount of self-esteem. They should engage in positive relationships with others and face reality to help patients do the same. If they are aware of and in control of what they convey to their patients verbally and nonverbally, nurses can function as role models. Some nurses, however, abandon their personal strengths and assume a mask of "professionalism" that is not true to their authentic self. This acts as a barrier to establishing mutuality with patients.

Other tasks of this phase include **gathering data** about the patient if information is available and **planning for the first interaction** with the patient. The nursing assessment is begun, but most of the work related to it is done with the patient in the second phase of the relationship.

Introductory, or Orientation, Phase

It is during the introductory phase that the nurse and patient first meet. One of the nurse's primary concerns is to find out **why the patient sought help** (Table 2-2). The reason for seeking help forms the basis of the nursing assessment, helps the nurse focus on the patient's problem, and determines the patient's motivation for treatment. It is important for the nurse to realize that **help-seeking varies among different cultures, social, and ethnic groups.** Another task is for the **patient and nurse to establish their partnership and agree on the nature of the problem and the patient's treatment goals.** The focus is on the patient's goals and not what the nurse believes should be done. Both the nurse and the patient may experience some degree of discomfort and nervousness in the introductory phase. Reasons that patients may have difficulty receiving help are listed in Box 2-3.

Forming a Contract. The tasks in this phase of the relationship are to establish a climate of trust, understanding, acceptance, and open communication and formulate a contract with the patient. Establishing a contract is a mutual process in which the patient participates as fully as possible. Box 2-4 lists the elements of a nurse-patient contract. The contract begins with the introduction of the nurse and patient, exchange of names, and explanation of roles. An explanation of roles includes the responsibilities and expectations of the patient and nurse, with a description of what the nurse can and cannot do.

This is followed by a discussion of mutually agreed on specific goals, in which the nurse focuses on what the patient identifies as important problems to be resolved. Because establishing the contract is a mutual process, it is a good opportunity to clarify misperceptions held by either the nurse or the patient. The issue of confidentiality is an important one to discuss with the patient at this time. **Confidentiality involves the disclosure of certain information only to another specifically authorized person** (Chapter 8). This means that information about the patient will be shared only with people who are directly involved in the patient's care in the form of verbal reports and written notes. This is important in providing for the continuity and comprehensiveness of patient care and should be clearly explained to the patient.

Critical Reasoning Talk with a friend or family member who received counseling. Why did the person do so? Did anything make the person uncomfortable about asking for help? What did the clinician do to put the person at ease?

Working Phase

Most of the therapeutic work is carried out during the working phase. **The nurse and the patient explore stressors and promote the development of insight in the patient by linking perceptions, thoughts, feelings, and actions.** These insights should be translated into action and a change in behavior. They can then be integrated into the individual's life experiences. The nurse helps the patient master anxieties, increase independence and self-responsibility, and develop constructive coping mechanisms. **Actual behavioral change is the focus of this phase.**

TABLE 2-2 ANALYSIS OF WHY PATIENTS SEEK PSYCHIATRIC HELP

REASONS FOR PATIENTS SEEKING PSYCHIATRIC CARE	APPROPRIATE NURSING APPROACH	SAMPLE RESPONSE
Environmental Change from Home to Treatment Setting		
They desire protection, comfort, rest, and freedom from demands of their home and work environments.	Emphasize the ability of the environment to provide protection and comfort while the healing process of the mind occurs.	"Tell me what it was at home/on the job that made you feel so overwhelmed."
Nurturance		
They wish for someone to care for them, cure their illness, and make them feel better.	Acknowledge their nurturance needs, and assure them that help and caring are available.	"I'm here to help you feel better."
Control		
They are aware of their destructive impulses directed toward themselves or others but lack internal control.	Offer sources of internal control, such as medication, if prescribed; reinforce external controls available through the staff.	"We're not going to let you hurt yourself. Tell us when these thoughts come to mind, and someone will stay with you."
Psychiatric Symptoms		
They describe symptoms of depression, nervousness, or crying spells and actively want to help themselves.	Ask for clarification of symptoms, and strive to understand life experiences of the patient.	"I can see that you're nervous and upset. Can you tell me about how things are at home/on the job so I can better understand?"
Problem Solving		
They identify a specific problem or area of conflict and express desire to reason it out and change.	Help patient look at problem objectively; use problem-solving process.	"How has drinking affected your life?"
Advised to Seek Help		
Family member, friend, or health professional has convinced them to get treatment. They may feel angry, ambivalent, or indifferent.	Confirm facts surrounding seeking of help, and set appropriate limits.	"I see that you're angry about being here. I hope that after we talk you might feel differently."

Modified from Burgess A, Burns J: *Am J Nurs* 73:314, 1973.

BOX 2-3 REASONS PATIENTS HAVE DIFFICULTY SEEKING HELP

- It may be hard to see or admit one's difficulties, first to oneself and then to another.
- It is not easy to trust or be open with strangers.
- Sometimes problems seem too large, too overwhelming, or too unique to share them easily.
- Sharing personal problems with another person can threaten one's sense of independence, autonomy, and self-esteem.
- Solving a problem involves thinking about some things that may be unpleasant, viewing life realistically, deciding on a plan of action, and then, most importantly, following through with whatever it takes to bring about a change. These activities place great demands on the patient's energy and commitment.

BOX 2-4 ELEMENTS OF A NURSE-PATIENT CONTRACT

- Names of individuals
- Roles of nurse and patient
- Responsibilities of nurse and patient
- Expectations of nurse and patient
- Mutually agreed on goals
- Confidentiality

Termination Phase

Termination is one of the most difficult but most important phases of the therapeutic nurse-patient relationship. It is a time to exchange feelings and memories and to evaluate mutually the patient's progress and goal attainment. Levels of trust and intimacy are heightened, reflecting the quality of the relationship and the sense of loss experienced by both nurse and patient. Box 2-5 lists criteria that can be used to determine whether the patient is ready to terminate.

Together the nurse and the patient review the progress made in treatment and the attainment of specified goals. It is appropriate to make referrals at this time for continued care or treatment. Successful termination requires that the patient work through feelings related to separation from emotionally significant people. The nurse can help by allowing the patient to experience and feel the effects of the anticipated loss, to express the feelings generated by the

BOX 2-5 CRITERIA FOR DETERMINING PATIENT READINESS FOR TERMINATION

- The patient experiences relief from the presenting problem.
- The patient's functioning has improved.
- The patient has increased self-esteem and a stronger sense of identity.
- The patient uses more adaptive coping responses.
- The patient has achieved the planned treatment outcomes.
- An impasse has been reached in the nurse-patient relationship that cannot be resolved.

impending separation, and to relate those feelings to former symbolic or real losses. **Helping the patient work and grow through the termination process is an essential goal of each relationship.**

Learning to bear the sorrow of the loss while integrating positive aspects of the relationship into one's life is the goal of termination for both the nurse and the patient. The patient's response will be affected by the nurse's ability to remain open, sensitive, empathic, and responsive to the patient's changing needs. The impending termination can be as difficult for the nurse as for the patient. Nurses who can begin this process by reviewing their thoughts, feelings, and experiences will be more aware of personal motivation and more responsive to patients' needs. The major tasks of the nurse during each phase of the nurse-patient relationship are summarized in Table 2-3.

Critical Reasoning How have you experienced terminated relationships in your life? How might this affect your work with patients?

TABLE 2-3 NURSE'S TASKS IN EACH PHASE OF THE RELATIONSHIP PROCESS

PHASE	TASK
Preinteraction	Explore own feelings, fantasies, and fears
	Analyze own professional strengths and limitations
	Gather data about patient when possible
	Plan for first meeting with patient
Introductory, or orientation	Determine why patient sought help
	Establish trust, acceptance, and open communication
	Mutually formulate a contract
	Explore patient's thoughts, feelings, and actions
	Identify patient's problems
	Define goals with patient
Working	Explore relevant stressors
	Promote patient's development of insight and use of constructive coping mechanisms
	Overcome resistance behaviors
Termination	Establish reality of separation
	Review progress of therapy and attainment of goals
	Mutually explore feelings of rejection, loss, sadness, and anger and related behaviors

FACILITATIVE COMMUNICATION

Communication, which takes place on two levels (verbal and nonverbal), can either facilitate the development of a therapeutic relationship or serve as a barrier to it (Shattell and Hogan, 2005; Sheldon et al, 2006). Everyone communicates constantly from birth until death. **All behavior is communication, and all communication affects behavior.** Communication is critical to nursing practice because of the following:

- Communication is the vehicle used to establish a therapeutic relationship. Without it, a therapeutic nurse-patient relationship is not possible.
- Communication is the means by which people influence the behavior of another, leading to the successful outcome of nursing intervention.

Verbal Communication

Verbal communication occurs through words, spoken or written. Taken alone, verbal communication can convey factual information accurately and efficiently. It is a less effective means of communicating feelings or subtle meanings. It represents only a small part of total human communication. Another limitation of verbal communication is that words can change meaning with different social or cultural groups because words have both denotative and connotative meanings. The **denotative** meaning of a word is its actual or concrete meaning. For example, the denotative meaning of the word *bread* is "a food made of a flour or grain dough that is kneaded, shaped, allowed to rise, and baked."

The **connotative** meaning of a word, in contrast, is its implied or suggested meaning. Thus the word *bread* can suggest many different connotative or personalized meanings. Depending on a person's experiences, preferences, and present frame of reference, the person may think of French bread, rye bread, or pita bread. When used as slang, "give me some bread" may mean "give me some money." Thus the characteristics of the speaker and the context in which the phrase is used influence the specific meaning of verbal language.

When communicating verbally, many people assume that they are "on the same wavelength" as the listener; but because words are only symbols, they seldom mean precisely the same thing to two people. And if the word represents an abstract idea such as "depressed" or "hurt," the chance of misunderstanding or misinterpretation may be great. In addition, many feeling states or personal thoughts cannot be put into words easily. Nurses should try to overcome these problems by checking their interpretation and incorporating information from the nonverbal level as well.

Today more than ever before, nurses need to be prepared to communicate effectively with people from a variety of

socioeconomic and ethnocultural backgrounds. For example, psychiatric patients may be evaluated in their second language, such as English, but competence in a second language varies depending on the individual and the stage of illness. In addition, cultural nuances in language often are not conveyed in translation, even when the patient uses similar words in the second language. Patients also may use a second language as a form of resistance to avoid intense feelings or conflicting thoughts, and events that may have occurred before a person learned English, if that is the second language, may not be easily communicated. The effective psychiatric nurse uses verbal communication sensitively to promote mutual respect based on understanding and acceptance of cultural differences. The nurse also may communicate respect for the patient's dialect by adapting to the patient's linguistic style by using fewer words, more gestures, or more expressive facial behaviors or by obtaining a trained interpreter.

Critical Reasoning Think of someone you know whose cultural background differs from your own. How does this difference influence your verbal and nonverbal communication?

Nonverbal Communication

Nonverbal communication includes all relayed information that does not involve the spoken or written word, including cues from all five senses. It has been estimated that about 7% of meaning is transmitted by words, 38% is transmitted by paralinguistic cues such as vocal tones, and 55% is transmitted by body cues. Nonverbal communication is often unconsciously motivated and may more accurately indicate a person's meaning than the words being spoken. People tend to say what they think the receiver wants to hear, whereas less acceptable or more honest messages may be communicated by the nonverbal route.

Types of Nonverbal Behaviors. The various types of nonverbal behaviors are all influenced by one's sociocultural background. Following are brief descriptions of five categories of nonverbal communication.

Vocal cues include all the nonverbal qualities of speech. Some examples include pitch; tone of voice; quality of voice; loudness or intensity; rate and rhythm of talking; and unrelated nonverbal sounds, such as laughing, groaning, nervous coughing, and sounds of hesitation ("um," "uh"). These are vital cues of emotion and can be powerful communicators of information.

Action cues are body movements, sometimes referred to as *kinetics*. They include automatic reflexes, posture, facial expression, gestures, mannerisms, and actions of any kind. Facial movements and posture can be particularly significant in interpreting the speaker's mood.

Object cues are the speaker's intentional and unintentional use of all objects. Dress, furnishings, and possessions all communicate something about the speaker's sense of self. These cues often are consciously selected by the individual and therefore may be chosen specifically to convey a certain look or message. Thus they can be less accurate than other types of nonverbal communication.

Space provides another clue to the nature of the relationship between two people. It must be examined based on sociocultural norms and customs. The following four zones of space are evident interpersonally in typical Western culture:

- **Intimate space: up to 18 inches.** This small degree of separation between people allows for maximal interpersonal sensory stimulation.
- **Personal space: 18 inches to 4 feet.** This zone is used for close relationships and when touching distance may be desired.
- **Social-consultative space: 9 to 12 feet.** This zone is less personal; it requires that speech be louder.
- **Public space: 12 feet and more.** This is used in speech giving and other large gatherings.

Observation of seating arrangements and use of space by patients can provide valuable information to the nurse, clarifying not only the nurse's assessment of the patient but also the way in which the nursing intervention should be implemented.

Touch involves both personal space and action. It is possibly the **most personal of the nonverbal messages.** A person's response to it is influenced by setting, cultural background, type of relationship, gender of communicators, ages, and expectations. It can be supportive or threatening. Touch can express a desire to connect with another person, as a way of meeting them or relating to them (holding hands). It can be a way of expressing a feeling of concern, empathy, or caring (patting a shoulder). There also is the concept of **therapeutic touch**—the nurse lays her hands on or close to the body of an ill person for the purpose of helping or healing. Touch continues to be the hallmark of nursing with its therapeutic, comforting effects. It is a universal and basic aspect of all nurse-patient relationships. It is often described as the first and most fundamental means of communication.

Critical Reasoning Describe the zones of space used by people from another cultural group.

Interpreting Nonverbal Behavior. All types of nonverbal messages are important, but interpreting them correctly can present problems for the nurse. It is impossible to examine nonverbal messages out of context, and sometimes the individual's body reveals a number of different and perhaps conflicting feelings at the same time.

Sociocultural background is a major influence on the meaning of nonverbal behavior. In the United States, with its diverse communities, messages between people of different upbringing can easily be misinterpreted. For instance, Arab Americans tend to stand closer together when speaking, and Asian Americans tend to touch more; touching in the United States is often minimized because of perceived sexual overtones. Because the meaning attached to nonverbal behavior is so subjective, it is essential that the nurse check and evaluate its meaning carefully.

Nurses should note and respond to the variety of nonverbal behaviors displayed by the patient, particularly voice inflections, body movements, gestures, facial expressions, posture, and physical energy levels. Incongruent behavior and contradictory messages are especially significant communications. The nurse should refer to the specific behavior observed and try to confirm its meaning and significance with the patient. The nurse may use the following three kinds of responses to the patient:

1. Questions or statements intended to increase the patient's awareness
2. Statements that reflect content
3. Statements suggesting the nurse's responsiveness

These possible responses are illustrated in the following interaction.

THERAPEUTIC DIALOGUE

Patient (shifting nervously in his chair, eyes scanning the room and avoiding the nurse) What… what do you want to talk about today?

Nurse Response No. 1 I sense that you are uncomfortable talking to me. Could you describe to me how you are feeling?

Nurse Response No. 2 You're not sure what we should be talking about, and you want me to start us off?

Nurse Response No. 3 You look very nervous, and I can feel those same feelings in me as I sit here with you.

The nurse's first possible response is a reflection of and an attempt to validate the patient's feelings. The purpose is to communicate to the patient the nurse's awareness of his feelings, to show acceptance of those feelings, and to request that he focus on them and elaborate on them. The nurse's second possible response deals with the content of the patient's message. The nurse clarifies what the patient is trying to say. The third possible response shares both the nurse's perception of her patient's feelings and the personal disclosure that she has some of those same feelings. This type of response may help the patient feel that the nurse accepts and understands him.

Implications for Nursing Care. Besides responding to patients' nonverbal behavior, nurses should incorporate aspects of it into patient care. For example, patients who resist closeness will be disturbed by entry into their intimate space. The nurse can assess the patient's level of spatial tolerance by observing the distance the patient maintains with other people. The nurse also can be alert to the patient's response during their interaction. If the nurse sits next to the patient on the sofa, does the patient get up and move to a chair? If the nurse moves closer to the patient, does the patient move away to reestablish the original space? Sometimes increasing the space between the nurse and an anxious patient can reduce the anxiety enough to allow the interaction to continue. A decrease in the distance the patient chooses to maintain from others may indicate a decrease in interpersonal anxiety.

Height may communicate dominance and submission. **Communication is made easier when both participants are at similar eye levels.** Orientation of the participants' body positions also is significant. Face-to-face confrontation is more threatening than oblique (sideways) body positions. The physical setting also has spatial meaning. Control issues are minimized when communication takes place in a neutral area that belongs to neither participant. However, people quickly identify their own turf, even in unfamiliar settings, and then begin to exert ownership rights over this area. A common example of this can be seen in most classroom settings. At the beginning of the semester, people sit randomly, but the arrangement usually solidifies after a couple of classes. Students then feel vaguely annoyed if they arrive in class to find another person in "their seat." They are experiencing an invasion of personal space.

Touch also should be used carefully. Patients who are sensitive to issues of closeness may experience a casual touch as an invasion or an invitation to intimacy, which may be even more frightening. If procedures requiring physical contact must be carried out, careful explanations should be given both before and during the procedure. In addition, the nurse should always be aware of the potential for touch to be interpreted in a sexual way, thus creating problems related to the sexual conduct of the nurse within the nurse-patient relationship. Despite these issues, touch is a significant part of psychiatric nursing practice. Reasons that nurses use touch include the following:

- Establishing contact with the patient
- Enhancing communication
- Communicating caring, interest, and recognition
- Providing reassurance and comfort

Finally, **nurses must be aware not only of patients' nonverbal cues but also of their own.** The nurse's nonverbal cues can communicate interest, respect, and genuineness or disinterest, annoyance, and lack of respect. Positive nonverbal behaviors include smiles, head nods, gestures, eye contact, and leaning one's body forward.

Critical Reasoning Follow the treatment team making patient rounds, and observe body positions. Are staff and patients at eye level? What personal space is maintained? Is touch used at all?

The Communication Process

The three elements of the communication process are perception, evaluation, and transmission. **Perception** occurs when the sensory end organs of the receiver are activated. The impulse is then transmitted to the brain. Human beings mostly rely on visual and auditory stimuli for communications.

When the sensory impulse reaches the brain, evaluation takes place. Personal experience allows for the evaluation of the new experience. If the person encounters a new experience for which there is no frame of reference, confusion results. **Evaluation** results in two responses: a cognitive response related to the informational part of the message and

an affective response related to the relationship aspect of the message. Most messages stimulate both types of responses.

When the evaluation of the message is complete, **transmission** takes place that the sender receives as feedback. This feedback influences the continued course of the communication cycle. It is impossible not to transmit some kind of feedback. Even lack of any visible response is feedback to the sender that the message did not get through, was considered unimportant, or was an undesirable interruption. Feedback stimulates perception, evaluation, and transmission by the original sender. The cycle continues until the participants agree to end it or one participant physically leaves the setting.

Structural Model. Theoretical models of the communication process show visual relationships more clearly and can help in finding and correcting communication breakdowns or problems. The structural model of communication has five components: the sender, the message, the receiver, the feedback, and the context (Figure 2-4):

1. The **sender** is the person who sent the message.
2. The **message** is the information that is sent from the sender to the receiver.
3. The **receiver** is the recipient of the message.

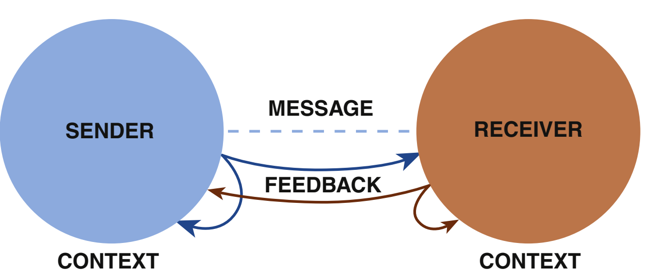


FIG 2-4 Components of communication.

4. The **feedback** is the verbal or behavioral response of the receiver to the sender.
5. The **context** is the setting in which the communication takes place.

Knowledge of context is necessary to understand the full meaning of the communication. For example, the phrase "I don't understand what you mean" may have different meanings in the context of a classroom or a courtroom. Context involves more than the physical setting for communication. It also includes the psychosocial setting, which includes the relationship between the sender and the receiver, their past experiences with each other, their past experiences with similar situations, and cultural values and norms. Consider again the meaning of "I don't understand what you mean" in the following contexts: two college students discussing a philosophy assignment, a wife responding to her husband's accusation of infidelity, and a Japanese tourist asking directions in San Francisco. Although the content of the message is the same, its meaning is different, depending on the context in which the communication takes place.

In evaluating communication from the perspective of the structural model, specific problems can be identified (Table 2-4).

Sender. If the sender is communicating the same message on both the verbal and nonverbal levels, it is called **congruent communication.** However, if the levels are not in agreement, it is called **incongruent communication,** which can be a problem. Incongruent, or double-level, messages produce a dilemma for the listener, who does not know to which level to respond, the verbal or nonverbal. Because it is not possible to respond to both levels, the listener is likely to feel frustrated, angry, or confused. Both patients and nurses can display incongruent communication if they are not

TABLE 2-4 PROBLEMS WITH THE STRUCTURAL ELEMENTS OF THE COMMUNICATION PROCESS

STRUCTURAL ELEMENT	COMMUNICATION PROBLEM	DEFINITION
Sender	Incongruent communication	Lack of agreement between the verbal and nonverbal levels of communication
	Inflexible communication	Exaggerated control or permissiveness by the sender
Message	Ineffective messages	Messages that are not goal directed or purposeful
	Inappropriate messages	Messages not relevant to the progress of the relationship
	Inadequate messages	Messages that lack a sufficient amount of information
	Inefficient messages	Messages that lack clarity, simplicity, and directness
Receiver	Errors of perception	Various forms of listening problems
	Errors of evaluation	Misinterpretation because of personal beliefs and values
Feedback	Misinformation	Communication of incorrect information
	Lack of validation	Failure to clarify and ratify understanding of the message
Context	Constraints of physical setting	Noise, temperature, or various distractions
	Constraints of psychosocial setting	Impaired previous relationship between the communicators

aware of their internal feeling states and the nature of their communication.

THERAPEUTIC DIALOGUE

CONGRUENT COMMUNICATION

Verbal Level I'm pleased to see you.

Nonverbal Level Warm tone of voice, continuous eye contact, smile.

INCONGRUENT COMMUNICATION

Verbal Level I'm pleased to see you.

Nonverbal Level Cold and distant tone of voice, little eye contact, neutral facial expression.

Another problem initiated by the sender is inflexible communication that is either too rigid or too permissive. A rigid approach by the nurse does not allow for spontaneous expression by the patient, nor does it allow the patient to contribute to the flow or direction of the interaction. An example of this is when the nurse uses "yes" and "no" questions that do not allow the patient to fully explain a response. Exaggerated permissiveness, on the other hand, refers to the lack of a direction and mutuality in the interaction established by the nurse. An example of this is when the nurse allows a patient to talk for long periods of time without focus or structure. The patient may interpret the nurse's behavior as incompetence or lack of interest.

Message. The message of the communication process also can pose problems. Messages can be ineffective, inappropriate, inadequate, or inefficient. Ineffective messages distract and prevent the objectives of the nurse-patient relationship from being met. Inappropriate messages are not relevant to the progress of the relationship. They may include failures in timing, stereotyping the receiver, or overlooking important information. Inadequate messages lack sufficient information. In this case, senders assume that receivers know more than they actually do. Inefficient messages lack clarity, simplicity, and directness. Using more energy than is necessary, these messages confuse or complicate the information.

Receiver. The third element, the receiver, may experience errors of perception. The receiver may miss nonverbal cues, respond only to content and ignore messages of emotion, be selectively inattentive to the speaker's message because of physical or psychological discomfort, be preoccupied with other thoughts, or have a physiological vision or hearing impairment. The receiver also may have problems in evaluating the message. The meaning of the message may be misinterpreted because the receiver views it in terms of one's own value system rather than that of the speaker.

Feedback. Errors in the feedback element include all of those that apply to the message. Feedback also can convey to the sender incorrect information about the message. Another serious error occurs when the receiver fails to use feedback to validate understanding of the message. Although feedback is the last step, it has the potential for correcting previous errors and clarifying the nature of the communication.

Context. The fifth element, context, also can contribute to communication problems. The setting may be physically noisy, cold, or distracting to one or both parties. The psychosocial context, or past relationship between the communicators, may be one of mistrust, fear, or resentment. This analysis shows the complexity of the communication process. It may seem surprising that successful communication can occur, given all of these potential problems. However, it does occur among people who understand the process and use appropriate techniques.

Therapeutic Communication Techniques

There are two requirements for therapeutic communication:

1. **All communication must preserve the self-respect of both individuals.**
2. **One should communicate understanding and acceptance before giving any suggestions or advice.**

When the nurse uses therapeutic communication skills, the collection of data, planning, implementation, and evaluation **activities are carried out *with* the patient, not *for* the patient.** Although they seem simple on the surface, these techniques are difficult and require practice. Because they are techniques, they are only as effective as the person using them. If they are used appropriately, they can enhance the nurse's effectiveness. If they are used as automatic responses, they will block the formation of a therapeutic relationship, negate both the nurse's and the patient's individuality, and deprive them of their dignity.

To ensure that the nurse is using these skills effectively, the nurse should record interactions with the patient in some way and then analyze them. An example of part of a process recording is shown in Table 2-5. The nurse can seek feedback from others and may benefit from maintaining a journal or diary of thoughts, feelings, and impressions in relation to clinical work. In addition, rating scales may be used to assess communication competencies and simulated psychiatric scenarios can assist with skill building (Grant et al, 2011; Hermanns et al, 2011a,b). Only by analyzing the interaction can nurses evaluate how well they are using therapeutic communication techniques. Descriptions of some of the most helpful techniques follow.

Listening. Listening is essential to understanding the patient. The only person who can tell the nurse about the patient's feelings, thoughts, and perception of the self is the patient. Therefore **the first rule of a therapeutic relationship is to listen to the patient.** It is the foundation on which all other therapeutic skills are built (Kagan, 2008a,b). Inexperienced nurses often find it difficult not to talk. This may be due to their anxiety, their need to prove themselves, or their usual way of interacting. It is helpful to remember that the patient should be talking more than the nurse during the interaction; the task of the nurse is to listen.

TABLE 2-5 PROCESS RECORDING

PATIENT VERBAL *(NONVERBAL)*	NURSE VERBAL *(NONVERBAL)*	NURSE ANALYSIS	SUPERVISOR'S COMMENTS
Sometimes I think that life isn't worth living and that my family would be better off without me. *(looking down, with sad expression and twirling the tassel on her belt)*	You sound very "down" today. I can feel a sense of hopelessness. Am I right about that? *(using a low voice)*	I was trying to express empathy and mirror her sense of sadness.	Very good in reflecting, promoting the therapeutic alliance, and asking for clarification.
Yes, when I found out that my husband was having an affair, it triggered a whole range of feelings. *(looks up at me as she finishes the sentence)*	Tell me more about them. *(maintaining eye contact)*	I was shocked by her disclosure and really wasn't sure what to say.	I understand, but you handled it well. Asking for more information was a good response, and it encouraged the patient's emotional catharsis.
Well, I began to feel that I'm not smart enough, not pretty enough, not accomplished enough… and so he found someone else who is everything I'm not. *(looks uncomfortable but also as if she is looking for some confirmation from me)*	Are these feelings that you've had in the past or are they new—a reaction to what is going on in your life now? *(trying to be objective)*	I didn't feel like I could reassure her so I tried to learn more about her.	Again, a good approach. You did not make automatic assumptions, nor did you give false reassurance.
No… actually I have always felt pretty good about myself. I have been a good wife and mother and thought that I had something to contribute. *(seemed brighter as she was talking)*	So let's put things in perspective. You're still that same person. Maybe something is going on with your husband. Have you talked with him about all this? *(using direct eye contact)*	I thought she should explore what was going on, particularly with her husband, to confirm or discount her perceptions. I thought I could help her with this.	Examining the evidence is a useful strategy. Your approach was supportive and helpful.
No, I've not had the courage to do it. *(looks down again, frowning, and twirls her wedding ring)*	That's silly. You're a very strong person. *(said with animation)*	I guess this wasn't as helpful as I had wanted it to be. I think it might have come across as a bit demeaning.	Perhaps. I think your intentions were good, but your choice of expression did not effectively confirm her sense of self-efficacy.
Maybe you're right. Maybe it's not that I am a failure, but maybe it has more to do with the both of us. I guess I really do need to talk with him… if I can do it right. *(speaks tentatively)*	What do you mean by "do it right"? *(moved body slightly toward her while looking interested)*	I wanted to see what she was thinking here and to use clarification.	That was worth following up on, and clarification is good. You did miss an opportunity to confirm her sense of self and the fact that her husband was also responsible for his actions.
Well… not make him mad or not cry like a baby. *(shifts in her seat and seems uncomfortable)*	It sounds like you feel responsible for his responses. *(moved back in chair and said firmly)*	I hope I did not come across as disapproving. I thought she was assuming all the guilt and she needed to separate her feelings and behaviors from those of her husband. She also reminded me of my mother and how she assumed all the responsibility for my father's behavior.	Your intentions were appropriate. Good use of confrontation and sharing perceptions. Also your body language was responsive to her. This is also an example of how our personal issues come to the surface with our patients and how we need to be constantly vigilant about separating our own issues from those of our patients.
Yes, I guess that's the overresponsible part of me. It really hasn't worked though. It's only made me feel bad. *(looks up expectantly)*	So what's an alternative? *(eye contact with hopeful expression)*	I was trying to help her with problem solving.	Very appropriate and well timed.

TABLE 2-5 PROCESS RECORDING—cont'd

PATIENT VERBAL *(NONVERBAL)*	NURSE VERBAL *(NONVERBAL)*	NURSE ANALYSIS	SUPERVISOR'S COMMENTS
I guess I can just let him know how I feel as truthfully as possible and then see how he reacts. *(said somewhat tentatively)*	Are you willing to try that? *(asked supportively)*	I wanted to move her into taking action.	Exactly—because insight alone does not result in resolving life issues.
Yes, I think I can. Maybe we can talk about how it goes? *(moves forward in her chair and seems eager to have someone to process this with)*	Absolutely. It's always good to problem solve together. *(using positive eye contact)*	I was a bit surprised that she agreed so readily and also pleased that it seemed like she wanted to share how things went with me. Did I sound too eager?	Positive feedback is important to us as nurses as well. Your response let her know that she had a partner in this process and that no matter how the discussion went, she had someone with whom to share and analyze it. Isn't that similar to how we use this process recording? Well done.

Real listening is difficult. **It is an active, not a passive, process.** The nurse should give complete attention to the patient and should not be preoccupied. The nurse should stop thinking of one's own personal experiences, issues, or problems. Listening is a sign of respect for the patient and is a powerful reinforcer.

Broad Openings. Broad openings—such as "What are you thinking about?" "Can you tell me more about that?" and "What shall we discuss today?"—encourage the patient to select topics to discuss. **Broad openings let the patient know that the nurse is accessible and following what the patient is saying.** Also useful are acceptance responses, such as "I understand," "And then what happened?" "Uh huh," or "I follow you."

Restating. Restating is the nurse's repeating of the main thought the patient has expressed. Sometimes only a part of the patient's statement is repeated. **Restating shows that the nurse is listening,** and it can focus attention on something important that might otherwise have been overlooked.

Clarification. **Clarification is when the nurse tries to put into words vague ideas or thoughts that are implicit or explicit in the patient's verbal message.** It is necessary because statements about emotions and behaviors are rarely straightforward. The patient's verbalizations, especially if the patient is upset or overwhelmed with feelings, are not always clear and obvious. The nurse should not overlook anything she does not understand. Because of this uncertainty, clarification responses often are tentative or phrased as questions, such as "I'm not sure what you mean. Are you saying that…?" or "Could you go over that again?" This technique is important because two functions of the nurse-patient relationship are (1) to help clarify feelings, ideas, and perceptions, and (2) to provide an explicit link between them and the patient's actions.

Reflection. Reflection can communicate understanding, empathy, interest, and respect for the patient. It increases the level of involvement between the nurse and patient. **Reflection of content** is also called **validation,** which lets the patient know that the nurse has heard what was said and understands the content. It consists of repeating in fewer or different words the essential ideas of the patient and is like paraphrasing. Sometimes it helps to repeat a patient's statement, emphasizing a key word.

THERAPEUTIC DIALOGUE

Patient When I walked into the room, I felt like I was going to faint. I knew I had tried to do too much too quickly, and I just wasn't ready for it.

Nurse You thought you were ready to put yourself to the test, but when you got there, you realized it was too much too soon.

Reflection of feelings is a response to the patient's feelings about what was said. These responses let the patient know that the nurse is aware of what the patient is feeling. **The purpose of reflecting feelings is to focus on feeling rather than content to bring the patient's vaguely expressed feelings into clear awareness.** It helps the patient accept those feelings. The steps in reflection of feelings are to determine what feelings the patient is expressing, describe these feelings clearly, observe the effect, and judge by the patient's reaction whether the reflection was correct. Sometimes even inaccurate reflections can be useful because the patient may correct the nurse and then state feelings more clearly.

THERAPEUTIC DIALOGUE

Patient It's not so much that I mind changing jobs. It's just that I let down all the people working for me… relying on me.

Nurse You feel responsible for your employees, and so you're both sad and guilty about what has happened at work.

Patient Yes—sad, guilty… and pretty angry now that we're talking about it.

Although reflecting techniques are some of the most useful, it is possible for the nurse to use them incorrectly. One common error is stereotyping of responses; that is, the nurse begins reflections in the same monotonous way, such as "You think" or "You feel." A second error involves timing. Reflecting on almost everything the patient says provokes feelings of irritation, anger, and frustration in the patient because the nurse appears to be insincere and fails to be therapeutic.

Sometime nurses have trouble interrupting patients who continue talking in long monologues. It is difficult to capture a feeling after it has passed, and by not commenting, the nurse is failing to be a responsible, active partner in the relationship. Interruptions may at times be productive and necessary. A final error is responding with an inappropriate depth of feeling. The nurse fails by being either too superficial or too deep in assessing the patient's feelings. The final error is use of language that is inappropriate to the patient's sociocultural experience and educational level. Effective language is language that is natural to the nurse and readily understood by the patient.

Focusing. Focusing helps the patient expand on a topic of importance. **It can help the patient become more specific, move from vagueness to clarity, and focus on reality.** By avoiding abstractions and generalizations, focusing helps the patient face problems and analyze them in detail. It helps a patient to talk about life experiences or problem areas and accept responsibility for improving them. If the goal is to change thoughts, feelings, or beliefs, the patient must first identify and own them. Encouraging a description of the patient's perceptions, encouraging comparisons, and placing events in time sequence are focusing techniques that promote specificity and problem analysis.

THERAPEUTIC DIALOGUE

Patient Women always get put down. It's as if we don't count at all.

Nurse Tell me how you feel as a woman.

Sharing Perceptions. **Sharing perceptions involves asking the patient to verify the nurse's understanding of what the patient is thinking or feeling.** The nurse can ask for feedback from the patient while possibly providing new information. Perception checking is a way to explore incongruent communication. "You're smiling, but I sense that you're really angry about what happened." Perception checking conveys understanding to the patient and clears confusing communication. It includes paraphrasing what the patient is saying or doing, asking the patient to confirm the nurse's understanding, and allowing the patient to correct that perception if necessary. Perception checking also can note the implied feelings of nonverbal language. It is best to describe the observed behavior first and then reflect on its meaning.

THERAPEUTIC DIALOGUE

Patient She was such a good girl… and really seemed to care about other people. I don't know what's happened to her… what I could have done differently?

Nurse You seem to be very disappointed with your daughter and maybe with yourself. Am I right about that?

Theme Identification. **Themes** are underlying issues or problems experienced by the patient that emerge repeatedly during the course of the nurse-patient relationship. Once the nurse has identified the patient's basic themes, the nurse can better decide which of the patient's many feelings, thoughts, and beliefs to respond to and pursue. Important themes tend to be repeated throughout the relationship. They can relate to feelings (depression or anxiety), behavior (rebelling against authority or withdrawal), experiences (being loved or hurt), or combinations of all three.

Silence. Silence on the part of the nurse has varying effects, depending on how the patient perceives it. To a talkative patient, silence on the part of the nurse may be welcome, as long as the patient knows the nurse is listening. When patients pause, they often expect and want the nurse to respond. If the nurse does not, patients may perceive this as rejection, hostility, or disinterest. With a depressed or withdrawn patient, the nurse's silence may convey support, understanding, and acceptance. In this case, talking by the nurse may be perceived as pressure or frustration.

Silence can prompt the patient to talk. Some introverted people find that they can be quiet but still be liked. **Silence allows the patient time to think and to gain insights.** Silence can slow the pace of the interaction. In general, the nurse should allow the patient to break a silence, particularly when the patient has introduced it. The nurse must be sensitive about this because silence should not develop into a contest. However, if the nurse is unsure how to respond to a patient's comments, a safe approach is to maintain silence. If the nurse's nonverbal behavior communicates interest and involvement, the patient often will elaborate or discuss a related issue.

As a general technique, **direct questioning has limited usefulness in the therapeutic relationship.** Repetitive questioning takes on the tone of an interrogation and blocks mutuality. "Why" questions are particularly ineffective and are to be avoided, as are questions that can be answered by "yes" or "no." One consequence of these types of questions is that patients do not take the initiative and are discouraged or prevented from engaging in the process of self-exploration.

Humor. Humor is a basic part of the personality and has a place within the therapeutic relationship. As a part of interpersonal relationships, **it is a constructive coping behavior.** By learning to express humor, a patient may be able to learn to express other feelings. As a planned approach to nursing intervention, humor can promote insight by making conscious repressed issues. A change in the expression of humor

BOX 2-6 POSITIVE FUNCTIONS OF HUMOR

- Establishes relationships
- Reduces stress and tension
- Promotes social closeness
- Provides social control
- Permits cognitive reframing
- Reflects social change
- Provides perspective
- Expresses emotion
- Facilitates learning
- Reinforces self-concept
- Voices social conflict
- Avoids conflict
- Facilitates enculturation
- Instills hope

and the quality of interpersonal relationships may be signs of significant changes in the patient.

Humor can serve many positive functions within the nurse-patient relationship (Box 2-6). There are no rules for determining how, when, or where humor should be used in the therapeutic relationship. It depends on the nature and quality of the relationship and the relevance of the humor. Humor may be therapeutic in the following situations:

- When the patient is experiencing mild to moderate levels of anxiety, humor can serve as a tension reducer. It is inappropriate if a patient has severe or panic anxiety levels.
- When it helps a patient cope more effectively, facilitates learning, puts life situations in perspective, decreases social distance, and is understood by the patient for its therapeutic value.
- When it is consistent with the social and cultural values of the patient and when it allows the patient to laugh at life, the human situation, or a particular set of stressors.

Humor also can have a negative effect on the relationship. It is inappropriate when it violates a patient's values, ridicules people, or belittles others. It is inappropriate when it demeans the patient, promotes maladaptive coping responses, masks feelings, increases social distance, or allows the individual to avoid coping with difficult situations. If it is used inappropriately it may be destructive to the relationship and anxiety producing for the patient.

Informing. **Informing, or information giving, is an essential nursing technique in which the nurse shares simple facts or information with the patient.** It is a skill used by nurses in health teaching or patient education, such as explaining to a patient when to take medication, what precautions should be taken, and what side effects may occur. Giving information is not the same as giving suggestions or advice.

Suggesting. **Suggesting is the presentation of alternative ideas.** As a therapeutic technique, it is a useful intervention in the working phase of the relationship when the patient has analyzed the problem area and is exploring alternative coping mechanisms. At that time, suggestions by the nurse will increase the patient's perceived options. Suggesting, or giving advice, also can be nontherapeutic. Some patients who seek help expect the health care professional to tell them exactly what to do to solve their problem. So too, nursing students often perceive their function as giving "common sense" advice. In these instances giving advice shifts responsibility from the patient to the nurse and reinforces the patient's dependence. Another limitation is that the patient may take the nurse's advice and still have an unsuccessful outcome. The patient then returns to blame the nurse for failure.

The nurse who falls into the trap and responds with advice can receive the patient's anger and contempt. A more productive strategy is for the nurse to deal with the patient's feelings first—feelings of indecision, dependence, and perhaps fear. Then the request for advice can be looked at and responded to in its proper perspective. Suggesting is nontherapeutic if it occurs early in the relationship before the patient has analyzed personal conflicts or if it is a technique the nurse uses frequently. Then it blocks mutuality and implies that the patient is incapable of assuming responsibility for thoughts and actions.

The nurse's intent in using the suggesting technique should be to provide feasible alternatives and allow patients to explore their values in their unique life situation. The nurse can then focus on helping the patient explore the advantages and disadvantages and the meaning and implications of the alternatives. In this way suggestions can be offered in a non-authoritarian manner with phrases such as "Some people have tried… . Do you think that would work for you?" When using the technique of suggesting, nurses must be careful about both the timing of their intervention and their underlying motivation. The therapeutic communication techniques presented in this chapter are summarized in Box 2-7.

Critical Reasoning Which therapeutic communication techniques listed in Box 2-7 are you skilled in using? Which techniques are more difficult for you?

MOTIVATIONAL INTERVIEWING

Motivational interviewing is designed to help patients change their behavior (Chapter 27). **The focus is on helping people talk about their ambivalence toward change and then to use their own motivation, energy, and commitment to learn new skills and make needed changes in their lives.** It was first used with patients who had problems with alcohol and drug use, but it has since expanded and been found to be very effective in managing a range of physical illnesses, medication adherence difficulties, and a variety of psychiatric problems. The most important element is the attitude of the nurse. It focuses on the effective use of four communication techniques:

- **Asking** patients open questions about what they would like to see different in their lives
- **Listening** actively and receptively to each patient

BOX 2-7 THERAPEUTIC COMMUNICATION TECHNIQUES

Listening

Definition: an active process of receiving information and examining reaction to the messages received
Example: maintaining eye contact and receptive nonverbal communication
Therapeutic value: nonverbally communicates to the patient the nurse's interest and acceptance
Nontherapeutic threat: failure to listen

Broad Openings

Definition: encouraging the patient to select topics for discussion
Example: "What are you thinking about?"
Therapeutic value: indicates acceptance by the nurse and the value of the patient's initiative
Nontherapeutic threat: domination of the interaction by the nurse; rejecting responses

Restating

Definition: repeating the main thought the patient expressed
Example: "You say that your mother left you when you were 5 years old."
Therapeutic value: indicates that the nurse is listening and validates, reinforces, or calls attention to something important that has been said
Nontherapeutic threat: lack of validation of the nurse's interpretation of the message; being judgmental; reassuring; defending

Clarification

Definition: attempting to put into words vague ideas or unclear thoughts of the patient to enhance the nurse's understanding or asking the patient to explain what he means
Example: "I'm not sure what you mean. Could you tell me about that again?"
Therapeutic value: helps to clarify feelings, ideas, and perceptions of the patient and provides an explicit correlation between the nurse and the patient's actions
Nontherapeutic threat: failure to probe; assumed understanding

Reflection

Definition: directing back the patient's ideas, feelings, questions, or content
Example: "You're feeling tense and anxious, and it's related to a conversation you had with your husband last night?"
Therapeutic value: validates the nurse's understanding of what the patient is saying and signifies empathy, interest, and respect for the patient
Nontherapeutic threat: stereotyping the patient's responses; inappropriate timing of reflections; inappropriate depth of feeling of the reflections; inappropriate to the cultural experience and educational level of the patient

Informing

Definition: the skill of information giving
Example: "I think you need to know more about how your medication works."
Therapeutic value: helpful in health teaching or patient education about relevant aspects of patient's well-being and self-care
Nontherapeutic threat: giving advice

Focusing

Definition: questions or statements that help the patient expand on a topic of importance
Example: "I think that we should talk more about your relationship with your father."
Therapeutic value: allows the patient to discuss central issues and keeps the communication process goal directed
Nontherapeutic threat: allowing abstractions and generalizations; changing topics

Sharing Perceptions

Definition: asking the patient to verify the nurse's understanding of what the patient is thinking or feeling
Example: "You're smiling, but I sense that you are really very angry with me."
Therapeutic value: conveys the nurse's understanding to the patient and has the potential for clearing up confusing communication
Nontherapeutic threat: challenging the patient; accepting literal responses; reassuring; testing; defending

Theme Identification

Definition: underlying issues or problems experienced by the patient that emerge repeatedly during the course of the nurse-patient relationship
Example: "I've noticed that in all of the relationships that you have described, you've been hurt or rejected by the man. Do you think this is an underlying issue?"
Therapeutic value: allows the nurse to best promote the patient's exploration and understanding of important problems
Nontherapeutic threat: giving advice; reassuring; disapproving

Silence

Definition: lack of verbal communication for a therapeutic reason
Example: sitting with a patient and nonverbally communicating interest and involvement
Therapeutic value: allows the patient time to think and gain insights, slows the pace of the interaction, and encourages the patient to initiate conversation, while conveying the nurse's support, understanding, and acceptance
Nontherapeutic threat: questioning the patient; asking for "why" responses; failure to break a nontherapeutic silence

BOX 2-7 **THERAPEUTIC COMMUNICATION TECHNIQUES—cont'd**

Humor

Definition: the discharge of energy through the comic enjoyment of the imperfect

Example: "That gives a whole new meaning to the word *nervous*," said with shared kidding between the nurse and patient.

Therapeutic value: can promote insight by making conscious repressed material, resolving paradoxes, tempering aggression, and revealing new options; a socially acceptable form of sublimation

Nontherapeutic threat: indiscriminate use; belittling patient; screen to avoid therapeutic intimacy

Suggesting

Definition: presentation of alternative ideas for the patient's consideration relative to problem solving

Example: "Have you thought about responding to your boss in a different way when he raises that issue with you? For example, you could ask him whether a specific problem has occurred."

Therapeutic value: increases the patient's perceived options or choices

Nontherapeutic threat: giving advice; inappropriate timing; being judgmental

- **Informing** patients of their options and opportunities, including the costs and benefits of each
- **Respecting** patient choice and decision making and offering help accordingly

It uses a guiding, rather than a directive, approach with patients and complements a nurse's existing communication skills. The "spirit" of motivational interviewing has been described as *collaborative, evocative,* and *honoring of a patient's autonomy* (Rollnick et al, 2008). Instead of giving the patient advice or recommendations, it draws from the patient's resources or strengths they already have in order to activate their own motivation and resources for change. Five basic principles are used with this approach:

1. **Express empathy through reflective listening.** This communicates respect for and acceptance of patients and their feelings. It also establishes a safe and open environment that helps in examining issues and exploring personal reasons for change.
2. **Understand your patients' motivations.** Ask them what they would like to change and how they might do it.
3. **Identify discrepancies between a patient's goals or values and current behavior.** Focus the patient's attention on how current behavior differs from one's desired or ideal behavior.
4. **Avoid trying to make things right.** Telling a patient what to do or trying to convince a patient that a problem exists or that change is needed could lead the patient to be defensive and resistant. Such conversations can be demoralizing and often turn into a power struggle. They do not enhance motivation for beneficial change.
5. **Support self-efficacy.** This requires the nurse to recognize the patient's strengths and bring these to the forefront whenever possible. It involves supporting hope, optimism, and the feasibility of accomplishing change.

Motivational interviewing starts by understanding that people want to be healthy. Many people know what their problems are and would like to do the right thing. However, change is difficult and may be painful, expensive, and inconvenient. For example, most people would like to lose weight, but they may dislike exercising. They may want to stop drinking, but enjoy the social aspect of it. They are, therefore, ambivalent about actually changing and this is reflected when they say "Yes, but…" in talking with their health care provider.

The nurse's goal is to elicit "change talk" from the patient. The nurse looks for words such as "might, could, should, and would like to." The patient can then be helped to identify the pros and cons of behavior change, including one's desire, ability, reasons, and need to change. From this, the patient can make a commitment to change and take active steps on the road to health.

RESPONSIVE DIMENSIONS

The nurse must possess certain skills or qualities to establish and maintain a therapeutic relationship. These include responsive dimensions and action dimensions (Carkhoff and Berenson, 1967; Carkhoff and Truax, 1967; Carkhoff, 1969). The responsive dimensions include genuineness, respect, empathic understanding, and concreteness. The helping process can block the patient's growth rather than promote it, depending on the level of the nurse's responsive and facilitative skills.

The responsive dimensions are crucial in a therapeutic relationship to establish trust and open communication, and to convey a sense of hope. Hope consists of four elements: attachment, mastery, survival, and spirituality, and each is essential to growth and recovery (Stuart, 2010). The nurse's goal is to understand the patient and to help the patient gain self-understanding and insight. These responsive conditions then continue to be useful throughout the working and termination phases.

Genuineness

Genuineness means that the nurse is an open, honest, sincere person who is actively involved in the relationship. Genuineness is the opposite of self-alienation, which occurs when many of an individual's real, spontaneous reactions to life are suppressed. **Genuineness means that the nurse's response is sincere.** The nurse is not thinking and feeling one thing and saying something different. It is an essential quality because nurses cannot expect openness, self-acceptance, and personal freedom in patients if they lack these qualities themselves. Whatever the nurse shows must be real and not merely a "professional" response that has been learned and repeated. In focusing on the patient, many of the nurse's personal needs

are put aside, as well as some of the usual ways of relating to others. The following is an example of genuineness.

THERAPEUTIC DIALOGUE

Patient I'd like my parents to give me my freedom and let me do my own thing. If I need them or want their advice, I'll ask them. Why don't they trust what they taught me? Why do parents have to make it so hard—like it's all or nothing?

Nurse I know what you mean. My parents acted the same way. They offered advice, but what they expected was obedience. When they saw I could handle things on my own and used good judgment, they began to accept me as an individual. There are still times when they slip back into their old ways, but we understand each other better now. Do you think you and your parents need to share more openly and honestly your feelings and ideas?

Respect

Respect is also called **unconditional positive regard.** It does not depend on the patient's behavior. Caring, liking, and valuing are other terms for respect. **Respect means that the patient is regarded as a person of worth.** The nurse's attitude is nonjudgmental; it is without criticism, ridicule, or reservation. This does not mean that the nurse condones or accepts all aspects of the patient's behavior as desirable or likable. Patients are accepted for who they are, as they are. The nurse does not demand that the patient change or be perfect to be accepted. Imperfections are accepted along with mistakes and weaknesses as part of the human condition.

Although the nurse should have a basic respect for the patient simply as a person, respect is increased with understanding of the patient's uniqueness. It can be communicated in many different ways such as sitting silently with a patient who is crying or accepting the patient's request not to share a certain experience. Being genuine with and listening to the patient also are signs of respect. In contrast, fostering feelings of dependency in patients makes the nurse the evaluator and superior in the relationship, blocking mutuality. The inexperienced nurse may have difficulty accepting the patient without transferring feelings about the patient's thoughts or actions. However, acceptance means viewing the patient's actions as coping behaviors that will change as the patient becomes less threatened and learns more adaptive ways. It involves viewing the patient's behavior as natural, normal, and expected, given the circumstances.

Critical Reasoning It is said that "respect needs to be earned." How does this idea affect the lives of psychiatric patients?

Empathic Understanding

Empathy is the ability to enter into the life of another person, to accurately perceive the person's current feelings and their meanings, and to communicate this understanding to the patient. **Empathy is an essential part of the therapeutic process** (Norcross et al, 2006). When communicated, it forms the basis for a therapeutic relationship between nurse and patient. Rogers (1975) described it as "to sense the client's private world as if it were your own, but without losing the 'as if' quality. A high degree of empathy is one of the most potent factors in bringing about change and learning—one of the most delicate and powerful ways we have of using ourselves."

Accurate empathy involves more than knowing what the patient means. It also involves sensitivity to the patient's current feelings and the nurse's ability to communicate this understanding in a language understood by the patient. It means frequently confirming with the patient the accuracy of personal perceptions and being guided by the patient's responses (Shattell et al, 2006). It requires that the nurse put aside personal views and values to enter another's world without judgment or prejudice.

Empathy can significantly promote constructive learning and change. First, it dissolves the patient's sense of isolation by connecting the patient to another person. The patient can perceive that "I make sense to another human being… so I must not be so strange… . And if I am in touch with someone else, I am not so alone." On the other hand, if not responded to empathically, the patient may believe, "If no one understands me, if no one can see what I'm experiencing, then I must be very bad off… . I'm sicker than even I thought." Another benefit of empathy is that the patient can feel valued, cared for, and accepted as a person. Then perhaps he will come to think, "If this other person thinks I'm worthwhile, maybe I could value and care for myself… . Maybe I am worthwhile after all."

Development of Empathy. Empathic understanding consists of a number of stages. If patients allow nurses to enter their private world and attempt to communicate their perceptions

BOX 2-8 RESEARCH FINDINGS ABOUT EMPATHY

- Empathy is related to positive clinical outcome.
- The ideal therapist is first of all empathic.
- Empathy is correlated with self-exploration and self-acceptance.
- Empathy early in the relationship predicts later success.
- Understanding is provided by, not drawn from, the therapist.
- More experienced therapists are more likely to be empathic.
- Empathy is a special quality in a relationship, and therapists offer more of it than even helpful friends.
- The better self-integrated the therapist, the higher the degree of empathy.
- Experienced therapists often fall far short of being empathic. Brilliance and diagnostic skills are unrelated to empathy.
- An empathic way of being can be learned from empathic people.

and feelings, nurses must be receptive to this communication. Next, nurses need to understand the patient's communication by putting themselves in the patient's place. Nurses must then step back into their own role and communicate understanding to the patient. If nurses fail in this task the patient will feel misunderstood, which can damage or destroy the therapeutic relationship (Gaillard et al, 2009).

It is not necessary or even desirable for nurses to feel the same emotion as the patient. Empathy also should not be confused with sympathy, which is feeling sorry for the patient. Instead, it is an appreciation and awareness of the patient's feelings. Box 2-8 summarizes research showing its importance in counseling.

Empathic Responses. First, the nurse needs to be consistently genuine when interacting with the patient and communicate unconditional positive regard for the patient. Then the understanding conveyed to the patient through empathy gives the patient personhood or identity. The patient incorporates these aspects into a new, changing self-concept. Once self-concept changes, behavior also changes, thus producing the positive clinical outcome of therapy. Research has shown a connection between nurse-expressed empathy and positive patient outcomes. Specific verbal and nonverbal behaviors that convey high levels of empathy to the patient are as follows:

- Having nurses introduce themselves to patients
- Head and body positions turned toward the patient and occasionally leaning forward
- Verbal responses to the patient's comments and responses that focus on the patient's strengths and resources
- Consistent eye contact and response to the patient's nonverbal cues, such as sighs, tone of voice, restlessness, and facial expressions
- Showing interest, concern, and warmth by the nurse's own facial expressions
- A tone of voice consistent with facial expression and verbal response
- Mirror imaging of body position and gestures between the nurse and patient

High levels of empathy communicate "I am with you"; the nurse's responses fit perfectly with the patient's current feelings and content. The nurse's responses expand the patient's awareness of hidden feelings through the use of clarification and reflection. Such empathy is communicated by the language used, voice qualities, and nonverbal behavior, all of which reflect the nurse's engagement and depth of feeling. At low levels of empathy, the nurse ignores the patient's feelings, goes off on a tangent, or misinterprets what the patient is feeling. The nurse at this level may be uninterested in the patient or concentrating on the "facts" of what the patient says rather than on current feelings and experiences. The nurse is doing something other than listening, such as evaluating the patient, documenting, giving advice, or thinking about personal problems or needs. The increasing levels of empathy are evident in the following example:

THERAPEUTIC DIALOGUE

Patient I'm really jittery today, and I hope I can get things out right. It started when I saw Bob on Friday, and it's been building up since then.

Nurse You're feeling tense and anxious, and it's related to a talk you had with Bob on Friday.

Patient Yes. He began putting pressure on me to have sex with him again, even though I told him how I felt about it.

Nurse It sounds like you resent it when he pressures you for sex.

Patient I do. Why does he think things always have to be his way? I guess he knows I'm a pushover.

Nurse It makes you angry when he wants his way even though he knows you feel differently. But you usually give in and then you wind up disappointed in yourself and feeling like a failure.

Patient It happens just like that over and over. It's as if I never learn.

Nurse So when the incident's all over, you're left blaming yourself and feeling bad.

Patient I guess that's right… pretty bad cycle, huh?

Sociocultural differences between nurses and patients can be barriers to empathy if nurses are not sensitive to them. Differences in gender, age, income, belief systems, education, and ethnicity can block the development of empathic understanding. However, the greater the nurse's cultural sensitivity and the greater the openness to the world view of others, the greater will be the potential for understanding people. Identical or similar experiences are not essential for empathy. No man can really experience what it is like to be a woman; no white person can experience what it is like to be an African-American person. It is not necessary to be exactly like another, but it is desirable for nurses to prepare themselves in any way they can to understand potential patients.

Critical Reasoning What can you do to prepare yourself to empathize with a patient from a culture different from your own?

Concreteness

Concreteness is the use of specific terminology rather than abstractions when discussing the patient's feelings, experiences, and behavior. **It involves asking for examples and details rather than generalities.** It avoids vagueness and ambiguity and is the opposite of generalizing, labeling, and making assumptions about the patient's experiences. Concreteness has three functions:

1. Keeping the nurse's responses close to the patient's feelings and experiences
2. Fostering accuracy of understanding by the nurse
3. Encouraging the patient to attend to specific problem areas

The level of concreteness should vary during the various phases of the nurse-patient relationship (Figure 2-5). In the orientation phase, concreteness should be high; at that time it can contribute to empathic understanding. It is essential for

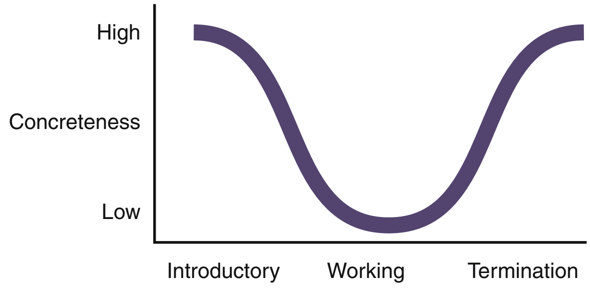


FIG 2-5 Levels of concreteness in the therapeutic relationship.

the formulation of specific goals and plans. While patients explore various feelings and perceptions related to their problems in the working phase of the relationship, concreteness should be at a low level to facilitate a thorough self-exploration. High levels of concreteness are again desirable at the end of the working phase, when patients are engaging in action, and during the termination phase. Concreteness is evident in the following examples:

THERAPEUTIC DIALOGUE

EXAMPLE 1

Patient I wouldn't have any problems if people would quit bothering me. They like to upset me because they know I'm high strung.

Nurse What people try to upset you?

Patient My family. People think being from a large family is a blessing. I think it's a curse.

Nurse Could you give me an example of something someone in your family did that upset you?

EXAMPLE 2

Patient I don't know what the problem is between us. My wife and I just don't get along anymore. We seem to disagree about everything. I think I love her, but she isn't affectionate or caring—hasn't been for a long time.

Nurse You say you're not sure what the problem is, and you think you love your wife. But the two of you argue often and she hasn't given you any sign of love or affection. Have you felt affectionate toward her, and when was the last time you let her know how you felt?

ACTION DIMENSIONS

The action-oriented conditions for facilitative interpersonal relationships are confrontation, immediacy, therapist self-disclosure, catharsis, and role playing. These dimensions must have a context of warmth and understanding. This is important for inexperienced nurses to remember because they may be tempted to move into high levels of action dimensions without having established adequate understanding, empathy, warmth, or respect. The responsive dimensions allow the patient to achieve insight, but this is not enough. With the action dimensions, the nurse moves the therapeutic relationship forward by identifying obstacles to the patient's progress and the need for specific behavior change.

Confrontation

Confrontation often implies venting anger and engaging in aggressive behavior. However, confrontation as a therapeutic action dimension is an assertive rather than aggressive action. Confrontation is an expression by the nurse of perceived discrepancies in the patient's behavior. Three categories of confrontation include the following (Carkhoff, 1969):

- Discrepancies between the patient's expression of what he is (self-concept) and what he wants to be (self-ideal)
- Discrepancies between the patient's verbal self-expression and nonverbal behavior
- Discrepancies between the patient's expressed experience of himself and the nurse's experience of him

Confrontation is an **attempt by the nurse to make the patient aware of incongruence in feelings, attitudes, beliefs, and behaviors.** It also may lead to the discovery of ambivalent feelings in the patient. Confrontation is not limited to negative aspects of the patient. It includes pointing out discrepancies involving resources and strengths that are unrecognized and unused.

It requires that the nurse collect data about the patient's history along with observations of verbal and nonverbal communication so that validation of reality is possible. The nurse must have developed an understanding of the patient to perceive discrepancies, inconsistencies in word and deed, distortions, defenses, and evasions. The nurse must be willing and able to work through the issues after confronting the patient. Without this commitment the confrontation lacks therapeutic potential and can be damaging to both nurse and patient. Done correctly, confrontation can promote growth.

Timing in Relationships. Before confrontation, nurses should assess the following factors:

- Trust level
- Timing in the relationship
- Patient's stress level
- Strength of the patient's defense mechanisms
- Patient's level of anxiety and tolerance for hearing another's perception

Patients have the capacity to deny or accept nurses' observations, and their response to the confrontation can serve as a measure of its success or failure. Acceptance indicates appropriate timing and patient readiness. Denial serves to avoid any threat that the confrontation posed to the patient. It provides nurses with additional information; it tells them that patients are resisting change and are unwilling to expand their view of reality at this time.

Confrontation must be appropriately timed to be effective (Figure 2-6). In the orientation phase of the relationship, the nurse should use confrontation infrequently and pose it as an observation of incongruent behavior. A simple mirroring of the discrepancy between a patient's actions and words is the most nonthreatening type of confrontation. The nurse might say, "You seem to be saying two different things." This type of confrontation closely resembles clarification at this time. Nurses also might identify discrepancies

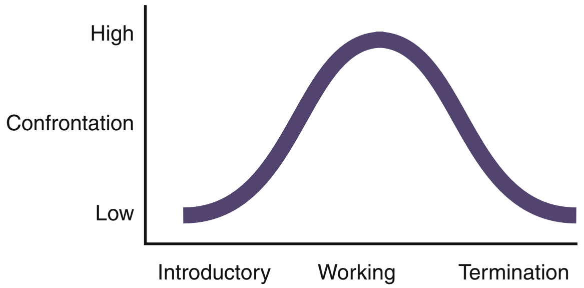


FIG 2-6 Levels of confrontation in the therapeutic relationship.

between how they and patients are experiencing their relationship, point out unnoticed patient strengths or untapped resources, or provide patients with objective but perhaps different information about their world. Most importantly, **confrontation requires high levels of empathy and respect to be effective.**

In the working phase of the relationship, more direct confrontations may focus on specific patient discrepancies. The nurse may confront the patient with areas of weakness or shortcomings or may focus on the discrepancy between the nurse's perception of the patient and the patient's self-perception. This expands the patient's awareness and helps the patient move to higher levels of functioning. **Confrontation is especially important in pointing out when the patient has developed insight but has not changed behavior.** This encourages the patient to act in a reasonable and constructive manner, rather than being dependent and passive in life.

Effective counselors use confrontation frequently, confronting patients with their strengths more often in earlier interviews and with their limitations in later interviews. In the initial interview these confrontations were based on attempts to clarify the relationship, eliminate misconceptions, give patients more objective information about themselves and their world, and emphasize patient strengths and resources. In contrast, inexperienced nurses often avoid confrontation. It can be nontherapeutic when it is not associated with empathy or warmth or when it is used to vent the nurse's feelings of anger, frustration, and aggressiveness. However, carefully monitored confrontation can be viewed as an extension of genuineness and concreteness. It is a useful therapeutic intervention that can further the patient's growth and progress. The following are examples of confrontation:

THERAPEUTIC DIALOGUE

EXAMPLE 1

Nurse I see you as someone who has a lot of strength. You've been able to give a tremendous amount of emotional support to your children at a time when they needed it very much.

EXAMPLE 2

Nurse You say you want to feel better and go back to work, but you're not taking your medicine, which will help you to do that.

EXAMPLE 3

Nurse The fact that Sue didn't accept your date for Friday night doesn't necessarily mean she never wants to go out with you. She could have had another date or other plans with her family or girlfriends. But if you don't ask her, you'll never find out why she refused you or if she'll accept in the future.

EXAMPLE 4

Nurse You tell me that your parents don't trust you and never give you any responsibility, but each week you also tell me how you stayed out beyond your curfew or had friends over when your parents weren't home. Do you see a connection between the two?

EXAMPLE 5

Nurse We've been talking for 3 weeks now about your need to get out and try to meet some people. We even talked of different ways to do that. But so far you haven't made any effort to join aerobics, take a class, or act on any of the other ideas we had.

Critical Reasoning Your friend tells you that she feels uncomfortable using confrontation with patients. Why do you think this might be, and what advice would you give her?

Immediacy

Immediacy involves focusing on the current interaction of the nurse and the patient in the relationship. It is a significant dimension because **the patient's behavior and functioning in the nurse-patient relationship reflect functioning in other interpersonal relationships.** Most patients experience difficulty in interpersonal relationships; thus the patient's functioning in the nurse-patient relationship must be evaluated. The nurse has the opportunity to intervene directly with the patient's problem behavior, and the patient has the opportunity to learn and change behavior. Immediacy involves sensitivity to the patient's feelings and a willingness to deal with these feelings rather than ignore them. This is particularly difficult when the nurse must recognize and respond to negative feelings the patient expresses toward the nurse. The difficulty is complicated by the fact that patients often express these messages indirectly.

It is not possible or appropriate for the nurse to focus continually on the immediacy of the relationship. It is most appropriate to do so when the relationship seems to be stalled or is not progressing. It also is helpful to look at immediacy when the relationship is progressing particularly well. In both instances the patient is actively involved in describing what is helping or hindering the relationship. As with the other dimensions, high-level immediacy responses should not be presented suddenly to the patient. The nurse must first know and understand the patient and must have developed a good, open relationship. The nurse's initial expressions of immediacy should be tentatively phrased, such as "Are you trying to tell me how you feel about our relationship?" As the relationship progresses, observations related to immediacy can be made more directly, and as communication improves, the need for immediacy responses may decrease. The following are two examples of immediacy:

THERAPEUTIC DIALOGUE

EXAMPLE 1

Patient I've been thinking about our meetings, and I'm really too busy now to keep coming. Besides, I don't see the point in them, and we don't seem to be getting anywhere.

Nurse Are you trying to say you're feeling discouraged and you feel our meetings aren't helping you?

EXAMPLE 2

Patient The staff here couldn't care less about us patients. They treat us like children instead of adults.

Nurse I'm wondering if you feel that I don't care about you or perhaps I don't value your opinion?

BOX 2-9 GUIDELINES FOR SELF-DISCLOSURE

Cooperation: Will the disclosure enhance the patient's cooperation, which is necessary to the development of a therapeutic alliance?

Learning: Will the disclosure assist the patient's ability to learn about himself, to set short- and long-term goals, and to deal more effectively with life's problems?

Catharsis: Will the disclosure assist the patient to express formerly held or suppressed feelings, important to the relief of emotional symptoms?

Support: Will the disclosure provide the patient with support or reinforcement for attaining specific goals?

Nurse Self-Disclosure

Self-disclosures are subjectively true, personal statements about the self, intentionally revealed to another person. **The nurse shares experiences or feelings that are similar to those of the patient and may emphasize both the similarities and the differences.** This kind of self-disclosure is a measure of the closeness of the relationship and involves a particular kind of respect for the patient. It is an expression of genuineness and honesty by the nurse and is an aspect of empathy. Research provides evidence that therapist self-disclosure increases the likelihood of patient self-disclosure. Patient self-disclosure is necessary for a successful therapeutic outcome. However, the nurse must use self-disclosure carefully, and this is determined by the quality, quantity, and appropriateness of the disclosures. Criteria for self-disclosure include the following:

- To model and educate
- To foster the therapeutic alliance
- To validate reality
- To encourage the patient's autonomy

The number of self-disclosures appears to be crucial to the success of the therapy. Too few nurse self-disclosures may fail to produce patient self-disclosures, whereas too many may decrease the time available for patient disclosure or may alienate the patient. The problem for the nurse is determining a middle ground. Clinical experience is necessary to determine the optimal therapeutic level.

The appropriateness or relevance of the nurse's self-disclosure also is important. The nurse should self-disclose in response to statements made by the patient. If the nurse's disclosure is far from what the patient is experiencing, it can distract the patient from the problem or cause feelings of alienation. A patient who is experiencing severe anxiety may feel threatened or frightened by the nurse's self-disclosure. In these cases the nurse must be careful not to burden a patient with self-disclosures.

Above all, disclosure by the nurse is always for the patient's benefit. **When self-disclosing, the nurse should have a particular therapeutic goal in mind.** The nurse does not disclose to meet personal needs or to feel better. Guidelines that nurses can use to evaluate the potential usefulness of their self-disclosure are listed in Box 2-9. These guidelines govern the "dosage" and timing of self-disclosures and help the nurse assess the appropriateness, effectiveness, and anticipated response of the patient to the disclosure. Self-disclosure by the nurse is evident in the following example:

THERAPEUTIC DIALOGUE

Patient When he told me he didn't want to see me again, I felt like slapping him and hugging him at the same time. But then I knew the problem was really me and no one could ever love me.

Nurse When I broke off with a man I had been seeing, I felt the anger, hurt, and bitterness you just described. I remember thinking I would never date another man.

In this example the nurse self-disclosed to emphasize that the patient's feelings were natural. She also reinforced the external cause for the separation (boyfriend's decision to leave versus the patient's inadequacy) and implied that, with time, the patient will be able to resolve the loss.

Emotional Catharsis

Catharsis occurs when the patient is encouraged to talk about things that are most bothersome. **Catharsis brings fears, feelings, and experiences out into the open so that they can be examined and discussed with the nurse.** The expression of feelings can be very therapeutic in itself, even if behavioral change does not result. The previously described responsive dimensions create an atmosphere within the nurse-patient relationship in which emotional catharsis is possible. The patient's responsiveness depends on the confidence and trust the patient has in the nurse. The nurse must be able to recognize cues from the patient concerning readiness for discussion of problems. It is important that the nurse proceed at the rate chosen by the patient and provide support when discussing difficult areas. Forcing emotional catharsis on the patient could trigger a panic episode because the patient's defenses are attacked without sufficient alternative coping mechanisms being available.

Patients are often uncomfortable expressing their feelings. Nurses may be equally uncomfortable with expressing feelings, particularly sadness or anger. Nurses often assume that they know the patient's feelings and do not attempt to specifically validate them. The dimensions of empathy and

immediacy require the nurse to notice and express emotions. Unresolved feelings and feelings that are avoided can cause stalls or barriers in the nurse-patient relationship. Specific examples are transference and countertransference phenomena, which are discussed later in this chapter. If patients have difficulty in expressing feelings, nurses may help by suggesting how they or others might feel in the patient's specific situation. Some patients respond directly to the question, "How did that make you feel?" Others intellectualize and avoid the emotional element in their answer. When patients realize they can express their feelings within an accepting relationship, they expand their awareness and potential acceptance of themselves.

The following example illustrates emotional catharsis:

THERAPEUTIC DIALOGUE

Nurse How did you feel when your boss corrected you in front of all those customers?

Patient Well, I understood that he needed to set me straight, and he's the type that flies off the handle pretty easily anyhow.

Nurse It sounds like you're defending his behavior. I was wondering how you felt at that moment.

Patient Awkward… uh… upset, I guess. *(pause)*

That would have made me pretty angry if it had happened to me.

Patient Well, I was. But you can't let it show, you know. You have to keep it all in because of the customers. But he can let it out. Oh sure! *(emphatically)* He can tell me anything he wants. Just once I'd like him to know how I feel.

Role Playing

Role playing involves acting out a particular situation. **It increases the patient's insight into human relations and can deepen the ability to see the situation from another person's point of view.** The purpose of role playing is to closely represent real-life behavior that involves individuals holistically, to focus attention on a problem, and to permit individuals to see themselves in action in a neutral situation. Role playing provides a bridge between thought and action in a safe environment in which the patient can feel free to experiment with new behavior. It is action oriented, provides immediate information, and consists of the following steps:

1. Defining the problem
2. Creating a readiness for role playing
3. Establishing the situation
4. Casting the characters
5. Briefing and warming up
6. Acting
7. Stopping
8. Analyzing and discussing
9. Evaluating

When role playing is used to change attitudes, a key element of the exercise is role reversal. The patient may be asked to assume the role of a certain person in a specific situation or to play the role of someone with opposing beliefs. Role reversal can help a person reevaluate another person's intentions and become more understanding of the other person's position. After experiencing role reversal, patients may be more receptive to modifying their own attitudes.

Used as a method of promoting self-awareness and conflict resolution, role playing may help the patient "experience" a situation, which can be more helpful than just talking about it. Role playing can elicit feelings in the patient that are similar to those that would be experienced in the actual situation. It provides an opportunity for the patient to develop insight and to express emotion. In this way, role playing can heighten a patient's awareness of feelings related to a specific situation.

One of the ways in which role playing can be used to resolve conflicts and increase self-awareness is through a dialogue that requires the patient to take turns speaking for each person or each side of a problem. If the conflict is internal, the dialogue occurs in the present tense and alternates between the patient's conflicting selves until one part of the conflict outweighs the other. If the conflict involves a second person, the patient is instructed to "imagine that the other person is sitting in the chair across from you." The patient is told to begin the dialogue by directing comments to the other person. Then the patient changes chairs, assumes the role of the other person, and responds to what was just said. The patient assumes the first role again and responds to the other person. Using dialogue in this way not only serves as practice for the patient in expressing feelings and opinions but also provides a reality base from which the probable response from the other party involved in the conflict can be explored. Often this can eliminate the barrier that is keeping the patient from making a decision and acting on it.

Role playing is included as an action dimension because in addition to helping patients develop insight, **it also can help patients practice new and more adaptive behaviors.** For example, role playing can help patients develop better social, assertiveness, and anger management skills. Role playing can be particularly effective when an impasse has been reached in the patient's progress or when it is difficult for the patient to translate insight into action. In these instances it can reduce tension and give the patient the opportunity to practice or test new behaviors for future use.

Table 2-6 summarizes the responsive and action dimensions for therapeutic nurse-patient relationships. It is important to remember that the nurse's effectiveness is based on openness to learning what works best with particular kinds of patients in particular situations. **Both the use of communication techniques and the therapeutic conditions must be individualized to the nurse's personality and the patient's needs.** The nurse must be willing to try other approaches that can be helpful if the current approach is not effective.

Critical Reasoning Try using role playing to work through a difficult situation in your own life.

TABLE 2-6 RESPONSIVE AND ACTION DIMENSIONS FOR THERAPEUTIC NURSE–PATIENT RELATIONSHIPS

DIMENSION	DESCRIPTION
RESPONSIVE	
Genuineness	Implies that the nurse is an open person who is self-congruent, authentic, and transparent.
Respect	Suggests that the patient is regarded as a person of worth who is valued and accepted without qualification
Empathic understanding	Views the patient's world from the patient's internal frame of reference, with sensitivity to the patient's current feelings and the verbal ability to communicate this understanding in a language attuned to the patient
Concreteness	Involves the use of specific terminology rather than abstractions in the discussion of the patient's feelings, experiences, and behavior
ACTION	
Confrontation	Nurse expresses perceived discrepancies in the patient's behavior to expand the patient's self-awareness
Immediacy	Occurs when the current interaction of the nurse and patient is focused on for the purpose of learning about the patient's functioning in other interpersonal relationships
Nurse self-disclosure	Nurse reveals personal information, ideas, values, feelings, and attitudes to the patient to facilitate the patient's cooperation, learning, or catharsis or to indicate support of the patient
Emotional catharsis	Takes place when the patient is encouraged to talk about the things that are most bothersome
Role playing	Patient acts out a particular situation to increase insight into human relations and enhance the ability to see a situation from another point of view; it also allows the patient to experiment with new behaviors in a safe environment

THERAPEUTIC IMPASSES

Therapeutic impasses are blocks in the progress of the nurse-patient relationship. They develop for a variety of reasons, but all impasses create stalls in the therapeutic relationship. Impasses provoke intense feelings in both the nurse and the patient, which may range from anxiety and apprehension to frustration, love, or intense anger. Four specific therapeutic impasses and ways to overcome them are discussed here: resistance, transference, countertransference, and boundary violations.

BOX 2-10 FORMS OF RESISTANCE DISPLAYED BY PATIENTS

- Suppression and repression of pertinent information
- Intensification of symptoms
- Self-devaluation and a hopeless outlook on the future
- Forced flight into health in which a sudden but short-lived recovery is experienced by the patient
- Intellectual inhibitions, which may be evident when the patient says he has "nothing on his mind" or that he is "unable to think about his problems" or when he breaks appointments, is late for sessions, or is forgetful, silent, or sleepy
- Acting-out or irrational behavior
- Superficial talk
- Intellectual insight in which the patient verbalizes self-understanding with correct use of terminology yet continues destructive behavior or uses the defense of intellectualization in which no insight is verbalized
- Contempt for normality, which is evident when the patient has developed insight but refuses to assume the responsibility for change on the grounds that normality "isn't so great"
- Transference reactions

Resistance

Resistance is the **patient's reluctance or avoidance of talking about or experiencing troubling aspects of oneself.** Resistance is often caused by the patient's unwillingness to change when the need for change is recognized. Patients usually display resistance behaviors during the working phase of the relationship because the greater part of the problem-solving process occurs during this phase. Resistance also may be a reaction by the patient to the nurse who has moved too quickly or too deeply into the patient's feelings or who has intentionally or unintentionally communicated a lack of respect. It also may simply be the result of a patient working with a nurse who is an inappropriate role model for therapeutic behavior. Resistance may take many forms. Box 2-10 lists some of the forms of resistance that patients display.

Secondary gain may be another cause of resistance. **Secondary gain** is a related benefit that patients experience as a result of their illness. For example, the development of the illness may result in the patient experiencing favorable environmental, interpersonal, monetary, or situational changes. Specific types of secondary gain include being financially compensated, avoiding unpleasant situations, receiving increased sympathy or attention, escaping from work or other responsibilities, gaining attempted control of people, and lessening of social pressures. Secondary gain can become a powerful force in perpetuating an illness because it makes the environment more comfortable and change less desirable.

Transference

Transference is an unconscious response in which patients experience feelings and attitudes toward the nurse that were originally associated with other significant figures in their life. They may be triggered by a superficial similarity, such as a

facial feature or manner of speech, or by a personality style or trait. These reactions are the patient's attempt to reduce anxiety. **Transference is characterized by the inappropriate intensity of the patient's response.** It reduces self-awareness by allowing the patient to maintain an inaccurate view of the world in which all people are seen in a similar way. Thus the nurse may be viewed as an authority figure from the past, such as a parent figure, or as a lost loved person, such as a former spouse. Transference reactions are harmful to the therapeutic process only if they remain ignored and unexamined.

Two types of transference are particularly problematic in the nurse-patient relationship. The first is the **hostile transference.** If the patient internalizes anger and hostility, this resistance may be expressed as depression and discouragement. The patient may ask to terminate the relationship on the grounds that there is no chance of getting well. If the hostility is externalized, the patient may become critical, defiant, and irritable and may express doubts about the nurse's training, experience, or competence. The patient may attempt to compete with the nurse by reading books on psychology and debating intellectual issues rather than working on real-life problems.

Hostility also may be expressed by the patient as detachment, forgetfulness, irrelevant chatter, or preoccupation with childhood experiences. An extreme form of uncooperativeness and negativism is evident in prolonged silences. Some of the most frustrating moments for the nurse are those spent in total silence with a patient. This is not the therapeutic silence that communicates mutuality and understanding. Rather, it is the silence that seems to be hostile, oppressive, and eternal. It is particularly disturbing for the nurse in the orientation phase, before a relationship has been established. The nurse's task is to understand the meaning of the patient's silence and decide how to deal with it despite feeling somewhat awkward and uncertain.

A second difficult type of transference is the **dependent reaction transference.** This resistance is characterized by patients who are submissive, subordinate, and ingratiating and who regard the nurse as a godlike figure. The patient overvalues the nurse's characteristics and qualities, and their relationship becomes jeopardized because the patient views it as magical. In this reaction the nurse must live up to the patient's overwhelming expectations, which is impossible because these expectations are completely unrealistic. The patient continues to demand more of the nurse, and when these needs are not met, the patient is filled with hostility and contempt.

Overcoming Resistance and Transference. Resistances and transferences can be difficult problems for the nurse. The psychiatric nurse must be prepared for being exposed to powerful negative and positive emotional feelings coming from the patient—feelings that often have an irrational basis. The relationship can become stalled and nonbeneficial if the nurse is not prepared to deal with the patient's feelings. Sometimes resistances occur because the nurse and patient have not arrived at mutually acceptable goals or plans of action. This may occur if the contract was not clearly defined in the orientation stage of the relationship. The appropriate action then is to return to clarifying the goals, purposes, and roles of the nurse and patient in the relationship. Whatever the patient's motivations, **resistance and transference must be analyzed so that the patient gains awareness of motivations and learns to be responsible for all actions and behavior.**

The first thing the nurse must do is listen. When the nurse recognizes the resistance, clarification and reflection of feeling can be used. Clarification gives the nurse a more focused idea of what is happening. Reflection of content may help patients become aware of what has been going on in their own minds. Reflection of feeling acknowledges the resistance and mirrors it to the patient. The nurse may say, "I sense that you're struggling with yourself. Part of you wants to explore the issue of your marriage, and another part says 'No—I'm not ready yet.'" However, it is not sufficient to merely identify that resistance is occurring. The behavior must be explored and possible reasons for its occurrence analyzed. The depth of exploration and analysis engaged in by the nurse and patient is related to the nurse's experience and knowledge base.

BOX 2-11 FORMS OF COUNTERTRANSFERENCE DISPLAYED BY NURSES

- Difficulty empathizing with the patient concerning certain problem areas
- Feelings of depression during or after the session
- Carelessness about implementing the contract, such as being late, running over time, and so on
- Drowsiness during the sessions
- Feelings of anger or impatience because of the patient's unwillingness to change
- Encouragement of the patient's dependency, praise, or affection
- Arguments with the patient or a tendency to push before the patient is ready
- Attempts to help the patient in matters not related to the identified nursing goals
- Personal or social involvement with the patient
- Dreams about or preoccupation with the patient
- Sexual or aggressive fantasies toward the patient
- Recurrent anxiety, unease, or guilt related to the patient
- Tendency to focus on only one aspect or way of looking at information presented by the patient
- Need to defend nursing interventions used with the patient to others

Countertransference

Countertransference is a therapeutic impasse created by the nurse's specific emotional response to the qualities of the patient. This response is inappropriate to the content and context of the therapeutic relationship and inappropriate in the degree of intensity of emotion. **Countertransference is transference applied to the nurse.** Inappropriateness is the important element of this impasse, just as it is with transference.

It is natural, for example, that the nurse will feel warmth toward or liking for some patients more than others, and the nurse also will be genuinely angry at times about the actions of other patients. However, in the case of countertransference,

the nurse's responses are not justified by reality. In such cases nurses identify the patient with individuals from their past, and personal needs interfere with their therapeutic effectiveness. Countertransference reactions are usually of the following three types:

1. Reactions of intense love or caring
2. Reactions of intense disgust or hostility
3. Reactions of intense anxiety, often in response to resistance by the patient

Through the use of immediacy, the nurse can identify countertransference in one of its various forms, some of which are listed in Box 2-11. These reactions can be powerful tools for exploring and uncovering inner states. They are destructive only if they are ignored or not taken seriously. If studied objectively, these reactions can lead to learning more information about the patient. The ability to remain objective does not mean that the nurse may not at times become irritated or dislike what the patient says. The patient's resistance to acquiring insight and transforming it into action and the refusal to change maladaptive and destructive coping mechanisms can be frustrating. However, the nurse's ability to understand these feelings helps to maintain a working relationship with the patient.

Countertransference also can be a group phenomenon. Psychiatric staff members can become involved in countertransference reactions when they overreact to a patient's aggressive behavior, ignore available patient data that would promote understanding, or become locked in a power struggle with a patient. Other types of countertransference might include ignoring patient behavior that does not fit the staff's diagnosis, minimizing a patient's behavior, joking about or criticizing a patient, or becoming caught up in intimidation.

The experienced nurse is constantly on the lookout for countertransference, becomes aware of it when it occurs, and works with it to promote the therapeutic goals. In identifying a countertransference, the nurse applies the same standards of honest self-appraisal personally that are expected of the patient. The nurse should use self-examination throughout the course of the relationship, particularly when the patient attacks or criticizes. Asking oneself the following questions may be helpful:

- How do I feel about the patient?
- Do I look forward to seeing the patient?
- Do I feel sorry for or sympathetic toward the patient?
- Am I bored with the patient and believe that we are not progressing?
- Am I afraid of the patient?
- Do I get extreme pleasure out of seeing the patient?
- Do I want to protect, reject, or punish the patient?
- Do I dread meeting the patient and feel nervous during the sessions?
- Am I impressed by or trying to impress the patient?
- Does the patient make me very angry or frustrated?

If the answer to any of these questions suggests a problem, the nurse should pursue it: What is the patient doing to provoke these feelings? Who does the patient remind me of? The nurse must discover the source of the problem. Because countertransference can be harmful to the relationship, it should be dealt with as soon as possible. **When countertransference is recognized, the nurse can exercise control over it.** If the nurse needs help in dealing with countertransference, individual or group supervision can be most helpful.

Problem Patients. Countertransference problems are most evident when a patient is labeled a *problem* or *difficult patient.* Usually such a patient elicits strong negative feelings, such as anger, fear, and helplessness, and is often described by nurses as manipulative, dependent, inappropriate, and demanding. Problem or difficult patients typically provoke feelings of powerlessness in the nurse. In response, the nurse increases control over the patient and engages in a power struggle with the patient.

Skills that need to be present in order for nurses to empower patients are trust, knowledge, concern, communication, caring, respect, and courtesy. Control is linked to the concept of "power over," whereas competence can be seen as "power to." Psychiatric nurses need to minimize the former and maximize the latter. Strategies for managing difficult patients include the following (Battaglia, 2009; Melin and Couser, 2009):

- Acknowledging that the patient is difficult
- Developing empathy
- Seeking supervision
- Using a team approach
- Lowering treatment goals
- Expanding the treatment timeline
- Using positive comments and imagery

The label *problem patient* implies that the patient's behavior should change for the sake of the helper rather than for the patient's own benefit. This labeling often causes the patient and nurse to become adversaries and the nurse avoids contact. It is more productive for a nurse to view a problem patient as one who poses problems for the nurse. This turns the responsibility for action back onto the nurse. It forces the nurse to explore responses to the patient that reinforce the patient's unproductive behavior. In this way the nurse also makes patients responsible for their behavior. By stepping back and reviewing again the patient's needs and problems, the nurse can become aware of failing to use the responsive dimensions of genuineness, respect, empathic understanding, and concreteness. Without this groundwork, a therapeutic outcome is impossible.

Boundary Violations

A final but very important therapeutic impasse is that of **boundary violations,** which occur when a nurse goes outside the boundaries of the therapeutic relationship and establishes a social, economic, or personal relationship with a patient (Gutheil and Bordsky, 2008; Jones et al, 2008). As a general rule, whenever the nurse is doing or thinking of doing something special, different, or unusual for a patient, often a boundary violation is involved. A nurse should consider the possibility of a boundary violation if she encounters the following:

- Receives feedback that her behavior is intrusive with patients or their families
- Has difficulty setting limits with a patient

BOX 2-12 POSSIBLE BOUNDARY VIOLATIONS RELATED TO PSYCHIATRIC NURSES

- The patient takes the nurse out to lunch or dinner.
- The professional relationship turns into a social relationship.
- The nurse attends a party at a patient's invitation.
- The nurse regularly reveals personal information to the patient.
- The patient introduces the nurse to family members, such as a son or daughter, for the purpose of a social relationship.
- The nurse accepts free gifts from the patient's business.
- The nurse agrees to meet the patient for treatment outside the usual setting without therapeutic justification.
- The nurse attends social functions that include the patient.
- The patient gives the nurse an expensive gift.
- The nurse routinely hugs or has physical contact with the patient.
- The nurse does business with or purchases services from the patient.

- Relates to a patient like a friend or family member
- Has sexual feelings toward a patient
- Feels that she is the only one who understands the patient
- Receives feedback that she is too involved with a patient or family
- Feels that other staff members are too critical of a particular patient
- Believes that other staff members are jealous of her relationship with a patient

Specific examples of possible boundary violations are listed in Box 2-12. Boundary violations can occur in the following ways:

- **Intimacy and sexual boundaries:** Any and all intimate behavior and sexual exchange or contact with a patient are serious boundary violations. **Sexual contact of any kind is never therapeutic and never acceptable within the nurse-patient relationship.** Nurses engaging in intimacy and sexual boundary violations are vulnerable to patient-initiated lawsuits.
- **Role boundaries:** These are related to the psychiatric nurse's role. They are reflected in the question, Is this what a professional psychiatric nurse does? Problems with role boundaries require the insight of the nurse and the setting of firm therapeutic limits with the patient.
- **Time boundaries:** These relate to the time of day that the nurse implements treatment. Odd and unusual treatment hours that have no therapeutic necessity must be evaluated as potential boundary violations.
- **Place and space boundaries:** These are related to where treatment takes place. An office or hospital unit is the usual locale for most treatment. Treatment outside the office usually merits special scrutiny. Most often treatment provided over lunch, in the car, or in the patient's home must have a good therapeutic rationale and be related to explicit treatment goals. In an inpatient setting any time spent by a nurse in a patient's room should be done so only if indicated and with appropriate action taken to respect boundary concerns, such as leaving the door open and being sure other staff members are nearby.
- **Money boundaries:** These relate to evaluating the compensation for treatment between the nurse and patient. Bartering or seeing an indigent patient for free should be carefully reviewed for potential boundary violations.
- **Clothing boundaries:** These pertain to the nurse's need to dress in an appropriate therapeutic manner. Suggestive or seductive clothing of the nurse is unacceptable, and limits should be set on inappropriate dress by patients as well.
- **Language boundaries:** These raise questions of when patients should be addressed by their first or last names, the tone that the nurse uses when talking with the patient, and the nurse's choice of words in implementing care. Too familiar, sexual, off-color, or leading language constitutes a boundary violation.
- **Self-disclosure boundaries:** Inappropriately timed self-disclosure by the nurse and nurse self-disclosure that lacks therapeutic value are suspect for boundary violations, as discussed previously in this chapter.
- **Postdischarge social boundaries:** Postdischarge social contact of a patient by the nurse always raises questions of boundary violation. Such contacts confuse social support with professional support, can place the patient at risk, and disregard the basic tenets of the professional role.
- **Gifts and services boundaries:** Gifts can take many forms. They can be tangible or intangible, lasting or temporary. Tangible gifts may include items such as a box of candy, a bouquet of flowers, a hand-knit scarf, or a hand-painted picture. Intangible gifts can be the expression of thanks to a nurse by a patient who is about to be discharged or a family member's sense of relief and gratitude at being able to share an emotional burden with another caring person. The underlying element of all these gifts is that something of value is voluntarily offered to another person, usually to convey gratitude. Gifts can be divided into the following five types:
  1. Gifts to reciprocate for care given
  2. Gifts intended to manipulate or change the quality of care given or the nature of the nurse-patient relationship
  3. Gifts given as perceived obligation by the patient
  4. Gifts received by chance
  5. Gifts given to the organization to recognize excellence of care received

Because gifts can be so varied, it is inappropriate to lump them all together in deciding on a nursing action. Rather, the nurse's response to gift giving and the role it plays in the therapeutic relationship depend on the timing of the particular situation, the intent of the giver, and the meaning of the giving of the gift. Occasionally it may be most appropriate and therapeutic for the nurse to accept a patient's gift; on other occasions it may be quite inappropriate and harmful to the relationship. Gifts that are obvious boundary violations place undue obligations on the patient for the benefit of the nurse.

The nurse must carefully consider how to respond to each of these categories based on the possibility of boundary violations. Clinical supervision can be helpful in anticipating and avoiding possible boundary violations.

Critical Reasoning What unique situations and customs may complicate the task of maintaining treatment boundaries in small communities and rural areas? How should they be handled?

THERAPEUTIC OUTCOME

The nurse's effectiveness in working with psychiatric patients is related to knowledge base, clinical skills, and capacity for introspection and self-evaluation. The nurse and patient, as participants in an interpersonal relationship, are joined in a pattern of reciprocal emotions that directly affect the therapeutic outcome. The nurse conveys feelings to the patient. Some of these are in response to the patient; others arise from the nurse's personal life and are not necessarily associated with the patient.

Many painful feelings can arise within the nurse because of the nature of the therapeutic process, which can be quite stressful. These "normal" stresses are caused by a variety of factors. Although it is necessary to be a skilled listener, it is inappropriate for the nurse to discuss personal conflicts or responses, except when they may help the patient. This bottling up of emotions can be painful. The nurse is expected to empathize with the patient's emotions and feelings. At the same time, however, the nurse is expected to retain objectivity and not respond with sympathy. This can create a kind of double bind. Termination poses another stress when the nurse must separate from a patient she has come to know well and care for deeply. It is common to experience a grief reaction in response to the loss.

Many nurses find it emotionally draining when a patient communicates a prolonged and intense expression of emotion, such as sadness, despair, or anger. Discomfort also arises when the nurse feels unable to help a patient who is in great distress. Suicide dramatizes this situation. Treating suicidal individuals can arouse intense and prolonged anxiety in the nurse. The painful nature of these emotional responses makes the practice of psychiatric nursing challenging and stressful (Edmunds, 2010; Beck, 2011). The therapeutic use of self involves the nurse's total personality, and total involvement is not an easy task. It is essential that the nurse be aware of personal feelings and responses and receive guidance and support as needed.

CHAPTER IN REVIEW

- The therapeutic nurse-patient relationship is a mutual learning experience and a corrective emotional experience for the patient. The nurse uses personal attributes and specified clinical techniques in working with the patient to effect behavioral change.
- The qualities needed by nurses to be effective helpers include awareness of self, clarification of values, exploration of feelings, ability to serve as a role model, altruism, and a sense of ethics and responsibility.
- The four phases of the nurse-patient relationship are the preinteraction phase; introductory, or orientation, phase; working phase; and termination phase. Each phase builds on the preceding one and is characterized by specific tasks.
- In the preinteraction phase the nurse's initial task is one of self-exploration. Other tasks of this phase include gathering data about the patient if information is available and planning for the first interaction with the patient.
- In the introductory, or orientation, phase one of the nurse's primary concerns is to determine why the patient sought help. Other tasks in this phase of the relationship are to establish a climate of trust, understanding, acceptance, and open communication; to formulate a contract with the patient; to explore the patient's perceptions, thoughts, feelings, and actions; to identify pertinent patient problems; and to define mutual, specific goals with the patient.
- In the working phase the nurse and the patient explore stressors and promote the development of insight in the patient by linking perceptions, thoughts, feelings, and actions. These insights should be translated into action and a change in behavior.
- In the termination phase, learning is maximized for both the patient and the nurse as they exchange feelings and memories and evaluate mutually the patient's progress and goal attainment.
- Communication can take place on two levels—verbal and nonverbal—and both are critical to the success of the nurse-patient relationship. Types of nonverbal communication include vocal cues, action cues, object cues, space, and touch.
- The communication process involves perception, evaluation, and transmission. Problems can arise in any of these areas.
- Therapeutic communication techniques include listening, broad openings, restating, clarification, reflection, focusing, sharing perceptions, theme identification, silence, humor, informing, and suggesting.
- Motivational interviewing helps people talk about their ambivalence toward change and then to use their own motivation, energy, and commitment to learn new skills and make needed changes in their lives.
- Responsive dimensions of a therapeutic relationship include genuineness, respect, empathic understanding, and concreteness.
- Action dimensions of a therapeutic relationship include confrontation, immediacy, nurse self-disclosure, emotional catharsis, and role playing.
- Therapeutic impasses such as resistance, transference, countertransference, and boundary violations are roadblocks in the progress of the nurse-patient relationship. Sexual contact of any kind is never therapeutic and never acceptable within the nurse-patient relationship.
- The therapeutic outcome in working with psychiatric patients is related to the nurse's knowledge base, clinical skills, and capacity for introspection and self-evaluation.

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CHAPTER

3

The Stuart Stress Adaptation Model of Psychiatric Nursing Care

Gail W. Stuart

Much madness is Divinest Sense—To a discerning eye.

Emily Dickinson

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Discuss the theoretical assumptions underlying the Stuart Stress Adaptation Model of psychiatric nursing care.
2. Describe dimensions of mental health and mental illness in the United States.
3. Analyze the biopsychosocial components of the Stuart Stress Adaptation Model of psychiatric nursing care.
4. Compare coping responses, nursing diagnoses, health problems, and medical diagnoses.
5. Evaluate nursing activities appropriate to the various stages of psychiatric treatment.

Models provide a structure for thinking, observing, and interpreting what is seen. Nursing models can explain a person's response to stress and the process and desired outcomes of nursing interventions. Psychiatric nurses enhance their practice by basing their actions on a model of psychiatric nursing care that is inclusive, holistic, and relevant to the needs of patients, families, groups, and communities.

This textbook is based on the Stuart Stress Adaptation Model of psychiatric nursing care, which integrates biological, psychological, sociocultural, legal, ethical, policy, and advocacy aspects of patient care into a unified framework for practice. It was developed by Gail Stuart as a synthesis of diverse bodies of knowledge from the perspective of psychiatric nursing and, equally important, as an application of this knowledge to clinical practice. This model is based on five theoretical assumptions.

THEORETICAL ASSUMPTIONS

The first assumption of the Stuart Stress Adaptation Model is that nature is ordered as a social hierarchy from the simplest unit to the most complex (Figure 3-1). Each level of this hierarchy is an organized whole. Each level also is a part of all of the other levels, so nothing exists in isolation. Thus the individual is a part of the family, group, community, society, and the larger biosphere. Material and information flow across levels, and each level is influenced by all the others. The most basic level of nursing intervention is the individual. However, in working with the individual, the nurse also must consider how the individual relates to the whole.

The second assumption of the model is that nursing care is provided within a biological, psychological, sociocultural, legal, ethical, policy and advocacy context. Each of these aspects of care is described in detail in Chapters 5 through 9. The nurse must understand each of them in order to provide competent, holistic psychiatric nursing care. The theoretical basis for psychiatric nursing practice is derived from nursing science as well as from the behavioral, social, and biological sciences. The range of theories used by psychiatric nurses includes nursing, developmental psychology, neurobiology, pharmacology, psychopathology, learning, sociocultural, cognitive, behavioral, economic, organizational, political, legal, ethical, interpersonal, group, family, and milieu.

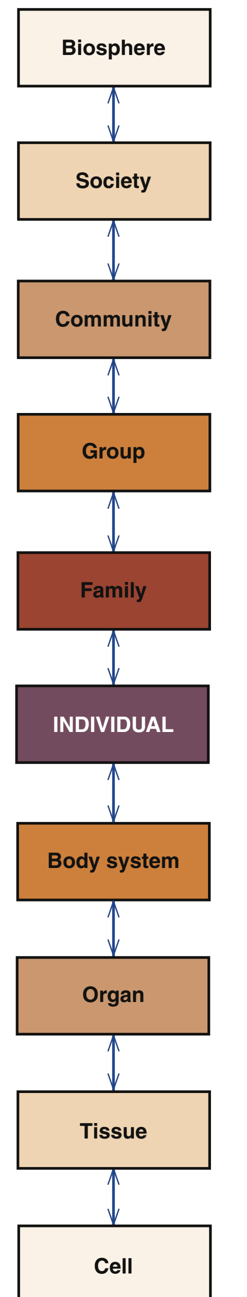

FIG 3-1 Levels of organization that comprise the social hierarchy.

The third assumption of the model is that health/illness and adaptation/maladaptation are two distinct continuums:

- **The health/illness continuum comes from a medical world view.**
- **The adaptation/maladaptation continuum comes from a nursing world view.**

This means that a person with a medically diagnosed illness may be adapting well to it. An example is the adaptive coping responses used by some people who have chronic physical or psychiatric illnesses. In contrast, a person without a medically diagnosed illness may have many maladaptive coping responses. This can be seen in the adolescent whose problematic behaviors reflect poor coping responses to the many issues that must be resolved during adolescence. These two continuums thus reflect the complementary nature of the nursing and medical models of practice.

The fourth assumption is that the model includes prevention, treatment and recovery by describing four stages of psychiatric care: crisis, acute, health maintenance, and health promotion. For each stage of treatment the model suggests a treatment goal, a focus of the nursing assessment, the nature of nursing interventions, and the expected outcome of nursing care. Because it includes the full continuum of care, it can direct nursing practice in the hospital, community, and home settings.

The fifth assumption of the Stuart Stress Adaptation Model is that it is based on the use of the nursing process and the standards of care and professional performance for psychiatric nurses (Chapter 11). Psychiatric nursing care is provided through assessment, diagnosis, outcome identification, planning, implementation, and evaluation. Each step of the process is important, and the nurse assumes full responsibility for all nursing actions implemented and the enactment of a professional nursing role.

The assumptions of the Stuart Stress Adaptation Model are summarized in Box 3-1.

BOX 3-1 ASSUMPTIONS OF THE STUART STRESS ADAPTATION MODEL

- Views nature as ordered on a social hierarchy
- Assumes a holistic biopsychosocial approach to psychiatric nursing practice
- Regards adaptation/maladaptation as distinct from health/illness
- Addresses prevention, treatment, and recovery in psychiatric care
- Identifies the four stages of care—crisis, acute, health maintenance, and health promotion—in nursing activities
- Can be used across health care settings and throughout the continuum of care
- Is based on standards of psychiatric nursing care and professional performance

DESCRIBING MENTAL HEALTH AND ILLNESS

The standards of mental health are less clear than those of mental illness. It is dangerous to assume that an unusual lifestyle is a sign of illness or abnormality. This can be avoided if one thinks of health/illness and conformity/deviance as separate concepts. Combining them creates four patterns: the healthy conformist, the healthy deviant, the unhealthy conformist, and the unhealthy deviant (Figure 3-2). Psychiatric nurses must carefully consider the meaning of an individual's behavior and its context, because it reflects an adaptation to issues in the individual's life and one's social and cultural environment.

A person should not be assessed against some vague or ideal notion of mental health. Each person should be seen in both

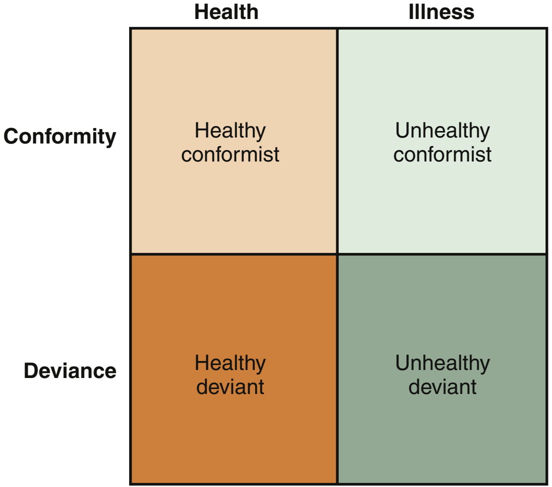

FIG 3-2 Patterns of behavior.

a group and an individual context. The issue is not how well someone fits an arbitrary sociocultural standard, but rather what is reasonable for a particular person in their life situation. Is there continuity or discontinuity with the past? Does the person adapt to changing needs throughout the life cycle?

Defining Mental Health

Mental health is a state of well-being associated with happiness, contentment, satisfaction, achievement, optimism, or hope. However these terms are difficult to define, and their meanings change as they relate to a particular person and life situation. Some suggest that mental health is not a simple concept or a single aspect of behavior. Instead, mental health involves a number of criteria that exist on a continuum. Although no one reaches the ideal in all the criteria, most people can approach the optimum.

> **Critical Reasoning** Do you think that a person with diabetes that is controlled with medication can still be regarded as healthy? How does this compare with a person who has schizophrenia that is controlled with medication?

Criteria of Mental Health. The following six criteria are indicators of mental health:

1. Positive attitudes toward self
2. Growth, self-actualization and resilience
3. Integration
4. Autonomy
5. Reality perception
6. Environmental mastery

Positive attitudes toward self include an acceptance of oneself and self-awareness. A person must have some objectivity about the self and realistic aspirations that necessarily change with age. A healthy person also must have a sense of identity, wholeness, belongingness, security, and meaningfulness.

Growth, self-actualization and resilience mean that the individual seeks new experiences to more fully explore aspects of oneself. Maslow (1958) and Rogers (1961) developed theories on the realization of the human potential. Maslow describes the concept of *self-actualization*, and Rogers emphasizes the *fully functioning person*. Both theories focus on the entire range of human adjustment. They describe a self as always seeking new growth, development, and challenges. These theories focus on the total person and whether the person has the following characteristics:

- Is in touch with one's self and able to use the available resources
- Has access to personal feelings and can integrate them with thoughts and behaviors
- Can interact freely and openly with the environment
- Can share with other people and grow from such experiences

This criterion includes the concept of **resilience,** which is the ability to achieve, retain, or regain a level of physical or emotional health after a tragedy, trauma, adversity or significant stressor. It is the idea that some people "bounce back" after a problem, and proposes that humans must weather periods of stress and change throughout life. Successfully weathering each period of disruption and reintegration leaves the person better able to deal with the next life change (Wagnild and Collins, 2009; Resnick and Inguito, 2011).

Integration is a balance between what is expressed and what is repressed, between outer and inner conflicts. It includes the regulation of emotional responses and a unified philosophy of life. This criterion can be measured by the person's ability to withstand stress and cope with anxiety. A strong but not rigid ego allows the person to handle change and grow as a result of it.

Autonomy involves self-determination, a balance between dependence and independence, and acceptance of the consequences of one's actions. It implies that the person is self-responsible for decisions, actions, thoughts, and feelings. As a result the person can respect autonomy and freedom in others.

Reality perception is the individual's ability to test assumptions about the world and to change perceptions based on new information. This criterion includes empathy, social sensitivity, and a respect for the feelings and attitudes of others.

Environmental mastery allows a mentally healthy person to feel success in an approved role in society. The person can deal effectively with the world, work out personal problems, and obtain satisfaction from life. The person should be able to cope with loneliness, aggression, and frustration without being overwhelmed. The mentally healthy person can respond to others, love and be loved, build new friendships and have satisfactory social group involvement.

Defining Mental Illness

Mental illness is a behavioral or psychological pattern demonstrated by an individual that causes significant distress, impaired functioning, and decreased quality of life. It reflects an underlying psychobiological dysfunction and is not the result of social deviance or conflicts with society.

BOX 3-2 KEY FACTS ABOUT MENTAL AND SUBSTANCE USE DISORDERS

Overall

- Almost one-fourth of all adult stays in general hospitals involves mental or substance use disorders.
- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.
- In 2008, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness; 2 million youths aged 12 to 17 had a major depressive episode during the past year.
- Up to 83% of people with serious mental illness are overweight or obese.
- People with serious mental illness have shortened life spans, living on average only until 53 years of age.
- About 64% of antidepressants are prescribed in primary care practices.

Substance Use

- Each year, approximately 5,000 youths under the age of 21 die as a result of underage drinking.
- Annually, tobacco use results in more deaths (443,000 per year) than AIDS, unintentional injuries, suicide, homicide, and alcohol and drug abuse combined. Almost half of these deaths occur among people with mental and substance use disorders.
- In 2008, an estimated 2.9 million persons aged 12 and older used an illicit drug for the first time within the past 12 months, an average of 8,000 initiates per day.
- Adults who began drinking alcohol before age 21 are more likely to be later classified with alcohol dependence or abuse than those who had their first drink at or after age 21.
- In 2009, an estimated 23.5 million Americans aged 12 and older needed treatment for substance use.
- Among persons aged 12 and older who used prescription pain relievers nonmedically in the past 12 months, 56% got them from a friend or relative for free.
- In 2009, the percentage of female youth aged 12 to 17 (14%) who were current drinkers was similar to the rate for male youth aged 12 to 17 (15%).
- In 2009, transition-age youths aged 18 to 25 had the highest rates of binge drinking (42%) and heavy alcohol use (14%) of any age group.
- About 44% of all cigarettes consumed are by individuals with a mental or substance abuse disorder.

Costs

- One estimate puts the total economic costs of mental, emotional, and behavioral disorders among youth in the United States at approximately $247 billion.
- The annual total estimated societal cost of substance abuse in the Unites States is $510.8 billion.
- Mood disorders rank first in work loss costs, second in total costs and third in health care costs.

Treatment

- Early treatment reduces disability, recurrence and death.
- Treatment rates exceed those for many medical illnesses:
  Bipolar disorder—80%
  Major depression—65%-80%
  Schizophrenia—60%
  Addiction—70%
- Pathways to recovery are highly personal.

Mental disorders are a major contributor to the burden of illness in the United States (Kessler et al, 2005a,b).

- Nearly 50% of all people ages 18 years and older have had a psychiatric or substance abuse disorder in their lifetimes.
- Half of all these lifetime cases start by age 14 and three-fourths start by age 24.

The seriousness and persistence of some disorders cause great strain on affected individuals, their families, communities, and the larger health care system. In addition, there is a substantial increased risk of premature death from natural and unnatural causes for people with common mental disorders (Druss and Bornemann, 2010). The Substance Abuse and Mental Health Services Administration (SAMHSA) has thus identified four important messages:

- **Behavioral health is an essential part of all health.**
- **Prevention works.**
- **Treatment is effective.**
- **People recover from mental health and substance use disorders.**

Box 3-2 presents other key facts about mental illness (SAMHSA, 2011).

Critical Reasoning Identify two key facts about mental illness presented in Box 3-2 that you did not know. How will these facts change your views about needed health care reform in the United States?

In 1996 the Global Burden of Disease Study examined the disabling outcomes of 107 diseases around the world. Of the 15 specific leading causes of disability in developed countries, five are mental health problems: (1) major depressive disorder, (2) alcohol use, (3) schizophrenia, (4) self-inflicted injuries, and (5) bipolar disorder (Murray and Lopez, 1996). **Depressive disorders as a single diagnostic category were the leading cause of disability worldwide.** Further, by the year 2020, mental disorders are projected to increase, and major depression is predicted to become the second leading cause in disease burden worldwide.

BIOPSYCHOSOCIAL COMPONENTS

The Stuart Stress Adaptation Model of psychiatric nursing care views human behavior from a holistic perspective that integrates biological, psychological, and sociocultural aspects of care. For instance, a man who has

had a myocardial infarction also may be severely depressed because he fears he will lose his ability to work and to satisfy his wife sexually. He also may have a family history of depression. Likewise, patients who seek treatment for major depression also may have gastric ulcers that are exacerbated by their depression. The holistic nature of psychiatric nursing practice examines all aspects of the individual, family, community and the environment. The specific biopsychosocial components of the Stuart Stress Adaptation Model are shown in Figure 3-3.

Predisposing Factors

Predisposing factors are **risk and protective factors** that influence the type and amount of resources the person can use to handle stress. They are biological, psychological, and sociocultural.

- **Biological** predisposing risk factors include genetic background, nutritional status, biological sensitivities, general health, and exposure to toxins.
- **Psychological** predisposing risk factors include intelligence, verbal skills, morale, personality, past experiences, self-concept and motivation, psychological defenses, and locus of control, or a sense of control over one's own fate.
- **Sociocultural** predisposing risk factors include age, gender, education, income, occupation, social position, cultural background, religious upbringing and beliefs, political affiliation, socialization experiences, and level of social integration or relatedness.

Precipitating Stressors

Precipitating stressors are stimuli that are challenging, threatening, or demanding to the individual. They require excess energy and produce a state of tension and stress. They may be biological, psychological, or sociocultural in **nature.** They may **originate** either in the person's internal environment or in the person's external environment. It also is important to assess the **timing** of the stressor, which includes when the stressor occurred, how long the person was exposed to the stressor, and the frequency with which it occurred. A final factor is the **number** of stressors an individual experiences within a certain period because stressful events may be more difficult to deal with when many of them occur close together.

Stressful Life Events. The relationship of stressful life events to the cause, onset, course, and outcomes of psychiatric illnesses has been the focus of much research. Focus has

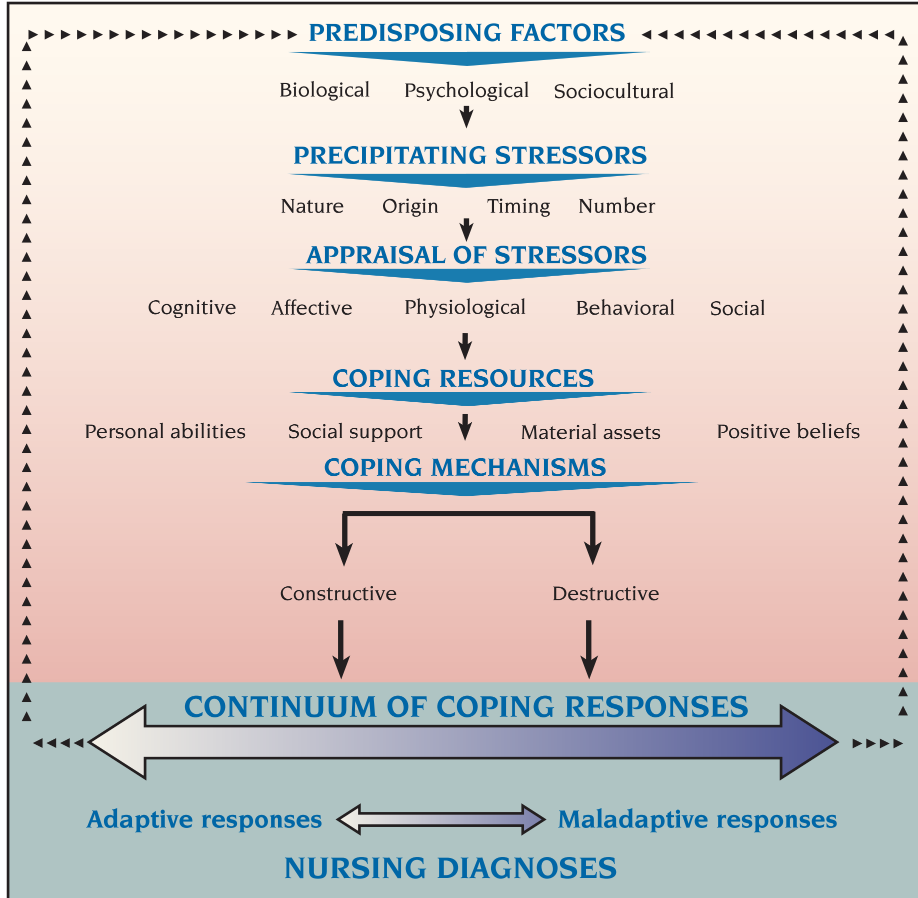

FIG 3-3 Biopsychosocial components of the Stuart Stress Adaptation Model of psychiatric nursing care.

been on the nature of the event and the amount of change it requires. There are three ways to categorize life events:

1. **By social activity.** This includes family, work, educational, social, health, financial, legal, or community crises.
2. **By social field.** These events are defined as entrances and exits. An entrance is the introduction of a new person into the individual's social field; an exit is the departure of a significant other from the person's social field.
3. **By social desirability.** Within social norms, events can be considered generally desirable, such as promotion, engagement, and marriage, or generally undesirable, such as death, financial problems, being fired, and divorce.

Unfortunately, it is hard to determine the exact role played by stressful life events. Although they have been correlated with the onset of anxiety and disease symptoms, the research has been criticized. For example, the particular events listed on a stressful life event scale may not be the most relevant to certain groups, such as students, working mothers, different cultural groups, the elderly, the poor, or the persistently mentally ill. Also the life-events approach provides no clues to the specific way in which the events affect physical or mental health.

It is better, therefore, to think about stressful life events along a continuum that can influence the development of psychiatric illness. At one end of the continuum, they may act as triggers that precipitate an illness in people who would have developed the illness eventually for one reason or another. At the other end of the continuum, stressful life events may make a person more vulnerable, reduce an individual's resistance and coping resources, and thus make the person more susceptible to psychiatric distress and illness.

> **Critical Reasoning** What sociocultural norms and values must be considered in evaluating the impact of potentially stressful life events?

Life Strains and Hassles. The stressful life-events theory is built on the idea of change in response to major life events. However, **small daily strains or hassles may have a greater effect on a person's mood and health than do major misfortunes**. Stress also can arise from smaller but more chronic problems or *life strains*, such as ongoing family tension, job dissatisfaction, and loneliness. Such life strains commonly occur in four areas:

1. Marital conflict
2. Parental issues with raising teenage and young adult children
3. Household finances
4. Dissatisfaction with one's job or work

Hassles are irritating, frustrating, or distressing incidents that occur in everyday life. These may include disagreements, disappointments, and unpleasant occurrences, such as losing a wallet, getting stuck in a traffic jam, or arguing with a family member. Research suggests that daily hassles may be better predictors of psychological and physical health than major life events. It has been shown that people who reported being exposed to more frequent and intense hassles had poorer overall mental and physical health. Major events did have some long-term effects, but these effects may be due to the daily hassles that are associated with them.

It is true that a certain amount of stress is necessary for survival, and degrees of it can challenge the individual to grow in new ways. However, too much stress at inappropriate times can place excessive demands on the individual and interfere with integrated functioning. The questions to be asked are these: How much stress is too much, and what is a stressful life event? These questions lead the nurse to explore the significance of the event as it relates to the individual's value system.

Appraisal of Stressors

Appraisal of a stressor involves determining the meaning of and understanding the impact of the stressful situation for the individual. It includes cognitive, affective, physiological, behavioral, and social responses. **Appraisal is an evaluation of the significance of an event in relation to a person's well-being.** The stressor assumes its meaning, intensity, and importance by the unique interpretation and significance given to it by the person at risk.

Cognitive Responses. Cognitive responses are a critical part of this model (Monat and Lazarus, 1991). Cognitive factors play a central role in adaptation. They account for the impact of the stressful event; the choice of coping patterns used; and the person's emotional, physiological, behavioral, and social reactions.

Cognitive appraisal mediates psychologically between the person and the environment in any stressful encounter. This means that the damage or potential damage of a situation is determined on the basis of the person's understanding of the situation's ability to do harm and the resources the person has available to neutralize or tolerate the harm. The three types of cognitive responses to stress are as follows:

1. **Harm/loss** that has already occurred
2. **Threat** of anticipated or future harm
3. **Challenge** that focuses on potential gain, growth, or mastery rather than on the possible risks

The perception of challenge plays an important role in resilience, psychological hardiness or resistance to stress. Resilient people are less likely to become ill as a result of stressful life events as seen in Box 3-3 (Alim et al, 2008). Resilient people typically possess the following characteristics:

- **Commitment**—the ability to involve oneself in whatever one is doing
- **Challenge**—- the belief that change rather than stability is to be expected in life, so events are seen as stimulating rather than threatening
- **Control**—the tendency to feel and believe that one is influencing events, rather than feeling helpless in the face of life's problems

In summary, resilient or stress-resistant people have a positive attitude toward life, an openness to change, a

BOX 3-3 THE SOCIOCULTURAL CONTEXT OF CARE

This study examined psychosocial factors associated with resiliency and recovery from psychiatric disorders in a high-risk sample of African-Americans exposed to severe traumas. It was found that:

- A sense of purpose in life was strongly associated with resilience.
- A sense of mastery was correlated with higher levels of self-efficacy and positive ethnic identity.
- Higher emotional expression was associated with resiliency, while suppression of emotions was associated with distress.
- Avoidant coping predicted poorer adjustment.
- Social support promoted resilience.

The investigators concluded that in resilient individuals, a number of stable characteristics such as optimism, mastery and purpose in life may foster adaptive coping strategies.

feeling of involvement in whatever they are doing, and a sense of control over events. Those who view stress as a challenge are more likely to turn events to their advantage and thus reduce their level of stress. In contrast, if a person uses passive, hostile, blaming, avoidant, or self-defeating tactics, the source of stress is not likely to resolve.

Critical Reasoning What is your level of hardiness as measured by the elements of commitment, challenge, and control? How will it influence your effectiveness as a nurse?

Affective Responses. An affective response is the arousal of a feeling. In the appraisal of a stressor, the major affective response is a generalized anxiety reaction, which becomes expressed as emotions. These may include joy, sadness, fear, anger, acceptance, distrust, anticipation, or surprise.

Emotions also may be described according to their type, duration, and intensity—characteristics that change over time and as a result of events. For example, when an emotion continues over a long period of time, it can be classified as a mood; when prolonged over an even longer time, it can be considered an attitude. **An insightful, optimistic, and positive attitude in dealing with life events can lead to greater feelings of well-being and perhaps even a longer life** (Lazarus, 1991).

Physiological Responses. Physiological responses reflect the interaction of several neuroendocrine axes involving growth hormones, prolactin, adrenocorticotropic hormones (ACTH), luteinizing hormones, follicle-stimulating hormones, thyroid-stimulating hormones, vasopressin, oxytocin, insulin, epinephrine, norepinephrine, and a variety of other neurotransmitters in the brain. The fight-or-flight physiological response stimulates the sympathetic division of the autonomic nervous system and increases activity of the pituitary-adrenal axis. In addition, stress has been shown to affect the body's immune system, influencing one's ability to fight disease.

Behavioral Responses. Behavioral responses are the result of emotional and physiological responses, as well as one's cognitive analysis of the stressful situation. Caplan (1981) described four phases of an individual's behavioral responses to a stressful event:

- *Phase 1* is behavior that changes the stressful environment or allows the individual to escape from it.
- *Phase 2* is behavior that allows the individual to change the external circumstances and their aftermath.
- *Phase 3* is intrapsychic behavior that serves to defend against unpleasant emotional arousal.
- *Phase 4* is intrapsychic behavior that helps one come to terms with the event and its sequelae by internal readjustment.

Social Responses. Finally, the possible social responses to stress and illness are many and are based on three activities (Mechanic, 1977):

1. **Search for meaning,** in which people seek information about their problem. This is necessary for devising a coping strategy because only through having some idea of what is occurring can one develop a reasonable response.
2. **Social attribution,** in which the person tries to identify the factors that contributed to the situation. Patients who see their problems as resulting from their own negligence may be "blocked" and not able to activate a coping response. They may see their problems as a sign of their personal failure and engage in self-blame and passive, defeatist, and withdrawn behavior.
3. **Social comparison,** in which people compare skills and capacities with those of others with similar problems. A person's self-assessment depends very much on those with whom comparisons are made. The outcome is an evaluation of the need for support from the person's social network or support system. Predisposing factors, such as age, developmental level, and cultural background, as well as the characteristics of the precipitating stressor, determine the perceived need for social support.

In summary the way a person appraises an event is the psychological key to understanding coping efforts and the nature and intensity of the stress response. Unfortunately, many nurses and other health professionals ignore this fact when they presume to know how certain stressors will affect a patient and thus provide "routine" care. This practice not only depersonalizes the patient but also undermines the basis of nursing care. The patient's appraisal of life stressors, with its cognitive, affective, physiological, behavioral, and social components, must be an essential part of the psychiatric nurse's assessment.

Critical Reasoning How might social attribution influence a nurse's response to a rape victim, a person with a substance abuse disorder, or a patient with human immunodeficiency virus (HIV)?

Coping Resources

Coping resources are options or strategies that help determine what can be done as well as what is at stake. They can take into account the coping options that are available, the chances that a given option will be successful and the likelihood that the person can apply a particular strategy effectively.

Coping resources are protective factors. They include economic assets, abilities and skills, social supports, and motivation, and incorporate all levels of the social hierarchy represented in Figure 3-1. Relationships among the individual, family, group, and society are critically important at this point of the model. Other coping resources include health and energy, spiritual supports, positive beliefs, problem-solving and social skills, social and material resources, and physical well-being.

- **Spiritual beliefs** can serve as a basis of hope and can sustain a person's coping efforts under the most adverse circumstances.
- **Problem-solving skills** include the ability to search for information, identify the problem, weigh alternatives, and implement a plan of action.
- **Social skills** help solve problems involving other people, increase the likelihood of getting cooperation and support from others, and give the individual greater social control.
- **Material assets** refer to money and the goods and services that money can buy. Obviously, monetary resources greatly increase a person's coping options in almost any stressful situation.
- **Knowledge and intelligence** are coping resources that allow people to identify different ways of dealing with stress.
- **Strong ego identity, commitment to a social network, cultural stability, a stable system of values and beliefs, and a preventive health orientation** are other coping resources.

Coping Mechanisms

It is at this point in the model that coping mechanisms emerge. This is an important time for nursing activities directed toward primary prevention. **Coping mechanisms** are any efforts directed at stress management and they can be constructive or destructive. The three main types of coping mechanisms are as follows:

1. **Problem-focused** coping mechanisms, which involve tasks and direct efforts to cope with the threat itself. Examples include negotiation, confrontation, and seeking advice.
2. **Cognitively-focused** coping mechanisms, by which the person attempts to control the meaning of the problem and thus neutralize it. Examples include positive comparison, selective ignorance, substitution of rewards, and the devaluation of desired objects.
3. **Emotion-focused** coping mechanisms, by which the patient is oriented to moderating emotional distress. Examples include the use of ego defense mechanisms, such as denial, suppression, or projection. A detailed discussion of coping and defense mechanisms appears in Chapter 15.

Coping mechanisms are constructive when anxiety is treated as a warning signal and the individual accepts it as a challenge to resolve the problem. In this way anxiety can be compared with a fever: both serve as warnings that the system is under attack. Once used successfully, constructive coping mechanisms modify the way past experiences are used to meet future threats. **Destructive coping mechanisms ward off anxiety without resolving the conflict, using evasion instead of resolution.**

PATTERNS OF RESPONSE

According to the Stuart Stress Adaptation Model an individual's response to stress is based on specific predisposing factors, the nature of the stressor, the perception of the situation, and an analysis of coping resources and mechanisms. Coping responses of the patient are then evaluated on a continuum of adaptation/maladaptation (see Figure 3-3).

- **Responses that support integrated functioning are seen as adaptive.** They lead to growth, learning, and goal achievement.
- **Responses that block integrated functioning are seen as maladaptive.** They prevent growth, decrease autonomy, and interfere with mastery of the environment.

Nursing Diagnoses

Responses to stress, whether actual or potential, are the subject of nursing diagnoses. A **nursing diagnosis** is a clinical judgment about individual, family, or community responses to stress. It is a statement of the patient's problem from a nursing perspective that includes both the adaptive and maladaptive responses and contributing stressors. These responses may be overt, covert, existing, or potential and may lie anywhere on the continuum from adaptive to maladaptive. Formulating the diagnosis and implementing treatment are nursing functions for which the nurse is accountable. NANDA International (NANDA-I)–approved nursing diagnoses are listed in Appendix A.

Relationship to Medical Diagnoses

A **medical diagnosis** is the health problem or disease state of the patient. In the medical model of psychiatry, these health problems are mental disorders or mental illnesses. It is important for psychiatric nurses to distinguish between nursing and medical models of care, as shown in Figure 3-4. In particular, the following differences should be noted:

- Nurses assess risk factors and look for vulnerabilities; physicians assess disease states and look for causes.
- Nursing diagnoses focus on the adaptive/maladaptive coping continuum of human responses; medical diagnoses focus on the health/illness continuum of health problems.
- Nursing intervention consists of caregiving activities; medical intervention consists of curative treatments.

A nurse implements the nursing process for maladaptive responses based on the Stuart Stress Adaptation Model regardless of whether a physician has diagnosed the presence of a medical or psychiatric illness. Also, patients with a persistent psychiatric illness may be adapting well to it. People can successfully adapt to an illness without recovering from it. This

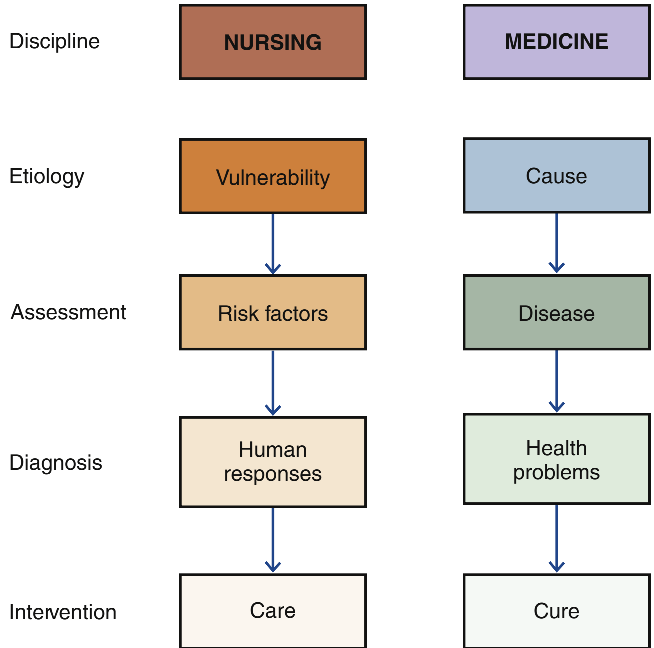

FIG 3-4 Comparison of nursing and medical models of care.

is an important aspect of the Stuart Stress Adaptation Model. **It means that psychiatric nurses can promote their patients' adaptive responses regardless of their health or illness state.**

Classifying Mental Disorders

Mental illnesses can be broadly differentiated as neurotic or psychotic. **Neuroses** have the following characteristics:

- A symptom or group of symptoms is distressing and is recognized as unacceptable and alien to the individual.
- Reality testing is intact.
- Behavior does not violate major social norms (although functioning may be significantly impaired).
- The disturbance is enduring or recurrent without treatment and is not a short-term reaction to stressors.
- No apparent organic cause or factor is present.

However, in situations of extreme conflict, the person may distort reality, such as in psychosis. **Psychosis** consists of the following characteristics:

- Regressive behavior
- Personality disintegration
- A significant reduction in level of awareness
- Great difficulty in functioning adequately
- **Gross impairment in reality testing**

This last characteristic is critical. When people demonstrate gross impairment in reality testing, their perceptions are not accurate and they draw incorrect inferences about external reality, even in the face of contrary evidence. Direct evidence of psychosis is the presence of delusions or hallucinations without insight into their pathological nature. Psychotic health problems reflect the most severe level of psychiatric illness.

DSM-IV-TR. Medical diagnoses are classified according to the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*) of the American Psychiatric Association (2000). The fifth edition of the DSM is scheduled for publication in 2013 (Kupfer and Reiger, 2010). The various illnesses are accompanied by a description of diagnostic criteria, tested for reliability by psychiatric practitioners. It has been noted, however, that the DSM diagnoses are not as precise as the diagnostic processes in the rest of medicine (Kendler, 2008; Pierre, 2010).

DSM-IV-TR uses a multiaxial system of various mental disorders, general medical conditions, aspects of the environment, and areas of functioning that might be overlooked if the focus were only on assessing a single presenting problem. Thus the individual is evaluated on the following axes:

- **Axis I: Clinical syndromes**
- **Axis II: Personality disorders**
- **Axis III: General medical conditions**
- **Axis IV: Psychosocial and environmental problems**
- **Axis V: Global assessment of functioning**

Axes I and II include the entire classification of mental disorders plus conditions that are not attributable to a mental disorder but that are a focus of attention or treatment. Axis III allows the clinician to identify any physical disorder relevant to the understanding or treatment of the individual. Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders. Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment, measuring its impact, and predicting outcomes (Smith et al, 2011). Axes I to V are presented in Appendix B. Psychiatric nurses use all five axes of the *DSM-IV-TR* and integrate the axes with related nursing diagnoses.

Cultural formulation. In addition to Axes I to V, the *DSM-IV-TR* has an outline for cultural formulation designed to help the clinician in systematically evaluating the person's cultural and social reference group and ways in which the cultural context is relevant to clinical care (Chapter 7). It is suggested that the clinician provide a narrative summary of the evaluation of the categories listed in Box 3-4 (see Appendix B for added detail).

BOX 3-4 OUTLINE FOR CULTURAL FORMULATION IN PSYCHIATRIC DIAGNOSIS

- Cultural identity of the individual
- Cultural explanations of the individual's illness
- Cultural factors related to one's psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and clinician
- Overall cultural assessment for diagnosis and care

The *DSM-IV-TR* also includes a list of **culture-bound syndromes** that are recurrent, locality-specific patterns of aberrant behavior and troubling experiences that may be linked to a particular *DSM-IV-TR* diagnostic category (Table 3-1). Although behaviors related to most *DSM-IV-TR* categories can be found throughout the world, the particular symptoms, course of illness, and social response are often influenced by cultural factors. In contrast, culture-bound syndromes are

TABLE 3-1 COMMON CULTURE-BOUND SYNDROMES

SYNDROME	REGION/POPULATION AFFECTED	DESCRIPTION
Amok	Malaysia	This is a dissociative episode typically preceded by a period of reflection and brooding, followed by an outburst of violent, aggressive, or homicidal behavior directed at people and objects. If the attacker is not killed, they often collapse and claim amnesia upon gaining consciousness.
Ataque de nervios	Latin America	Its literal translation is "attack of the nerves." The symptoms are transient, typically occur suddenly in response to a severe psychosocial stressor, and include impulsive, dramatic behaviors such as screaming uncontrollably, crying, trembling and nervousness, and anger and violence.
Brain fag	West Africa	Seen predominantly in male West African students, it generally manifests as vague somatic symptoms, depression, and difficulty concentrating.
Koro	South and east Asia	In men, it is the belief that the genitals are retracting into the abdomen, are shrinking and will soon disappear. For females, the belief focuses on the nipples retracting or shrinking. It is associated with anxiety symptoms.
Mal de ojo ("evil eye")	Mediterranean cultures and elsewhere in the world	Sometimes called "evil eye," it is a folk illness which most commonly affects children. It has been defined as a hex caused by a gaze from a more powerful or stronger person looking a weaker person (usually an infant or child but sometimes a woman). Symptoms include headaches, high fever, diarrhea, not sleeping well, increased fussiness, and weeping.

generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that give coherent meanings for certain common, patterned, and troubling sets of experiences and observations.

TREATMENT STAGES AND ACTIVITIES

The final aspect of the Stuart Stress Adaptation Model is the integration of the theoretical basis, biopsychosocial components, patterns of response, and nursing activities based on the patient's treatment stage. Once patterns of coping responses have been identified, the nurse determines the patient's treatment stage and implements the most appropriate nursing activities. The model identifies four possible treatment stages: (1) crisis, (2) acute, (3) health maintenance, and (4) health promotion. These stages reflect the range of the adaptive/maladaptive continuum and suggest a variety of nursing activities. For each stage the nurse identifies the treatment goal, focus of the nursing assessment, nature of the nursing intervention, and expected outcome of nursing care (Figure 3-5).

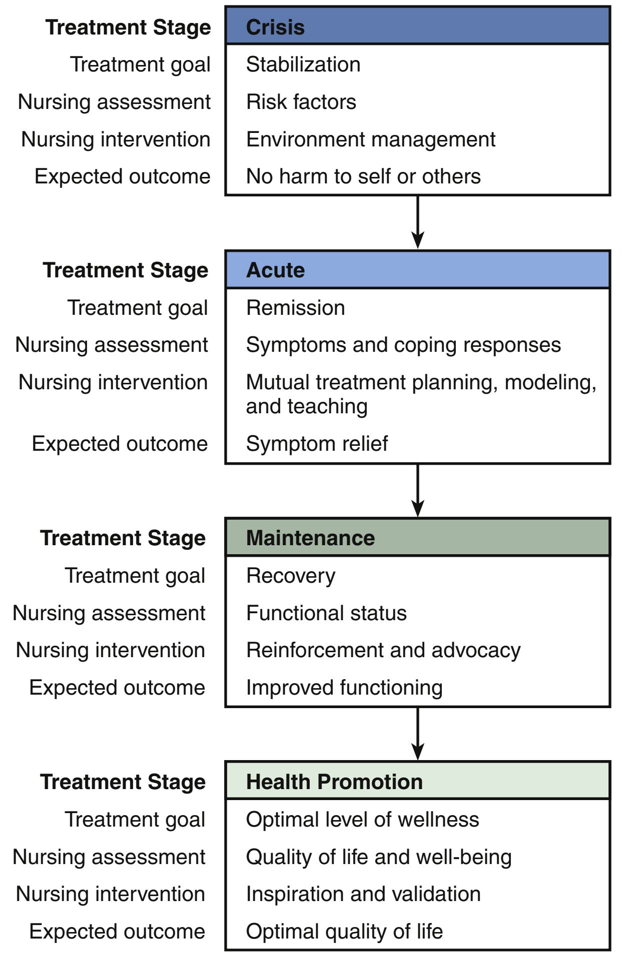

FIG 3-5 Psychiatric nursing treatment stages and activities.

Crisis Stage

Nursing goal: stabilization of the patient

Nursing assessment: focuses on risk factors that threaten the patient's health and well-being

Nursing intervention: directed toward managing the environment to provide safety

Nursing expected outcome of care: no harm to the patient or others

Acute Stage

Nursing goal: remission of the patient's illness

Nursing assessment: focuses on the patient's symptoms and maladaptive coping responses
Nursing intervention: directed toward treatment planning with the patient and the modeling and teaching of adaptive responses
Nursing expected outcome of care: symptom relief

Health Maintenance Stage

Nursing goal: complete recovery of the patient
Nursing assessment: focuses on the patient's functional status
Nursing intervention: directed toward reinforcement of the patient's adaptive coping responses and patient advocacy
Nursing expected outcome of care: improved patient functioning

Health Promotion Stage

Nursing goal: achievement of the patient's optimal level of wellness
Nursing assessment: focuses on the patient's quality of life and well-being
Nursing intervention: directed toward inspiring and validating the patient
Nursing expected outcome of care: optimal quality of life for the patient

This aspect of the model moves the field of psychiatric nursing beyond the usual activities associated with the stabilization of patients in crisis and remission of the acutely ill patient's symptoms. It identifies nursing responsibilities in the health maintenance and health promotion treatment stages as improving patients' functional status, enhancing their quality of life, and preventing future health problems.

These treatment stages are often overlooked but they are essential aspects of the contemporary psychiatric nursing role. These stages also relate to the levels of prevention in psychiatric care and the clinical chapters of this text, as shown in Table 3-2.

The synthesis of all elements of the Stuart Stress Adaptation Model of psychiatric nursing care is displayed in Figure 3-6. These elements also are summarized in Table 3-3. On the far left side of Figure 3-6 one can see the many theories that contribute to psychiatric nursing care. On the far right side are the six steps of the nursing process. In the middle of the figure, the top portion shows the impact of predisposing factors, precipitating stressors, appraisal of stressors, coping

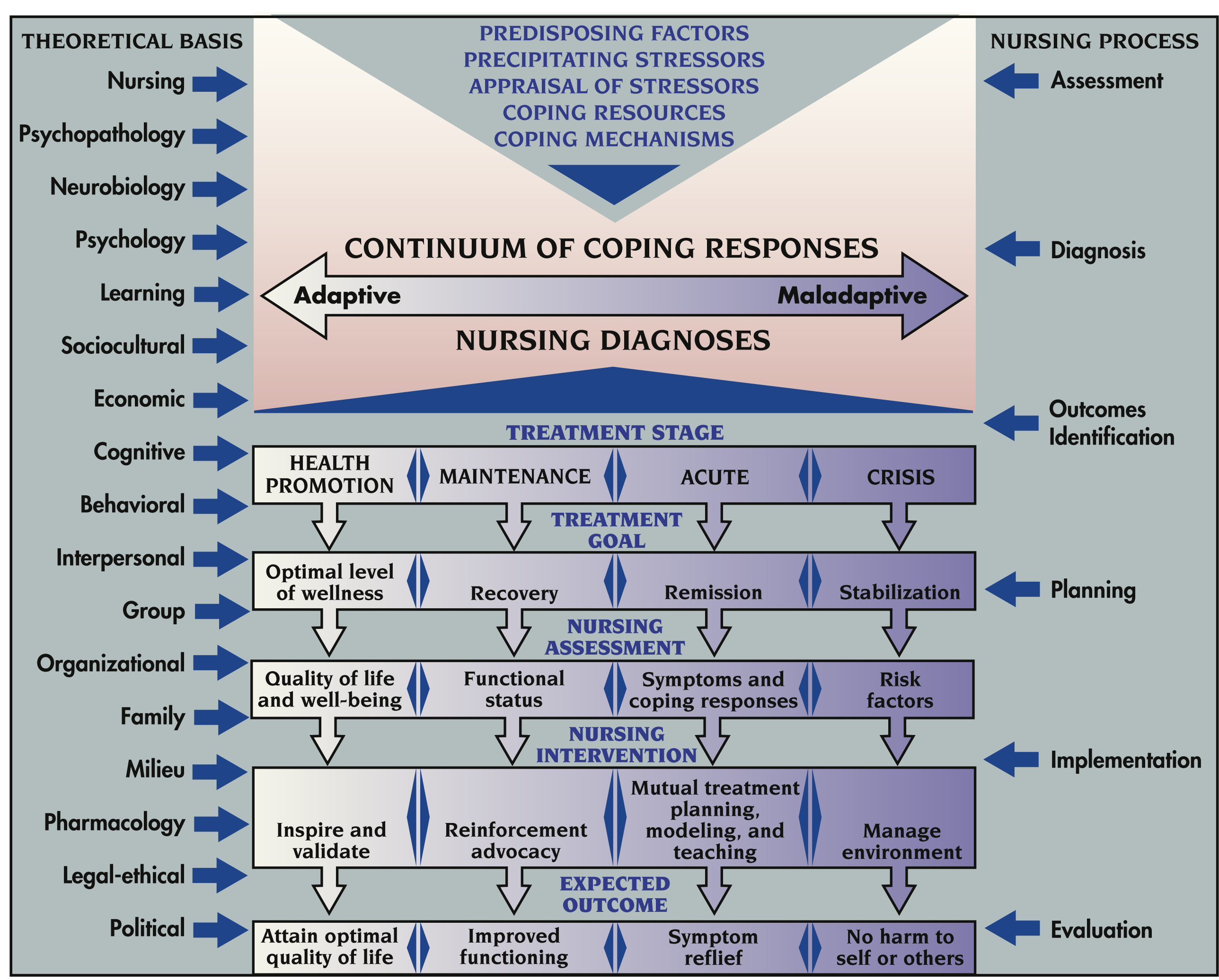

FIG 3-6 The Stuart Stress Adaptation Model of psychiatric nursing care.

TABLE 3-2 STAGES OF TREATMENT RELATED TO LEVELS OF PREVENTION AND CHAPTERS OF THE TEXT

STAGE OF TREATMENT	LEVEL OF PREVENTION	CHAPTER(S)
Health promotion	Primary prevention	12: Prevention and Mental Health Promotion
Crisis	Secondary prevention	13: Crisis Intervention
Acute	Secondary prevention	15-25: Clinical chapters
Health maintenance	Tertiary prevention	14: Recovery Support

resources, and coping mechanisms, all of which lead to either adaptive or maladaptive coping responses and related nursing diagnoses. Also in the middle of the figure one sees each treatment stage with its related treatment goal, nursing assessment, nursing intervention, and expected outcome of care.

Chapters 15 through 25 of this text explore various maladaptive coping responses and related medical diagnoses. The phases of the nursing process are described for patients with maladaptive responses. Each chapter begins with a continuum of coping responses, followed by a discussion of behaviors, predisposing factors, precipitating stressors, appraisal of stressor, coping resources, coping mechanisms, nursing diagnoses, and related interventions. Through consistent application of the Stuart Stress Adaptation Model, the art and science of psychiatric nursing practice emerge.

TABLE 3-3 SUMMARY OF THE ELEMENTS OF THE STUART STRESS ADAPTATION MODEL

ELEMENT	DEFINITION	EXAMPLES
Predisposing factors	Risk factors that influence both type and amount of resources person can elicit to cope with stress	Genetic background, intelligence, self-concept, age, ethnicity, education, gender, belief systems
Precipitating stressors	Stimuli that person perceives as challenging, threatening, or demanding and that require excess energy for coping	Life events, injury, hassles, strains
Appraisal of stressor	Evaluation of significance of a stressor for a person's well-being, considering stressor's meaning, intensity, and importance	Hardiness, perceived seriousness, anxiety, attribution
Coping resources	Evaluation of a person's coping options and strategies	Finances, social support, ego integrity
Coping mechanisms	Any effort directed at stress management	Problem solving, compliance, defense mechanisms
Continuum of coping responses	Range of adaptive or maladaptive human responses	Social changes, physical symptoms, emotional well-being
Treatment stage activities	Range of nursing functions related to treatment goal, nursing assessment, nursing intervention, and expected outcome	Environment management, patient teaching, role modeling, advocacy

CHAPTER IN REVIEW

- The Stuart Stress Adaptation Model assumes that: (1) nature is ordered as a social hierarchy; (2) psychiatric nursing care is provided through the nursing process within a biological, psychological, sociocultural, legal, ethical, political and advocacy context; (3) health/illness and adaptation/maladaptation are distinct concepts; (4) prevention, treatment and recovery are included in the four stages of psychiatric treatment—crisis, acute, health maintenance and health promotion; and (5) it is based on the use of the nursing process and the standards of care and professional performance for psychiatric nurses.
- Criteria of mental health include positive attitudes toward self; growth, self-actualization and resilience; integration; autonomy; reality perception; and environmental mastery.
- Mental illness is a behavioral or psychological pattern demonstrated by an individual that causes significant distress, impaired functioning, and decreased quality of life.
- It reflects an underlying psychobiological dysfunction and is not the result of social deviance or conflicts with society.
- Nearly one of every two people in the United States has experienced a psychiatric illness or substance abuse disorder in his or her lifetime. Half of these cases start by age 14.
- The biopsychosocial components of the model include predisposing factors, precipitating stressors, appraisal of stressors, coping resources, and coping mechanisms.
- Patterns of response include the individual's coping responses, which are the subject of NANDA-I nursing diagnoses, and the individual's health problems, which are the subject of medical diagnoses described by Axes I to V of the *DSM-IV-TR*. In addition, the *DSM-IV-TR* has an outline for cultural formulation designed to help in evaluating the person's cultural and social reference group and ways in which the cultural context is relevant to clinical care.
- Psychiatric nursing goals, assessment, intervention, and expected outcome can be identified for each of the four stages of treatment: crisis, acute, health maintenance, and health promotion.

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CHAPTER 4

Evidence-Based Psychiatric Nursing Practice

Gail W. Stuart

I have an almost complete disregard of precedent, and a faith in the possibility of something better. It irritates me to be told how things have always been done. I defy the tyranny of precedent. I go for anything that might improve the past.

Clara Barton

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Define evidence-based practice.
2. Describe the activities necessary for providing evidence-based psychiatric nursing care.
3. Analyze practice guidelines and their contribution to clinical care.
4. Examine the importance of outcome measurement in psychiatric nursing practice.
5. Evaluate the evidence base for psychiatric nursing practice and an agenda for psychiatric nursing research.

Evidence-based practices are a priority in health care, including care to those with psychiatric and substance use disorders. This is due in part to **the large gap that exists between the mental health care that research has found to be most effective and the mental health care that most people receive.**

Despite existing evidence and agreement on some of the effective treatments for persons with mental illness, research shows that few patients with psychiatric disorders receive evidence-based care (Horvitz-Lennon et al, 2009; Resnick and Rosenheck, 2009). In addition, research is limited on the evidence base of the policies and politics of the mental health delivery system, including agencies, programs, and service effectiveness.

Thus increasing national attention has been focused on evidence-based practice. In psychiatry some of the evidence-based treatments include the following:

- Medication treatment, evaluation and management
- Illness management and recovery
- Specialized psychotherapies
- Peer/consumer-operated services and support
- Family psychoeducation
- Psychosocial rehabilitation
- Supported employment
- Permanent supportive housing
- Assertive community treatment
- Substance abuse treatment integrated with mental health treatment
- Crisis/hospital diversion programs
- Treatment of depression in older adults
- Mental health promotion
- Specific interventions for children and adolescents, including therapeutic foster care, multisystemic therapy, positive behavior supports in schools, and parent-child interaction therapy

The National Registry of Evidence-Based Programs and Practices (NREPP), developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), is a source of information on a wide range of evidence-based interventions to prevent and treat mental and substance use disorders (www.nrepp.samhsa.gov) (Hennessy and Green-Hennessy, 2011).

For psychiatric nurses the use of evidence-based practices raises three questions:

1. **Do psychiatric nurses know the efficacy of their treatments and interventions?**
2. **Is the care they provide evidence-based?**
3. **Are they documenting the nature and outcomes of their nursing care?**

The answers to these questions are important in determining the contributions that nurses will make to mental health care.

This textbook uses an evidence-based approach to psychiatric nursing practice. It examines the research that supports psychiatric nursing care and highlights findings in the field by including **Summary of Evidence-Based Practice boxes in the chapters focused on treating clinical disorders (Unit 3).** It also provides primary sources of evidence in the references of each chapter.

EVIDENCE-BASED PRACTICE

Accountability for patient care outcomes is a basic responsibility of professional nurses. Central to this accountability is the ability to examine nursing practice patterns, identify the best available research related to them, and demonstrate sound clinical decision making that incorporates environmental and organizational influences (Figure 4-1). It also takes into account the patients' values, characteristics, preferences, and circumstances, as well as the skill and resources of the nurse (Fisher and Happell, 2009).

Psychiatric nurses cannot rely on traditional practices, opinion-based processes, or unproven theories. They need to question their current practices and find ways to improve patient care. To do this, nurses must research the literature, critically analyze research findings, and apply relevant evidence to practice. This is the essence of evidence-based practice.

Evidence-based practice is the conscientious, explicit, and judicious use of the best evidence gained from systematic research for the purpose of making informed decisions about

FIG 4-1 Evidence-based behavioral practice. (Modified from Spring B, Hitchcock K: Evidence-based practice in psychology. In Weiner IB, Craighead WE, editors: *Corsini's encyclopedia of psychology,* ed 4, pp 603-607, New York, 2009, Wiley.)

the care of individual patients (Sackett, 2003). **It blends a nurse's clinical expertise with the best available research evidence.** It also is a method of self-directed, career-long learning in which the nurse continuously seeks the best possible outcomes for patients and implements effective interventions based on the most current research evidence (Rice, 2008a; Melnyk and Fineout-Overholt, 2010).

The evidence-based model is based on the following assumptions:

- Information gathered only from one's own clinical practice often involves unsystematic observations and subjective judgments.
- All clinicians have biases that influence their clinical care.
- Even theories from respected colleagues must be tested and must provide evidence of efficacy in order to be useful to clinical practice.
- Knowing that conclusions were reached through scientific methodology permits a higher level of confidence in one's nursing actions.
- Replication of findings increases confidence in their validity.
- Randomized controlled clinical trials are the gold standard of research methodologies.
- Nurses who are able to critically review the research literature related to a specific clinical question will be able to provide better nursing care.

Bases for Nursing Practice

There are four bases for nursing practice (Stetler et al, 1998):

1. The lowest level is the **traditional basis** for practice, which includes rituals, unverified rules, anecdotes, customs, opinions, and unit culture.
2. The second level is the **regulatory basis** for practice, which includes state practice acts and reimbursement and other regulatory requirements.
3. The third level is the **philosophical or conceptual basis** for practice, which includes the mission, values, and vision of the organization; professional practice models; untested conceptual frameworks; ethical frameworks; and professional codes.
4. The fourth and highest level is **evidence-based practice,** which includes research findings, performance data, and consensus recommendations of recognized experts.

Apart from situations that require a philosophical or regulatory basis, **the best basis for clinical practice is the evidence of well-established research findings.** Such evidence comes from verifiable, replicable facts and relationships that have been subject to stringent scientific criteria. This research has less potential for bias than the other bases for practice, most particularly the traditional "that's how we've always done it" basis for practice.

It is important to remember that not all clinical practice is based on quantitative research and randomized clinical trials. Qualitative studies that aim to understand the nature of the human experience are another valid type of evidence

(Williamson, 2009). Also, some types of problems cannot be adequately tested empirically. Clinical experience is invaluable in these situations (Nolan, 2008).

Further, clinical acumen or intuition also is important, particularly with certain patient problems. For example, if a patient situation is very complex, scientific inquiry will not be able to give clear guidance on many of the variables related to clinical decisions, so the judgment developed from experience is essential to psychiatric nursing practice. Biases also may be present in the analysis and interpretation of research data. Thus the nurse needs to critically evaluate studies from both a methodological and a clinical perspective.

Finally, **cultural competence must be integrated into all evidence-based practices and at all stages of implementation**. Practices should be adapted when appropriate to the cultural and linguistic groups being served. Outcomes of evidence-based practices should be evaluated in terms of culture-specific and culturally relevant outcomes.

> **Critical Reasoning** Think of one or two examples of psychiatric nursing interventions that have been "handed down" from colleague to colleague without empirical validation. Compare these with one or two nursing interventions that do have a research basis.

Developing Evidence-Based Care

Evidence-based psychiatric nursing practice involves the following series of activities (Figure 4-2).

Defining the clinical question is the first step in the process. Clear answers require clear questions. A good clinical question involves defining the patient's problems, identifying the existing nursing intervention, and specifying the expected outcome (Rice, 2010). This process should be completed in partnership with the patient and family and in collaboration with other health care providers (Horsfall et al, 2011).

Finding the evidence is the next step. Most nurses rely on textbooks, journal articles, and drug booklets to help guide their practice. However, each of these poses a problem for the practicing psychiatric nurse who wants to stay current with findings in the field. For example, some textbooks are not evidence-based. All textbooks become outdated, requiring that nurses purchase the new editions of their favorite textbooks to stay current; journal articles may produce contradictory findings and be of poor design; and drug booklets may be filled with promotional material.

Thus finding the evidence can be challenging. However, advances in information technology have made it easier to search the health care literature, and a number of sources can be used to find the evidence (Box 4-1). Access to electronic

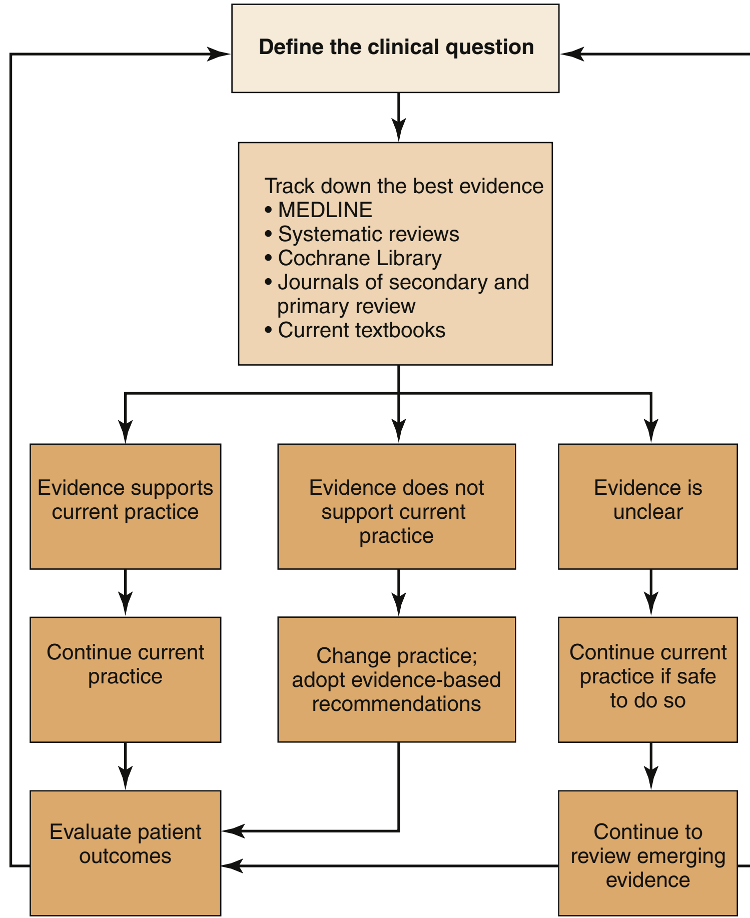

FIG 4-2 Developing evidence-based care.

databases such as Medline is widespread and journals offer access through their websites, displaying tables of contents, abstracts, and full-text articles.

Many of these articles are **systematic reviews** prepared by others. A systematic reviewer uses explicit methods of searching for and critically appraising the primary studies. If these are comparable, the reviewer may then perform a formal quantitative synthesis, called meta-analysis, of the results. A **meta-analysis** summarizes the findings from a number of studies in order to arrive at an objective and authoritative guide to treatment for a given condition (Mundy and Stein, 2008).

Analyzing the evidence requires that nurses understand appropriate research findings. Then they will be confident that the evidence selected is of high quality and is based on rigorous and scientific study. Evidence needs to be critically evaluated for its reliability and application to the particular clinical problem.

In evaluating the evidence the nurse should consider the hierarchy of research evidence (Rice, 2008b). A commonly used hierarchy (with 1 indicating the best) for research designs is presented in Box 4-2. Systematic reviews or meta-analyses of randomized controlled trials (RCTs) are the most reliable study design for the evaluation of treatments. However, for many interventions, RCTs may not exist, and the nurse needs to use evidence from the next level of the hierarchy, with the idea that the nurse selects the intervention that is supported by the best available evidence.

Using the evidence means that the nurse is able to apply research in a practical way. In fact, translating research findings into clinically usable information is one of the most challenging aspects of evidence-based practice. One resource that can help with this is the use of practice guidelines.

It is clear, however, that interpreting the evidence and translating it into health care decisions are complex processes. Evidence is helpful but not sufficient for clinical decision making. The key aspect of evidence-based practice is that it ensures the best use is made of the available scientific findings.

Evaluating the outcome is the final activity of evidence-based practice. Here the nurse asks whether the application of evidence leads to an improvement in care. This requires that psychiatric nurses demonstrate their effectiveness by ongoing evaluation of clearly specified outcomes. This process involves the use of outcome measurement and reevaluation.

Critical Reasoning Ask some practicing nurses how they stay current with the latest developments in the field. How will you stay current after graduation?

BOX 4-1 EVIDENCE-BASED PRACTICE RESOURCES

- **The Cochrane Collaboration** is a regularly updated electronic library available on computer disk and the Internet. It contains a unique, cumulative collection of systematic reviews that are valuable not only because they are rigorously methodological but also because they are regularly updated as new research evidence is published. The website can be accessed at www.cochrane.org.
- **The National Guideline Clearinghouse,** sponsored by the U.S. government, is a database of evidence-based clinical practice guidelines and related documents. The website can be accessed at www.guideline.gov.
- **The Substance Abuse and Mental Health Services Administration** (SAMHSA) and its Center for Mental Health Services (CMHS) have six Evidence-Based Practice Implementation Resource Kits to encourage the use of evidence-based practices in mental health. The website can be accessed at http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits.
- **The Joanna Briggs Institute,** based in Australia, produces best-practices information sheets and systematic reviews. The website can be accessed at www.joannabriggs.edu.au/pubs/best_practice.php.
- ***World Views on Evidence-Based Nursing*** is a quarterly journal from the Honor Society of Nursing, Sigma Theta Tau International, which bridges knowledge and application and takes a global approach to research, policy and practice, education, and management.
- ***Evidence-Based Mental Health*** is a quarterly British journal that publishes abstracts and commentaries on research in the field.

PRACTICE GUIDELINES

Practice guidelines in psychiatric care facilitate clinical decision making and provide patients with critical information about their treatment options. Although they vary in format, all **practice guidelines** are designed to provide methods and procedures for the effective treatment of each disorder. The goals of practice guidelines are as follows:

- Document preferred clinical practices.
- Increase consistency in care.
- Facilitate outcome research.
- Enhance the quality of care.
- Improve staff productivity.
- Reduce costs.

BOX 4-2 HIERARCHY OF RESEARCH EVIDENCE

1. A systematic review and meta-analysis of all relevant randomized controlled trials
2. At least one properly designed randomized controlled trial
3. Well-designed, controlled trials without randomization
4. Well-designed cohort, case-controlled, or other quasi-experimental study
5. Nonexperimental descriptive studies, such as comparative studies
6. Expert committee reports and opinions of respected authorities based on clinical experience

Practice guidelines can be developed in a variety of ways. The best mental health practice guidelines are based on a scientific review of the available clinical research literature to establish which treatments are safe and effective for particular psychiatric disorders. Professional associations, managed care companies, and academic centers also have developed guidelines, using techniques such as expert consensus and data analysis. Regardless of how guidelines are developed, it is essential that they be updated regularly to keep up with the latest findings in the field.

BOX 4-3 QUESTIONS TO ASK WHEN EVALUATING A PRACTICE GUIDELINE

- Who wrote the guideline? Was it created by only one professional discipline, or does it reflect an interprofessional point of view?
- Who sponsored the guideline? Where did the money come from that supported its creation and distribution?
- When was the guideline written? Does it reflect the latest developments in the field?
- What methodology was used? Was it based on scientific evidence? Does it differentiate between research findings and clinical opinion?
- Do the treatments recommended in the guideline respect consumer rights?
- Are the treatments recommended in the guideline affordable and accessible? Can the treatments be provided by a variety of clinicians in various settings, or are they limited in some way?
- Was the guideline reviewed by a variety of groups, including nurses and consumers?
- How does the guideline compare with other guidelines in the field?

Guidelines can vary in several ways:

- *Clinical orientation*—whether the focus is on a clinical condition, technology, or process
- *Clinical purpose*—whether information is presented on screening and prevention, evaluation or diagnosis, or various aspects of treatment
- *Complexity*—whether the guideline is relatively straightforward or presented with detail, complicated logic, or lengthy narrative
- *Format*—whether the guideline is presented as free text, tables, algorithms, critical pathways, or decision pathways
- *Intended audience*—whether the guideline is intended for practitioners, patients, regulators, or payers

Guidelines also vary in how they are used. One of the major limitations to their use is that they may not adequately take into account all four variables that influence treatment outcome:

1. Patient characteristics and preferences
2. The nature of the therapeutic relationship
3. Treatment interventions
4. The placebo effect

Another limitation is that practice guidelines are often developed in isolation by only one discipline and may contain treatment biases of that discipline's model of practice. Other concerns are that they may be based on insufficient evidence or be too rigid or inflexible. Box 4-3 lists questions that can be helpful in judging the potential usefulness of a practice guideline.

A taxonomy of building blocks for informed decision making in behavioral health assessment and treatment is presented in Figure 4-3 (Stuart et al, 2002). This taxonomy identifies treatment options from the most general to the most specific. Those at the top of the triangle provide maximum choice and flexibility, whereas those at the bottom of the

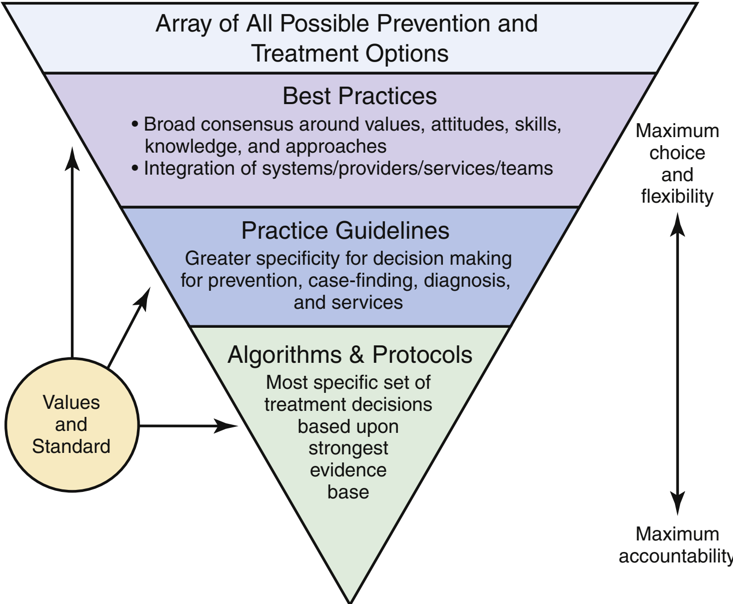

FIG 4-3 Taxonomy of building blocks for informed decision making in behavioral health assessment and treatment.

triangle provide for maximum accountability, leading to the following conclusions:

- **Best practices are broad consensus statements of a general nature.**
- **Practice guidelines have greater specificity.**
- **Algorithms or protocols are the most specific with the strongest evidence base.**

This taxonomy is a useful way of informing decision making in the practice setting. It is unique in that it incorporates prevention as well as treatment options, which is an underdeveloped area in most practice guidelines. Ten characteristics of good behavioral health practice guidelines are listed in Box 4-4.

> **Critical Reasoning** Should each profession develop its own guidelines, or should guidelines cross disciplines and treatment settings?

Clinical Pathways

Many health care organizations have created **clinical pathways,** which identify the key clinical processes and timelines involved in patient care as a way of achieving standard outcomes within a specific period of time. **A clinical pathway is a written plan that serves as both a map and a timetable for the efficient and effective delivery of health care.** Valid clinical pathways are developed over time by a multidisciplinary team. They can be constructed around *DSM-IV-TR* diagnoses, NANDA International (NANDA-I) diagnoses, clinical conditions, treatment stages, clinical interventions, or targeted behaviors.

Clinical pathways are most often used in inpatient settings, serve as a shortened version of the multidisciplinary plan of care for a patient, and require high levels of team cooperation and quality monitoring. Some clinical settings have computerized their paths to enhance the consistency and efficiency of care provided. The key elements of the clinical pathway are as follows:

- The identification of a target population
- The expected outcome of treatment described in a measurable, realistic, and patient-centered way
- Specified treatment strategies and interventions
- Documentation of patient care activities, variances, and goal achievement

The development of a clinical pathway involves reviewing for efficiency and necessity the many activities that occur from the time the patient enters the health care facility through discharge and aftercare. These activities include preadmission work-ups, tests, consultations, treatments, activities, diet, and health teaching.

> **Critical Reasoning** Many health care providers believe that clinical pathways are more difficult to develop in psychiatry than in other specialty areas. What problems would be particularly challenging in designing clinical pathways for psychiatric treatment?

BOX 4-4 CHARACTERISTICS OF GOOD BEHAVIORAL HEALTH PRACTICE GUIDELINES

1. Practice guidelines should be developed in partnership with recipients, consumers, family members, people in recovery, and a wide range of disciplines and organizations.
2. Practice guidelines should be clear, educational, and fully available to recipients, consumers, families, people in recovery, all mental health providers, and all payers.
3. Practice guidelines should be a toolbox of options, and not prescriptive in nature.
4. Practice guidelines should be flexible and accommodate consumer choice as well as consumer values, goals, and desired outcomes.
5. Practice guidelines should be sensitive and responsive to the individual's environment, ethnicity, culture, gender, sexual orientation, and socioeconomic status.
6. Practice guidelines should be based on scientific evidence of efficacy, effectiveness, and established best practices in the field.
7. Practice guidelines should be reviewed and updated regularly.
8. A prevention framework and public health paradigm should be incorporated into every practice guideline.
9. Practice guidelines should identify process and outcome measures, including engagement in the treatment process; adherence to treatment; continuity of care; symptom reduction; enhanced quality of life; improved functional ability; integration of medical, psychiatric, and substance abuse treatment; and improved social status related to employment, housing, or school.
10. Practice guidelines should produce positive clinical outcomes that are sensitive to time for quality improvement.

From Stuart GW, Rush AJ, Morris JA: *Adm Policy Ment Health* 30:21, 2002.

Clinical Algorithms

Clinical algorithms, focusing on treatment or medications, take practice guidelines to a greater level of specificity by providing step-by-step recommendations on issues such as treatment options, treatment sequencing, preferred dosage, and progress assessment. Thus they provide clinicians with a framework that can enhance treatment planning and decision making for individual patients. Algorithms help the clinician select from large databases of information relevant to decision making. They are cognitive tools for the clinician, intended to assist and not limit clinical decision making.

A clinical algorithm can be represented by a flowchart that identifies the clinical process that most likely will be followed based on a patient's current clinical status and response to prior treatments, thereby providing a more specific statement of priority, or the options available if the treatment has not been effective. Computerized medication algorithms also have been developed. They help clinician decision making by integrating patient information, such as drug allergies, age, weight, laboratory results, and clinical and prescription history, with up-to-date treatment guidelines for a primary condition. They can also assist in tracking patient follow-up and preventive care.

Critical Reasoning Clinical algorithms are presented simply as drawn diagrams. What advantages does such a display have over practice guidelines that can be as long as 50 pages?

OUTCOME MEASUREMENT

In the past, although mental health clinicians tried to give the best care possible to their patients, they did this most often without the benefit of reliable data that compared their work with that of others in the field. Increasing emphasis is now placed on providing the most effective care in the most appropriate setting. To accomplish this goal and demonstrate the effectiveness of clinical programs, outcome measurement is needed (Azocar et al, 2007).

Outcomes are the extent to which health care services are cost-effective and improve the patient's symptoms, functioning, and well-being. They include all the factors that affect the patient and family while they are in the health care system, such as health status, functional status, quality of life, the presence or absence of illness, type of coping response, and satisfaction with treatment. They include both positive (well-being) and negative (illness state) dimensions.

Outcome measurement can focus on a clinical condition, an intervention, or a caregiving process (Coughlin, 2001). It is important to measure both short-term and long-term outcomes when providing psychiatric care. These data are then used to make decisions affecting staffing levels, program development, and financial support. **Outcomes that can be examined include clinical, functional, satisfaction, and financial indicators** related to the provision of psychiatric care (Box 4-5). The specific purposes of outcome measurement are as follows:

- Evaluate the outcomes of care.
- Suggest changes in treatment.
- Analyze program effectiveness.
- Profile the practice pattern of providers.
- Determine the most appropriate level of care.
- Predict the path of a patient's illness and recovery.
- Contribute to quality improvement programs.

There are many problems involved in implementing outcome measurement, including deciding the outcomes that should be measured as well as the tools used for their measurement. One of the most difficult aspects is selecting an appropriate scale or measurement tool (Rush et al, 2008). Other difficulties involved in outcome measurement include the following:

- Resistance of clinicians to completing the rating scales
- High rates of spontaneous remission and placebo effect among patients
- Wide variety of therapeutic approaches and interventions used by mental health clinicians
- Many interacting biological, psychological, and sociocultural factors that affect a patient's improvement
- Lack of clarity regarding when to measure outcomes (before, during, or after treatment or during long-term follow-up)
- Validity and reliability problems with patient report and clinical report scales
- Lack of correlation between measures of patient satisfaction and clinical assessment of improvement
- Practical problems of administering, collecting, and analyzing the outcome data

In spite of these problems, psychiatric nurses should routinely use rating scales to assess their patients to determine their state at baseline (before beginning treatment), their progress during treatment, and the clinical progress they have made at the end of treatment (Melnyk et al, 2010). In this way nurses will be able to document the effectiveness of the care they provide. Table 4-1 presents issues that should be considered in selecting outcome measures in psychiatric nursing practice. Visit the Evolve website for examples of behavior rating scales commonly used in psychiatry (see http://evolve.elsevier.com/Stuart/principles/).

BOX 4-5 CATEGORIES OF OUTCOME INDICATORS

Clinical Outcome Indicators
High-risk behaviors
Symptomatology
Coping responses
Relapse
Recurrence
Readmission
Number of treatment episodes
Medical complications
Incidence reports
Mortality

Functional Outcome Indicators
Functional status
Social interaction
Activities of daily living
Occupational abilities
Quality of life
Family relationships
Housing arrangement

Satisfaction Outcome Indicators
Patient and family satisfaction with the following:
- Outcomes
- Providers
- Delivery system
- Caregiving process
- Organization

Financial Outcome Indicators
Cost per treatment episode
Revenue per treatment episode
Length of inpatient stay
Use of health care resources
Costs related to disability

Critical Reasoning One of your nursing colleagues complains about having to complete clinical rating scales on each new admission. She says she "doesn't have time for such busywork." How would you respond?

TABLE 4-1 CONSIDERATIONS IN SELECTING OUTCOME MEASURES IN PSYCHIATRIC NURSING PRACTICE

CONSIDERATION	DESIRED ATTRIBUTE
Applicable	Measures should address an important aspect of structure, process, and/or outcome of care.
Acceptable	Measures should be brief and easy to administer.
Practical	Measures should be simple to use and interpret and inexpensive to implement.
Integrity	Measures should have established reliability and validity and have been tested on the population to be assessed.
Sensitive to change	Measures should be able to detect even small changes in a patient's status over time.

Patient Satisfaction

Measurement of patient satisfaction in mental health services is the result of (1) the desire of clinicians and researchers to measure outcomes from the patient's unique perspective, and (2) the mandate of regulatory and certification agencies that treatment facilities collect and use patient satisfaction data in their quality assurance activities. However, some controversy exists about the methods used to measure patient satisfaction and the meaning and importance of patient satisfaction data in mental health services. For example, patients may report high levels of satisfaction with services because of a variety of factors, some unrelated to the actual treatment, including their relationship with the interviewing staff.

Patient satisfaction is multidimensional. This means that patients can be satisfied with the treatment staff but not satisfied with other parts of the treatment process, such as the environment or timeliness in which the treatment was provided. Thus patient satisfaction is an important outcome measure to consider in evaluating mental health services, but more research is needed before its relation to the structure, process, and outcome of psychiatric care can be fully determined.

Quality Report Cards

Another type of outcome measure is related not to the patient but to the performance of the behavioral health care organization itself. Report cards for mental health and substance abuse services are intended to provide feedback on achievements and problems. At least three dimensions must be considered when discussing these report cards: content, point of view, and intended audience.

- Content refers to the topics that are addressed. In school, content would be the courses being graded. Generally, report cards for behavioral health care services focus on one or more of the following domains of care: access, appropriateness, cost, and outcomes. Access and cost are the domains most commonly covered.
- Point of view refers to the perspective taken. In school the perspective is that of the teacher. In a behavioral service setting the perspective might be that of the payer, the managed care company, the provider, the consumer, or the family member.
- Intended audience can be explicit or implicit. In schools the explicit audience of a report card may be the parent; an implicit audience may be a future employer. In behavioral service settings the explicit audience could be the payer, the managed care entity, the provider, the consumer, or the family member.

Critical Reasoning Most discussions about report cards focus on their content. Why do you think the point of view and intended audience are often ignored? What are the implications of not attending to these other domains?

EVIDENCE BASE FOR PSYCHIATRIC NURSING PRACTICE

Psychiatric nurses are being asked to describe what they do and how they add value to the health care organization. Psychiatric nurses need to educate consumers, other health professionals, the business community, insurers, managed care companies, and legislators about the services they provide, including those related to prevention and recovery, and the ways in which they are able to deliver high-quality, cost-effective care. Nurses must then support this position with data from outcome studies that reflect clinical, functional, satisfaction, and financial indicators. This research is the essence of evidence-based psychiatric nursing practice.

Much of current psychiatric nursing practice is not evidence-based. For example, many psychiatric nurses do not access the latest research, use clinical rating scales, or assess outcomes in their practice; yet all these elements are an essential part of psychiatric nursing practice. Too often what psychiatric nurses do is based on untested theories or cherished traditions rather than on scientifically based evidence.

Little literature exists describing the use of practice guidelines by psychiatric nurses, and few studies of the clinical, functional, satisfaction, or financial outcomes of psychiatric nursing care have been conducted. In addition, most psychiatric nursing textbooks use secondary references instead of primary references, thus creating ambiguity about the evidence base for nursing practice. **Nurses need to know how to access, interpret, and use findings from outcome research before they can engage in evidence-based psychiatric nursing care.**

Agenda for Psychiatric Nursing Research

The relationship among practice, theory, and research is interactive and reciprocal. For theory to be useful, it must have implications for practice, and for practice to be tested

and validated, it must be based in theory (Stetler, 2001). Theory that arises out of practice is validated by research, which returns to direct practice and informed clinical care.

Descriptive and exploratory research can help to define a problem. Hypotheses may then be developed concerning relationships between identified variables, which may be tested in correlational or survey research designs. Cause-and-effect relationships among the variables can then be tested in various experiments with natural or controlled settings. Only after establishing cause and effect can specific interventions aimed at changing the clinical problem be prescribed and tested in randomized controlled clinical trials.

In this way studies feed knowledge back into practice to improve health care. **This progression of observing from practice, theorizing, testing in research, and subsequently modifying practice is an essential part of psychiatric nursing.**

Beyond Evidence-Based Practice

New ways of thinking take the field beyond evidence-based practice. It has been noted that there is **evidence-supported, evidence-informed, and evidence-suggested practice.** Also, the idea of **practice-based evidence** suggests that much is to be gained from gathering good data from routine practices. Although the movement toward evidence-based practice has been beneficial for all health care, it does reflect the fact that research to date has largely been focused on **programs of care.**

Another focus for the future research agenda will be on studying the **processes of care** occurring between patients and providers. Specifically, future studies might focus on processes such as collaborative goal setting, the nature of the therapeutic alliance, family engagement, environmental modifications, and coaching. It is likely that only by coming to understand how evidence-based processes complement evidence-based practices will the true value of psychiatric care emerge.

CHAPTER IN REVIEW

- Evidence-based practice is the conscientious, explicit, and judicious use of the best evidence gained from systematic research to make decisions about the care of individual patients.
- Evidence-based practice blends the nurse's clinical experience with the best available research evidence.
- The four bases for nursing practice are traditional, regulatory, philosophical, and evidence-based. The best basis for clinical nursing practice is evidence-based.
- The four steps to developing evidence-based care are defining the clinical question, finding the evidence, analyzing the evidence, and evaluating the outcome.
- Practice guidelines are developed to help clinical decision making and provide patients with information about their treatment options. The best practice guidelines are based on scientific review of the available clinical research literature to establish which treatments are safe and effective for particular psychiatric disorders.
- Clinical pathways identify the key clinical processes and corresponding timelines necessary for a patient to achieve standard outcomes within a specific period.
- Clinical algorithms or protocols provide step-by-step recommendations on issues such as treatment options, treatment sequencing, preferred dosage, and progress assessment.
- Outcome measurements provide important data about the clinical program and include clinical, functional, satisfaction, and financial indicators.
- Patient satisfaction indicators and quality report cards are used to measure the performance of the behavioral health care organization.
- Much current psychiatric nursing practice does not meet the ideals of evidence-based practice. Nurses need to use outcome measurements; test theories and interventions through randomized controlled clinical trials; and measure the clinical, functional, satisfaction, and financial outcomes of the care they provide.
- It is likely that only by coming to understand how evidence-based processes complement evidence-based practices will the true value of psychiatric care emerge.

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CHAPTER

5

Biological Context of Psychiatric Nursing Care

Donald L. Taylor

We must recollect that all our provisional ideas in psychology will someday be based on an organic substructure. This makes it probable that special substances and special chemical processes control the operation.

Sigmund Freud

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Apply knowledge about the structure and function of the brain to psychiatric nursing practice.
2. Describe how neuroimaging is used in psychiatry.
3. Examine the impact of biological rhythms and sleep on a person's abilities and moods.
4. Describe how psychoneuroimmunology relates to mental health and illness.
5. Discuss genetics and the impact of the Human Genome Project on the understanding of mental illness.
6. Assess patients from a biological perspective.

Interest in the brain and human behavior is as old as the human race. Records dating back to 3000 BC in Egypt describe brain anatomy and various brain injuries. Currently the field of neuroscience is rapidly expanding and includes many disciplines that combine for a more complete understanding of the human brain and how it is integrated with the body and the human environment (Figure 5-1). All nurses should have a working knowledge of the normal structure and function of the brain, just as all nurses should know about the structure and function of the heart.

STRUCTURE AND FUNCTION OF THE BRAIN

The brain weighs about 3 pounds. It is composed of trillions of groups of cells that have formed highly specific structures and sophisticated communication pathways that have changed over millions of years of evolution (Box 5-1). A brief review of key brain regions is presented in Figures 5-2 through 5-6 and in Box 5-2.

The brain develops and changes in utero and throughout the life span. This is known as **neural plasticity.** During adolescence the efficiency of the brain is refined by eliminating unneeded circuits, called **synaptic pruning,** and strengthening others. This process allows humans to have a brain that accommodates both its genetic potential and the environmental influences surrounding it.

The changing brain reacts to a variety of influences that can support health or promote illness, both before birth and across the life span. About 100 billion brain cells, or **neurons,** form groups or structures that are highly specialized. **Neurotransmission** is the process by which neurons communicate with each other through electrical impulses and chemical messengers.

This communication among neurons is carried out by chemical "first" messengers called **neurotransmitters,** and gives rise to human activity, body functions, consciousness, intelligence, creativity, memory, dreams, and emotion. **Neurotransmission is a key factor in understanding how**

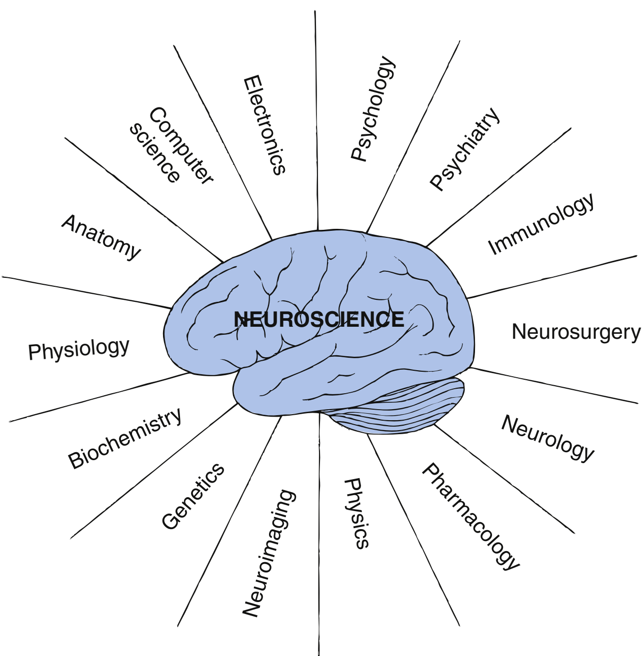

FIG 5-1 The field of neuroscience.

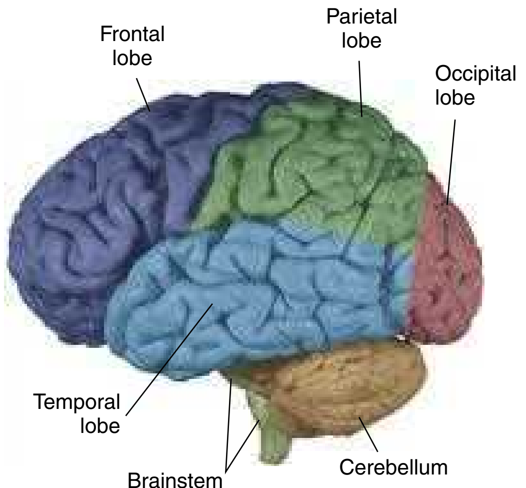

FIG 5-2 Lateral view of the left cerebral hemisphere of the brain. (From Nolte J, Angevine JB, Jr: *The human brain: in photographs and diagrams,* ed 2, St Louis, 2000, Mosby.)

BOX 5-1 ABOUT THE BRAIN

- At birth, an infant's brain is almost the same size as an adult's brain and contains most of the brain cells for one's entire life.
- From birth, the brain matures from back to front. With aging, it degenerates in the opposite direction.
- A newborn's brain grows about three times its size in the first year.
- The brains of 2-year-old children consume twice as much glucose as do adult brains.
- Compared to an environment with little stimulation, a stimulating environment can give a child a 25% greater ability to learn.
- By the age of 7 years, our brains are 95% of their adult size.
- It is a myth that we use only 10% of our brains. In fact, we use it all.
- Your skin weighs twice as much as your brain.
- The brain can live for 4 to 6 minutes without oxygen, and then it begins to die. No oxygen for 5 to 10 minutes will result in permanent brain damage.

various regions of the brain function and how interventions, such as medications and other therapies, affect brain activity and human behavior.

Neurotransmitters are manufactured in the neuron and released from the **axon,** or presynaptic cell, into the **synapse,** which is the space between neurons. From there the neurotransmitters are received by the **dendrite,** or postsynaptic cell, of the next neuron. This neurotransmission process makes communication among brain cells possible (Figure 5-7).

Like a key inserted into a lock, each of these chemicals fits precisely into specific receptor cells (made of protein) embedded in the membranes of the axons and dendrites. These receptor cells then either open or close doors **(ion channels)** into the cell, allowing for the interchange of chemicals, such as ions like sodium (Na^+), potassium (K^+), and calcium (Ca^{2+}).

This process, known as **depolarization,** changes the electrical charge of the cell. This change then triggers a cascade of chemical and electrical processes that are caused by a variety of chemicals called **second messengers** within the cell itself. The second messengers regulate the function of the ion channels, the production of neurotransmitters, and the release of neurotransmitters into the synapse—they continue the process of neurotransmission.

Depending on the chemical composition of the neurotransmitter, the signal it gives either excites the receiving cells, causing them to produce an action, or inhibits the receiving cells, which slows or stops an action. After release into the synapse and communication with receptor cells, the neurotransmitters are transported back from the synapse into the axon in a process called **reuptake,** where they are stored for future use or are inactivated **(metabolized)** by enzymes.

The nervous system cells are surrounded by **myelin sheaths** formed by specialized groups of cells called **glial cells.** These are support cells that insulate neurons, remove excess transmitters and ions from the extracellular spaces in the brain, provide glucose to some nerve cells, and direct the flow of blood and oxygen to various parts of the brain. Several chambers or **ventricles** within the brain carry **cerebrospinal fluid (CSF).** The CSF cushions, protects, and bathes the brain and spinal cord, carrying chemicals, nutrients, and wastes to and from the bloodstream.

Neurons are very specialized, and neurotransmitters perform vital functions in the normal working brain. Their absence or excess can play a major role in brain disease and behavioral disorders. A single neurotransmitter can affect other brain

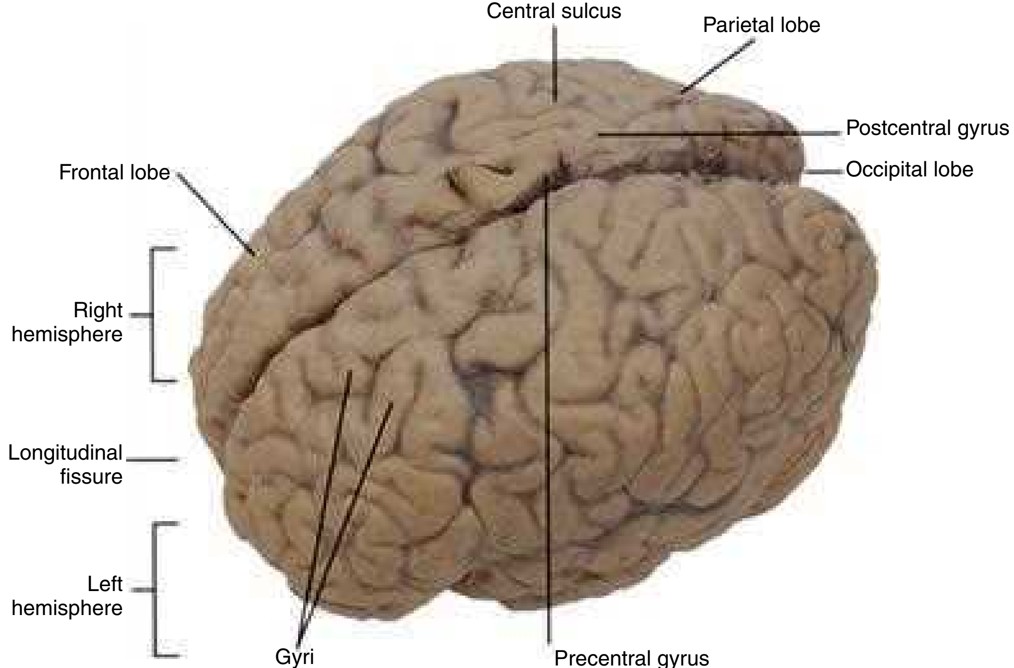

FIG 5-3 Superior view of the brain. (From Nolte J, Angevine JB, Jr: *The human brain: in photographs and diagrams,* ed 2, St Louis, 2000, Mosby.)

chemicals as well as several different subtypes of receptor cells, each located along tracts connecting different regions of the brain. Thus the same neurotransmitter can have one effect in one part of the brain and different effects in another part of the brain. Nearly all known neurotransmitters fall into one of two categories: small amine molecules (monoamines, acetylcholine, amino acids) and peptides. These are described in Table 5-1.

One clinical implication of this process is that abnormalities in the structure of the brain or in its ability to communicate in specific locations can cause or contribute to neuropsychiatric disorders. For example, a communication problem in one part of the brain can cause widespread dysfunction because brain communication is like a chain reaction causing changes from one cell to the next and thus from one structure to the next.

The following are examples of networks of nuclei, groups of brain cells that control cognitive, behavioral, and emotional functioning, and thus are of particular interest in the study of psychiatric disorders.

- **Cerebral cortex:** critical in decision making and higher-order thinking, such as abstract reasoning
- **Limbic system:** involved in regulating emotional behavior, memory, and learning
- **Basal ganglia:** coordinate involuntary movements and muscle tone
- **Hypothalamus:** regulates pituitary hormones; temperature; and desires such as hunger, thirst, and sex drive
- **Locus ceruleus:** makes norepinephrine, a neurotransmitter involved in the body's response to stress
- **Raphe nuclei:** make serotonin, a neurotransmitter involved in the regulation of sleep, behavior, and mood
- **Substantia nigra:** makes dopamine, a neurotransmitter involved in complex movements, thinking, and emotions

A second clinical implication is related to the use of therapeutic strategies, such as psychiatric medications (Chapter 26), behavior change and cognitive interventions (Chapter 27), somatic therapies (Chapter 29), and alternative therapies (Chapter 30). All of these interventions work by regulating neurotransmission in the brain with the goal of promoting normal brain communication, thus decreasing "symptoms" of illness and enhancing "normal" behavior.

Both psychotherapy and medications may have a similar mechanism of action—neural plasticity (that is, the modification of a person's brain structure)—which then results in a change in behavior or symptoms. Both psychotherapy and medications may produce clinical improvement based on the restructuring of neural pathways. Thus repairing brain tissue through both "talk therapy" and medications may provide a powerful synergy to heal the brain.

To date many of these interventions lack **specificity.** They cause not only desired changes but also unwanted changes, or **side effects.** Increased understanding of the structure and function of the brain and techniques such as **gene therapy** will provide more refined and focused treatments that are safer and have fewer side effects.

By understanding the neurobiological processes underlying psychiatric symptoms and the actions of interventions, the psychiatric nurse can make a correct diagnosis; select effective treatments; maximize positive effects; minimize unwanted effects; and predict, measure, and refine the outcomes of psychiatric nursing care.

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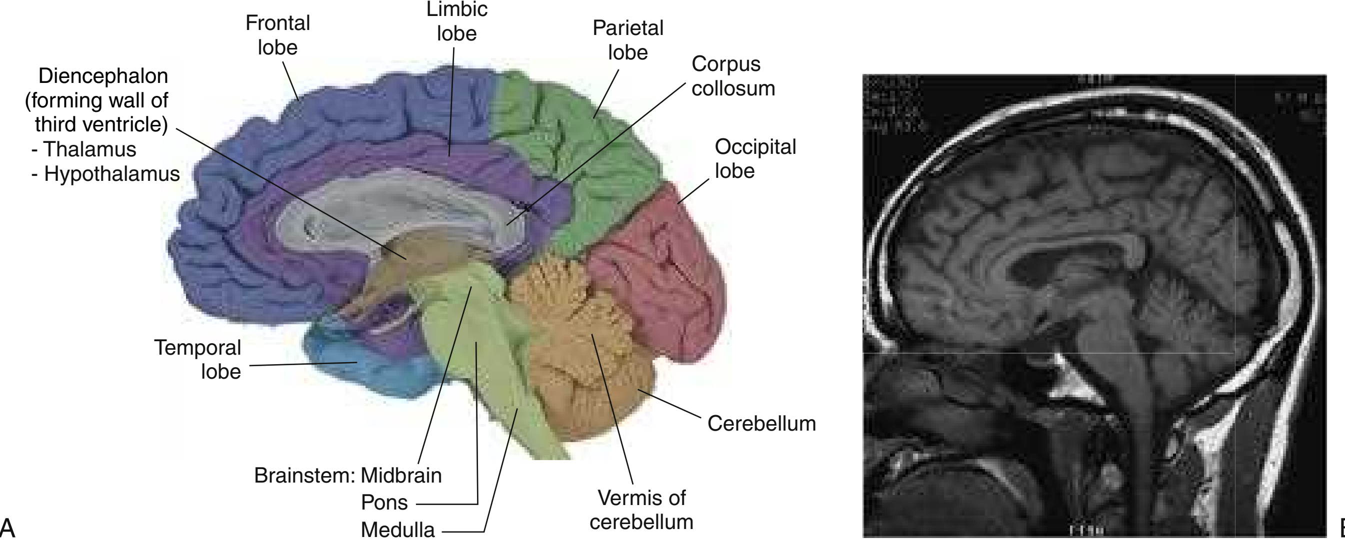


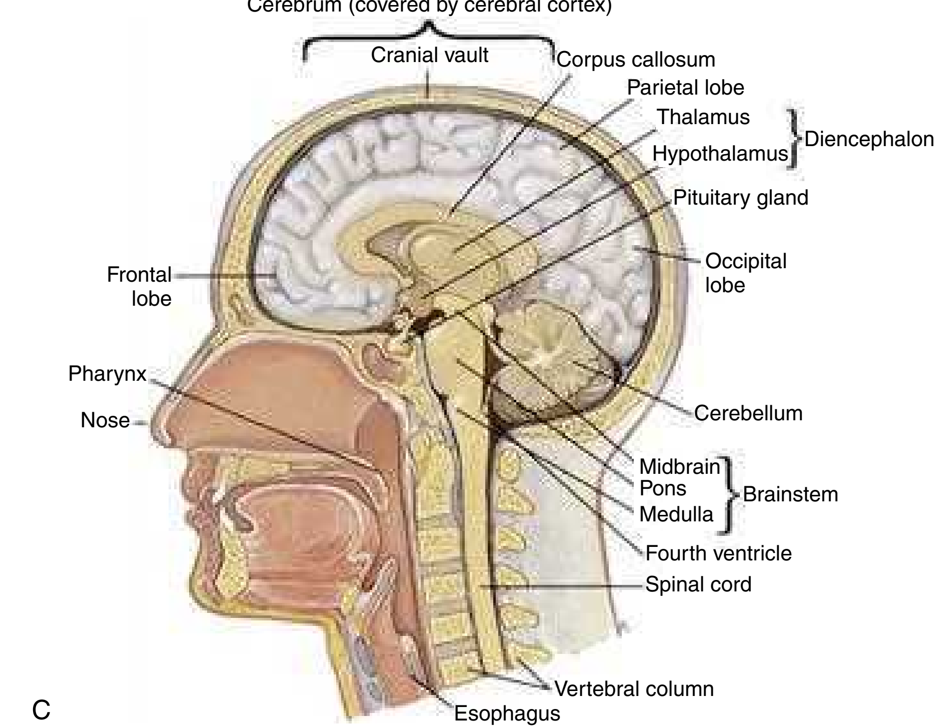


FIG 5-4 When the brain is cut between the two hemispheres down the middle (a midsagittal section), the main divisions can be seen clearly, as in **A** and **C,** which are schematic representations. **B,** A magnetic resonance imaging scan. **C,** Schematic representation of midsagittal section of the brain. (**A** from Nolte J, Angevine JB, Jr: *The human brain: in photographs and diagrams,* ed 2, St Louis, 2000, Mosby; **B** from Medical University of South Carolina, Charleston.)

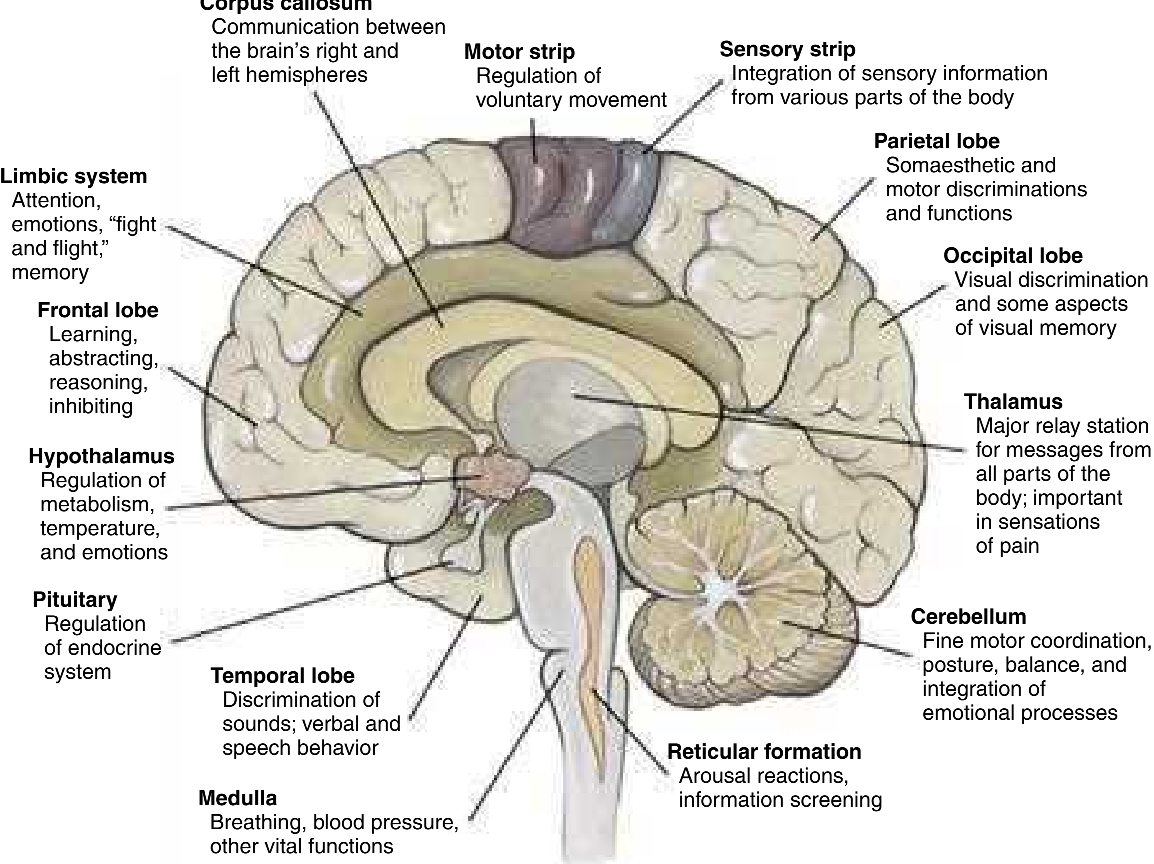


FIG 5-5 Structure and function of the brain. (From Carson RC, Butcher JN, Mineka S: *Abnormal psychology and modern life,* ed 11, Boston, 2000, Allyn & Bacon.)

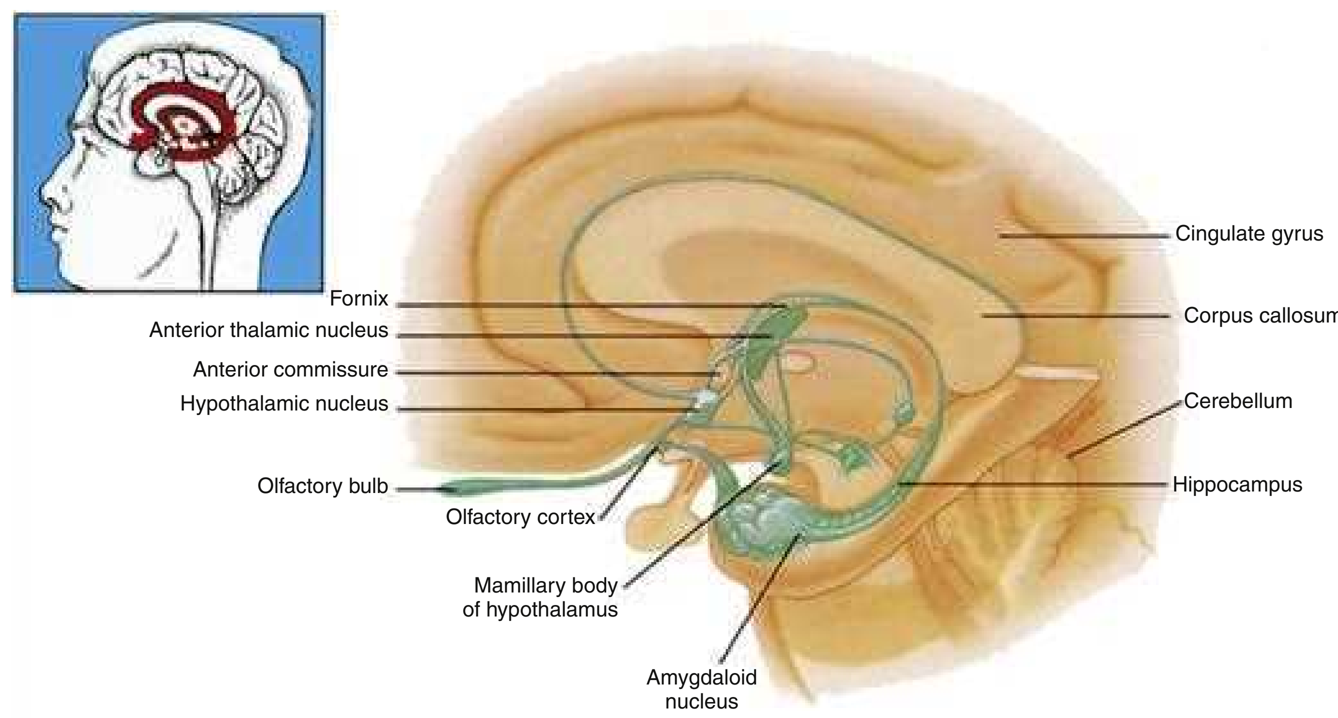


FIG 5-6 Structures of the limbic system. (Courtesy Scott Bodell, illustrator.)

BOX 5-2 STRUCTURE AND FUNCTION OF THE BRAIN

Cerebrum

Largest portion of the brain
Responsible for conscious perception, thought, and motor activity
Governs muscle coordination and the learning of rote movements
Can override most other systems
Divided into two hemispheres, each of which is divided into four lobes

Dominant Hemisphere

Left side is dominant in most people (in 95% of right-handed and more than 50% of left-handed people)
Responsible for the production and comprehension of language, mathematical ability, and the ability to solve problems in a sequential, logical fashion

Nondominant Hemisphere

Right side is nondominant in most people
Responsible for musical skills, recognition of faces, and tasks requiring comprehension of spatial relationships

Corpus Callosum

Largest fiber bundle in the brain
Connects the two cerebral hemispheres and passes information from one to the other, welding the two hemispheres together into a unitary consciousness, allowing the "right hand to know what the left hand is doing"

Cerebral Cortex

A few millimeters thick and about 2.5 square feet in area
Sheet of gray matter containing 30 billion neurons interconnected by almost 70 miles of axons and dendrites
Forms the corrugated surface of the four lobes of the cerebral hemispheres
Connected to various structures of the brain and has a great deal to do with the abilities we think of as uniquely human, such as language and abstract thinking, as well as basic aspects of perception, movement, and adaptive response to the outside world
Functional areas have been mapped by imaging technology
Damage to certain cortical areas usually results in predictable deficits, depending on the area affected

Frontal Lobes

Aid in planning for the future, motivation, control of voluntary motor function, and production of speech
Play an important part in emotional experience and expression of mood
Clinical example: Aphasia (absent or defective speech or comprehension) results from a lesion in the language areas of the cortex. The several types of aphasia depend on the site of the lesion. Damage to Broca area, which contains the motor programs for the generation of language, results in expressive, or motor, aphasia, with difficulty producing either written or spoken words but no difficulty comprehending language.

Parietal Lobes

Reception and evaluation of most sensory information (excluding smell, hearing, and vision)
Concerned with the initial processing of tactile and proprioceptive (sense of position) information, complex aspects of spatial orientation and perception, and the comprehension of language (share Wernicke area with the temporal lobes)
Damage within the parietal lobe may result in difficulty recognizing familiar objects, surroundings, or people (visual agnosia)

Central Sulcus

Groove or fissure on the surface of the brain that divides the frontal and parietal lobes

Temporal Lobes

Receive and process auditory information, involved in higher-order processing of visual information, involved in complex aspects of memory and learning, and are important in the comprehension of language
Associated with functions such as abstract thought and judgment
Clinical example: Damage to Wernicke area, which contains the mechanisms for the formulation of language, results in receptive, or sensory, aphasia, in which words are produced but their sequence is defective in linguistic content, resulting in paraphasia (word substitutions), neologisms (insertion of new and meaningless words), or jargon (fluent but unintelligible speech), and a general deficiency in the comprehension of language is noted. If the lesion occurs in the connection between Broca area and Wernicke area, conduction aphasia results, in which a person has poor repetition but good comprehension.

Lateral Fissure

Separates the temporal lobe from the rest of the cerebrum

Occipital Lobes

Reception and integration of visual input
Damage to the occipital lobes can result in blindness

Diencephalon

Constitutes only 2% of the central nervous system (CNS) by weight
Has extremely widespread and important connections; the great majority of sensory, motor, and limbic pathways involve the diencephalon

Thalamus

Composes 80% of the diencephalon
All sensory pathways and many other anatomical loops relay in the thalamus
Takes sensory information and relays it to areas throughout the cortex
Influences prefrontal cortical functions, such as affect and foresight
Influences mood and general body movements associated with strong emotions, such as fear or rage

Pineal Gland

Endocrine gland involved in reproductive cycles
During darkness it secretes an antigonadotropic hormone called *melatonin,* which decreases during light, thus increasing gonadal function

BOX 5-2 STRUCTURE AND FUNCTION OF THE BRAIN—cont'd

Important in mammals with seasonal sexual cycles; its effects in humans are not yet clear, although tumors of the pineal gland affect human sexual development
Also may be involved in the sleep-wake cycle

Hypothalamus

Weighs only 4 grams
Major control center for the pituitary gland; for maintaining homeostasis; and for regulating autonomic, endocrine, emotional, and somatic functions
Controls various visceral functions and activities involved in basic drives and is very important in a number of functions that have emotional and mood relationships
Directly involved in stress-related and psychosomatic illnesses and with feelings of fear and rage
Regulates feeding and drinking behavior, temperature regulation, cardiac function, gut motility, and sexual activity
Coordinates responses for the sleep-wake cycle to other areas of the body
Contains the mamillary bodies, which are involved in olfactory reflexes and emotional responses to odors

Brainstem

Connects the spinal cord to the brain
Location of cranial nerve nuclei
Controls automatic body functions, such as breathing and cardiovascular activity

Midbrain

Contains ascending and descending nerve tracts
Visual cortex center
Part of auditory pathway
Regulates the reflexive movement of the eyes and head
Aids in the unconscious regulation and coordination of motor activities
Contains the part of the basal ganglia, the substantia nigra, that manufactures dopamine

Pons

Contains ascending and descending nerve tracts
Relays between cerebrum and cerebellum
Reflex center
Contains the locus ceruleus, which manufactures most of the brain's norepinephrine

Medulla Oblongata

Conduction pathway for ascending and descending nerve tracts
Conscious control of skeletal muscles
Involved in functions such as balance, coordination, and modulation of sound impulses from the inner ear
Center for several important reflexes: heart rate, breathing, swallowing, vomiting, coughing, sneezing

Reticular Formation

Central core of the brainstem
Controls cyclical activities, such as the sleep-wake cycle (called the *reticular activating system [RAS]*)
Plays an important role in arousing and maintaining consciousness, alertness, and attention
Contributes to the motor system, respiration, cardiac rhythms, and other vital body functions
Clinical example: Damage to the RAS can result in coma. General anesthetics function by suppressing this system. It also may be the target of many tranquilizers. Ammonia (smelling salts) stimulates the RAS, resulting in arousal.

Basal Ganglia

Several deep gray matter structures that are related functionally and are located bilaterally in the cerebrum, diencephalon, and midbrain
Control muscle tone, activity, and posture
Coordinate large-muscle movements
Major effect is to inhibit unwanted muscular activity
Cause extrapyramidal syndromes when dysfunctional
Clinical example: Parkinson disease (characterized by muscular rigidity; a slow, shuffling gait; and a general lack of movement) is associated with a dysfunction of the basal ganglia, probably a destruction of the dopamine-producing neurons of the substantia nigra (part of the basal ganglia but located in the midbrain).

Limbic System

Forms the limbus, or border, of the temporal lobes and is intimately connected to many other structures of the brain
Concerned both with subjective emotional experiences and with changes in body functions associated with emotional states
Particularly involved in aggressive, submissive, and sexual behavior and with pleasure, memory, and learning
Associated with mood, motivation, and sensations, all central to preservation
Clinical example: Klüver-Bucy syndrome develops when the entire limbic system is removed or destroyed. Symptoms include fearlessness and placidity (absence of emotional reactions), an inordinate degree of attention to sensory stimuli (ceaseless and intrusive curiosity), and visual agnosia (the inability to recognize anything).

Hippocampus

Consolidates recently acquired information about facts and events, somehow turning short-term memory into long-term memory
Contains large amounts of neurotransmitters
Hippocampal volume loss (atrophy) associated with major depressive episodes; the direct effects of this atrophy are not yet fully understood
Clinical example: Surgical removal of the hippocampus results in the inability to form new memories of facts and events (names of new acquaintances, day-to-day events, inability to remember why a task was begun), although long-term memory, intelligence, and the ability to learn new skills are unaffected. A similar memory problem is Korsakoff syndrome, in which patients have intact intelligence but cannot form new memories. They typically confabulate (make up answers to questions), which occurs when the hippocampus and surrounding areas are damaged by chronic alcoholism. This also is seen in Alzheimer disease, in which the memory loss is profound, and extensive cellular degeneration in the hippocampus is noted.

Continued

BOX 5-2 STRUCTURE AND FUNCTION OF THE BRAIN—cont'd

Amygdala

Generates emotions from perceptions and thoughts (presumably through its interactions with the hypothalamus and prefrontal cortex)

Contains many opiate receptors

Amygdala hypertrophy (enlargement) is associated with various depressive syndromes

Clinical example: Electrical stimulation of the amygdala in animals causes responses of defense, raging aggression, or fleeing. In humans the most common response is fear and its related autonomic responses (dilation of the pupils, increased heart rate, and release of adrenaline). Conversely, bilateral destruction of the amygdala causes a great decrease in aggression, and animals become tame and placid. This is thought to be another kind of memory dysfunction that impairs the ability to learn or remember the appropriate emotional and autonomic responses to stimuli.

Fornix

Two-way fiber system that connects the hippocampus to the hypothalamus

Cerebellum

"Little brain"

Full range of sensory inputs finds its way here and in turn projects to various sites in the brainstem and thalamus

Although it is extensively involved with the processing of sensory information, it also is part of the motor system and is involved in equilibrium, muscle tone, postural control, and coordination of voluntary movements

It is thought that, because of connections to other brain regions, the cerebellum may be involved in cognitive, behavioral, and affective functions

Clinical example: The malnutrition often accompanying chronic alcoholism causes a degeneration of the cerebellar cortex, resulting in the anterior lobe syndrome in which the legs are primarily affected, and the most prominent symptom is a broad-based, staggering gait and a general incoordination, or ataxia, of leg movements.

Ventricles

Each cerebral hemisphere contains a large cavity, the lateral ventricle

A smaller midline cavity, the third ventricle, is located in the center of the diencephalon, between the two halves of the thalamus

The fourth ventricle is in the region of the pons and medulla oblongata and connects with the central canal of the spinal cord, which extends nearly the full length of the spinal cord

Clinical example: Although the clinical significance of these findings is uncertain, imaging techniques have shown enlargement of the ventricles in many psychiatric disorders, suggesting an atrophy of the many critical structures in the brain with these illnesses.

Spinal Fluid

Cerebrospinal fluid (CSF) is procured from the blood choroid plexuses, located in the ventricles, and fills the ventricles, subarachnoid space (between the brain and the skull), and the spinal cord

CSF bathes the brain with nutrients, cushions the brain within the skull, and exits through the bloodstream

Approximately 140 mL of spinal fluid within the CNS travels from its point of origin to the bloodstream at approximately 0.4 mL/min

Clinical example: Neurotransmitters and their metabolites can be measured in the CSF, plasma, and urine and give an approximation of neurotransmitter production and metabolism in the brain. This provides clues to abnormal neurotransmission in some mental illnesses.

Blood-Brain and Blood-CSF Barriers

Neuronal function requires a microenvironment that is protected from changes elsewhere in the body that may have an adverse effect

Blood-brain and blood-CSF barriers protect the CNS in several ways: Large molecules, such as plasma proteins, present in the blood, are excluded from the CSF and nervous tissue. The brain and spinal cord are protected from neurotransmitters in the blood, such as epinephrine produced by the adrenal gland. Neurotransmitters produced in the CNS are prevented from precipitously leaking into the general circulation. Toxins are excluded either because of their molecular size (too big) or because of their solubility (only substances soluble in water and cell-membrane lipids can pass these barriers); therefore many drugs are not able to enter the brain and spinal cord

Critical Reasoning How would you respond to a nursing colleague who says that psychiatric nurses do not need to know much about anatomy and physiology because what they do primarily is talk to people?

NEUROIMAGING

Until the last few decades the only way to directly study the brain was through brain surgery, open head trauma, or autopsy. **Brain-imaging techniques allow direct viewing of the structure and function of the intact, living brain.** These techniques help not only in diagnosing some brain disorders but also in mapping the regions of the brain, measuring the activity or function in these regions, and correlating this activity with the effects of interventions. These images are pictures of the working brain. Table 5-2 describes some of the imaging techniques used in brain research.

Computed tomography (CT) and magnetic resonance imaging (MRI) provide visualization of brain structures. They can detect structural abnormalities, changes in the

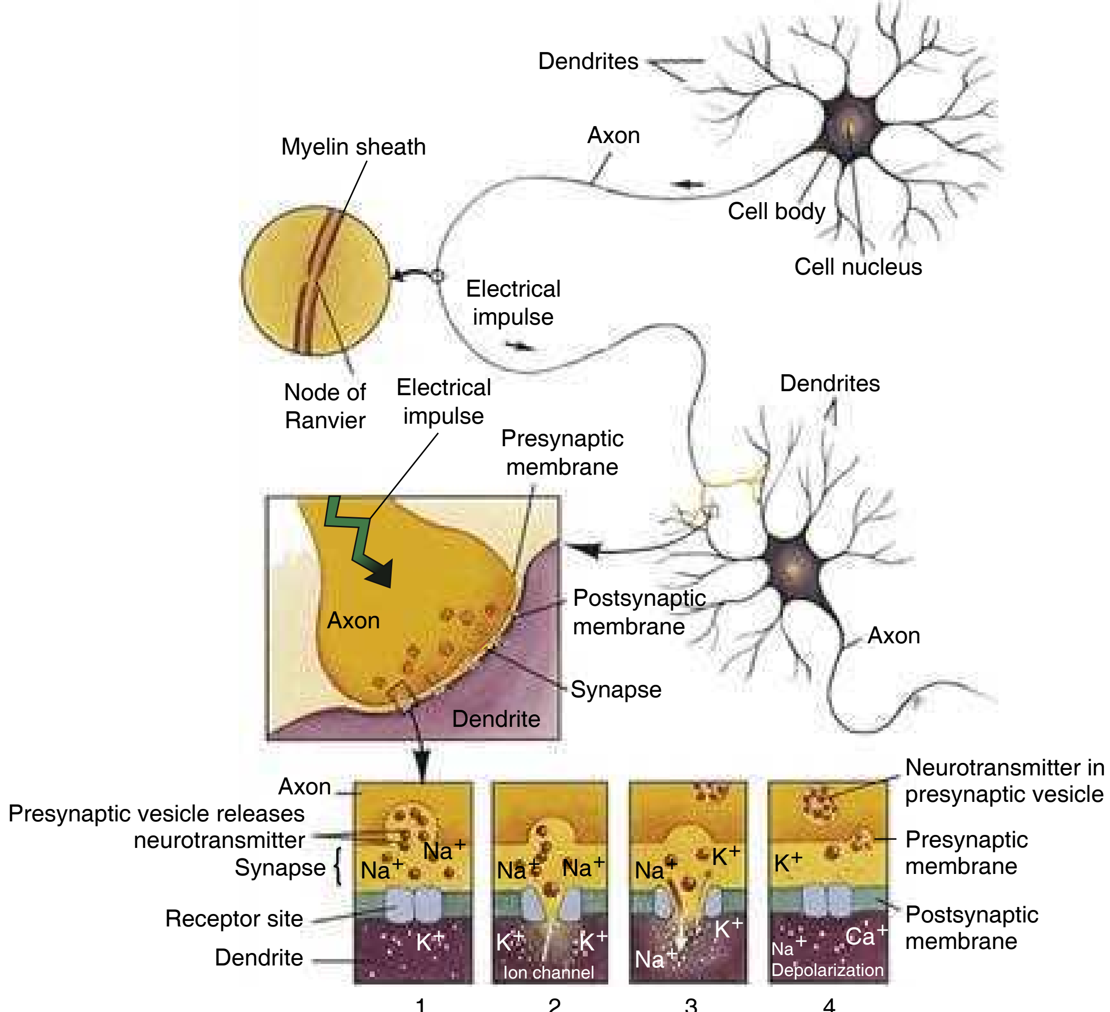


FIG 5-7 Neurotransmission. *Bottom: 1,* Neurotransmitter is released from presynaptic cell into synapse. *2,* Neurotransmitter, recognized by receptor cell, causes channel to open, and ions are exchanged. *3,* Exchange of ions causes impulse, which causes reaction in receptor cell. *4,* Neurotransmission has taken place, receptor channel closes, and neurotransmitter returns to presynaptic membrane (reuptake).

volume of brain tissue, and enlargement of the cerebral ventricles.

Brain function is studied using other imaging techniques to determine both normal activity and malfunctioning in specific regions. Techniques that show brain function include **brain electrical activity mapping (BEAM),** which measures sensory input; **positron emission tomography (PET),** which measures brain activity; and **single-photon emission computed tomography (SPECT),** which permits the study of brain metabolism and cerebral blood flow. Figure 5-8 shows PET scans of the normal brain.

PET, SPECT, and other functional magnetic resonance imaging (fMRI) techniques can measure the use of **glucose** (glucose utilization) and the amount of **blood flowing** in a region of the brain (regional cerebral blood flow). These are the two basic indicators of brain activity. The more active a region of the brain is, the more blood will flow through it, the more glucose it will use, and the brighter (yellow, orange, red) the imaging scan looks. When these techniques are coupled with neuropsychological test results, deficits in a person's performance, such as language or cognitive and sensory information processing, can be linked to the activity of the region of the brain responsible for those functions (see Figure 5-8).

Neuroimaging techniques are increasingly being utilized as a means of diagnosing psychiatric illnesses. These studies are collecting data showing distinct structural and functional differences between individuals with and without schizophrenia, bipolar disorder, depression, attention deficit hyperactivity disorder (ADHD), and other psychiatric disorders (Agarwal et al, 2010). The potential outcomes of this research are the ability to diagnose complex clinical presentations, and to distinguish between disorders that have similar symptoms and are difficult to differentiate.

An example is the assessment of bipolar disorder in children. In children, bipolar disorder is often mistaken for and

Text continued on p. 78.

TABLE 5-1 NEUROTRANSMITTERS AND NEUROMODULATORS IN THE BRAIN

SUBSTANCE	LOCATION	FUNCTION
Amines Amines are neurotransmitters that are synthesized from amino acid molecules such as tyrosine, tryptophan, and histidine. Found in various regions of the brain, amines affect learning, emotions, motor control, and other activities.		
Monoamines		
Norepinephrine (NE)	Derived from tyrosine, a dietary amino acid; located in brainstem (particularly locus ceruleus) *Effect*: can be excitatory or inhibitory	Levels fluctuate with sleep and wakefulness. Plays a role in changes in levels of attention and vigilance. Involved in attributing a rewarding value to a stimulus and in regulation of mood. Plays a role in affective and anxiety disorders. Antidepressants block reuptake of NE into presynaptic cell or inhibit monoamine oxidase from metabolizing it.
Dopamine (DA)	Derived from tyrosine, a dietary amino acid; located mostly in brainstem (particularly substantia nigra) *Effect:* generally excitatory	Involved in control of complex movements, motivation, and cognition and in regulating emotional responses. Many drugs of abuse (e.g., cocaine, amphetamines) cause DA release, suggesting a role in sensation of pleasure. Involved in movement disorders seen in Parkinson disease and in many of the deficits seen in schizophrenia and other forms of psychosis. Antipsychotic drugs block DA receptors in postsynaptic cells.
Serotonin (5-HT)	Derived from tryptophan, a dietary amino acid; located only in brain (particularly in raphe nuclei of brainstem) *Effect:* mostly inhibitory	Levels fluctuate with sleep and wakefulness, suggesting a role in arousal and modulation of general activity levels of CNS,* particularly onset of sleep. Plays a role in mood and probably in delusions, hallucinations, and withdrawal symptoms of schizophrenia. Involved in temperature regulation and pain-control system of body. The hallucinogenic drug LSD acts at 5-HT receptor sites. Plays a role in affective and anxiety disorders. Antidepressants block its reuptake into presynaptic cells.
Melatonin	Further synthesis of serotonin produced in pineal gland *Effect:* mostly inhibitory	Induces pigment-lightening effects on skin cells and regulates reproductive and immune function.
Acetylcholine	Synthesized from choline; located in brain and spinal cord but is more widespread in peripheral nervous system, particularly neuromuscular junction of skeletal muscle *Effect:* can have an excitatory or inhibitory effect	Plays a role in sleep-wakefulness cycle. Signals muscles to become active. Alzheimer disease is associated with degeneration in acetylcholine neurons. Myasthenia gravis (weakness of skeletal muscles) results from reduction in acetylcholine receptors.
Amino Acids		
Glutamate	Found in all cells of body, where it is used to synthesize structural and functional proteins; also found in CNS, where it is stored in synaptic vesicles and used as a neurotransmitter *Effect:* excitatory	Implicated in schizophrenia; glutamate receptors control the opening of ion channels that allow calcium (essential to neurotransmission) to pass into nerve cells, propagating neuronal electrical impulses. Its major receptor, NMDA, helps regulate brain development. This receptor is blocked by drugs (e.g., PCP) that cause schizophrenic-like symptoms. Overexposure to glutamate is toxic to neurons and may cause cell death in stroke and Huntington disease.

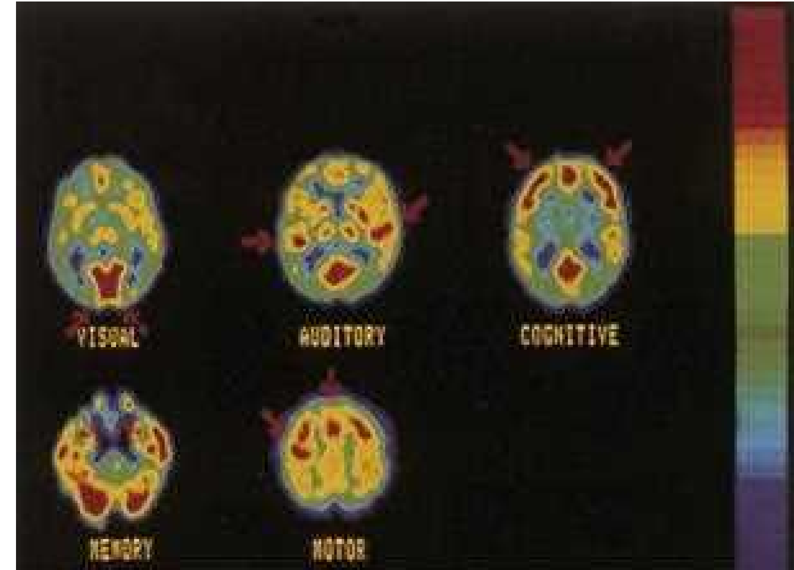
TABLE 5-1 NEUROTRANSMITTERS AND NEUROMODULATORS IN THE BRAIN—cont'd

SUBSTANCE	LOCATION	FUNCTION
Gamma-aminobutyric acid (GABA)	A glutamate derivative; most neurons of CNS have receptors *Effect:* major transmitter for postsynaptic inhibition on CNS	Drugs that increase GABA function, such as benzodiazepines, are used to treat anxiety and epilepsy and to induce sleep.
Histamine	Located in diencephalon, particularly hypothalamus (see Figure 5-4) *Effect:* can be excitatory or inhibitory	May play a role in alertness and learning. Is being investigated as potential mechanism for side effects commonly associated with psychotropic medications (weight gain, hyperlipidemia). Same substance as involved with immunological/allergic responses.
Peptides Peptides are chains of amino acids found throughout the body. New peptides are continually being identified, with 100 neuropeptides active in the brain, but their role as neurotransmitters is not well understood. Although they appear in very low concentrations in the CNS, they are very potent. They also appear to play a "second messenger" role in neurotransmission; that is, they modulate messages of nonpeptide neurotransmitters through G protein–linked receptors.		
Endorphins, enkephalins, dynorphins, and endomorphins	Widely distributed in CNS *Effect:* generally inhibitory	The opiates morphine and heroin bind to these endogenous opioid receptors on presynaptic neurons, blocking release of neurotransmitters and thus reducing pain.
Substance P	Spinal cord, brain, and sensory neurons associated with pain *Effect:* generally excitatory	Found in pain transmission pathway. Blocking release of substance P by morphine reduces pain.

CNS, Central nervous system; *LSD,* lysergic acid diethylamide; *NMDA, N*-methyl-D-aspartate; *PCP,* phencyclidine hydrochloride.

TABLE 5-2 BRAIN-IMAGING TECHNIQUES

TECHNIQUE	HOW IT WORKS	WHAT IT IMAGES	ADVANTAGES/ DISADVANTAGES
Computed tomography (CT)	Series of radiographs that are computer-constructed into "slices" of brain that can be stacked by computer, giving three-dimensional image	Brain structure	Provides clearer pictures of brain than radiographs alone
Magnetic resonance imaging (MRI)	Magnetic field surrounding head induces brain tissues to emit radio waves that are computerized to provide clear and detailed construction of sectional images of brain	Brain structure; newer functional MRI (fMRI) techniques show brain activity	Avoids use of harmful radiation, although MRI can be adapted to use radioactive materials also
Brain electrical activity mapping (BEAM)	Uses computed tomographic techniques to display data derived from electroencephalographic (EEG) recordings of brain electrical activity that can be sensory evoked by specific stimuli, such as a flash of light or a sudden sound, or cognitive evoked by specific mental tasks	Brain activity/function	Reflects cumulative activity of broad areas of brain, usually near surface, making it difficult to locate areas of possible pathological states
Positron emission tomography (PET)	Injected radioactive substance travels to brain and is displayed as bright spot on scan; different substances are taken up by brain in different amounts, depending on type of tissues and level of activity	Brain activity/function	Allows injection of labeled drugs for study of neurotransmitter receptor activity or concentration in brain
Single-photon emission computed tomography (SPECT)	Similar to PET but uses more stable substances and different detectors to visualize blood flow patterns	Brain activity/function	Useful in diagnosing cerebrovascular accidents and brain tumors



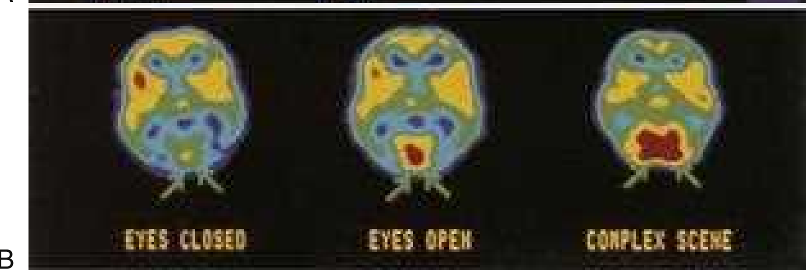


FIG 5-8 Positron emission tomography (PET) scan shows varying patterns of glucose consumption during different tasks. The color scale ranges from 2 (violet) to 45 (red).

A, Different kinds of tasks cause increased glucose consumption in distinct areas of the brain. A checkerboard visual stimulus activates the occipital lobes. An auditory stimulus causes increased glucose consumption in the temporal lobes. When an individual is engaged in an active, cognitive task rather than passive perception of stimuli, glucose consumption increases in the frontal lobes. Subjects trying to remember information from a verbal stimulus (a story) show increased glucose consumption in the temporal lobes. Sequential movements of the fingers of the right hand activate the motor cortex on the left and the supplementary motor arc *(vertical arrows)*.

B, Increasing complexity of a particular kind of task causes increased glucose consumption in progressively larger areas of the cortex. With the subject blindfolded ("eyes closed"), there is relatively little glucose consumption in the occipital lobes. With the eyes open, looking at a plain white light source activates the primary visual cortex of the occipital lobes. Looking at an outdoor scene ("complex scene") activates the visual association cortex in additional areas of the occipital lobes.

C, The left hemisphere usually plays a dominant role in language functions, and the right hemisphere is involved in musical and certain other functions. When a subject listens simultaneously to a Sherlock Holmes story and a Brandenburg concerto, both superior temporal lobes and both frontal lobes are activated. Listening to just the story activates predominantly the left hemisphere. Musical chords alone activate predominantly the right hemisphere. (**A** from Phelps ME, Mazziotta JC: *Science* 228:779, 1985; **B** from Mazziotta JC et al: *Neurology* 31:517, 1981; **C** from Mazziotta JC et al: *Neurology* 32: 921, 1982.)

looks very similar to ADHD. This can lead to treatment with ineffective medications and an extended time of intense symptoms. Being able to confirm, or refute, a diagnosis with neuroimaging in such situations can lead to improved patient outcomes. Perhaps the greatest potential of this research will be the ability to identify **biomarkers** of severe psychiatric illnesses before the patient experiences severe symptoms. Treatment could then be provided early, leading to improved long-term outcomes (Phillips, 2010; Perlis, 2011).

> **Critical Reasoning** What would be the benefits and risks that parents with a family history of psychiatric illness would consider in deciding about the use of neuroimaging with their children?

BIOLOGICAL RHYTHMS

Biological clocks keep track of time and govern timed activities, such as hormonal surges. They also account for the dysregulation characteristic of jet lag and the winter blues. **Biological rhythms affect every aspect of health and well-being, including lifestyle, sleep, mood, hunger, thirst, fertility, body temperature, and menses.** These rhythms can fluctuate in fractions of a second, such as those recorded in an electroencephalogram; or in a day, such as the 24-hour circadian rhythm; or in seasonal rhythms that span months or even years, such as those seen in migratory animals, birds, and insects; or in the billion years of evolutionary events (Table 5-3).

Various internal pacemakers set these clocks and underlie the simple to the most sophisticated human tasks. For

TABLE 5-3 **TIME: AN INSTANT TO ETERNITY**

MEASUREMENT	DESCRIPTION
1 nanosecond	One billionth of 1 second; the microprocessor inside a personal computer will typically take 2 to 4 nanoseconds to execute a single instruction, such as adding two numbers.
1⁄10 of 1 second	The duration of the fabled "blink of an eye"; the time it takes the human ear to distinguish between an echo and the original sound; the time it takes a hummingbird to beat its wings seven times.
1 minute	The brain of a newborn grows 1 to 2 milligrams in 1 minute; a person can speak about 150 words or read about 250 words in 1 minute.
1 day	In 1 day's time the human heart beats about 100,000 times, whereas the lungs inhale about 11,000 liters of air; the baby blue whale gains 200 pounds; the earth turns once on its axis.
1 year	The earth circles the sun and spins on its axis 365.26 times; North America moves about 3 centimeters away from Europe; ocean surface currents travel one fourth of the way around the globe.
1 million years	The time it takes for a spaceship moving at the speed of light and traveling to the Andromeda galaxy 2.3 million light-years away to reach the halfway point; Los Angeles will creep about 40 kilometers northwest of its present location in the next million years.
1 billion years	The newly formed earth cooled, developed oceans, gave birth to single-celled life, and developed an oxygen-rich atmosphere.

Modified from Labrador D: *Sci Am* 287:56, 2002. Copyright © 2002 by Scientific American, Inc. All rights reserved.

this reason timing mechanisms offer insights into aging and disease. Cancer, Parkinson disease, seasonal depression, and attention deficit disorder have all been linked to defects in biological clocks.

The interval timer acts as the brain's stopwatch, marking seconds, minutes, and sometimes hours. It helps one judge how fast to run to catch a ball or how long to lounge in bed after the alarm rings. It helps tap a foot to music, dodge an oncoming car, and know how long the traffic light will stay yellow before turning red. The interval timer is flexible and can easily be turned on and off. It acts as the brain's stopwatch, contributing to the seamless execution of everyday moment-to-moment activities.

Circadian Rhythms

Circadian rhythm is like a network of internal clocks that coordinate events in the body according to a 24-hour cycle (Figure 5-9). This cycle corresponds to the time it takes the earth to spin on its axis, exposing all of life to daily rhythms of light, darkness, and temperature.

Because the body's fluids and tissues function according to circadian rhythms, physical and mental abilities and moods may vary widely from one time of day to another. To function according to the 24-hour clock, the circadian system must have a time cue from the external environment. **That time cue is usually sunlight, which resets the clock each day and synchronizes the body's complex set of rhythms.**

Light enters the retina of the eye, which acts like an antenna of the brain. From the retina specialized nerve cells send signals of light and dark through special pathways to the hypothalamus and other regions of the brain (Figure 5-10). One of the most important internal timekeepers is located in the hypothalamus. It consists of two clusters of nerve cells called the suprachiasmatic nuclei (SCN). A direct tract leads from the retina to these two clusters of cells, which in turn respond to the light signals from the retina.

The SCN is the pacemaker of circadian rhythm; it sends electrical and chemical messages to other parts of the brain, including the hypothalamus, pituitary gland, pineal gland, and parts of the brainstem. These brain structures send hormonal messages to other control systems in the body, such as the heart, adrenal glands, liver, kidney, and intestines, keeping them regulated to the internal clock and modulating thoughts, moods, body functions, and human activities.

Sleep

Most people sleep between 6 and 9 hours per night. Few people normally sleep less than 5 or more than 10 hours. Usually, people sleep in one nightly phase, although in some cultures and during some times of life, a siesta, or afternoon nap, is common. **Studies show that the sleep cycle is related to the timing of circadian rhythms, changes in light and darkness, and temperature changes.**

Generally, each night a person's sleep passes through a repeated sequence of five stages. The first stage is that of "falling asleep," which is called stage 1 sleep. A person then progresses into sleep itself (stage 2), followed by deep sleep, also called delta sleep (stages 3 and 4). After a brief return to stage 2 sleep, the person moves into stage 5, or rapid eye movement (REM), sleep. Stages 2 through REM repeat themselves several times each night, with deep sleep becoming briefer in the course of a night and REM sleep becoming progressively longer (Figure 5-11).

REM sleep occupies approximately 20% to 25% of the sleep time of adults, stage 2 about 50%, and stages 3 and 4 about 15%. Stages 3 and 4 occur primarily in the first half of the sleep period. The lighter stages of sleep and longer REM periods typically occur in the second half. Usually, during REM sleep the individual has vivid dreams, and the eyes show bursts of rapid movement beneath the closed lids.

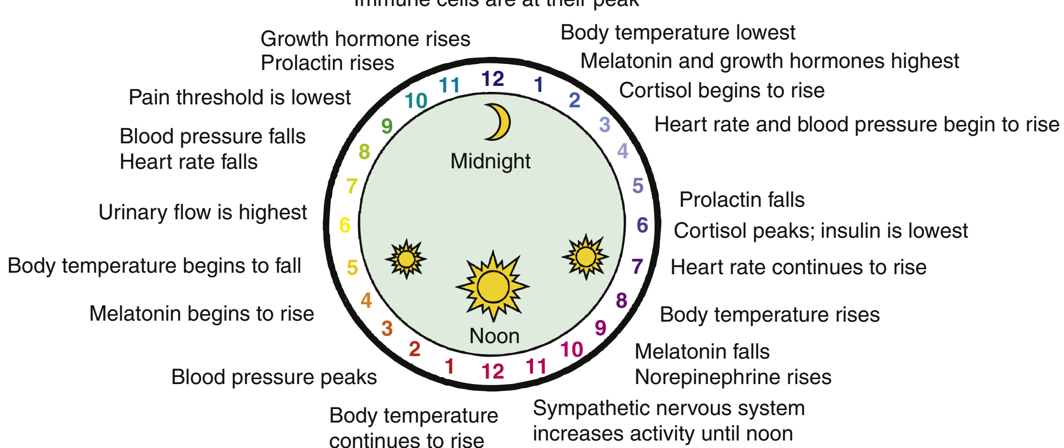


FIG 5-9 The day within: a sample of the body's daily rhythms.

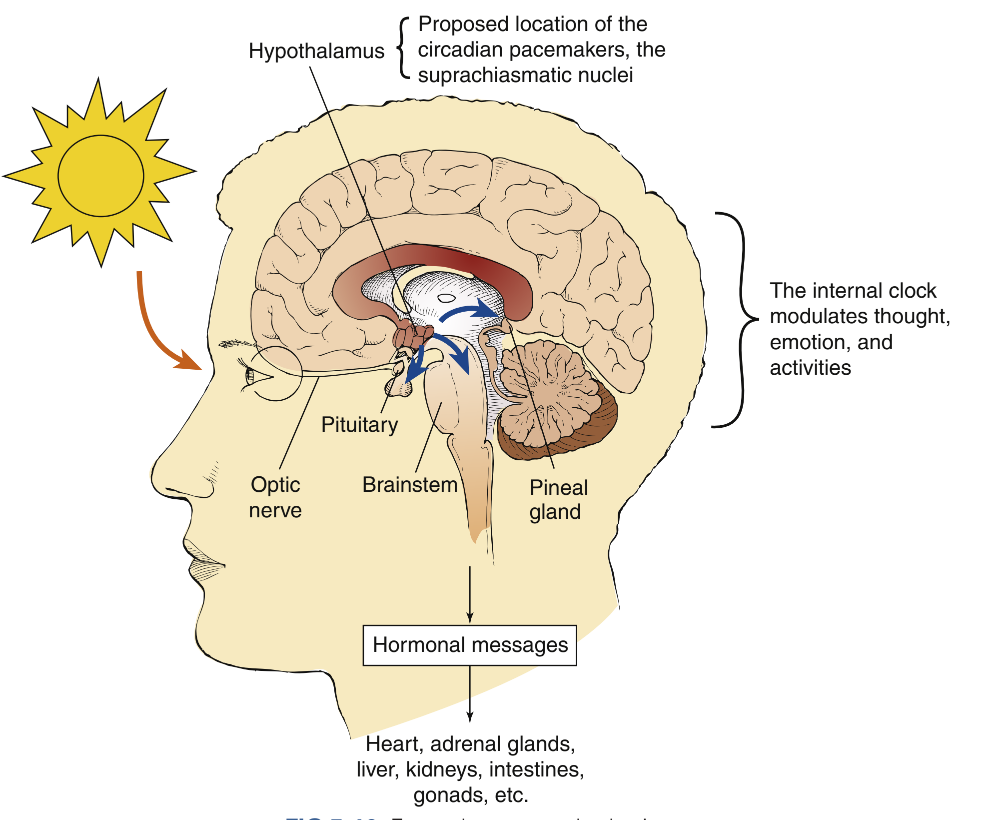


FIG 5-10 From the sun to the brain.

It is important for optimal health that people progress through the normal stages of sleep each night. Studies show that in depressed persons, REM sleep is excessive, the deeper stages of sleep are decreased, and dreams may be unusually intense. Thus, although they may sleep 6 to 9 hours each night, people with depression frequently report fatigue, poor concentration, and irritability associated with sleep deprivation.

Critical Reasoning How much sleep do you need each night? How does it affect your functioning if you have less sleep or more sleep?

PSYCHONEUROIMMUNOLOGY

Psychosocial factors can have a profound effect on a person's immune system. The brain and the immune system continuously signal each other, often along the same pathways, which may explain how state of mind influences health. **The job of the immune system is to keep foreign pathogens away from the body and to recognize and destroy those that penetrate its shield.**

The immune system must neutralize dangerous toxins, help repair damaged or worn tissues, and dispose of normal cells, while ensuring its activity is not directed at its own body, which would cause autoimmune diseases. In particular,

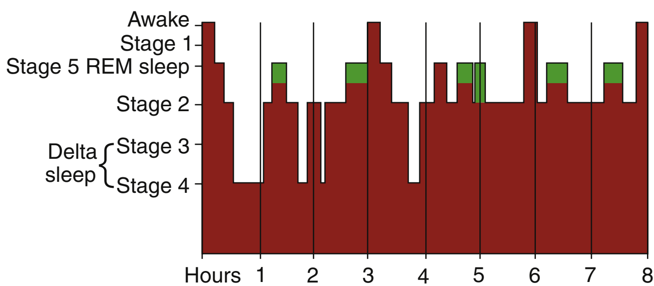


FIG 5-11 Normal sleep architecture. Green areas indicate REM sleep.

psychosocial stressors and the mental state associated with them may depress immune function to the point of enhancing vulnerability to almost any antigen to which the person is exposed. The central nervous system (CNS) is involved in mediating this problem.

Psychoneuroimmunology explores the interactions among the CNS, the endocrine system, and the immune system; the impact of behavior and stress on these interactions; and how psychological and pharmacological interventions may buffer these interactions. These systems communicate by a feedback loop of chemical messengers from each system: neurotransmitters produced by nerve cells, hormones secreted by endocrine glands, and cytokines and other peptides secreted by immune cells.

Research has shown the suppression of white blood cells and increased susceptibility to illness following sleep deprivation, marathon running, space flight, death of a spouse, and during the course of depression. Another example is that of natural killer (NK) cells, which are believed to play a role in tumor surveillance and the control of viral infections. These cells seem to decrease in number with increasing levels of stress.

GENETICS

The history of biology was altered forever by the launching of the **Human Genome Project,** a research program that has characterized the complete set of genetic instructions of the human. Science is showing that the complexity of human emotions and behavior is governed by a variety of genes and their interplay with each other, environmental factors, personality, and life experiences (Cole et al, 2010).

Determination of the DNA sequence for the human gene was completed in April 2003, marking the end of the Human Genome Project, 2 years ahead of schedule. One of the most daunting challenges remaining is that of understanding how all the parts of cells—genes, proteins, and many other molecules—work together to create complex living organisms in health and illness (NHGRI, 2011). Some of the highlights of what has been learned thus far are listed in Box 5-3.

DNA from all organisms is composed of the same chemical and physical components. The **DNA sequence** is the particular side-by-side arrangement of bases along the DNA strand (e.g., ATTCCGGA). This order spells out the exact instructions required to create a particular organism with its own unique traits.

BOX 5-3 INSIGHTS GAINED FROM THE HUMAN DNA SEQUENCE

- The human genome contains 3 billion nucleotide bases (A, C, T, G), combinations of which comprise all genetic codes. The average gene has 3000 bases. Humans have about 30,000 genes (one third as many as previously thought), the same number as found in a laboratory mouse.
- The functions of more than 50% of the discovered genes are still unknown.
- The human genome sequence is almost (99.9%) exactly the same in all people.
- Slight variations in DNA sequences can have a major impact on the manifestation of a disease process and on responses to environmental factors, such as the presence of microbes, toxins, and drugs.
- Single-nucleotide polymorphisms (SNPs) are sites in the human genome where individuals differ in their DNA sequence, often only by a single base. Sets of SNPs on the same chromosome are inherited in blocks and may help determine the etiology of disease as well as the efficacy of new treatments.
- Additional information about the Human Genome Project is available at www.genome.gov.

The **genome,** an organism's complete set of DNA instructions, is organized into **chromosomes,** which contain many genes, the basic physical and functional units of heredity. **Genes** are specific sequences of bases that encode instructions on how to make **proteins,** which are large, complex molecules made up of amino acids. It is the proteins that perform most life functions and constitute the majority of cellular structures.

The entire set of all proteins in a cell is called its **proteome.** The proteome is a dynamic molecular machine that constantly changes as a result of the many environmental signals within a cell, and within the communities of cells that make up the 100 trillion cells in a human (Figure 5-12). Studies designed to explore protein structure and activities, known as **proteomics,** will help discover the molecular basis of health and illness (Human Genome Project Information, 2008).

Genetic mapping, also called linkage mapping, is the first step in isolating a gene. It can offer firm evidence that a disease transmitted from parent to child is linked to one or more genes, and it provides clues as to which chromosome contains the gene and where the gene is on the chromosome. Although genetic maps have helped successfully identify single genes responsible for some rare diseases, the maps also have become useful as a guide by which scientists can identify the many genes that are believed to interact to cause more common disorders, such as asthma, heart disease, diabetes, and psychiatric disorders.

Genetic testing is a commercial medical application of the new genetic discoveries, used to diagnose disease, confirm a diagnosis, provide prognostic information about the course of a disease, confirm the existence of a disease in asymptomatic individuals, and detect predispositions to disease in healthy individuals and their offspring. Currently, several

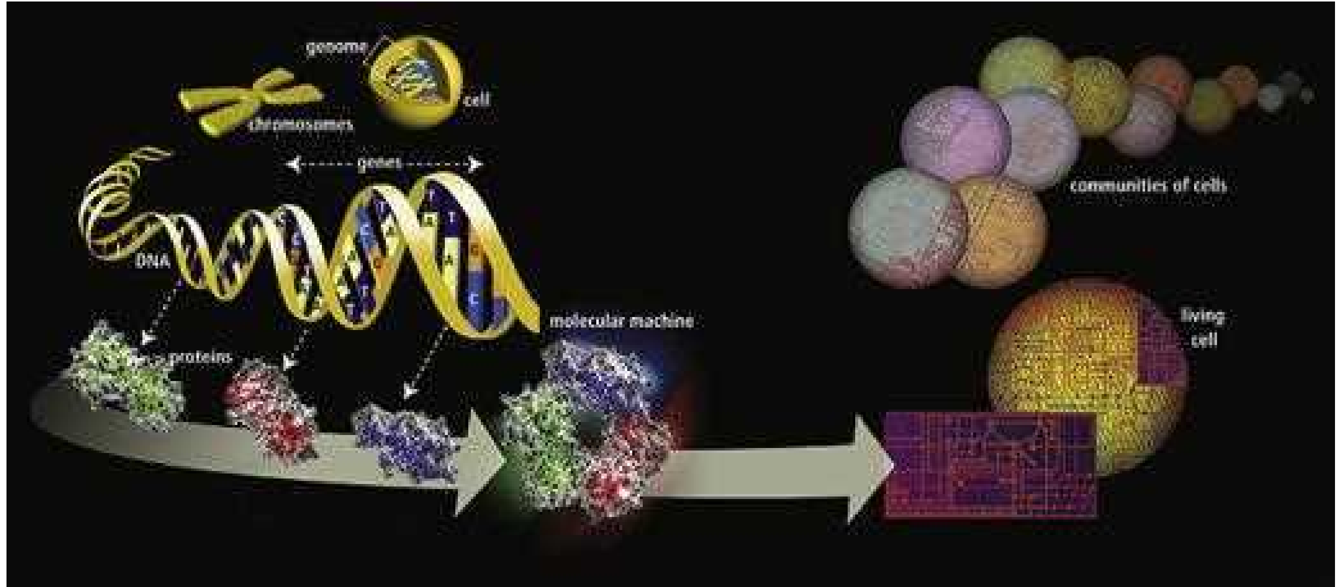


FIG 5-12 A primer: from DNA to life. Cells contain DNA—the hereditary material of all living things. The genome is an organism's complete set of DNA and is organized into chromosomes. DNA contains genes whose sequence specifies how and when to build proteins. Proteins perform most essential life functions, often working together as molecular machines. Molecular machines interact through complex, interconnected pathways and networks to make the cell come alive. Communities of cells range from associations of microbes (each a single cell) to the hundred trillion cells in a human. (Courtesy U.S. Department of Energy Office of Science, http://genomics.energy.gov/.)

hundred genetic tests are in clinical use for illnesses such as muscular dystrophies; cystic fibrosis; sickle cell anemia; Huntington disease; and breast, ovarian, and colon cancers.

The new field of **pharmacogenetics,** the discipline that blends pharmacology with genomic capabilities, will eventually allow researchers to match DNA variants with individual responses to medical treatments. This will allow for the design of custom drugs based on individual genetic profiles. These drugs will be specific for the targeted causes of the illness and will avoid nonillness targets in the body, thereby eliminating unwanted drug effects.

Gene therapy, still an experimental field, holds potential for treating or even curing genetic and acquired diseases such as cancer and acquired immunodeficiency syndrome (AIDS) by using normal genes to supplement or replace defective genes or to bolster a normal function, such as immunity (NHGRI, 2011). As of 2011, more than 1700 clinical gene therapy trials have been identified worldwide (*Journal of Gene Medicine*, 2011).

Although having relevant genetic information can help patients and their health care providers manage illnesses more effectively, there are drawbacks as well. These can include emotional and psychological effects on individuals and their families, confusion about the meaning of the information from an ethical or moral perspective (Williams et al, 2006), discrimination at work or by insurance companies, the use of genetic information in reproductive decision making, and lack of privacy and confidentiality regarding genetic information, which may lead to stigmatization.

Increasing emphasis on genetic causes of mental illness also may influence people's orientation to treatment. One study found that perceptions of genetic causes were associated with more extreme and biological forms of intervention, along with greater pessimism that the intervention will be effective (Phelan et al, 2006).

Geneticists (a medical specialty) and genetic counselors (a graduate-level specialty) are trained to diagnose and explain disorders from a genetic perspective. They can review available options for testing and treatment and provide emotional support to individuals or families who have genetic disorders or are at risk for them or need information about risks to their offspring.

Critical Reasoning Do you believe that there is a gene responsible for alcohol dependence, aggressive behavior, or sexual preference? How would your belief affect the nursing care you give patients?

Genetics of Mental Illness

The search for the genes that cause mental illness has been challenging and has stimulated scientific, political, and clinical debate (Kendler, 2005). **Genetic research shows that familial and genetic factors underlie most major psychiatric illness by involving multiple genes and mechanisms impacting gene expression.** This is in contrast to the earlier view of genetics where a single gene was thought to be the causative factor.

An example of a genetically heterogeneous (caused by more than one gene) disorder is the rare form of Alzheimer disease (AD) that affects people before age 65 years. Early-onset AD affects only about 10% of cases and seems to be

TABLE 5-4 STUDY DESIGNS FOR INHERITANCE AND GENETIC RESEARCH ON MENTAL DISORDERS

TYPE OF STUDY	WHO IS STUDIED	GOAL OF THIS STUDY DESIGN
Population	Subjects in general population	Establish lifetime incidence
Family	First- and second-degree relatives (pedigree) of affected person (proband)	Establish familiarity; estimate mode of transmission and risk to relative cases
Twin	Monozygotic (identical—share all their genes) and dizygotic (fraternal—share half their genes) twins	Distinguish genetic from environmental effects
Adoption	Adoptees and their adoptive and biological relatives	Distinguish genetic from environmental effects
Linkage	Nuclear and/or extended families	Establish chromosomal location of a disease susceptibility gene
Association	Unrelated affected persons and controls	Identify a specific disease susceptibility gene
Transgenic	Gene expression and function in animals	Specify developmental outcomes/pathways

linked to mutations in any of three specific genes responsible for amyloid-beta, causing excess deposits of this substance in the brains of persons with AD. The search for the genes responsible for the more common late-onset AD and for other neuropsychiatric illnesses is ongoing.

Current research on the genetics of mental health and illness is confirming the genetic transmission of mental illness but also confronting many challenges. One challenge is the chronic nature of many mental illnesses and the gradual increase of symptoms and behavioral problems over time. Also challenging is the length of time required for therapeutic effects of many treatments. These gradual changes in brain function may be a function of **epigenetics,** mechanisms that can modify gene expression long term without amending the genetic code (Tsankova et al, 2007).

The proteins surrounding DNA affect which portions of the DNA strand are accessible for transcription. This manipulation of DNA can affect gene activity but does not alter the genetic code. Another complication is that psychiatric illnesses are not caused by simple genetic mechanisms but rather by small, cumulative effects from multiple genes (Kendler, 2006; Baum et al, 2007).

Although the search for the genes of neuropsychiatric illness continues to hold promise, current information regarding the transmission of mental illness is based primarily on investigations into human inheritance, such as family, twin, and adoption studies. The study designs for inheritance and genetic research on mental disorders are listed in Table 5-4.

The other proposed uses of genetics in psychiatry include the following:

- **Developing new drugs** that will target molecular regulators of gene expression that control neuroproteins and neuroenzymes in brain regions shown to be abnormal in a particular psychiatric illness
- **Conducting gene therapy**—the introduction of genes into existing cells to prevent or cure disease
- **Implementing studies that use "candidate genes"** (cloned human genes that are functionally related to the disease of interest) in research procedures in the laboratory

Patients and their families are increasingly knowledgeable about genetics from the lay press and commercially-marketed products. The nurse is in the position to answer questions from patients and families about the genetics of mental illness and to educate them about the accuracy and limitations of current testing procedures (Braff and Freedman, 2008; Gottesmann et al, 2011; Lea et al, 2011). The nurse can objectively share the current evidence while reminding them that this information is often preliminary, yet growing. This discussion must be conducted with the highest respect for the patient's and family's autonomy. Referral to a genetic counselor should be considered when the questions are persistent and complex.

Impact of the Human Genome Project

The information gained from the Human Genome Project has thus far provided limited clinical relevance for the treatment of neuropsychiatric disorders. However, there are reasons to be optimistic about the future (Green and Guyer, 2011). It is anticipated that gene therapies will become common in the future of health care, including mental health. Standard clinical practice will likely include an assessment of the significance of genetic risk factors for each patient, an interpretation of this information to patients and families, and assistance in understanding the latest available gene-based interventions.

BIOLOGICAL ASSESSMENT OF THE PATIENT

Psychiatric nurses are faced with the challenge of integrating the latest neuroscientific information when providing holistic, evidence-based, and individualized psychiatric nursing care. This begins with a thorough biological assessment of the patient (Pestka, 2008).

Several steps are necessary in the assessment of psychiatric patients from a biological perspective. Brain disorders can be physical or "neurological" and can include many different diagnoses, such as stroke, head and spinal cord injury, brain tumors, multiple sclerosis, Parkinson disease, and Huntington disease. Schizophrenia, depression, anxiety disorders, and Alzheimer disease also are brain disorders, although they are classified as psychiatric disorders.

The symptoms of psychiatric versus neurological illnesses can overlap and can even mimic each other. However,

the treatments can be very different. Treatments for one disorder may make another disorder worse. Thus the ability to screen for both undiagnosed physical and psychiatric disorders is critical for the psychiatric nurse in the assessment of the presenting symptoms, treatment selection, and possible need for referral to a specialist in another discipline.

Undiagnosed physical illness, particularly organic brain disorders, can be costly and dangerous if treated incorrectly. Physical illnesses such as brain tumors and endocrine disorders can cause psychiatric symptoms and exacerbate an existing psychiatric illness. In addition, patients who are psychiatrically ill may be misdiagnosed in nonpsychiatric settings.

A serious problem is the higher rates of mortality and medical comorbidity among patients who are mentally ill. Psychiatric patients experience high rates of a wide range of undiagnosed and untreated physical illnesses, including heart disease, diabetes, hypertension, cancer, and pulmonary illness (Roshanaei-Moghaddam and Katon, 2009; Platt et al, 2010). They also have many risk factors for preventable disease, including smoking, obesity, sedentary lifestyles, and poor nutrition (Correll et al, 2010; Mangurian et al, 2010).

These patients often lack a primary care provider and do not always receive adequate physical assessments in their mental health care settings (Carson et al, 2010). For these reasons psychiatric nurses must include a thorough biological assessment in their evaluation of psychiatric patients. **They must address both mental and physical health needs in their assessments, treatment plans, and patient education.**

The psychiatric nurse is well suited for the task of screening patients for the major signs of physical and organic disorders that may complicate a patient's psychiatric status. The purpose of such screening is to identify physical illnesses that may have been overlooked and then to refer the patient for a thorough medical diagnostic work-up if indicated. In fact, this is one of the unique areas of expertise that the psychiatric nurse brings to the mental health treatment team, and it is essential that psychiatric nurses continue to demonstrate their competence in all aspects of their biopsychosocial assessment.

A complete health care history of the patient, including lifestyle review, physical examination, analysis of laboratory values, and discussion of presenting symptoms and coping responses, is essential to a baseline biological assessment (Box 5-4). The nurse should be able to perform a basic physical examination to assess for gross abnormalities and be able to interpret the results of more complex physical examinations. Appearance; gait; coordination; bilateral strength; speech; and symptoms such as tremors and tics, headaches, blurred vision, dizziness, vomiting, motor weakness, disorientation, confusion, and memory problems should be assessed in detail.

Obtaining permission from the patient to access other people and documents that will help the nurse and health care team gain a thorough view of the patient is an important step in the screening process. Particularly when brain disorders, whether physical or psychiatric, are suspected, the nurse should pay close attention to inconsistencies in the patient's account, between those of other people, and in previous health care records. Throughout the course of the screening, the nurse should be alert for any indications of head trauma at any time in the patient's life as a result of incidents such as accidents, fevers, surgery, or seizures.

Critical Reasoning Why is a history of psychiatric medications taken from a patient's first-degree relatives an important part of the psychiatric nurse's biological assessment?

Only after a patient has been carefully screened can the nurse determine which of the patient's problems are primarily psychiatric and amenable to psychiatric intervention and which may need the attention of a consultant in another specialty. The identified problems that can be treated appropriately by psychiatric intervention then become the target symptoms of specific interventions, and progress toward expected outcomes can be measured throughout the course of treatment.

BOX 5-4 BIOLOGICAL ASSESSMENT OF THE PSYCHIATRIC PATIENT

Health Care History

General Health Care

Regular and specialty health care provider
Frequency of health care visits
Date of last examination
Any unusual circumstances of birth, including mother's preterm habits and condition
Allergies
Immunizations
Papanicolaou smear and mammogram
Chest x-ray and ECG
TB test

Hospitalizations, Surgeries, and Medical Procedures

When, why indicated, treatments, outcome

Brain Impairment

Diagnosed brain problem
Head trauma
Details of accidents or periods of unconsciousness for any reason: blows to the head, electrical shocks, high fevers, seizures, fainting, dizziness, headaches, falls

Cancer

Full history: particularly consider metastases (lung, breast, melanoma, gastrointestinal tract, and kidney cancers are most likely to metastasize)
Results of treatments (chemotherapy and surgeries)

BOX 5-4 BIOLOGICAL ASSESSMENT OF THE PSYCHIATRIC PATIENT—cont'd

Lung Problems

Details of any condition or event that restricts the flow of air to the lungs for more than 2 minutes or adversely affects oxygen absorption (the brain uses 20% of the oxygen in the body), such as with chronic obstructive pulmonary disease, near drowning, near strangulation, high-altitude oxygen deprivation, and resuscitation events

Cardiac Problems

Childhood illnesses, such as scarlet fever or rheumatic fever
History of heart attacks, strokes, or hypertension
Arteriosclerotic conditions

Diabetes

Stability of glucose levels

Endocrine Disturbances

Thyroid and adrenal function particularly

Menstrual History

Age at occurrence of first menstrual period
Regularity of menstrual periods, impact on lifestyle
Date of last menstrual period, duration
Menopausal history
Assess for premenstrual syndromes

Sexual History

Assess sexual function and activity
Screen for sexual dysfunction
History of sexual abuse
Safe-sex practices and sexually transmitted diseases

Reproductive History

Number of pregnancies, births, children and their ages
Assess birth control methods

Lifestyle

Eating

Details of unusual or unsupervised diets, appetite, weight changes, cravings, and caffeine intake

Medications

Full history of current and past psychiatric medications for self and first-degree relatives
Full history of current use of nonpsychiatric prescription medicines, over-the-counter medicines, and herbal and other alternative remedies

Substance Use

Alcohol, drug, caffeine, and tobacco use

Toxins

Overcome by automobile exhaust or natural gas
Exposure to lead, mercury, insecticides, herbicides, solvents, cleaning agents, lawn chemicals
Fetal alcohol syndrome

Occupation (Current and Past)

Chemicals in the workplace (e.g., pesticides used in farming, solvents used in painting)
Work-related accidents (e.g., construction, mining)
Military experiences
Stressful job circumstances

Injury

Contact sports and sports-related injuries
Exposure to violence or abuse
Rape or molestation

Impact of Culture, Race, Ethnicity, and Gender

Physical Examination

Review of Physiological Systems

Integumentary: skin, nails, hair, and scalp
Head: eyes, ears, nose, mouth, throat, and neck
Breast
Respiratory
Cardiovascular
Hematolymphatic
Gastrointestinal tract
Urinary tract
Genital
Neurological, soft signs, and cranial nerves
Musculoskeletal
Nutritive
Restorative: sleep and rest
Endocrine
Allergic and immunological
Gait, coordination, and balance

Laboratory Values

Hematology: CBC and erythrocyte sedimentation rate, screen for anemia
Chemistry: BUN, glucose, thyroid, adrenal, liver and kidney function, etc.
Serology: especially syphilis screen, HIV, hepatitis
Urinalysis: screen for drugs
Stool tests for occult blood

Presenting Symptoms and Coping Responses

Description: nature, frequency, and intensity
Threats to safety of self or others
Functional status
Quality of life
Support system

BUN, Blood urea nitrogen; *CBC,* complete blood count; *ECG,* electrocardiogram; *HIV,* human immunodeficiency virus; *TB,* tuberculosis.

CHAPTER IN REVIEW

- All nurses should have a working knowledge of the normal structure and function of the brain related to mental health and neuropsychiatric illness, just as all nurses should know the structure and function of the heart.
- Neurotransmission is a key factor in understanding how various regions of the brain function and communicate with each other and how interventions, such as medications and other therapies, affect brain activity and human behavior.
- One clinical implication of the neurotransmission process is that abnormalities in the structure of the brain or in its ability to communicate in specific locations can cause or contribute to neuropsychiatric disorders.
- Brain-imaging techniques allow direct viewing of the structure and function of the intact, living brain. These techniques help in mapping the regions of the brain, measuring the activity or function in these regions, and correlating this activity with the effects of interventions. The results of neuroimaging techniques are increasingly studied as a means of diagnosing psychiatric illnesses.
- Biological rhythms affect every aspect of health and well-being, including lifestyle, sleep, mood, hunger, thirst, fertility, body temperature, and menses.
- Circadian rhythm is like a network of internal clocks that coordinate events in the body according to a 24-hour cycle.
- Studies show that the sleep cycle is related to the timing of circadian rhythms and changes in light, darkness, and temperature. For optimal health it is important that people progress through the normal stages of sleep each night.
- Psychoneuroimmunology explores the interactions among the CNS, the endocrine system, and the immune system; the impact of behavior/stress on these interactions; and how psychological and pharmacological interventions may buffer these interactions.
- Science is uncovering information showing that the complexity of human emotions and behavior is governed by a variety of genes and their interplay with each other, environmental factors, personality, and life experiences.
- Genetic research continues to demonstrate that familial and genetic factors underlie most of the major psychiatric illnesses.
- Psychiatric nurses are faced with the challenge of integrating the latest neuroscientific information when providing psychiatric nursing care. This begins with a thorough biological assessment of the patient.
- Psychiatric nurses must address both mental and physical health needs in their assessments, treatment plans, and patient education.
- The psychiatric nurse is well suited for the task of screening patients for the major signs of physical or organic disorders that may complicate a patient's psychiatric status. The purpose of such screening is to identify physical illnesses that may have been overlooked and then to refer the patient for a thorough medical diagnostic work-up if indicated.
- A complete health care history of the patient, including lifestyle review, physical examination, analysis of laboratory values, and discussion of presenting symptoms and coping responses, is essential to a baseline biological assessment.

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CHAPTER

6

Psychological Context of Psychiatric Nursing Care

Gail W. Stuart

Information is of no value for its own sake, but only because of its personal significance.

Eric Berne

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the nature, purpose, and process of the mental status examination.
2. Examine the observations and clinical implications of each category of the mental status examination.
3. Identify commonly used psychological tests.
4. Analyze the value of using behavioral rating scales in psychiatric nursing practice.

Holistic psychiatric mental health nursing care requires the nurse to complete an assessment of the patient's biological, psychological, and sociocultural health status. The assessment of the patient's psychological well-being should include a mental status examination. All nurses, regardless of the clinical setting, should be proficient in administering the mental status examination and be able to incorporate findings from it into the nursing care plan for the patient.

The mental status examination is a cornerstone in the evaluation of any patient with a medical, neurological, or psychiatric disorder that affects thought, emotion, or behavior (American Psychiatric Association, 2006). It is used to detect changes in a person's intellectual functioning, thought content, judgment, mood, and affect. **The mental status examination is to psychiatric nursing what the physical examination is to general medical nursing.**

MENTAL STATUS EXAMINATION

The **mental status examination** represents a cross section of the patient's psychological life and the nurse's observations and impressions at one point in time. It involves observing the patient's behavior and describing it in an objective, nonjudgmental manner. **The elements of the examination depend on the patient's clinical presentation, as well as on the patient's educational and sociocultural background.** It also serves as a basis for future comparison in tracking the patient's progress over time.

The examination itself is usually divided into several parts. They can be arranged in different ways, as long as the nurse covers all the areas. Much of the information needed for the mental status examination can be gathered during the course of the routine nursing assessment. It should be integrated into the nurse's assessment in a smooth manner.

Some parts of the mental status examination are completed through simple observation of the patient, such as noting the patient's clothing or facial expressions. Other aspects require asking specific questions, such as those related to memory or attention span. Most of all, the nurse should remember that the mental status examination does not reflect how the patient was in the past or will be in the future. **The mental status examination is an evaluation of the patient's current state.**

Information obtained during the mental status examination is used along with other objective and subjective data. These include findings from the physical examination; laboratory test results; patient history; description of the presenting problem; and information obtained from family, caregivers, and other health professionals. With these data the nurse is able to formulate nursing diagnoses and design the plan of care with the patient.

Critical Reasoning Do nurses on medical-surgical units routinely assess a patient's psychological status? Explain your findings given that all nurses should be providing holistic, biopsychosocial nursing care.

Obtaining Clinical Information

The mental status examination requires a clinical rather than social approach to the patient. The nurse listens closely to what is said and reflects on what is not said. The nurse structures the process to allow for the broad exploration of many areas, the uncovering of potential problems, and the identification of symptoms or maladaptive coping responses. **The patient is observed carefully, and recorded information is specific and objective, not global or judgmental.**

The skilled nurse attends to both the content and the process of the patient's communication. **Content** is the overtly communicated information. **Process** is how the communication occurs and includes feelings, intuition, and behaviors that accompany speech and thought. The content and process may not always be congruent. For example, a patient may deny feeling depressed and yet appear sad and cry. In this case the stated message does not match the process, and the nurse should record this incongruity.

It also is important for nurses to monitor their own feelings and reactions while implementing the mental status examination. A nurse's gut reactions may reflect subtle emotions being expressed by the patient. For example, a depressed patient may make the nurse feel sad, and a hostile patient may make the nurse feel threatened and angry. The nurse's feelings are useful information to consider in formulating the mental status assessment of a patient. The nurse needs to be aware of these feelings and respond in a therapeutic manner toward the patient, regardless of the nature of such feelings.

The nurse should remain calm throughout the interview and simply reflect observations back to the patient. These observations should be related in an objective and nonthreatening manner, as in "You are obviously quite upset about this," or "It seems like you don't feel safe here." By conveying a sense of calm, the nurse also demonstrates being in control, even if the patient is not.

The nurse should try to blend specific questions into the general flow of the interview. For example, questions about orientation, arithmetic problems, or proverbs may be introduced by talking with the patient about potential problems with concentration, memory, or understanding of written material. The nurse might then suggest that the patient try answering a few questions to determine whether such problems exist. As with any skill, nurses need to practice performing the mental status examination to gain proficiency and be comfortable with the process. The nurse might start by observing a colleague conduct the examination. Videos and simulations of patient interviews are particularly effective teaching-learning tools.

BOX 6-1 CATEGORIES OF THE MENTAL STATUS EXAMINATION

General Description
Appearance
Speech
Motor activity
Interaction during interview

Emotional State
Mood
Affect

Experiences
Perceptions

Thinking
Thought content
Thought process

Sensorium and Cognition
Level of consciousness
Memory
Level of concentration and calculation
Information and intelligence
Judgment
Insight

CONTENT OF THE EXAMINATION

The mental status examination includes information in a number of categories (Box 6-1). It is one part of a complete psychiatric nursing assessment tool. In completing this examination, it is critically important to be aware that **sociocultural factors can greatly influence the outcome of the examination** (Box 6-2). The content, observations, and some of the clinical implications associated with each category are described in the following sections (Robinson, 2002).

Appearance

In the mental status examination, the nurse notes the patient's appearance. This part of the examination is intended to provide an accurate mental image of the patient.

CLINICAL EXAMPLE

Mr. W was a middle-aged, white male of average weight who appeared older than his stated age. He was disheveled, dressed in a torn shirt and jeans, and unshaven. He was slightly jaundiced and had a prominent red nose and a scar on his left cheek. He sat slumped in the chair and made little eye contact with the interviewer.

BOX 6-2 SOCIOCULTURAL CONTEXT OF CARE

Clinical Judgment or Sociocultural Bias?

In completing the mental status examination clinicians need to be aware of the possibility that they may be using subconscious and culturally determined criteria when judging a patient. Examples of potential sociocultural clinician bias include the following:

- How is the manner of dress judged (i.e., what is unusual or expected dress)?
- Do all cultures accept the U.S. norm of direct eye contact?
- What are the clinician's values about personal hygiene, and how do these values influence assessment?
- Does a person's speech and use of language vary based on social class and lifestyle?
- How does body language and use of personal space vary by ethnicity and social group?
- Given that 20 to 30 million U.S. adults lack basic educational skills, what is the expected "norm" regarding reading, writing, or problem-solving tasks?
- How familiar are common proverbs? Which interpretations of them are truly correct?

Observations. The following physical characteristics should be included in the assessment:

- **Apparent age**
- **Manner of dress**
- **Cleanliness**
- **Posture**
- **Gait**
- **Facial expressions**
- **Eye contact**
- **Pupil dilation or constriction**
- **General state of health and nutrition**

Clinical Implications

- Dilated pupils are sometimes associated with drug intoxication.
- Pupil constriction may indicate narcotic addiction.
- Stooped posture is often seen in patients with depression.
- Manic patients may dress in colorful or unusual attire.

Speech

Speech is usually described in terms of rate, volume, amount, and distinct characteristics. Rate is the speed of the patient's speech, and volume is how loud a patient talks.

Observations. Speech can be described as follows:

- **Rate:** rapid or slow
- **Volume:** loud or soft
- **Amount:** paucity, muteness, pressured speech
- **Characteristics:** stuttering, slurring of words, or unusual accents

Clinical Implications

- Speech disturbances are often caused by specific brain disturbances. For example, mumbling may occur in patients with Huntington chorea, and slurring of speech may occur in intoxicated patients.
- Manic patients often show pressured speech.
- People with depression often are reluctant to speak at all.

Motor Activity

Motor activity describes the patient's physical movement.

Observations. The nurse should record the following:

- **Level of activity:** lethargic, tense, restless, or agitated
- **Type of activity:** tics, grimaces, or tremors
- **Unusual gestures or mannerisms:** compulsive behavior

Clinical Implications

- Excessive body movement may be associated with anxiety, mania, or stimulant abuse.
- Little body activity may suggest depression, organic mental disorders, catatonic schizophrenia, or drug-induced stupor.
- Tics and grimaces may suggest medication side effects.
- Repeated motor movements or compulsive behavior may indicate obsessive-compulsive disorder.
- Repeated picking of lint or dirt off of clothing is sometimes associated with delirium or toxic conditions.

Critical Reasoning Which category of psychotropic medications is most often associated with tics and grimaces?

Interaction During the Interview

Interaction describes how the patient relates to the nurse during the interview. Because this part of the examination relies heavily on nurses' emotional subjectivity, nurses must carefully examine their responses based on their own personal and sociocultural biases. They must guard against overinterpreting or misinterpreting patients' behavior because of social or cultural differences between patients and nurses (Chapter 7).

CLINICAL EXAMPLE

The patient was interviewed in her room on the second day of hospitalization. She was a white woman, slightly overweight, and neatly dressed in jeans and a sweater, and she appeared younger than her 36 years of age. Although she was cooperative, her guarded responses to all questions seemed excessively self-centered. She gave the interviewer the feeling that she did not trust anyone and was preoccupied during the interview. When asked how other people treated her, she responded angrily, "I'd rather not say!"

Observations. Is the patient hostile, uncooperative, irritable, guarded, apathetic, defensive, suspicious, or seductive? The nurse may explore the observed behavior by asking, "You seem irritated about something. Is that true?"

Clinical Implications

- Suspiciousness may be evident in patients with paranoia.
- Irritability may suggest an anxiety disorder.

Mood

Mood is the patient's self-report of one's emotional state and reflects the patient's life situation.

Observations. Mood can be evaluated by asking a simple, nonleading question, such as "How are you feeling today?" Does the patient report feeling sad, fearful, hopeless, euphoric, or anxious? Asking the patient to rate his mood on a scale of 0 to 10 can help provide the nurse with an immediate reading. It also can be valuable for comparing changes that occur during treatment.

If the potential for suicide is suspected, the nurse should ask the patient directly about thoughts of self-harm (Chapter 19). Has the patient felt the desire to harm himself or someone else? Have any previous attempts been made to cause harm, and if so, what events surrounded the attempts? **To judge a patient's suicidal or homicidal risk, the nurse should assess the patient's plans, the patient's ability to carry out those plans** (e.g., the availability of guns), **the patient's attitude about death,** and **support systems available to the patient.**

CLINICAL EXAMPLE

The patient responded to most of the questions in a flat, dull manner. Although he stated that he felt sad about the recent changes in his life, his lifeless posture and tone of voice did not convey any emotional response. He denied any current suicidal or homicidal plans. He related having made two suicidal gestures in the past year by "taking pills."

Clinical Implications

- Most people with depression describe feeling hopeless, and 25% of those with depression have suicidal ideation.
- Suicidal ideation also is common in patients with anxiety disorders and schizophrenia.
- Elation is most common in those with mania.

Affect

Affect is the patient's apparent emotional tone. The patient's statements of emotions and the nurse's empathic responses provide clues to the appropriateness of the affect.

Observations. Affect can be described in terms of the following:

- **Range**
- **Duration**
- **Intensity**
- **Appropriateness**

Flat affect is the absence of emotional expression, as seen by a patient who reports significant life events without showing any emotional response. Other patients may demonstrate great **lability** in expression by undergoing frequent changes from one affective response (such as sadness) to another (happiness) quickly in the same conversation. The nurse also should assess whether the patient's **emotional response is congruent or in agreement with the speech content.** For example, it would be **incongruent** if a patient reports being persecuted by the police and then laughs.

Clinical Implications

- Labile affect is often seen in patients with mania.
- Flat affect and incongruent affect are often evident in those with schizophrenia.

Perceptions

The two major types of perceptual problems are hallucinations and illusions. **Hallucinations** are defined as false sensory impressions or experiences. **Illusions** are false perceptions or false responses to a sensory stimulus.

Observations. Hallucinations may occur in any of the five major sensory modalities:

- **Auditory** (sound)
- **Visual** (sight)
- **Tactile** (touch)
- **Gustatory** (taste)
- **Olfactory** (smell)

Auditory hallucinations are the most common. **Command hallucinations** are those that tell the patient to do something, such as to kill oneself, harm another, or join someone in the afterlife. The nurse might inquire about the patient's perceptions by asking, "Do you ever see or hear things?" or "Do you have strange experiences as you fall asleep or on awakening?"

Clinical Implications

- Auditory hallucinations suggest schizophrenia.
- Visual hallucinations suggest organic mental disorders.
- Tactile hallucinations suggest organic mental disorders, cocaine abuse, and delirium tremens.

Critical Reasoning You see in the chart that a nursing order has been written placing a patient with command hallucinations on one-to-one observation. What is the rationale for this nursing intervention?

Thought Content

Thought content is the specific meaning expressed in the patient's communication. It refers to the "what" of the patient's thinking.

Observations. Although the patient may talk about a variety of topics during the interview, several specific content areas should be noted in the mental status examination (Box 6-3). Tactful questioning by the nurse is needed to explore these areas. Does the patient have recurring, persistent thoughts? Is the patient afraid of certain objects or situations, or does

BOX 6-3 THOUGHT CONTENT DESCRIPTORS

Delusion: false belief that is firmly maintained even though it is not shared by others and is contradicted by social reality
- **Religious delusion:** belief that one is favored by a higher being or is an instrument of that being
- **Somatic delusion:** belief that one's body or parts of one's body are diseased or distorted
- **Grandiose delusion:** belief that one possesses greatness or special powers
- **Paranoid delusion:** excessive or irrational suspicion and distrust of others, characterized by systematized delusions that others are "out to get them" or spying on them

Thought broadcasting: belief that one's thoughts are being aired to the outside world
Thought insertion: belief that thoughts are being placed into one's mind by outside people or influences
Depersonalization: the feeling of having lost self-identity and that things around the person are different, strange, or unreal
Hypochondriasis: somatic overconcern with and morbid attention to details of body functioning
Ideas of reference: incorrect interpretation of casual incidents and external events as having direct personal references
Magical thinking: belief that thinking equates with doing, characterized by lack of realistic relationship between cause and effect
Nihilistic ideas: thoughts of nonexistence and hopelessness
Obsession: an idea, emotion, or impulse that repetitively and insistently forces itself into consciousness, although it is unwelcome
Phobia: a morbid fear associated with extreme anxiety

the patient worry excessively about body and health issues? Does the patient ever feel that things are strange or unreal? Has the patient ever experienced being outside his body? Does the patient ever feel singled out or watched or talked about by others? Does the patient think that thoughts or actions are being controlled by an outside person or force? Does the patient claim to have psychic or other special powers or believe that others can read the patient's mind? **It is important that the nurse only obtain information about the patient's thinking and not challenge or try to correct the patient's beliefs.**

CLINICAL EXAMPLE

The patient's speech was rapid, and he said he felt that his thoughts were coming too fast, saying, "My mind is racing ahead." Rapid speech made it difficult to understand him as he quickly moved from one topic to another unrelated topic often in the same breath. He denied any visual or auditory hallucinations; however, he believed that he could talk with God directly if he needed advice on his life. He believed this was a special blessing given to him over others.

BOX 6-4 THOUGHT PROCESS DESCRIPTORS

Circumstantial: thought and speech associated with excessive and unnecessary detail that is usually relevant to a question, and an answer is eventually provided
Flight of ideas: overproductive speech characterized by rapid shifting from one topic to another and fragmenting ideas
Loose associations: lack of a logical relationship between thoughts and ideas that renders speech and thought inexact, vague, diffuse, and unfocused
Neologisms: new word or words created by the patient, often a blend of other words
Perseveration: involuntary, excessive continuation or repetition of a single response, idea, or activity; may apply to speech or movement, but most often verbal
Tangential: similar to circumstantial but the person never returns to the central point and never answers the original question
Thought blocking: sudden halt in the train of thought or in the middle of a sentence
Word salad: series of words that seem totally unrelated

Clinical Implications

- Obsessions and phobias are symptoms associated with anxiety disorders.
- Delusions, depersonalization, and ideas of reference suggest schizophrenia and other psychotic disorders.

Thought Process

Thought process is the "how" of the patient's self-expression. A patient's thought process is observed through speech. The patterns or forms of verbalization rather than the content are assessed.

Observations. A number of problems in a patient's thinking can be assessed (Box 6-4). The nurse might ask questions to evaluate the patient's thought process. Does the patient's thinking proceed in a systematic, organized, and logical manner? Is the patient's self-expression clear? Is it easy for the patient to move from one topic to another?

Clinical Implications

- Circumstantial thinking may be a sign of defensiveness or paranoid thinking.
- Loose associations and neologisms suggest schizophrenia or other psychotic disorders.
- Flight of ideas indicates mania.
- Perseveration is often associated with brain damage and psychotic disorders.
- Word salad represents the highest level of thought disorganization.

Level of Consciousness

Mental status examinations routinely assess a patient's orientation to the current situation. Deciding whether a patient is oriented involves evaluating some basic cognitive functions.

BOX 6-5 QUESTIONS USEFUL IN DETERMINING ORIENTATION

Questions Related to Time

Have you been keeping track of the time lately?

What is the date today? (If patient claims not to recall, ask for an estimate. Estimates can help assess level of disorientation.)

What month (or year) is it?

How long have you been here?

Questions Related to Place

There has been a lot happening these past few days (or hours); I wonder if you can describe for me where you are.

Do you recall what city we are in?

What is the name of the building we are in right now?

Do you know what part of the hospital we are in?

Questions Related to Person

What is your name?

Where are you from?

Where do you currently live?

What kinds of activities do you engage in during your free time?

Are you employed? If so, what do you do for a living?

Are you married? If so, what is your spouse's name?

Do you have any children?

Observations. A variety of terms can be used to describe a patient's level of consciousness, such as **confused, sedated,** or **stuporous.** In addition, the patient should be questioned regarding **orientation to time, place, and person** through the use of three simple questions:

- **Person:** What is your name?
- **Place:** Where are you today (e.g., in what city or in what particular building)?
- **Time:** What is today's date?

If the patient answers correctly, the nurse can note "oriented times three." Fully functioning patients may be offended by questions about orientation, so the skilled nurse should integrate these questions in the course of the interview. For example, the nurse could use some of the approaches listed in Box 6-5.

Clinical Implications

- Patients with organic mental disorders may give grossly inaccurate answers, with orientation to person remaining intact longer than orientation to time or place.
- Patients with schizophrenic disorders may say that they are someone else or somewhere else or reveal a personalized orientation to the world.

Memory

A mental status examination can provide a quick screen of potential memory problems but not a definitive answer to whether there is a specific impairment. A formal neuropsychological assessment is needed to specify the nature and extent of memory impairment. Memory is broadly defined as the ability to recall past experiences.

Observations. The following areas must be tested:

- **Remote memory:** recall of events, information, and people from the distant past
- **Recent memory:** recall of events, information, and people from the past week or so
- **Immediate memory:** recall of information or data to which a person was just exposed

Recall of **remote events** involves reviewing information from the patient's history. This part of the evaluation can be woven into the history-taking portion of the nursing assessment. This involves asking the patient questions about time and place of birth, names of schools attended, date of marriage, ages of family members, and so forth.

The problem with an evaluation of the patient's remote memory is that the nurse is often unable to tell whether the patient is reporting events accurately. This situation raises the possibility that **confabulation** is being used, which is when the patient makes up stories about situations or events that cannot be remembered. Because these stories can sound very believable, the nurse may need to check on past records or the report of family or friends to confirm this historical information.

Recent memory can be tested by asking the patient to recall the events of the past 24 hours or past week. A reliable informant may be needed to verify this information. **Immediate recall** can be tested by asking the patient to repeat a series of numbers either forward or backward within a 10-second interval. The nurse should begin with a short series of numbers and proceed to longer lists. Another test of recent memory is asking the patient to remember three words (an object, a color, an address) and then repeat these three words 15 minutes later in the interview.

Clinical Implications

- Loss of memory occurs with organic mental disorders, dissociative disorder, and conversion disorder.
- Patients with Alzheimer disease retain remote memory longer than recent memory.
- Anxiety and depression can impair immediate retention and recent memory.

Level of Concentration and Calculation

Concentration is the patient's ability to pay attention during the course of the interview. Calculation is the person's ability to do simple math. These and other areas of cognitive functioning may vary in expected and unexpected ways (Box 6-6).

Observations. The nurse should note the patient's level of distractibility. Calculation can be assessed by asking the patient to do the following:

- Count from 1 to 20 rapidly.
- Do simple calculations, such as 2×3 or $21 + 7$.
- Serially subtract 7 from 100.

If patients have difficulty subtracting 7 from 100, they can be asked to subtract 3 from 20 in the same way. Finally, more functional calculation skills can be assessed by asking

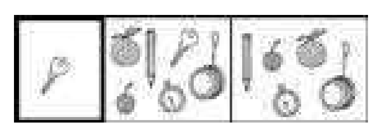
BOX 6-6 GENDER DIFFERENCES IN THE BRAIN

Women and men differ in physical attributes and in the way they think. The effect of sex hormones on brain organization appears to occur early in life, so the effects of the environment are secondary to the effects of biology. Behavioral, neurological, and endocrinologic studies help explain the processes leading to gender differences in the brain. Major gender differences in intellectual functioning seem to lie in patterns of ability rather than in the overall level of intelligence. For example, the problem-solving tasks favoring women and men are shown below.

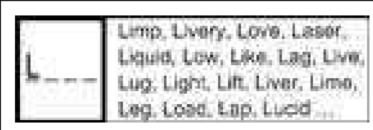
Problem-Solving Tasks Favoring Women

Women tend to perform better than men on tests of perceptual speed, in which subjects must rapidly identify matching items, as in pairing the house on the far left with its twin.

In addition, women remember whether an object or a series of objects has been displaced or rearranged.

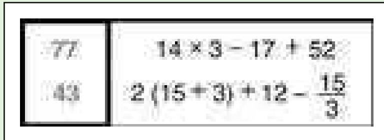


On some tests of ideational fluency, such as those in which subjects must list objects that are the same in color, and on tests of verbal fluency, in which participants must list words that begin with the same letter, women also outperform men.



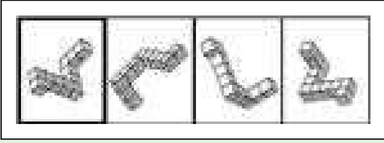
Women do better on precision manual tasks—that is, those involving fine motor coordination—such as placing the pegs in holes on a board.

And women do better than men on mathematical calculation tests.

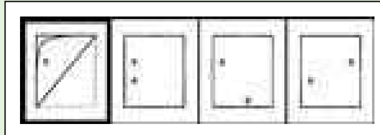


Problem-Solving Tasks Favoring Men

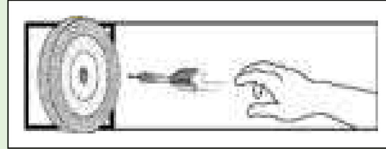
Men tend to perform better than women on certain spatial tasks. They do well on tests that involve mentally rotating an object or manipulating it in some fashion, such as imagining turning this three-dimensional object



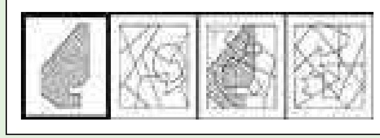
or determining where the holes punched in a folded piece of paper will fall when the paper is unfolded.



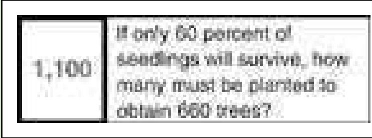
Men also are more accurate than women in target-directed motor skills, such as guiding or intercepting projectiles.



Men do better on disembedding tests, in which they have to find a simple shape, such as the one on the left, hidden within a more complex figure.



And men tend to do better than women on tests of mathematical reasoning.



From Kimura D: *Sci Am* 267:120, 1992. Illustrated by Jared Schneidman.

practical questions, such as "How many nickels are there in $1.35?"

Clinical Implications

- Many psychiatric illnesses impair the ability to concentrate and complete simple calculations.
- It is particularly important to differentiate among organic mental disorder, anxiety, and depression.

Information and Intelligence

Information and intelligence are controversial areas of assessment. **The nurse should be cautious about judging intelligence after a brief and limited contact typical of the time it takes to conduct a mental status examination.** The nurse also should remember that information in this category is highly influenced by sociocultural factors of the nurse, the patient, and the treatment setting.

Further, it has been suggested that there is more than one type of intelligence. Gardner (2006) describes seven different types of intelligence:

1. Linguistic intelligence
2. Logical-mathematical intelligence
3. Spatial intelligence
4. Musical intelligence
5. Body-kinesthetic intelligence
6. Interpersonal intelligence
7. Intrapersonal intelligence

The last two intelligences taken together (interpersonal and intrapersonal) can be described as forming one's personal intelligence or "emotional quotient" (Goleman, 2000, 2006). Emotional intelligence has four elements: (1) self-awareness, (2) self-management, (3) social awareness, and (4) social skills (Scott, 2009).

This expanded view of intelligence takes into account the talents people express in the arts or athletics, their ability to work cooperatively with people, and their self-definition, as well as the more traditional verbal and mathematical skills usually assessed in standard intelligence tests. Nurses should therefore take a broad approach to the assessment of intellectual functioning, allowing for the identification of the intellectual strengths, skills, and abilities of patients that may otherwise be overlooked.

Observations. The nurse should assess the patient's last grade of schooling completed, general knowledge, and use of vocabulary. It is also critically important to assess the patient's level of literacy. The ability to conceptualize and abstract can be tested by having the patient explain a series of proverbs. The patient can be given an example of a proverb and its interpretation and then be asked to explain what several other proverbs mean. Common proverbs include the following:

- When it rains, it pours.
- A stitch in time saves nine.
- A rolling stone gathers no moss.
- The proof of the pudding is in the eating.
- People who live in glass houses shouldn't throw stones.
- A bird in the hand is worth two in the bush.

Most adults are able to interpret proverbs as being symbolic of human behavior or events. However, sociocultural background should be considered when assessing a patient's information and intelligence.

If the patient's educational level is below the eighth grade, asking the patient to list similarities between a series of paired objects may better help the nurse assess the ability to abstract. The following paired objects are often used for this purpose:

- Bicycle and bus
- Apple and pear
- Television and newspaper

To assess a patient's general knowledge, the nurse can ask the patient to name the last three presidents, the mayor, five large cities, or the occupation of a well-known person.

Clinical Implications

- The patient's educational level and any learning disabilities should be carefully evaluated.
- Mental retardation should be ruled out whenever possible.
- The patient's level of literacy may be part of a general assessment, but it also is an important factor in any health teaching or didactic information presented to the patient.

Judgment

Judgment involves making decisions that are constructive and adaptive. It involves the ability to understand facts and draw conclusions from relationships.

Observations. Judgment can be evaluated by exploring the patient's involvement in activities, relationships, and vocational choices. For example, is the patient regularly involved in illegal or dangerous activities or engaged in destructive relationships with others? It is also useful to determine whether the judgments are deliberate or impulsive. Finally, several hypothetical situations can be presented for the patient to evaluate:

- What would you do if you found a stamped, addressed envelope lying on the ground?
- How would you find your way out of a forest in the daytime?
- What would you do if you entered your house and smelled gas?
- If you won $10,000, what would you do with it?

Clinical Implications

- Judgment is impaired in organic mental disorders, schizophrenia, psychotic disorders, intoxication, and borderline or low intelligence quotient (IQ).
- It also may be impaired in manic patients and those with personality disorders.

> **Critical Reasoning** What factors would you consider in evaluating the judgment of a man who engages in bungee jumping, rock climbing, and skydiving? How would this compare with a woman who has been in many relationships with abusive men?

Insight

Insight is the patient's understanding of the nature of one's problem or illness.

Observations. It is important for the nurse to determine whether the patient accepts or denies the presence of a problem or illness. In addition, the nurse should ask whether the patient blames the problem on someone else or some external factors. Several questions may help to determine the patient's degree of insight. What does the patient think about the current situation? What does the patient want others, including the nurse, to do about it?

CLINICAL EXAMPLE

The patient described several problems he was having at work. He reluctantly stated that he might have to change but really thought his difficulties were because of his wife's drinking. He believed he could do nothing until she changed.

Clinical Implications

- Insight is impaired in those with many psychotic illnesses, including organic mental disorders, psychosis, substance abuse, eating disorders, personality disorders, and borderline or low IQ.
- Whether a patient sees the need for treatment is important to the formation of the therapeutic alliance, establishment of mutual goals, and implementation of and adherence to the treatment plan.
- **Motivational interviewing** can assess the patient's readiness to change (Chapter 2 and 27).

Documenting Clinical Information

Information from the mental status examination may be recorded in various ways. Some clinicians write a descriptive report such as the one presented in the case study in Box 6-7. Written reports should be brief, clear, and concise and address all categories of information. Clinicians also may use an outline format that is completed with short answers or a computerized information system. Regardless of the format, important findings should be documented, and verbatim responses by the patient should be recorded whenever they add important information and support the nurse's assessment.

Mini-Mental State Examination

At times it is not practical or desirable to complete a full mental status examination. On these occasions, nurses may find it helpful to use the **Mini-Mental State Examination, a simplified, scored form of the cognitive mental status examination** (Folstein et al, 1975). It consists of 11 questions, requires only 5 to 10 minutes to administer, and can therefore be used quickly and routinely. It is "mini" because it concentrates on only the cognitive aspects of mental functions and excludes questions concerning mood, abnormal psychological experiences, and the content or process of thinking.

PSYCHOLOGICAL TESTS

Psychological tests are of two types: those designed to evaluate intellectual and cognitive abilities and those designed to describe personality functioning. Commonly used **intelligence tests** are the Wechsler Adult Intelligence Scale (WAIS) and the Wechsler Intelligence Scale for Children (WISC). Although intelligence tests often are criticized as being culturally biased, their ability to determine a person's strengths and weaknesses within the culture provides important therapeutic information.

Projective tests reflect aspects of a person's personality, including reality testing ability, impulse control, ego defenses, interpersonal conflicts, and self-concept. A battery of tests is usually administered to provide comprehensive information. The Rorschach Test, Thematic Apperception Test (TAT), Bender Gestalt Test, and the Minnesota Multiphasic Personality Inventory (MMPI) are commonly used by clinical psychologists.

BOX 6-7 CASE STUDY

Ms. T was a stylishly dressed, neatly groomed, slender woman in apparent good physical health who appeared to be her stated 22 years of age. She was cooperative during the interview but had difficulty expressing herself in specific terms. Her vague responses left the interviewer feeling uncertain about the difficulties she was describing.

The patient was alert and awake and oriented to person, place, and time. Immediate recall and recent memory were intact, demonstrated by her ability to recall three unrelated objects immediately and again 15 minutes later. Some of the historical information given was inconsistent with historical facts reported by her father. Although the vocabulary used by Ms. T and her knowledge of general information was congruent with her twelfth-grade education and past employment, she had difficulty completing the serial sevens but performed serial threes with ease. She stated that she was "nervous," which may be a factor related to performance. She was able to abstract two of three proverbs presented.

PROVERB	INTERPRETATION
Don't cry over spilled milk.	"If something happens, then forget about it. Maybe things will get better."
A rolling stone gathers no moss.	"If a person stays active, he won't get depressed."
People who live in glass houses shouldn't throw stones.	"The glass will break."

Her responses to hypothetical situations were appropriate; however, the manner in which she coped with difficulties at work and home showed impaired judgment about personal issues. Ms. T's speech was clear, coherent, and of normal rate and tone. Except for the vague, tangential manner in which she discussed her concern for her aunt, her communication was goal directed. There were no apparent delusions, hallucinations, or illusions. She denied any obsessions, compulsions, or phobias.

The central theme during the interview was her fear of being irresponsible and hurting her aunt. Her sadness and concern about her behavior in relation to the aunt pervaded the interview. She appeared nervous (looking away, fidgeting) and cried whenever she talked about her aunt. She described her mood as "low" and rated it as a 4 on a scale of 1 to 10. She denied having any suicidal or homicidal ideas or plan either previously or at the present time. Her insight was questionable because she was not sure that she needed help, but she did agree to return. She knew that a problem existed but was unaware of the causes of her behavior.

Critical Reasoning Psychological tests have typically been standardized on white, middle class populations. What implications does this have for the validity and reliability of these tests when used with individuals from other cultural backgrounds?

BEHAVIORAL RATING SCALES

The psychological context of psychiatric nursing care goes beyond the important assessment of a patient's mental status. Neither mental health nor mental illness can be measured directly. Rather, measurement of mental health depends on gathering a number of behavioral indicators of adaptive or maladaptive responses, which together represent the overall concept.

There are many behavioral rating scales and measurement tools (Coughlin et al, 2001; Rush et al, 2008). They help clinicians do the following (Duffy et al, 2008; Elmquist et al, 2010):

- **Measure the extent of the patient's problems.**
- **Make an accurate diagnosis.**
- **Track patient progress over time.**
- **Document the efficacy of treatment.**

Each of these points is very important to the psychiatric nurse. The knowledge base for psychiatric care is expanding rapidly, and increased emphasis is being placed on clearly describing the nature of the patient's problems and the extent of the patient's progress toward attaining the expected outcomes of treatment. Thus nurses must be able to demonstrate in a valid and reliable way what problems they are treating and what affect their nursing care is having on attaining the treatment goals.

Nurses should become familiar with the many standardized rating scales that are available to enhance each stage of the nursing process. Some of the commonly used behavioral rating scales are listed by category on the Evolve site. Nurses with training can use any of these scales. These tools do not replace required nursing documentation. Rather, they are used to complement nursing care and provide measurable indicators of treatment outcome. For example, if the nurse is caring for a patient with depression, it would be helpful to use one of the depression rating scales with the patient at the beginning of treatment to establish a baseline profile of the patient's symptoms and help confirm the diagnosis. The nurse might then administer the same scale at various times during the course of treatment to measure the patient's progress. Finally, completing the rating scale at the end of treatment would document the efficacy of the care provided.

CHAPTER IN REVIEW

- All nurses, regardless of the clinical setting, should be proficient in administering the mental status examination and be able to incorporate findings from it into the nursing care plan for the patient.
- The mental status examination represents a cross section of the patient's psychological life at that moment in time. It requires the nurse to observe the patient's behavior and describe it in an objective, nonjudgmental manner.
- Sociocultural factors can greatly influence the outcome of the examination.
- Nurses should attend to both the content and the process of the patient's communication.
- It is also important for the nurse to monitor her own feelings and reactions during the mental status examination.
- The nurse should blend specific questions into the general flow of the interview.
- The categories assessed in the mental status examination include the patient's appearance, speech, motor activity, mood, affect, interaction during the interview, perceptions, thought content, thought process, level of consciousness, memory, level of concentration and calculation, information and intelligence, judgment, and insight.
- The nurse should know what observations to make in each of the above categories and what the clinical implications of the findings would be.
- Psychological tests evaluate intellectual and cognitive abilities and describe personality functioning.
- Behavioral rating scales help clinicians measure the extent of the patient's problem, make an accurate diagnosis, track patient progress over time, and document the efficacy of treatment. These scales should be used by psychiatric nurses to complement nursing care and provide measurable indicators of treatment outcome.

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CHAPTER

7

Social, Cultural, and Spiritual Context of Psychiatric Nursing Care

Linda D. Oakley

We know what we belong to, where we come from, and where we are going.
We may not know it with our brains, but we know it with our roots.

Noel Coward, This Happy Breed

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the aims of cultural competency in psychiatric nursing care.
2. Analyze the social, cultural, and spiritual risk factors and protective factors in developing, experiencing, and recovering from psychiatric illness.
3. Apply knowledge of social, cultural, and spiritual contexts to psychiatric nursing assessment and diagnosis.
4. Examine the treatment implications of culturally competent psychiatric nursing care.

Disparities are widespread in the diagnosis and treatment of mental illness, as in other areas of health care (Miranda et al, 2008; Alegria et al, 2011; Lagomasino et al, 2011). The Surgeon General of the United States issued a report titled *Mental Health: Culture, Race and Ethnicity* (USDHHS, 2001) that emphasized the significant impact that sociocultural factors have on the mental health of all people. Its main message was that culture counts. The report underscored the following points:

- **Mental illnesses are real, disabling conditions that affect all populations, regardless of race or ethnicity.**
- **Striking disparities in mental health care are found for racial and ethnic minorities.**
- **Disparities impose a greater disability burden on minorities.**
- **Racial and ethnic minorities should seek help for mental health problems and illnesses.**

Holistic psychiatric nursing care must take into consideration a wide range of patient characteristics in the assessment, diagnosis, treatment, and recovery process. People live within social, cultural, and spiritual contexts that shape and give meaning to their lives. These characteristics are expressed as beliefs, norms, and values and they can have both direct and indirect influences on patients' perceptions of health and illness, their help-seeking behavior, and their treatment outcomes. They are strong determinants of actual and potential coping resources and coping responses, and they influence all phases of an illness, including treatment effectiveness.

These social, cultural, and spiritual characteristics can impact the person's access to mental health care, the risk for or protection against developing a certain psychiatric disorder, the way in which symptoms will be experienced and expressed, the ease or difficulty of participating in psychiatric treatment, and the ability to achieve recovery. Thus quality psychiatric nursing care must incorporate the unique

BOX 7-1 THE FUNCTIONS OF CULTURE

Perception: Perception of reality is based on a cultural interpretation and understanding of events.
Motives: Motives for behavior are conditioned by the values assumed by a culture.
Behavior: Personal behaviors reflect the integration of cultural norms.
Identity: Individual and group identity is fostered by the oral, written, and social constructs defining a culture.
Values: Ethical values and morality are conditioned by cultural background.
Communication: Language, music, and dance are three of many ways of communicating and expressing culture.
Emotions: Emotions are experienced and shaped by cultural ideas, practices, and institutions.

aspects of the individual into every element of practice and be based on an understanding of the importance of culture, as outlined in Box 7-1.

CULTURAL COMPETENCY

Cultural competency is a necessary step in the elimination of disparities in the diagnosis and treatment of mental illness, and is essential in patient-centered psychiatric nursing care. A specific competency for nurses, as defined by the American Association of Colleges of Nursing (2008), states that patient assessment, treatment, and evaluation are improved by applying knowledge of cultural factors, using relevant data, promoting quality health outcomes, advocating for social justice, and engaging in competency skill development.

Culturally competent nursing practice requires far more than recording the patient's age, gender, ethnicity, and religion. It must first be based in desire, awareness, and understanding. In addition to being knowledgeable, skilled, willing, and concerned, the culturally competent nurse must be self-aware and self-reflective (Secor-Turner et al, 2010; Hoke and Robbins, 2011). Questions that the nurse can ask to assess one's cultural competency are presented in Box 7-2.

As a practice skill, **cultural competency** is the ability to view each patient as a unique individual, fully considering the patient's cultural experiences within the context of common developmental challenges faced by all people and the broader social environment. The nurse applies this information in nursing interventions that are consistent with the life experiences and values of each patient.

Five areas of cultural competency for nurses have been identified (Campinha-Bacote, 2009):

- **Cultural desire—**the motivation of the nurse to want to engage in the process of becoming culturally competent
- **Cultural awareness—**the conscious self-examination and in-depth exploration of one's own personal biases, stereotypes, prejudices, and assumptions about people who are different from oneself

BOX 7-2 CULTURAL COMPETENCE SELF-ASSESSMENT

- How much awareness do you have about your own values, attitudes, and beliefs—including potential biases and prejudices—toward cultures different from your own?
- What factors from your own background might influence the way in which you care for people from different sociocultural contexts?
- Do you have the skills needed to conduct a cultural assessment and perform a culturally sensitive mental status and physical examination?
- Do you plan and implement care in partnership with patients while being respectful of their individual sociocultural needs, preferences, and values?
- What knowledge do you have about the patient's world view, including culture-bound illnesses?
- What interactions have you had with patients from diverse cultural backgrounds and what did you learn from them?
- When you encounter a sociocultural discrepancy that impacts patient care, how do you deal with it?
- How will cultural competency make you a better nurse?

- **Cultural knowledge—**the process of seeking and obtaining a sound educational base about different cultures including their health-related beliefs about practices and cultural values, disease incidence and prevalence, and treatment efficacy
- **Cultural skill—**the ability to collect relevant cultural data regarding the patient's presenting problem and accurately perform a culturally based assessment
- **Cultural encounters—**the deliberate seeking of face-to-face interactions with culturally diverse patients

Effectiveness in these five areas provides evidence of culturally competent psychiatric nursing care that is both appropriate and high quality (Williamson and Harrison, 2010; Wilson, 2011).

Cultural competency requires the nurse to ask the patient informed questions that are free of bias (Tillett, 2010). For example, a study of the association of ethnicity and sexual orientation (lesbian, gay, or bisexual) with risk of suicide attempt in black, Caucasian, and Latino youth found that young age and substance abuse behavior did not predict risk of suicide attempt. Instead, the risk of suicide attempt was associated with daily life experiences with multiple sources of stigma, bias, prejudice, and discrimination related to their sexual orientation and ethnicity (O'Donnell et al, 2011). These findings show the value of general cultural knowledge and the need to ask patients about their specific personal life experiences.

Patient-centered care requires knowledge of how social, cultural, and spiritual life experiences and personal characteristics may influence mental health, psychiatric nursing care, and treatment outcomes without bias, assumptions, or overly simplistic views of complex life experiences. Nurses who routinely ask patients questions about these aspects of their lives convey concern about their well-being and avoid stereotyping.

Critical Reasoning Challenge the evidence for one of your own cultural biases that is a result of your upbringing or personal experiences.

RISK FACTORS AND PROTECTIVE FACTORS

The concept of risk factors and protective factors is important to understanding how people acquire, experience, and recover from illness (Carpenter-Song et al, 2007). They develop over time and may change with personal circumstances.

These factors are the same as the **predisposing factors** that nurses assess in the Stuart Stress Adaptation Model of psychiatric nursing care (Chapter 3). Understanding the risk and protective factors involved in health and illness is essential in the prevention, early detection, and effective treatment of both physiological and psychological illnesses.

- **Risk factors** are individual characteristics that can increase the potential for illness onset, decrease the potential for recovery, or both.
- **Protective factors** are individual characteristics that can decrease the potential for illness onset, increase the potential for recovery, or both.

Six patient characteristics, influenced by social norms, cultural values, and spiritual beliefs, have been shown to be predisposing factors related to mental health and mental illness. **These factors are age, ethnicity, gender, education, income, and spirituality**. They influence the patient's exposure to stressors, appraisal of stressors, coping resources, and coping responses, as described in the Stuart Stress Adaptation Model (Figure 7-1).

For example, poverty is a risk factor for many psychiatric disorders, such as depression and anxiety, and numerous psychosocial problems, such as divorce and abuse. However, poverty also can occur as a *result* of a psychiatric disorder such as schizophrenia. So too, spirituality, religion, and family and cultural traditions can sustain hope and promote positive coping behaviors in the face of overwhelming adversity, whereas their loss can lead to mood and cognitive changes or destabilization that increases the risk of psychiatric disorders.

The culturally competent nurse does not assume knowledge of a patient based on casual observations of age, ethnicity, or gender. Neither should a nurse draw generalizations about groups based on these factors. Literature that describes and summarizes the values or beliefs of specific populations, such as Black Americans, Hispanics, and Asians, often creates new stereotypes, and these generalizations can further depersonalize nursing care. In contrast, the sociocultural view is based on the assessment of social, cultural, and spiritual factors that are individualized and that change over time.

Critical Reasoning Think of one group you are a member of based on your sociocultural characteristics. What are the stereotypes about this group? Do you fit these stereotypes?

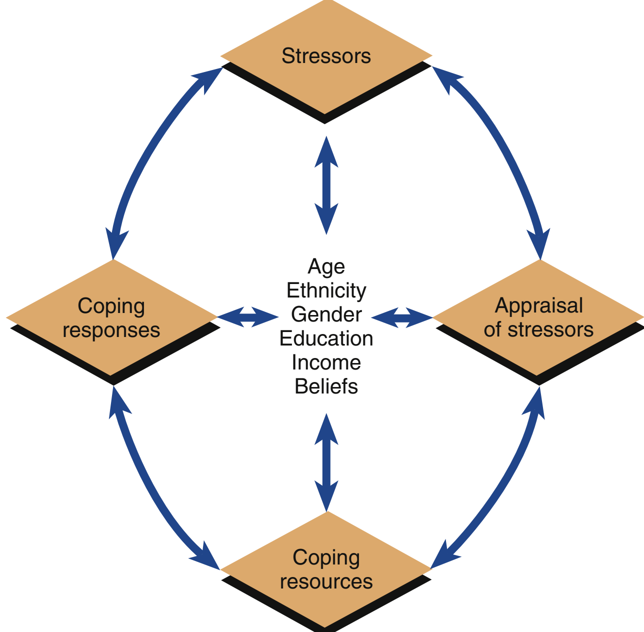

FIG 7-1 Sociocultural context of psychiatric care.

Findings about these risk and protective factors and their possible health effects are described in the following sections. Box 7-3 lists some sociocultural trends and their influence on the health care system.

Age

Age influences an individual's experience of life stressors, variations in support resources, and coping skills. From school age, to young adult, to retirement and fragile old age, individuals are faced with challenges and changes in their life. Age-related increases and decreases in the use of mental health services can reflect emerging trends in the physical, social, cultural, and spiritual domains of life.

Young adolescents can face many social stressors, such as bullying, at a time when they have not yet developed effective coping skills. Such social stressors can be distressing at any age. However, when they are experienced during transition age periods, such as early adolescence, new parenthood, or recent retirement, they can seem more overwhelming if at the same time the individual must develop new skills and resources to cope effectively.

Aging "baby boomers" will face the same challenges as previous generations but boomers have different expectations. Many expect to be able to remain active, healthy, and independent. Their expectations can mean greater demands on all health care services, including mental health care.

Although age alone can be a determining personal characteristic, age interacts with all other characteristics and therefore can be somewhat less predictable. For example, different interactions of age and income, age and gender, and age and ethnicity can yield different effects. Culturally competent practice requires asking the patient about specific age-related experiences and concerns.

BOX 7-3 SOCIOCULTURAL DIVERSITY AND THE HEALTH CARE SYSTEM

The following U.S. sociocultural trends will influence the health care system and the way health care is provided:

- The population will increase by 60% to 420 million by the year 2050.
- Growth will be concentrated at the two ends of the age spectrum. By 2050 the number of people in the population ages 65 years and older will more than double, and those ages 85 years and older will be the fastest-growing age-group.
- The population will become more diverse by race and ethnicity. By 2050 Hispanics will be about 25% of the population; African Americans about 14%; Asian and Pacific Islanders about 8%; Native American Indians, Eskimos, and Aleuts about 1%; and whites about 53%.

These trends will have a profound impact on the health care system for the following reasons:

- As the aging population grows, an increase in chronic conditions and chronic diseases related to behavior will occur that will exact a greater toll on the health care system.
- A rise in the number of young people will bring new waves of problems typically committed by the young, such as murder, rape, robbery, and assault. Almost half of all violent crimes are committed by people younger than age 24, with those 15 to 19 years of age responsible for the most crime. The overall crime rate has increased 500% since 1960.
- Minority populations are currently underserved, a problem that may only intensify. In addition, an increase in low–birth-weight babies among minority populations is anticipated.
- Minority populations are underrepresented in all health care professions, causing concern about whether health care providers will understand health problems within a cultural context and be able to provide culturally sensitive care.

From CRS Report for Congress: *The changing demographic profile of the U.S.,* Library of Congress, 2011.

Critical Reasoning Do you think it is possible that two patients displaying the same symptoms could receive two different diagnoses based on the age of either the patient or the clinician?

Ethnicity

Ethnicity is a cultural characteristic based on racial, national, tribal, genetic, linguistic, and family origins. Individual members of culturally intact groups can have more shared beliefs and values and less variation between communities. However, because ethnicity is largely a cultural characteristic, persons who have similar physical features can have important cultural differences and distinctions.

For example, *Latin American, Hispanic,* and *Hispanic American* are terms used to represent native Spanish speakers. Yet the racial, national, language, and cultural backgrounds of Hispanic people are as diverse as Mexico, the Caribbean islands (including Puerto Rico, Cuba, and the Dominican Republic), Central and South America, and Spain. Each group has its own distinct history, customs, beliefs, and traditions.

Similarly, the terms *Asian* and *Asian American* refer to 40 different ethnic groups with 30 different languages. As a census category, *Native American* includes Alaskan and Hawaiian natives, but both groups have hundreds of tribes, each with their own history, languages, and traditions. *Black Americans* living in the United States also represent highly diverse countries, as do *Caucasian Americans*. Although there may be similarities in physical characteristics for each of these groups, differences in ethnic and cultural heritage may be immense.

For ethnic and racial minority groups, personal protective factors often are embedded in a tightly shared social identity. Such groups may have well-defined healing practices and traditions that are important positive resources for the nurse to consider when providing care.

In contrast, patient ethnicity also can have direct and indirect negative effects on the development of and recovery from psychiatric disorders and access to health care services. Many minority individuals lack medical insurance or access to health care providers (Kovandzic et al, 2011). Difficulty with language and communication or lack of knowledge in how to negotiate the mental health care system also limits their ability to receive needed care.

Stigma is associated with mental illness, and this can be another barrier for those in need of mental health services (Pope, 2011). Ethnic minority groups, who may already confront prejudice and discrimination because of their group affiliation, often suffer a double stigma when faced with the burdens of mental illness. This is one reason why some ethnic minority group members who would benefit from mental health services decide not to seek or accept recommended treatments (Oakley et al, in press).

Differences exist in the prevalence of certain disorders among various ethnic groups and in their use of mental health services (Hatzenbuehler et al, 2008; Keyes et al, 2008). Misdiagnosis, overdiagnosis, and undertreatment are particular areas of concern (Hampton, 2007).

For example, African-American men are less likely to be diagnosed with depression and anxiety and more likely to be diagnosed as psychotic or paranoid (Metzl, 2009). In turn, the observation that African-American men can be more likely to receive this diagnosis increases the stigma of mental illness in some African-American communities.

Some ethnic minorities who historically were prohibited from seeking mainstream health care or who were subjected to experimental health care without their consent may consider distrust of health professionals to be an important shared cultural value and belief, which can contribute to existing health disparities.

Other minority group members may delay seeking help until their problems are intense, chronic, and at a difficult-to-treat stage, or until community and family support systems have been exhausted. Delays in accessing care and early

termination from care can result in a poorer prognosis and create a cyclical reliance on more costly health care services.

> **Critical Reasoning** How might ethnicity influence the coping responses and the specific symptoms expressed by a patient? Give a specific example.

Gender

As a predisposing factor, gender is similar to ethnicity in that at first glance there appears to be distinctive male and female patterns of risk and protection. However, when all psychiatric disorders are included, **the prevalence of mental illness among males and females is approximately equal.**

The difference between the two groups is in the type of disorder that is most commonly diagnosed. Substance abuse and antisocial personality disorder are the most prevalent psychiatric disorders among males, whereas affective disorders and anxiety disorders are most prevalent among females. In contrast, the prevalence of schizophrenia and manic episodes for males and females is about equal.

These findings suggest that male and female role socialization plays a part in the perception of health and illness, and that the risk of psychiatric disorders may be gender typed by sociocultural factors, including the way they perceive and cope with life stressors. For example, women are more likely to ruminate about distressing life experiences, whereas men are more likely to seek distractions.

Recent studies of human genes and psychiatric disorders have opened new avenues of understanding about male and female differences based on biological predisposing factors.

The following clinical example demonstrates the interaction of ethnicity and gender and the way in which they can affect a person's response to stress.

CLINICAL EXAMPLE

Jose, a 36-year-old Mexican-American male, planned to graduate from college in May and marry his fiancée, Lisa, in June. The couple met in class 2 years ago and has dated most of that time. Jose recently visited Lisa's family for the first time. Lisa's parents were of German descent and were unhappy to learn that she planned to marry Jose in 3 months. Lisa's father told her that if she goes through with her wedding plans he will disown her. He said that her mother and brothers agreed with him and that Lisa would have to choose between her plans and her family. When Lisa told Jose about her father's reaction, he reminded her that his family welcomes their marriage and they can be happy together. Lisa said she could not marry Jose if it meant going against her family.

Jose was hurt and angry and did not understand Lisa's decision. Driving back to campus he was cited for speeding. When he returned to his apartment he spent 2 days alone drinking beer. He did not eat, sleep, shave, or shower. By the third day his shock and hurt feelings still had not improved. He went out for a walk thinking he might buy more beer or go home to his family. While walking he passed a group of men, one of whom called him "illegal." This upset him even more. When he got back to his apartment he wrecked his desk and threw out everything on it, including his completed master's thesis that had been accepted for publication.

Exhausted, he finally called his father and told him everything. His father said, "Son, I love you so much; your family is so proud of you; you're a good son. I'll be there in an hour, OK?" Jose agreed and then sat down and waited for his dad to arrive.

> **Critical Reasoning** How might psychiatric nurses' views of gender-appropriate behavior influence their diagnosis and treatment of male and female patients?

Education

Education is a coping resource that can decrease the risk of developing stress-related psychiatric disorders or increase the probability of a recovery. For example, it has been shown that more years of schooling is associated with decreased risk for developing psychiatric disorders, better treatment outcomes, and more complete recovery. Education is more important than income in determining the use of mental health services, with those with the highest educational level using mental health services most often.

However, education is more than the number of completed years of schooling. Mental status examinations are often used to determine diagnosis and treatment for various psychiatric disorders (Chapter 6), yet questions have been raised about the cultural context of such evaluations. Also, access to education is socially and culturally determined and not necessarily an indication of intelligence.

For example, cognitive therapy, which helps patients by assisting them to assess and improve their distressing thoughts, has been shown to be highly effective in patients with varied educational backgrounds. Thus it is important to remember that patients with less education could have the ability but lack opportunity, family and community support, or self-confidence.

Patients with less education also may also have limited income. The close interaction of education and income requires that they be assessed as related characteristics. Perhaps the most consistent impact of education has to do with problem-solving capacity. Education can increase a patient's ability to effectively use health information as a resource. But again, other factors can come into play. For example, education could have little actual impact for persons who prefer faith over information as a coping resource.

Finally, **language barriers** also can influence the benefits of education. It has been noted that patients who are not proficient in English are often misdiagnosed. Therefore programs need to adapt to the needs of people with limited English proficiency by providing either clinicians who speak native languages or skilled translators and interpreters who can facilitate communication between patients and care providers. Written materials and forms also need to be printed in

the native languages of the patients and at the literacy levels of the populations being served.

The following clinical example illustrates the potential effect of education as a risk factor.

CLINICAL EXAMPLE

May, a 22-year-old Chinese-American female, is employed at the university computer center and is a part-time law student. Her roommate, a second-year graduate student in history, has a very active social life. Because May's work and courses are demanding and her family expects her to be highly successful, she spends all of her time working or studying. While studying one Friday afternoon, May's roommate came home with several student friends, including a man in May's law class whom she finds very attractive. She was nervous but happy to see him and told him so. Then she realized that he was her roommate's date for the evening. Although her greeting was actually rather quiet, May felt humiliated by her behavior and abruptly left the apartment. As she left she heard her roommate call her "Little Miss Perfect."

May could not stop thinking about her behavior and her humiliation. The more she thought about it the more upset she became. As was her pattern, when she felt upset she worried about her weight. Although she is thin, May feels she could improve her relationship with her mother and her employer, her grades, and her social life if only she could lose weight. May walked for hours, and despite becoming exhausted, she did not stop to rest, drink, or eat.

Income

The profound negative impact of poverty as a risk factor for psychiatric illness is evident regardless of age, ethnicity, gender, or education. The relationship of poverty and severe financial stressors to poor health has been well documented.

Although the impact of poverty can be generalized to all social and cultural groups, higher prevalence rates of poverty are consistently found among children, women, the elderly, and ethnic and racial minorities (Groh, 2007). Poverty seems to multiply the impact of other risk factors. Alternatively, poverty might undermine the impact of protective factors.

The obvious benefits of income as a protective factor generally have to do with being better able to avoid life events associated with the development of severe psychiatric disorders and having faster and easier access to psychiatric services.

While poverty seems to be a clear risk factor for complex psychiatric injuries or illness, wealth alone is not the ultimate protective factor. The highly publicized breakdowns and substance-related arrests of celebrities and wealthy people show that the effects of poverty tend to be more predictable than the effects of wealth.

The following clinical example illustrates the impact of ethnicity and income on self-esteem.

CLINICAL EXAMPLE

John, a 20-year-old African-American male, was looking for employment. He had several job interviews with local employers. Over the phone, the employers seemed very interested in hiring him, but his interviews never led to job offers. Each time he called back after an interview, he was told that the position he applied for had been filled but that his application would be kept on file.

John obtained a job interview for an entry-level teller position at his bank, and he felt certain he would be successful in getting hired. He thought his luck finally had changed. He arrived a few minutes early for his interview, but after waiting an hour to meet with the interviewer, the receptionist told him that the position was now no longer available.

John was shocked. He felt that he was not being treated fairly. His first concern was that the interviewer had observed him and decided he did not like what he saw. John asked the receptionist if the position had become unavailable before or after his arrival. The receptionist immediately called over a security officer who told John he had to leave. Angry and embarrassed, he left the building.

As he walked away John thought about the stereotype of the unemployed young African-American man who is unwilling to work and he thought about the history books on the social bias against African-American men given to him by his favorite teacher. He knew he could refuse to look for work, never go to another job interview, live with his parents, sleep until noon everyday, and spend all of his time "hanging out." And he knew that finding employment was difficult for African-American males long before his experience today.

John had a choice. He decided to find out what he could about his application for the teller position and to continue to look for a good job.

Critical Reasoning Most single-parent households in the United States are headed by women, and many have household incomes that are below the poverty level. Given these circumstances, identify the potential risk factors and protective factors.

Beliefs

Personal beliefs touch all aspects of life. **A person's belief system, world view, religion, or spirituality can have a positive or negative effect on mental health.**

- **Adaptive belief systems** can enhance health and well-being, improve quality of life, and support recovery from psychiatric disorders.
- **Maladaptive belief systems** can contribute to poor health status, refusal of necessary treatment, nonadherence with treatment recommendations, or even self-injury.

Beliefs help people make sense of their lives and the world in which they live. This need can become especially powerful in the face of threat, loss, or uncertainty. Beliefs can provide answers to questions without answers, solutions to problems that cannot be solved, and hope when hope is all that remains.

Personal beliefs can have many different sources. These sources can range from formal teachings, to actual lived experiences, to community cultural ideals. A system of beliefs can be large enough to give meaning and purpose to one's life and

daily activity. The human quest for meaning also includes searching for meaning in mental illness and its treatments.

Health-related life experiences often lead to serious questioning of one's social, cultural, and spiritual beliefs. These experiences include being diagnosed and treated for a psychiatric disorder. Beliefs develop slowly but they can change over time. For example, a patient who is profoundly depressed but does not believe in taking psychiatric medications can, over time, become open to questioning and testing such beliefs.

There are many ways in which spirituality, religion, and belief systems can interact with mental health and mental illness (Koenig, 2009). Spiritual beliefs that promote healthy living and effective stress management can reduce the risk of some psychiatric disorders. For example, certain religious belief systems stress avoidance of alcohol, illicit drugs, and cigarette smoking. Spiritual and religious beliefs that promote greater life satisfaction, happiness, positive affect, morale, and general well-being also can promote self-esteem and social identity, and provide hope under difficult life circumstances.

Although religion generally has beneficial effects, there are circumstances in which religious beliefs may adversely affect mental health care (Reeves et al, 2011). Some patients may develop feelings of excessive guilt and condemnation because of religion. In others, religion may cause or increase anxiety. Intense religious experiences can lead to transient psychotic episodes and delusions are often based on religious ideas.

Thus spirituality and religion should be incorporated into one's nursing care when appropriate, and it should be avoided if it might worsen the patient's condition or the patient does not desire it. Finally, the degree of compatibility between the patient's and provider's belief systems can influence patient satisfaction with and responses to treatment (Larrison et al, 2011). Significant problems can occur if the beliefs of the patient and provider conflict or if the patient's beliefs are overlooked.

Critical Reasoning Think about two patients you took care of last week. Did you discuss with them their beliefs about their health and current illnesses? Did you ask about their world view, religion, or spirituality? If not, how might this information have influenced your nursing interventions with them?

NURSING ASSESSMENT AND DIAGNOSIS

Self-assessment is essential in the delivery of culturally competent psychiatric nursing care. Nurses should explore their responses to the following questions:

- What personal characteristics of the patient have I noted, and what are my reactions, positive and negative, to those characteristics?
- What differences do I think may exist between the patient and myself, and what assumptions have I made based on them?
- Does the patient's appearance or language make me think that what I am seeing or hearing is abnormal?
- What labels am I subconsciously applying to this patient, and how did I learn them?
- What other explanations might account for the patient's behavior?
- Have I given the patient the opportunity to express his beliefs, values, expectations, and concerns about his symptoms and possible treatment?

BOX 7-4 SOCIOCULTURAL STRESSORS

Disadvantagement: the lack of socioeconomic resources that are basic to biopsychosocial adaptation

Discrimination: differential treatment of individuals or groups not based on actual merit

Intolerance: unwillingness to accept different opinions or beliefs from people of different backgrounds

Prejudice: a preconceived, unfavorable belief about individuals or groups that disregards knowledge, thought, or reason

Racism: the belief that inherent differences among the races determine individual achievement and that one race is superior

Stereotype: a depersonalized conception of individuals within a group

Stigma: an attribute or trait deemed by the person's social environment as unfavorable

The nurse should be aware of sociocultural stressors that can hinder the delivery of psychiatric care. These are listed in Box 7-4. In addition, the nurse can ask specific questions of the patient during the assessment process in order to better understand the patient's understanding of the situation. These might include:

- What do you think is causing your problem?
- Has this happened before? If so, what helped and what made it worse?
- How is this problem affecting your home and work?
- What do you think will help you now?
- What is your goal for treatment?
- What concerns do you have about the care you will receive?

Critical Reasoning Damon, a Black American is 52 years old, divorced, and looking forward to retirement after 30 years on the job in a large urban fire department. Last year Damon was diagnosed with type 2 diabetes and post-traumatic stress disorder. His older sister became concerned about his health and encouraged him to join her church. Since joining the church, Damon started dating and has gained weight. He frequently has vivid nightmares and says he is afraid that he might be turning into one of those "germ phobic" types. As part of your psychiatric nursing assessment, what sociocultural questions would you ask Damon?

Social, cultural, and spiritual assessment of the patient, including personal risk and protective factors, greatly enhances the nurse's ability to establish a therapeutic alliance, identify the patient's problems, and develop a treatment plan that is accurate, appropriate, and culturally relevant. Box 7-5 presents questions the nurse might ask related to each of the factors described in this chapter.

BOX 7-5 QUESTIONS RELATED TO SOCIOCULTURAL RISK AND PROTECTIVE FACTORS

Age

Questions

What is the patient's current stage of development?
What are the developmental tasks of the patient?
Are those tasks age appropriate for the patient?
What are the patient's attitudes and beliefs regarding the patient's age-group?
With what age-related stressors is the patient coping?
What impact does the patient's age have on mental and physical health?

Example

Assessment. Jim is 38 years old and trying to come to terms with balancing his need for intimacy with that of finding his own identity and sense of purpose in life. He describes feelings of anxiety along with waves of hopelessness. He states, "At my age I should stop acting like I'm twenty-something and accept myself, but I just can't seem to do that."

Evaluation. Jim is worried that he will never settle down into an adult lifestyle, but he is more afraid of the high stress and loss of social attractiveness that he associates with middle-age.

Ethnicity

Questions

What is the patient's ethnic background?
What is the patient's ethnic identity?
Is the patient traditional, bicultural, multicultural, or culturally alienated?
What are the patient's attitudes, beliefs, and values regarding his ethnic group?
With what ethnicity-related stressors is the patient coping?
What impact does the person's ethnicity have on mental and physical health?

Example

Assessment. Aarikka, an adult Black-American woman, identifies with the West African culture. She dresses in traditional clothing and follows traditional diet restrictions and preferences. She feels that there would be less poverty in Black communities if more people adopted traditional West African values and beliefs. Aarikka recently stopped visiting her conservative parents after they dismissed her beliefs as "uppity." She also has become socially isolated, withdrawing from most of her friends since they espouse Western norms and lifestyle.

Evaluation. Aarikka has a close relationship with her parents and they are an important source of social support for her. However, her search for a positive ethnic identity that promotes her self-esteem and protects her self-confidence is at odds with her parent's sense of ethnic identity and the norms of her peer group. She is in an approach-avoidance conflict.

Gender

Questions

What is the patient's gender?
What is the patient's gender identity?
How does the patient define gender-specific roles?
What are the patient's attitudes and beliefs regarding males and females and masculinity and femininity?
With what gender-related stressors is the patient coping?
What impact does the person's gender have on mental and physical health?

Example

Assessment. Ravindra is male, and enacting the male role is very important to him. As a man he feels he must provide for his family by working hard, making money, and being smart. Ravindra feels that his wife should respect how hard he works and support his plans for providing for her. Recently, he and his wife have had increasing marital conflict. He states, "I am doing what is right for both of us. All my wife has to do is help me." Yet he states that his wife does not want him to work 7 days per week and that she does not want to wait until he builds their house before she can go to college. He reports drinking more in the past couple of months and admits that it is difficult for him to express his emotional needs or to respond to those of his wife.

Evaluation. Ravindra defines masculinity as authority, and it is extremely important to his self-image. He is unable to express feelings and is struggling to maintain a self-ideal that is in conflict with his wife's needs for her own growth as an individual and as a spouse.

Education

Questions

What is the patient's education level?
What are the patient's educational experiences?
What are the patient's attitudes and beliefs regarding education in general and the patient's own education in particular?
With what education-related stressors is the patient coping?
What impact does the patient's education have on mental and physical health?

Example

Assessment. Ron completed eighth grade and then dropped out of school. He learned to be a plumber by working with a family friend who owned a plumbing business. Recently the friend retired and sold the business to Ron. Ron wants his son to work with him and learn the business, but his son wants to go to college. Ron and his son have been having arguments about this issue. Ron has told him, "College is what you do when you don't know anything. Do you think that by going to college you'll be better than me?"

Evaluation. Ron regrets his lack of formal education and the negative stereotypes people hold about plumbers. His insecurity makes it difficult for him to support his son's desire to attend college because he fears that his relationship with his son will suffer and that his son will think less of him in the future.

Income

Questions

What is the patient's income?
What is the source of the patient's income?
How does the patient describe his income group?
What are the patient's attitudes and beliefs regarding personal socioeconomic status?

Continued

BOX 7-5 QUESTIONS RELATED TO SOCIOCULTURAL RISK AND PROTECTIVE FACTORS—cont'd

With what income-related stressors is the patient coping?
What type of health insurance does the patient have, if any?
What impact does the patient's income have on mental and physical health?

Example

Assessment. Amanda is unemployed. She has always believed that people who are in good health should work; however, Amanda has never been employed. She married a wealthy, older man when she was 19 years old, and for 10 years he supported her. Then with little warning, her husband filed for divorce and plans to marry a much younger woman. Amanda describes herself as a "penniless, homeless, loser." Although her father has offered her a job with his company Amanda has not accepted the position.

Evaluation. Amanda's marriage defined her self-concept and her wealth was her only source of self-esteem. She is unprepared for a life as a single working woman. Recent life events have been overwhelming for her.

Beliefs

Questions

What are the patient's beliefs about health and illness?
What was the patient's religious or spiritual upbringing?
What are the patient's current religious or spiritual beliefs?
Who is the patient's regular health care provider?
With what belief system–related stressors is the patient coping? What impact does the patient's belief system have on mental and physical health?

Example

Assessment. Dave was born and raised on a dairy farm in the Midwest. He believes that illness of the mind is a symptom of moral weakness. Since his mother's death 2 months ago, he has experienced nightly insomnia, debilitating fatigue, weight loss, and persistent worry and anxiety. He has not been able to work and his father is concerned. He berates Dave daily, telling him hard work is the only way he will ever get well.

Evaluation. Dave has not been able to grieve the loss of his mother. He believes strong emotions and sad thoughts are unacceptable for him. His feelings and thoughts also impair his normal way of coping by doing hard work for long hours. Seeking professional help would shame him. His father has continued to work and does not understand why he cannot expect the same in his son.

Critical Reasoning Abdul is Muslim American, 22 years old, and married. He is the father of two children and works in the IT department of a large state department. At age 17 Abdul was diagnosed with bipolar I disorder. Although his symptoms have been well managed with moderate doses of mood stabilizing medications, he has stopped taking all psychiatric medications. Now he is having trouble sleeping and is becoming increasingly irritable. As part of your psychiatric nursing assessment, what sociocultural questions would you ask Abdul?

A culturally competent psychiatric nursing diagnosis considers relevant social, cultural, and spiritual characteristics of the patient. Often nurses exclude sociocultural information in their analysis because they want to avoid stereotyping the patient; believe that the patient's health care problems are not related to the patient's age, ethnicity, gender, income, education, or beliefs; or incorrectly assume that the patient shares their world view. However, social, cultural, and spiritual information must be included in each phase of the nursing process because each has a significant influence on health and health care outcomes.

Critical Reasoning Ramona, a Brazilian female, is a freshman college student attending a large state university. She is 18 years old, single, unemployed, and lives in a campus dorm with one female roommate. Although always quiet and reserved, Ramona has stopped accepting social invitations from her roommate and has become very quiet and withdrawn. She has started sleeping during the day between classes. As part of your psychiatric nursing assessment, what sociocultural questions would you ask Ramona?

TREATMENT IMPLICATIONS

The therapeutic treatment process is influenced by the social, cultural, and spiritual contexts of both the nurse and the patient. Social inclusion strategies designed to decrease disparities include provision of qualified interpreter services; recruitment and retention of a diverse professional and consumer staff; continuous opportunities for cultural competency training; education and awareness programs on non-Western healing traditions; community, church, workplace, campus, and school mental health promotion programs; immersion training experiences; and administrative and organizational accommodations (Siegel et al, 2011).

In terms of treatment planning, it is clear that the psychiatric nurse needs to be sensitive to sociocultural issues but also must transcend them. Together, the nurse and patient need to agree on the nature of the patient's problem, the patient's coping responses, the means for solving problems, and the expected outcomes of treatment.

A central responsibility of the nurse is to understand what the illness means to the patient and the way in which the patient's beliefs can help to mediate the stressful events or make them easier to bear by redefining them as opportunities for personal growth. As an essential aspect of psychiatric nursing care, cultural competency improves the quality of nurse-patient interactions and patient satisfaction, two aspects of treatment that can have significant treatment outcome implications (Oakley et al, 2011).

Service Utilization

Cultural competency has been shown to be an important factor in the utilization of available mental health care services. Low utilization rates are associated with mental health disparities in population groups who do not feel comfortable with health professionals who seem to have limited knowledge and awareness of cultural competence practice standards.

All patients desire and are entitled to accessible, affordable psychiatric care delivered by skilled professionals who reflect important social, cultural, and spiritual characteristics of their communities. To successfully deliver such services, mental health providers need to make a major commitment to building community relationships, receiving continuing education training in cultural competency, and translating research into action. Mental health care programs need to find ways to ensure the active participation of patient community representatives in the design, delivery, and evaluation of psychiatric services.

A culturally competent mental health care system acknowledges the importance of culture and incorporates this value into all levels of care. To do this requires the assessment of cross-cultural relations, an understanding of the dynamics of cultural differences, an expansion of knowledge about different cultures, and a commitment to adapt services to meet culturally based needs. In this way culturally competent mental health care provides better access to more appropriate, effective care and the opportunity for improved outcomes.

Specifically, service use can be improved by the standardization of clinical assessment and treatment guidelines that address patients' cultural issues. In addition, delivery systems should be sensitive to the fact that if a mental health service operates under the auspices of a dominant ethnic, socioeconomic, or religious group, people who are not members of that group may feel uncomfortable or unable to access that service. Staffing also has been shown to affect service use by minorities in that use of diverse staff who understand the language and culture of patients enhances service use.

Finally, an administrative environment must be created that places importance on the role of culture in understanding mental illness and treatment. Criteria should be established that hold clinicians accountable for practicing in culturally appropriate ways and provide them with the necessary tools, training, and performance measurements.

> **Critical Reasoning** Look at the furniture, pictures, and other aspects of the environment in one of your clinical settings. What does it communicate about culture? Would an African-American man, Indian woman dressed in traditional clothes, Latino man learning to speak English, disabled adult in a wheelchair, lesbian college student, or low-income Caucasian single mother feel comfortable in this setting?

Therapeutic Nurse–Patient Interactions

Effective, culturally responsive counseling considers each patient's ethnic identity and acculturation, cultural beliefs, family influences, gender-role socialization, religious and spiritual values and traditions, and immigration experiences. Expert nurses have learned the importance and treatment value of skilled nurse-patient interactions, as well as the potential for problems.

Common examples of such problems include patient misperceptions of the nurse as disinterested, disapproving, or disrespectful. Many vulnerable sociocultural groups are wary of psychiatric care and fear that the costs of treatment may include their dignity. For others, persistent misperceptions could be rooted in a history of harmful mistreatment or fear of deportation.

Alternatively, healthy recognition of nurse-patient sociocultural differences can enrich the health care experience for both the nurse and the patient. Building mutually respectful therapeutic interactions with patients begins with asking effective questions that promote an understanding of the way the patient describes, communicates and experiences illness. In this way the nurse can create the ideal circumstances for both the nurse and the patient to recognize, value, and benefit from shared sociocultural diversity.

Family systems, friends, and community groups can be major sources of strength for people with mental illness. Nurses should view them as allies and integral parts of the treatment process. Families can provide an important economic and emotional buffer against the burden imposed by the patient's illness and give the patient a supportive environment for recovery (Chapter 10). Support networks also are sources of economic, social, and emotional relief from the many personal and social burdens of psychiatric disorders.

Religion can be a core social and spiritual resource. Patients may expect to have members of their religious, faith-based, or spiritual networks play an active role in their psychiatric care and in the sociocultural context of their recovery. They also may look to their religious and spiritual relationships for guidance with psychiatric disorders.

As with any network, membership offers collective support, opportunities for self-expression, and the ability to help others, which can give meaning to life. Supernatural belief systems also may provide a natural support system for people with mental illness, as well as a culturally based way of understanding how the illness fits into the patient's life. For example, some people believe they are looked after by a protective "angel." **Whatever the context, culturally competent nurses should support adaptive patient beliefs and strive to incorporate them into their nurse-patient interactions.**

Psychopharmacology

Patients' social, cultural, and spiritual attributes can have direct as well as subtle effects on their attitudes and behavior regarding psychiatric medications. Specifically, **a patient's ethnicity, gender, beliefs, and age can impact medication pharmacokinetics, pharmacodynamics, effectiveness, and side-effect risks.**

For example, ethnicity is one of the most important variables that contribute to variations in patients' biological

responses to medications (Campinha-Bacote, 2007). Racial and ethnic differences in response to psychotropic drugs include the following:

- Extrapyramidal effects occur at lower dosage levels in Asians.
- Lower effective dosage levels are needed and a lower side-effect threshold exists for Hispanics administered antidepressants.
- Higher red blood cell plasma/lithium ratios are needed for drug efficacy in African-Americans.

Gender differences also may result in the need for different doses of psychotropic drugs. For example, women secrete 40% less stomach acid than men, so drugs such as tricyclic antidepressants, benzodiazepines, and certain antipsychotic drugs are more likely to be absorbed before they can be neutralized by the acid, thus requiring a lower dose of the drug. In addition, over time, women accumulate more of a drug in their bodies than men do because fatty tissue stores psychotropic drugs better.

Although ethnicity and gender can have direct and indirect psychopharmacology effects, cultural and spiritual beliefs can have somewhat unpredictable effects. Some religious beliefs reject the consumption of drugs for any purpose despite the trend of medications becoming the first line of treatment for an increasing number of psychiatric disorders.

The social stigma attached to psychiatric medications is another influence that must be considered. People who view psychiatric disorders as personal failings rather than disorders may have great ambivalence about taking psychiatric medications and stop taking recommended medications despite full symptom relief and meaningful improvement in psychosocial functioning.

Some patients may question taking any medication designed to alter brain functioning for sociocultural reasons. Secondhand stories of the medication experiences of others, reports found on websites, media articles, and direct marketing are just a few of the patient information sources that nurses must understand. African-American patients may have undisclosed mistrust of prescription medications, and persistent health disparities among African-Americans and a history of racial exploitation may account for their sometimes fatalistic attitude toward illness.

Equally important is that indigenous systems of health beliefs and practices persist in all societies, including those exposed to modern Western medicine. **The nurse should keep in mind that, despite the availability of Western medicine, traditional herbal medicines and alternative therapies continue to be used extensively by many different cultural groups living in the United States** (Chapter 30). Some of these have properties that may interfere with other medications. Dramatic increases in the availability of herbal medicines and remedies from around the world ensure that public interest in and use of such products will continue in the future.

CHAPTER IN REVIEW

- Disparities in mental health care are found for racial and ethnic minorities.
- Social, cultural, and spiritual characteristics can impact the person's access to mental health care, the risk for or protection against developing a certain psychiatric disorder, the way in which symptoms will be experienced and expressed, the ease or difficulty of participating in psychiatric treatment, and the ability to achieve recovery.
- Cultural competency is the ability to view each patient as a unique individual, fully considering the patient's cultural experiences within the context of the common developmental challenges faced by all people.
- The culturally competent nurse understands the importance of social, cultural, and spiritual forces; recognizes the uniqueness of each patient; respects nurse-patient differences; and incorporates sociocultural information into psychiatric nursing care.
- Risk factors for psychiatric disorders are characteristics of a person that can increase the potential for developing a psychiatric disorder, decrease the potential for recovery, or both. Protective factors are characteristics of a person that can significantly decrease the potential for developing a psychiatric disorder, increase the potential for recovery, or both.
- The culturally competent nurse does not assume knowledge of a patient based on casual observations of age, ethnicity, or gender. Neither should a nurse draw generalizations about groups based on these factors.
- Age-related variations in life stressors, support resources, and coping skills are common.
- For ethnic and racial minority groups, personal protective factors often are embedded in a tightly woven social identity. Members of minorities may have difficulty gaining access to appropriate mental health services. Ethnicity also has been shown to influence the development of and recovery from psychiatric disorders.
- When all psychiatric disorders are included, the prevalence of mental illness among males and females is about equal. The actual difference between the two groups is in the type of disorder that is most commonly diagnosed.
- Education is an important coping resource in protecting against the development of and promoting recovery from mental illness. Language barriers can influence the impact of education.
- The profound negative impact of poverty as a risk factor for psychiatric illness is evident regardless of age, ethnicity, gender, or education.

CHAPTER IN REVIEW—cont'd

- Adaptive belief systems, world view, religion, or spirituality can enhance health and well-being; improve quality of life; and support recovery from psychiatric disorders. Maladaptive belief systems may contribute to poor health status, refusal or nonadherence with needed treatment, or even self-injury.
- Social, cultural, and spiritual assessment of the patient, including personal risk and protective factors, greatly enhances the nurse's ability to establish a therapeutic alliance, identify the patient's problems, and develop a treatment plan that is accurate, appropriate, and culturally relevant. Together, the nurse and patient need to agree on the nature of the patient's problem, the coping responses of the patient, the means for solving problems, and the expected outcomes of treatment.
- A culturally competent mental health care system assesses cross-cultural relations, understands the dynamics of cultural differences, expands knowledge about different cultures, and is committed to adapt services to meet culturally based needs.
- Culturally responsive counseling should consider ethnic identity and acculturation, family influences, gender-role socialization, religious and spiritual influences, and immigration experiences.
- A patient's ethnicity, gender, beliefs, and age can impact medication pharmacokinetics, pharmacodynamics, effectiveness, and side-effect risks.

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CHAPTER

8

Legal and Ethical Context of Psychiatric Nursing Care

Gail W. Stuart

Is it not, then, an atrocious anomaly that the treatment often meted out to insane persons is the very same treatment which would deprive some sane persons of their very reason?

Clifford Beers, A Mind that Found

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe ethical standards, decision making, and dilemmas impacting psychiatric nursing practice.
2. Compare and contrast the two types of admission to a psychiatric hospital and the ethical issues raised by commitment.
3. Examine involuntary community treatment and its implications for improving the care received by psychiatric patients.
4. Analyze the common personal and civil rights retained by psychiatric patients and ethical issues related to them.
5. Discuss the insanity defense and the psychiatric criteria used in the United States to determine criminal responsibility.
6. Evaluate the rights, responsibilities, and potential conflict of interest that arise from the three legal roles of the psychiatric nurse.

The relationship between psychiatry and the law reflects the tension between individual rights and social needs. Both psychiatry and the law deal with human behavior and the relationships and responsibilities that exist among people. Both also play a role in controlling socially undesirable behavior, and together they analyze whether the care psychiatric patients receive is therapeutic, custodial, repressive, or punitive.

Differences also exist between psychiatry and the law. For example, psychiatry is concerned with the meaning of behavior and the life satisfaction of the individual. In contrast, the law addresses the outcome of behavior and the enforcement of a system of rules to encourage orderly functioning among groups of people.

The legal and ethical context of care is important for all psychiatric nurses because it focuses concern on the rights of patients and the quality of care they receive. However, **laws vary from state to state, and psychiatric nurses must become familiar with the laws of the state in which they practice.** This knowledge enhances the freedom of both the nurse and the patient, informs ethical decision making, and ultimately results in better care.

ETHICAL STANDARDS

Psychiatric nurses may encounter complex ethical situations in caring for patients and families with mental illness. As professionals they are held to the highest standards of ethical accountability in their clinical practice (Murray, 2007). A number of essential ethics skills are listed in Box 8-1. These allow the nurse to provide care that is socially responsible and personally accountable.

BOX 8-1 ESSENTIAL ETHICS SKILLS IN PSYCHIATRIC PRACTICE

- The ability to recognize ethical issues in psychiatric practice, including a working knowledge of ethical concepts as they apply to the care of mental illness
- The ability to be aware of one's own values, strengths, and biases as they apply to work with patients, including the ability to sense one's own discomfort as a sign of potential ethical problems
- The ability to identify the limits of one's clinical skills and competence
- The ability to anticipate specific ethical dilemmas in treatment
- The ability to access clinical ethics resources, to obtain ethics consultation, and to access ongoing supervision of difficult cases
- The ability to introduce additional safeguards into the clinical care of the patient and to monitor their effectiveness

From Roberts L, Geppert CM, Bailey R: *J Psychiatr Pract* 8:290, 2002.

An **ethic** is a standard of behavior or a belief valued by an individual or group. It describes **what ought to be, rather than what is**—a goal to which an individual aspires. These standards are learned through socialization, growth, and experience. They are not static but evolve with social change. Ethical standards, guidelines, and principles are not legally enforceable unless they have been incorporated into the law.

Ethical Decision Making

Ethical decision making involves trying to distinguish right from wrong in situations without clear guidelines. A decision-making model can help identify factors and principles that affect a decision. A model for critical ethical analysis that describes steps or factors that the nurse should consider in resolving an ethical dilemma is shown in Figure 8-1.

1. The first step is **gathering background information** to obtain a clear picture of the problem. This includes finding available information to clarify the underlying issues.
2. The next step is **identifying the ethical components** or the nature of the dilemma, such as freedom versus coercion or treating versus accepting the right to refuse treatment.
3. The third step is the **clarification of the rights and responsibilities of all ethical agents,** or those involved in the decision making. This can include the patient, the nurse, and possibly many others, including the patient's family, physician, health care institution, clergy, social worker, and perhaps even the courts. Those involved may not agree on how to handle the situation, but their rights and duties can be clarified.
4. **All possible options must then be explored** in light of everyone's responsibilities, as well as the purpose and potential result of each option. This step eliminates alternatives that violate rights or seem harmful.
5. The nurse then engages in the **application of principles,** which stem from the nurse's philosophy of life and nursing, scientific knowledge, and ethical theory. Ethical theories suggest ways to structure ethical dilemmas and judge potential solutions. Four possible approaches include the following:
   a. **Utilitarianism,** which focuses on the consequences of actions. It seeks the greatest amount of happiness or the least amount of harm for the greatest number, or "the greatest good for the greatest number."
   b. **Egoism** is a position in which the individual seeks the solution that is best personally. Oneself is most important, and others are secondary.

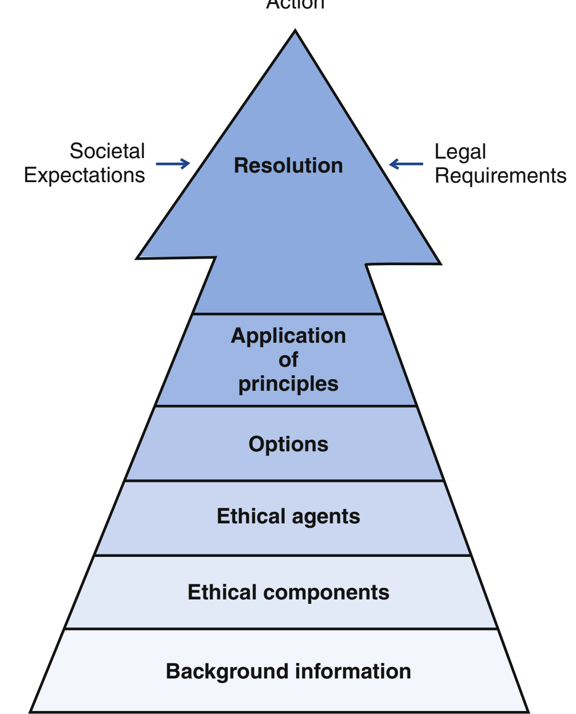

FIG 8-1 Model for ethical decision making. (From Curtin L: *Nurs Forum* 17:12, 1978.)

   c. **Formalism** considers the nature of the act itself and the principles involved. It involves the universal application of a basic rule, such as "do unto others as you would have them do unto you."
   d. **Fairness** is based on the concept of justice, and benefit to the least advantaged in society becomes the norm for decision making.
6. The final step is **resolution into action.** Within the context of social expectations and legal requirements, the nurse decides on the goals and methods of implementation. Table 8-1 summarizes these steps and suggests questions nurses can ask themselves in making complex ethical choices in psychiatric nursing practice.

Critical Reasoning Think of an ethical problem you have encountered in caring for a psychiatric patient and family. Use the model for ethical decision making to decide on the best course of action.

TABLE 8-1 STEPS AND QUESTIONS IN ETHICAL DECISION MAKING

STEPS	RELEVANT QUESTIONS
Gathering background information	Does an ethical dilemma exist? What information is known? What information is needed? What is the context of the dilemma?
Identifying ethical components	What is the underlying issue? Who is affected by this dilemma?
Clarification of agents	What are the rights of each involved party? What are the obligations of each involved party? Who should be involved in the decision making? For whom is the decision being made? What degree of consent is needed by the patient?
Exploration of options	What alternatives exist? What is the purpose or intent of each alternative? What are the potential consequences of each alternative?
Application of principles	What criteria should be used? What ethical theories are advocated? What scientific facts are relevant? What is the nurse's philosophy of life and nursing?
Resolution into action	What are the social and legal constraints and ramifications? What is the goal of the nurse's decision? How can the resulting ethical choice be implemented? How can the resulting ethical choice be evaluated?

Ethical Dilemmas

An **ethical dilemma** exists when moral claims conflict with one another. It can be defined as follows:

- A difficult problem that seems to have no satisfactory solution
- A choice between equally unsatisfactory alternatives

Ethical dilemmas pose questions such as "What should I do?" and "What is the right thing to do?" They can occur both at the nurse-patient-family level of daily nursing care and at the policymaking level of institutions and communities.

Although ethical dilemmas arise in all areas of nursing practice, some are unique to psychiatric and mental health nursing. Many of these dilemmas fall under the umbrella issue of **behavior control.** It might seem that behavior control is a simple issue: Behavior is a personal choice, and any behavior that does not violate the rights of others is acceptable. Unfortunately, this does not address complex situations.

For example, a severely depressed person may choose suicide as an alternative to an intolerable existence. On one level this is an individual choice not directly harming others, yet suicide is forbidden in U.S. society. In many states it is a crime that can be prosecuted. Another example is that in some states it is illegal for consenting adults of the same sex to have sexual relations, although it is not illegal for a man to rape his wife.

These examples raise difficult questions: When is it appropriate for society to regulate personal behavior? Who will make this decision? Is its goal personal adjustment, personal growth, or adaptation to social norms? And finally, how do we measure the costs and benefits of attempting to control personal freedom in a free society?

The growing knowledge about the genetic basis of psychiatric disorders will present even more ethical issues. Current evidence suggests that the etiology of most psychiatric disorders is a result of a combination of genes and environmental factors.

As tests for genes become more easily available, pressures will grow for prenatal testing, screening of children and adults, selection of potential adoptees, and premarital screening. Ethical issues here will relate to knowledge about genetics, the impact of this information on one's sense of self, the boundaries of personal choice, as well as the potential discriminatory use of genetic information to deny people access to insurance and employment (Cheung, 2009; Appelbaum, 2010).

One of the basic problems is the blurry line between science and ethics in the field of psychiatry. Theoretically, science and ethics are separate. Science is descriptive, deals with what is, and rests on validation. Ethics is predictive, deals with what ought to be, and relies on judgment. However, psychiatry is neither purely scientific nor value free.

Nurses must identify their own professional commitment. Are they committed to the happiness of the individual or to the smooth functioning of society? Ideally, these values should not conflict, but in reality they sometimes do.

The patient's rights to treatment, to refuse treatment, and to informed consent highlight this conflict-of-interest question. Nurses must consider whether they are forcing the patient to be socially or politically acceptable at the expense of the patient's personal happiness. Nurses may not be working for either the patient's best interests or their own; they may be acting as agents of society and not be aware of it.

It is, therefore, critically important for each nurse to analyze ethical dilemmas such as freedom of choice versus coercion, helping versus imposing values, and focusing on cure versus prevention. The nurse also must become active in defining adequate treatment and deciding important resource allocations.

HOSPITALIZING THE PATIENT

Hospitalization can be either traumatic or supportive for the patient, depending on the institution, attitude of family and friends, response of the staff, and type of admission (Newton-Howes and Mullen, 2011; Sheehan and Burns, 2011). The two major types of admission are voluntary and involuntary. Table 8-2 summarizes their distinct characteristics.

> **Critical Reasoning** What were your impressions as you walked through the doors of a psychiatric hospital for the first time? How might you use your perceptions and responses to provide better nursing care for patients being admitted for inpatient treatment?

Voluntary Admission

Under voluntary admission any citizen of lawful age may apply in writing (usually on a standard admission form) for admission to a public or private psychiatric hospital. The person agrees to receive treatment and abide by hospital rules. People may seek help based on their personal decision or the advice of family or a health professional. If someone is too ill to apply but voluntarily seeks help, a parent or legal guardian may request admission. In most states children under the age of 16 years may be admitted if their parents sign the required application form.

Voluntary admission is preferred because it is similar to a medical hospitalization. It indicates that the patient acknowledges problems in living, seeks help in coping with them, and will participate in finding solutions. Most patients who enter psychiatric units do so voluntarily.

When voluntarily admitted, the patient retains all civil rights, including the right to vote, have a driver's license, buy and sell property, manage personal affairs, hold office, practice a profession, and engage in a business. It is a common misconception that all admissions to a mental hospital involve the loss of civil rights.

Although voluntary admission is the most desirable, it is not always possible. Sometimes a patient may be acutely disturbed, suicidal, or dangerous to self or others yet rejects any therapeutic intervention. In these cases involuntary commitments are necessary.

> **Critical Reasoning** Should a psychotic person be allowed to sign forms for voluntary admittance to the hospital? If not, should all voluntary patients be screened for competence before hospitalization?

Involuntary Admission (Commitment)

Involuntary admission or **commitment** means that the patient did not request hospitalization and may have opposed it or was indecisive and did not resist it. Most laws permit commitment of the mentally ill on one or more of the following three grounds:

1. **Dangerous to self or others**
2. **Mentally ill and in need of treatment**
3. **Unable to provide for own basic needs**

The Commitment Process. State laws vary, but they try to protect the person who is not mentally ill from being detained in a psychiatric hospital against his will for political, economic, family, or other nonmedical reasons. Certain procedures are standard. The process begins with a sworn petition by a relative, friend, public official, physician, or any interested citizen stating that the person is mentally ill and needs treatment. Some states allow only specific people to file such a petition. One or two physicians must then examine the patient's mental status; some states require that at least one of the physicians be a psychiatrist.

The decision of whether to hospitalize the patient is made next. The person who makes this decision determines the nature of the commitment:

- **Medical certification** means that physicians make the decision.
- **Court** or **judicial commitment** is made by a judge or jury in a formal hearing.

TABLE 8-2 CHARACTERISTICS OF THE TWO TYPES OF ADMISSION TO PSYCHIATRIC HOSPITALS

	VOLUNTARY ADMISSION	INVOLUNTARY ADMISSION
Admission	Written application by patient	Application did not originate with patient
Discharge	Initiated by patient	Initiated by hospital or court but not by patient
Civil rights	Retained fully by patient	Patient may retain none, some, or all, depending on state law
Justification	Voluntarily seeks help	Mentally ill and one or more of following: Dangerous to self or others Need for treatment Unable to meet own basic needs

- **Administrative commitment** is determined by a special tribunal of hearing officers.

If treatment is necessary, the person is hospitalized. The length of hospital stay varies depending on the patient's needs. Figure 8-2 presents a clinical algorithm of the involuntary commitment process. It identifies three types of involuntary hospitalization: emergency, short term, and long term.

> **Critical Reasoning** Most states specify that any physician, not necessarily a psychiatrist, can certify a person for involuntary commitment to a psychiatric hospital. Do you agree with this? What is required by law in your state?

Emergency Hospitalization. Almost all states permit emergency commitment for patients who are acutely ill with the goal of controlling an immediate threat to self or others. In states lacking such a law, police often jail the acutely ill person on a disorderly conduct charge, which is a criminal charge. Such a practice is inappropriate and often harmful to the patient's mental status. **Most state laws limit the length of emergency commitment to 48 to 72 hours.**

Short-Term or Observational Hospitalization. Observational commitment is used for diagnosis and short-term therapy and does not require an emergency situation. Again, the commitment is for a specified time that varies from state to state. If at the end of the period the patient is still not ready for discharge, a petition can be filed for a long-term commitment.

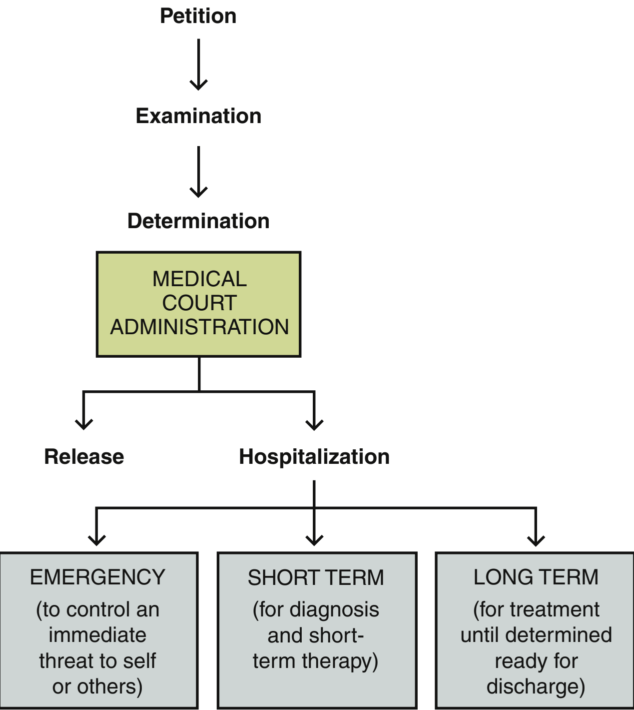

FIG 8-2 Clinical algorithm for the involuntary commitment process.

Long-Term Hospitalization (Formal Commitment). A long-term commitment provides for hospitalization for an indefinite time or until the patient is ready for discharge. Patients in public or state hospitals have indefinite commitments more often than patients in private hospitals. Even when committed, these patients maintain their right to consult a lawyer at any time and to request a court hearing to determine whether additional hospitalization is necessary.

> **Critical Reasoning** Do you agree with the criteria for committing patients to psychiatric hospitals? How would you assess whether a person met these criteria?

Commitment Dilemma. How ill does a person need to be to merit commitment? A person's dangerousness to self or others is a major consideration. Psychiatric professionals consider hospitalization in this instance to be a humanitarian gesture that protects both the individual and society. However, dangerousness is a vague term.

> **Critical Reasoning** According to a survey commissioned by *Parade* magazine, more than 57% of Americans think mentally ill people are more likely to commit acts of violence than other people. How does this compare with the facts? How do the media contribute to this impression of the mentally ill?

Dangerousness. Interestingly, courts guard the freedom of people who are mentally healthy but dangerous. For example, after a prison sentence is served, the person is automatically released and can no longer be retained. However, someone who is mentally ill and dangerous can be confined indefinitely. The idea of preventive detention does not exist in most areas of the law. Only illegal acts result in prolonged confinement for most citizens, except the mentally ill.

Most mentally ill people are not dangerous to themselves or others. Studies show that the vast majority of people with serious mental illness, particularly women, are not violent, but rather are often the victims of violence. Research does suggest, however, that a subgroup of people with mental illness may be more dangerous and that they share sociodemographic features of violent offenders in the general population, including poverty (Elbogen and Johnson, 2009). Patients in this subgroup have one or more of the following:

- **Violent behavior**
- **Psychosis**
- **Noncompliance with medications**
- **Current substance abuse**
- **Antisocial personality disorder**
- **Lack of perceived need for treatment**
- **Lack of perceived treatment effectiveness**

These characteristics can serve as predictors of potential violence.

It is important that patients with severe psychiatric disorders be identified and appropriately treated. It also should be remembered that **violent behavior by people with serious**

mental illness is only one part of a larger problem: the failure of public psychiatric services and the lack of adequate community support for the mentally ill (Chapter 34). This has resulted in large numbers of mentally ill people among the homeless, a large number of mentally ill people in jails and prisons, and a revolving door of psychiatric readmissions.

The real underlying issue may be nonconformity in ways that offend others. For example, before the law all men and women are equal, but it is also true that most committed patients are members of lower socioeconomic groups.

This raises questions regarding the sociocultural context of psychiatric care (Chapter 7) and the role of mental health professionals as enforcers of social rules and norms. Thus the behavioral standard of dangerousness can change the function of the psychiatric hospital from a place of therapy for mental illness to a place of confinement for offensive behavior.

> **Critical Reasoning** How do you explain the fact that society condones certain kinds of dangerous behavior, such as race car driving, but objects to other kinds?

Freedom of Choice. The legal and ethical question thus raised is freedom of choice. Some professionals believe that at certain times the individual cannot be self-responsible. To protect both the patient and society, it is necessary to confine the patient and make decisions for him.

An example is the suicidal patient. In most states suicide is against the law, so law and psychiatry join to protect the person and help individuals resolve personal conflicts. How does this compare with patients who have cancer or cardiac disease and decide to reject medical advice and the prescribed treatment? Should society, through law and medicine, attempt to cure these patients against their will?

Some clinicians view civil commitment as basically a benevolent system that makes treatment available. They disagree with the assumption that mentally ill people are competent to exercise free will and make decisions in their own best interest, such as whether to take medications or remain outside a hospital. They believe that some mentally ill people may not be physically dangerous but may still endanger their own prospects for a normal life.

Others oppose commitment. They favor responsibility for self and the right to choose or reject treatment. If a person is not dangerous then they believe that a person should not be coerced into treatment. If a person's actions violate criminal law, they suggest that the person be punished through the penal system. Currently a middle ground is being sought between meeting the needs of the severely mentally ill and preserving their legal rights and freedom of choice.

> **Critical Reasoning** Who should decide what is in the patient's best interest if a patient is involuntarily committed? Should it be the patient, a family member, a health care professional, or the judicial system?

Discharge

The patient who is voluntarily admitted to the hospital can leave at any time. The voluntarily admitted patient can be discharged by the staff when maximum benefit has been received from the treatment. Voluntary patients also may request discharge.

Most states require written notice of patients' desire to leave and also require that patients sign a form that states they are leaving against medical advice (AMA). This form then becomes part of the patient's permanent record.

Research has shown that discharge AMA was most commonly predicted by patient factors such as young age, single marital status, male gender, co-morbid diagnosis of personality or substance use disorders, disruptive behavior, and history of many hospitalizations ending AMA. Provider variables included failure to orient patients to hospitalization and failure to establish therapeutic provider-patient relationships. Clinical outcomes included reduced benefit from treatment; poorer psychiatric, medical, psychosocial, and socioeconomic functioning; overused emergency care; underused outpatient services; and more frequent rehospitalizations (Brook et al, 2006).

Documentation of AMA patient requests should include the following:

- The mental status of the patient
- The patient's own description of why he wants to leave
- Content of discussions in which possible risks of leaving were described
- Instructions on medications and follow-up care
- Conversations with significant others who may have been present
- Destination of the patient and means of transportation

In some states voluntarily admitted patients can be released immediately; in others they can be detained 24 to 72 hours after submitting a discharge request. This allows hospital staff time to confer with the patient and family members and decide whether additional inpatient treatment is indicated. If additional treatment is needed and the patient will not withdraw the request for discharge, the family may begin involuntary commitment proceedings, thereby changing the patient's status.

An involuntarily committed patient has lost the right to leave the hospital at his own request. **If a committed patient leaves before discharge, the staff has the legal obligation to notify the police and committing courts.** Often these patients return home or visit family or friends and can be easily located. The legal authorities then return the patient to the hospital. Additional steps are not necessary because the original commitment is still in effect.

Ethical Considerations

Nurses must analyze their beliefs regarding the voluntary and involuntary hospitalization of psychiatric patients. What should be done if the nonconformist does not wish to change behavior? Do nonconformists maintain freedom to choose even if their thinking appears to be irrational or abnormal? Is coercion fair or justified? Can social interests be served by less restrictive methods, such as outpatient therapy?

Nurses are responsible for reviewing commitment procedures in their state and working for needed clinical, ethical, and legal reforms. The commitment dilemma exposes current practices and reveals controversial issues that will benefit from closer examination. For example, studies show that more than half of the homeless population have psychiatric or substance abuse disorders. Homeless mentally ill people have more service needs than homeless people who use only social services.

Many seriously mentally ill people cannot obtain or maintain access to community resources such as housing, a stable source of income, or treatment and rehabilitative services. Homeless people lack supportive social networks and underuse psychiatric, medical, and welfare programs. Many avoid the mental health system entirely, often because they are too confused to respond to offers of help. As a consequence they are often admitted into acute psychiatric hospitals or jailed because of their lack of shelter and other resources, even though such restrictive environments may not best address their psychiatric needs.

Unfortunately, many local communities deny the problem by resisting halfway houses or sheltered homes in their neighborhoods. Third-party insurance often does not cover extended outpatient psychiatric care. In today's mobile society, family and friends may be unable to care for the newly discharged patient, who can then end up in a boarding house with little to do but watch television. Psychiatric nurses, patients, families, and citizens must address these issues across the United States. The value of commitment, goals of hospitalization, quality of life, and rights of patients must be preserved through the judicial, legislative, and health care systems.

INVOLUNTARY COMMUNITY TREATMENT

Community initiatives have been developed to respond to the mandate to offer psychiatric patients treatment in the least restrictive setting. The most common of these is court-ordered treatment in the community or outpatient commitment.

Outpatient commitment is the process by which the courts can order patients committed to a course of outpatient treatment specified by their clinicians. This type of commitment is an alternative to inpatient treatment for people who meet the involuntary commitment criteria. It is also called **mandatory outpatient treatment.**

Almost all states have laws permitting outpatient commitment, but its use varies greatly. Reasons for not using them include concerns about civil liberties, liability and financial costs, lack of information and interest, problems with enforcement and ways to deal with lack of compliance, and criteria that are too restrictive.

Like inpatient commitment, involuntary outpatient treatment also is controversial (Swartz and Swanson, 2008). Some believe that it is necessary to reach people who need help but do not realize it. These are people who lack insight because of their illness, refuse treatment, and eventually become homeless or are relegated to jails or hospitals.

Supporters of outpatient commitment have presented research showing that patients in outpatient commitment had fewer hospital admissions and hospital days after the court order requiring the outpatient treatment; had improved functioning, reduced risk of suicide, greater use of outpatient and residential services, and reductions in arrest; and were more compliant with medication (Cullen-Drill and Schilling, 2008; Gilbert et al, 2010; Phelan et al, 2010).

Others disagree and claim this law is coercive and plays into public fear of the dangerousness of the mentally ill. They believe that outpatient commitment may not improve public safety, may not be more effective than voluntary services, and may in fact drive consumers away from the mental health system (Galon and Wineman, 2010).

Questions also have been raised about the legality of limiting the rights of patients who are not incompetent and who would not qualify for inpatient commitment in a court of law. Finally, the use of outpatient commitment is not a substitute for intensive treatment and requires dedicated treatment resources to be effective.

> **Critical Reasoning** How might sociocultural factors influence a nurse's beliefs about involuntary treatment in the hospital or the community? How might nurses guard against potential bias based on their personal world view?

PATIENTS' RIGHTS

Some of the most important factors in ensuring patients' rights are the attitude, knowledge, and commitment of the nurse. Sensitivity to patients' rights cannot be imposed by the court, the legislature, administrative agencies, or professional groups. If nurses ignore them, implement them casually, or are outwardly hostile about honoring them, patients' rights are an empty legal concept; but if nurses are sensitive to patients' needs in their relationships with them, they will secure these human and legal rights.

Although the variation among states is great, psychiatric patients have their rights listed in Box 8-2. Some of these rights deserve a more thorough discussion.

> **Critical Reasoning** In your experience are patients in general hospital settings granted their patient rights? How about patients in psychiatric inpatient units? What specific things could nurses do to see that these rights are honored in all hospitals?

Right to Communicate With People Outside the Hospital

This right allows patients to visit and hold telephone conversations in privacy and send unopened letters to anyone they wish, including judges, lawyers, families, and staff. Although the patient has the right to communicate in an uncensored manner, the staff may limit access to the telephone or visitors when it could harm the patient or be a source of harassment

BOX 8-2 RIGHTS OF PSYCHIATRIC PATIENTS

- Right to communicate with people outside the hospital through correspondence, telephone, and personal visits
- Right to keep clothing and personal effects with them in the hospital
- Right to religious freedom
- Right to be employed if possible
- Right to manage and dispose of property
- Right to execute wills
- Right to enter into contractual relationships
- Right to make purchases
- Right to education
- Right to habeas corpus
- Right to independent psychiatric examination
- Right to civil service status
- Right to retain licenses, privileges, or permits established by law, such as a driver's or professional license
- Right to sue or be sued
- Right to marry and divorce
- Right not to be subject to unnecessary mechanical restraints
- Right to periodic review of status
- Right to legal representation
- Right to privacy
- Right to informed consent
- Right to treatment
- Right to refuse treatment
- Right to treatment in the least restrictive setting

for the staff. The hospital also can limit the times when telephone calls are made and received and when visitors can enter the facility.

Right to Keep Personal Effects

The patient may bring clothing and personal items to the hospital, taking into consideration the amount of storage space available. The hospital is not responsible for their safety, and valuable items should be left at home. If the patient brings something of value to the hospital, the staff should place it in the hospital safe or otherwise provide for safekeeping. The hospital staff is also responsible for maintaining a safe environment and should take dangerous objects away from the patient if necessary.

Critical Reasoning How are patients informed of their rights on your psychiatric unit? Talk to some of the patients and see whether they can recall any of the rights that were explained to them.

Right to Enter into Contractual Relationships

The court considers contracts valid if the person understands the circumstances of the contract and its consequences. A psychiatric illness does not invalidate a contract, although the nature of the contract and degree of judgment needed to understand it are influencing factors.

Critical Reasoning Did you know that many states still have laws on the books that restrict the right of some people with treatable psychiatric illnesses to vote? How do you think such laws perpetuate stigma, prejudice, and discrimination against people with mental illness? Does your state have such laws?

Incompetency. Related to this right is the issue of mental incompetency. Every adult is assumed to be mentally competent, meaning mentally able to carry out personal affairs. To prove otherwise requires a special court hearing to declare an individual incompetent.

Incompetence is a legal term without a precise medical meaning. To prove incompetence in court, all of the following must be shown:

1. **The person has a mental disorder.**
2. **This disorder causes a defect in judgment.**
3. **This defect makes the person incapable of handling personal affairs.**

The psychiatric diagnosis of the person is not important. If a person is declared incompetent, the court will appoint a legal guardian to manage affairs. This often is a family member, friend, or bank executive. Incompetency rulings are most often filed for people with senile dementia, cerebral arteriosclerosis, chronic schizophrenia, and mental retardation.

If ruled incompetent, a person cannot vote, marry, drive, or make contracts. A release from the hospital does not necessarily restore competency. Another court hearing is required to reverse the previous ruling before the person can once again manage private affairs.

Critical Reasoning How is education provided for emotionally ill children living in your community? Are they mainstreamed into the school system, given special educational resources, or both?

Right to Education

Many parents exercise the right to education on behalf of their emotionally ill or mentally retarded children. The U.S. Constitution guarantees this right to everyone, although many states have not provided adequate education to all citizens in the past and are now required to do so.

Critical Reasoning How is the right to education honored in a children's psychiatric inpatient setting? How does this compare with the education provided children in a pediatric hospital?

Right to Habeas Corpus

Habeas corpus is an important constitutional right for all patients. **It provides for the speedy release of any person who claims to be detained illegally.** A committed patient

may file a writ at any time on the grounds of being sane and eligible for release. The hearing takes place in court, where those who wish to restrain the patient must defend their actions. Patients are discharged if they are judged to be sane.

Right to Privacy

The right to privacy implies the person's right to keep some personal information completely secret or confidential. Confidentiality means not disclosing information about a person to someone else unless authorized by that person. **Every psychiatric professional is responsible for protecting a patient's right to confidentiality, including even the knowledge that a person is in treatment or in a hospital.** Revealing such information might result in damage to the patient. The protection of the law applies to all patients.

Clinicians are free from legal responsibility if they release information after they obtain the patient's written and signed consent. It should be made a part of the patient's permanent record. As a rule it is best to reveal as little information as possible and discuss with the patient what will be released.

Confidentiality builds on the element of trust necessary in a patient-clinician relationship. Patients place themselves in the care of others and reveal vulnerable aspects of their personal life. In return, they expect high-quality care and the protection of their interests. Thus the patient-clinician relationship is an intimate one that demands trust, loyalty, and privacy.

> **Critical Reasoning** One of the adolescent girls on your unit runs away while going to the hospital cafeteria. When you speak to the girl's mother to let her know what has happened, the mother asks you to call the radio and television stations and have them announce it so that the girl can be found. How would you respond to this request?

HIPAA. Many agencies require information about a patient's history, diagnosis, treatment, and prognosis, and methods for obtaining information through computer systems have been developed. These methods threaten the individual's right to privacy and, in part, contributed to the passage of the Health Insurance Portability and Accountability Act (HIPAA) in 2003.

HIPAA provides patients with access to their medical records and gives patients more control over how their personal health information is used and disclosed. It guarantees patients four rights related to the release of information:

1. **To be educated about HIPAA privacy protection**
2. **To have access to their own medical records**
3. **To request correction or amendment of their health information to which they object**
4. **To require their permission for disclosure of their own personal information**

Many treatment facilities keep psychiatric records separately so that they are less accessible than medical records. The law and psychiatric professionals view them as more sensitive than medical records. If a patient requests access to personal records, the clinician should explore the reasons for the request, prepare the patient for the review, and be present with the patient to discuss any questions the patient might have.

The clinician must not alter or destroy any part of the record. The physical record itself is the property of the treatment facility or therapist, but the information contained in the record belongs to the patient. **Thus the original record should never be given to the patient; only a copy of it should be provided.** A patient's record or chart can be brought into court and its contents used in a lawsuit because privilege does not apply to records or charts.

Privileged Communication. The legal term **privilege** or, more accurately, testimonial privilege, applies only in court-related proceedings. It includes communications between husband and wife, attorney and client, and clergy and church member. The right to reveal information belongs to the person who spoke, and the listener cannot disclose the information unless the speaker gives permission. This right protects the patient, who could sue the listener for disclosing privileged information.

Testimonial privilege between health professionals and patients exists only if established by law. It varies greatly among professions, even within the same state. A minority of the states allow privilege between nurses and patients. Nurses also may be covered in states that have adopted privileges between psychotherapists and patients.

> **Critical Reasoning** What is the law in your state regarding testimonial privilege between nurses and patients? How would you change the law if it does not include nurses?

Circle of Confidentiality. The circle of confidentiality is shown in Figure 8-3. Within the circle, patient information may be shared. Those outside the circle require the patient's permission to receive information. Within the circle are treatment team members, staff supervisors, health care students and their faculty (only if they are working with the patient), and consultants who actually see the patient. All these people

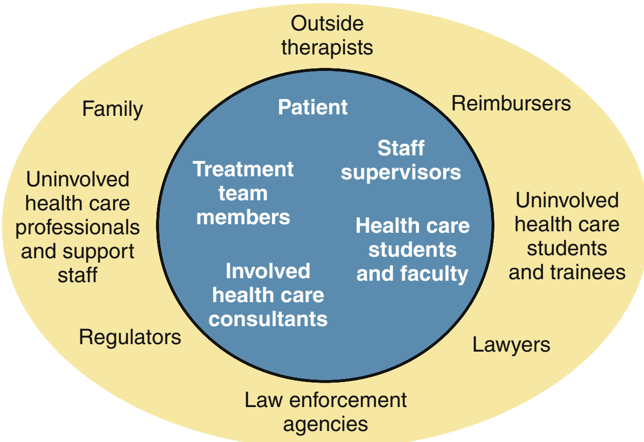

FIG 8-3 The circle of confidentiality.

must be informed about the patient's clinical condition to be able to help. The patient also is inside the circle because they can reveal any aspect of their lives, problems, treatments, and experiences to anyone.

Many people are outside the circle, and the nurse must carefully consider these relationships. For example, family members of adult patients are not automatically entitled to clinical information about the patient. Although nurses may wish to engage the family in a therapeutic alliance, it is equally important to remember that information about the patient belongs to the patient. The nurse should first discuss with the patient the benefits of involving the family in the treatment process and obtain clear consent from the patient before doing so. This may create uncomfortable situations for the nurse who is pressured by a family to reveal patient information, but it is a critical aspect of patient confidentiality and the nurse-patient relationship.

Legal representatives, outside or previous therapists, reimbursers or insurance companies, students, health care professionals and support staff not directly involved in the care of the patient, and the police or other law enforcement or regulatory agencies are outside the circle of patient confidentiality. A signed written consent from the patient is required to release information to any of these parties. However, in some situations breaching confidentiality and testimonial privilege is both ethical and legal. These exceptions are listed in Box 8-3.

Critical Reasoning The parents of one of your patients ask for information about their adult son. The patient has been very specific about not wanting to see his family and not wanting them to know anything about his treatment. How would you respond?

Protecting a Third Party. Another aspect of confidentiality and privilege stems from the case of *Tarasoff v Regents of the University of California et al* (1974). In this case the psychotherapist did not warn Tatiana Tarasoff or her parents that his patient had stated he intended to kill Tatiana. In the lawsuit that followed Tatiana Tarasoff's death, California's Supreme Court decided that the treating therapist had a duty to warn the intended victim of his patient's violence.

When a therapist is reasonably certain that a patient is going to harm someone, the therapist has the responsibility to breach the confidentiality of the relationship and warn or protect the potential victim. Courts have extended the Tarasoff duty to include mental health paraprofessionals and a duty to protect property as well as persons.

Right to Informed Consent

The goal of informed consent is to help patients make better decisions. Informed consent means that a clinician must give the patient a certain amount of information about the proposed treatment and must obtain the patient's consent, which must be informed, competent, and voluntary. The clinician should explain the treatment and possible complications and risks.

The information to be disclosed in obtaining informed consent is listed in Box 8-4. The patient must be able to consent and not be a minor or judged legally incompetent.

Informed consent allows patients and clinicians to become partners in the treatment process and respects patients' autonomy, needs, and values. Even if a patient is psychotic, the clinician must still attempt to obtain informed consent for treatment. Psychosis does not necessarily mean that a person is unable to consent to treatment, and many psychotic patients are capable of giving informed consent (Hamann et al, 2005; Yanos et al, 2009). For patients not able to consent and for minors, informed consent should be obtained from a substitute decision maker. The clinician should adhere to the **principles of informing** listed in Box 8-4.

Consent forms usually require the signature of the patient, a family member, and two witnesses. Nurses are often asked to be witnesses. The form then becomes part of the patient's permanent record. **Informed consent should be obtained for all psychiatric treatments, including medication, particularly antipsychotics; somatic therapies, such as electroconvulsive therapy (ECT); and experimental treatments.**

Critical Reasoning How is informed consent obtained in your psychiatric treatment setting? Ask to observe this process, and evaluate it based on the criteria listed in Box 8-4.

Right to Treatment

Early court cases extended the right to treatment to all mentally ill and mentally retarded people who were involuntarily hospitalized. The courts defined three criteria for adequate treatment:

1. **A humane psychological and physical environment**
2. **A qualified staff with a sufficient number of members to administer adequate treatment**
3. **Individualized treatment plans**

BOX 8-3 EXCEPTIONS ALLOWING THE RELEASE OF INFORMATION WITHOUT THE PATIENT'S CONSENT

- Emergency situations when acting in the patient's best interests
- Court-ordered evaluations or reports
- If the patient is incompetent and consent is obtained from a guardian or is not available
- Commitment proceedings
- Criminal proceedings
- Acting to protect third parties
- Child custody disputes
- Reports required by state law (contagious diseases, gunshot wounds, child abuse)
- Patient-litigant exceptions
- Child abuse proceedings

BOX 8-4 OBTAINING INFORMED CONSENT

Information to Disclose

Diagnosis

Description of the patient's problem

Treatment

Nature and purpose of the proposed treatment

Consequences

Risks and benefits of the proposed treatment, including physical and psychological effects, costs, and potential resulting problems

Alternatives

Viable alternatives to the proposed treatment and their risks and benefits

Prognosis

Expected outcome with treatment, with alternative treatments, and without treatment

Principles of Informing

- Assess the patient's ability to give informed consent.
- Simplify the language so that a layperson can understand.
- Offer opportunities for the patient and family to ask questions.
- Test the patient's level of understanding after the explanation.
- Reeducate as often as needed.
- Document all relevant factors, including what was disclosed, the patient's level of understanding, competency, voluntary agreement to treatment, and the actual consent.

Most important is the requirement for an individualized treatment plan. Failure to provide it means that the patient must be discharged unless agreeing to stay voluntarily.

The right to treatment is not a guarantee of treatment for all patients. It applies only to involuntary or committed patients. In addition, the right to treatment identifies minimal treatment standards, not optimal treatment. It does not guarantee that adequate treatment occurs, and it does not require that a range of treatments be available (one treatment choice is adequate). Thus although much has been gained through this legislation, much remains to be done.

Right to Refuse Treatment

The relationship between the right to treatment and the right to refuse treatment is complex. The right to refuse treatment includes the right to refuse involuntary hospitalization. It has been called the right to be left alone.

Some people believe that therapy can control a person's mind, regulate thoughts, and change personality, and the right to refuse treatment protects the patient. This argument states that involuntary therapy conflicts with two basic legal rights: freedom of thought and the right to control one's life and actions as long as they do not interfere with the rights of others.

Forcing Medications. Patients may refuse medication for many reasons. Symptoms such as delusions and denial may cause the refusal, and patients who refuse medication are often sicker than those who comply. Nurses should judge each situation on a case-by-case basis. Criteria that may justify coerced treatment are as follows:

- The patient must be judged to be dangerous to self or others.
- It must be believed by those administering treatment that it has a reasonable chance of benefiting the patient.
- The patient must be judged to be incompetent to evaluate the necessity of the treatment.

Even if these three conditions are met, the patient should not be deceived but should be informed regarding what will be done, the reasons for it, and its probable effects.

Critical Reasoning Is the refusal of treatment the same as noncompliance? If not, how would you distinguish between them, and what nursing intervention would be most appropriate for each?

Nurses are often on the front line in dealing with patients who refuse treatments and medications. Voluntary patients have the right to refuse any treatment and should not be forcibly medicated except in exceptional situations when the patient is actively violent to self or others and when all less restrictive means have been unsuccessful. The behavior of the patient should be clearly documented and all interventions recorded.

Nurses must know the guidelines identified by the courts and the legislature in the state in which they practice to administer medication properly to involuntarily committed patients. Some questions that can help guide the nurse's decision are as follows:

- Has the patient been given a psychiatric diagnosis?
- Is the treatment consistent with the diagnosis?
- Is there a set of defined target symptoms?
- Has the patient been informed about the treatment outcome and side effects?
- Have medical and nursing assessments been completed?
- Are therapeutic effects of treatment being monitored?
- Are side effects being monitored?
- Is the patient overmedicated or undermedicated?
- Is drug therapy being changed too quickly?
- Are prn (pro re nata, when required) and stat doses being used too often?
- Is drug therapy being prescribed for an indefinite period of time?

Finally, it is important for the nurse to remember that a therapeutic nurse-patient relationship is critical in working with a patient who refuses to take medication. **A positive, caring relationship between the nurse and patient can play a vital role in reversing treatment refusal.**

Critical Reasoning Imagine that your mother was admitted to a psychiatric hospital in need of treatment. Once there, however, she refused to take any medication. How would you feel if the staff forced medication on her? How would you feel if they honored her right to refuse treatment? What could you do to help your mother get the treatment she needed?

Right to Treatment in the Least Restrictive Setting

The right to treatment in the least restrictive setting is closely related to the right to adequate treatment. **Its goal is evaluating the needs of each patient and maintaining the greatest amount of personal freedom, autonomy, dignity, and integrity in determining treatment**. This right applies to both hospital-based and community programs.

Another consideration in the right to the least restrictive alternative is that it applies not only to when a person should be hospitalized but also to how a person receives care. It requires that a patient's progress be carefully monitored so that treatment plans are changed based on the patient's current condition.

Issues related to the use of **seclusion** and **restraints** are of particular concern. There must be adequate rationale for the use of these practices. Documentation should include a description of the event that led to seclusion or restraint; alternatives attempted or considered; the patient's behavior while secluded or restrained, nursing interventions, and ongoing evaluation of the patient. It is important to remember that seclusion and restraint must be therapeutically indicated and justified (Chapter 28).

Restriction has two aspects: (1) the nature of the choices being restricted and (2) the method by which choices are restricted. Box 8-5 presents a hierarchy of restrictiveness that proceeds from the most restrictive to the least restrictive.

Critical Reasoning Which do you think is more restrictive—to be living in the community while being actively psychotic or to be involuntarily committed to a psychiatric hospital for treatment?

Ethical Considerations

Ensuring patients' rights is often complicated by ethical considerations. For example, consider the element of power. In the psychiatric setting the nurse can function in many roles, from a custodial "keeper of the keys" to a skilled therapist. Each of these roles includes a certain amount of power because all nurses have the ability to influence the patient's treatment and serve as the major source of information regarding a patient's behavior.

This is particularly true in inpatient settings, in which a nurse and patient spend more time together and the nursing staff is the only group to work a 24-hour day. Nurses also participate in team meetings, individual and group psychotherapy, and behavior change programs. Finally, nurses can greatly influence decisions about patient medications, such as type, dosage, and frequency.

Many ethical dilemmas arise from health care professionals' paternalistic attitude toward patients. **Paternalism** or **maternalism** can be defined as deciding what is best for another person without consideration of the person's thoughts, feelings, or preferences. It occurs when something is done "for the patient's own good" even though the patient may disagree with the action. This attitude reduces adult patients to the status of children and interferes with their freedom of action.

An example of this is seen in a study of patients' and staff members' attitudes about the rights of hospitalized psychiatric patients. The most consistent finding of the study was that staff members were more likely to express the view that patients' rights should be compromised if they conflicted with what the staff perceived to be a clinical need (Roe et al, 2002).

The right to treatment also poses several ethical questions. One deals with the untreatable patient. Should such a patient be released after a certain length of time? Another problem is the unwilling patient. Might a person refuse treatment and then seek release, claiming that the right to adequate treatment was denied?

Ethical dilemmas also arise in considering the right to refuse treatment. Does the right apply to all treatments, including medications, or only to those that are hazardous, intrusive, or severe? How can staff meet their obligation for the right to treatment when a patient refuses to be treated? How can refusal, resisting treatment, and noncompliance be differentiated, and does each of these require a different response?

Finally, the right to treatment in the least restrictive setting raises a number of difficult questions. How do mental health professionals balance human rights with the human needs of patients? Are sufficient funds available to provide adequate supportive care in the community? Can community centers provide better care than institutions? How can one deal with community resistance to local placement of mentally ill

BOX 8-5 HIERARCHY OF RESTRICTIVENESS

1. Body movement, for example, four-point restraint (hands and feet)
2. Movement in space, for example, seclusion rooms, restriction to the unit
3. Decisions of daily life, for example, selection of food or a television program, the choice of when or where to smoke or with whom to socialize
4. Meaningful activities, for example, participation in treatment, access to work
5. Treatment choice, for example, court-mandated treatment, unwanted social interventions
6. Control of resources, for example, use of money
7. Emotional or verbal expression, for example, censorship, discouraging personal expression

From Olsen DP: *J Clin Ethics* 9:235, 1998.

patients? And most important, given economic constraints, how can limited resources be used wisely to provide a full range of needed mental health services?

PSYCHIATRY AND CRIMINAL RESPONSIBILITY

The determination of criminal responsibility concerns the accused person's condition when the crime was committed. It has received much public attention as the "insanity defense." It proposes that a person who has committed an act usually considered criminal is not guilty by reason of "insanity." It has been estimated that a successful insanity defense occurs in fewer than 1% of all criminal prosecutions because proving the state of another person's mind is quite difficult.

The "insanity" defense is based on the humanitarian rationale that people should not be blamed for crimes if they did not know what they were doing or could not help themselves. A more recent change is the movement away from using the defense "not guilty by reason of insanity" (NGBI) to the more recent "guilty but mentally ill" (GBMI). In addition, five states—Montana, Idaho, Nevada, Utah, and Kansas—have abolished the insanity defense completely.

Three sets of criteria are used in the United States to determine the criminal responsibility of an offender who is mentally ill: the M'Naghten Rule, the Irresistible Impulse Test, and the American Law Institute's Test (Table 8-3). The M'Naghten Rule is used in 24 states; the American Law Institute's Test is used in 19 states. Texas used the M'Naghten Rule when Andrea Yates, who drowned her five children in a bathtub, was first found guilty and convicted, because the jury believed that Andrea knew her actions were wrong. She was later retried and acquitted by reason of insanity.

Disposition of Mentally Ill Offenders

Those found not guilty by reason of insanity (NGBI) are rarely set free. In some states they may be committed at the court's discretion, and in almost one third of the states they are automatically hospitalized. Some offenders are treated in special hospitals, others are sent to state mental hospitals, and still others go to prison treatment facilities. Those found guilty but mentally ill (GBMI) are never freed.

Because the insanity defense is used most often in capital offenses, it is usually better to send the offender to a place with good security, and penal institutions or maximum security forensic psychiatric hospitals are the best option. After hospitalization and recovery, the court that ordered the commitment may discharge the patient. In other states the governor may discharge the patient. Still others allow the mental institution to make that decision. The major criteria for discharge are that the patient is not likely to repeat the offense and that it is safe to release the patient into the community.

> **Critical Reasoning** Do you believe in the legal defenses of NGBI and GBMI? What are the pros and cons of each insanity defense?

LEGAL ROLE OF THE NURSE

Professional nursing practice is not determined by simply following patients' rights. Rather, it is an interplay among the rights of patients, the legal role of the nurse, and concern for quality psychiatric care. The psychiatric nurse as provider performs three roles while completing professional and personal responsibilities: provider of services, employee or contractor of services, and private citizen (Figure 8-4). These roles are fulfilled simultaneously, and each carries certain rights and responsibilities.

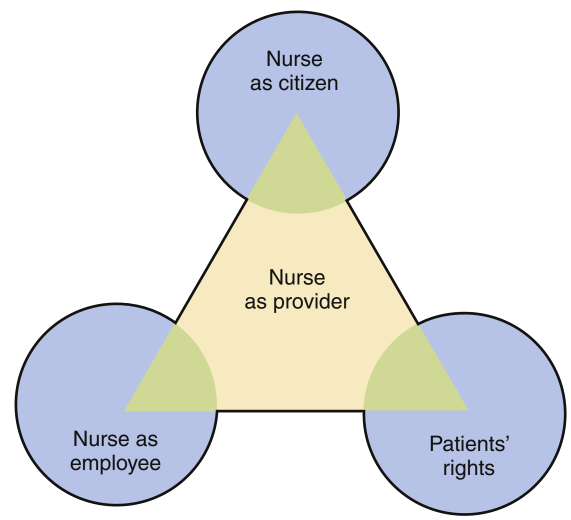

FIG 8-4 Legal influences on psychiatric nursing practice.

TABLE 8-3 THREE SETS OF CRITERIA USED TO DETERMINE THE CRIMINAL RESPONSIBILITY OF A MENTALLY ILL OFFENDER

NAME OF TEST	CRITERIA
M'Naghten Rule	The person did not know the nature and quality of the act. The person did not know that the act was wrong.
Irresistible Impulse Test	The person is impulsively driven to commit the criminal act with lack of premeditation and a strong urge to do so. This test is typically used with the M'Naghten Rule.
American Law Institute's Test	The person lacks the capacity to appreciate the wrongfulness of an act or to conform conduct to the requirements of the law.

Nurse as Provider

Malpractice. All psychiatric professionals have legally defined duties of care and are responsible for their own work. If these duties are violated, malpractice exists. Malpractice involves the failure of professionals to provide the proper and competent care that is warranted by members of their profession, a failure that results in harm to the patient (Reising and Allen, 2007). **All nurses are held to national standards of care.**

Most malpractice claims are filed under the law of **negligent tort.** A tort is a civil wrong for which the injured party is entitled to compensation. Under the law individuals are responsible for their own torts, so each nurse can be held responsible in malpractice claims. For this reason all nurses should carry malpractice liability insurance. Under the law of negligent tort, the plaintiff must prove the following:

- **A legal duty of care existed.**
- **The nurse performed the duty negligently.**
- **Damages were suffered by the plaintiff as a result.**
- **The damages were substantial.**

When patients are admitted to a psychiatric hospital, the problems of litigation in connection with their care are varied.

Litigation. Lawsuits alleging malpractice in psychiatric diagnosis or treatment are increasing. Some of the more common sources of malpractice suits are listed in Box 8-6. Lawsuits against nurses can occur when the nurse errs while acting either dependently or independently.

The most common causes of malpractice suits against psychiatric nurses are negligence in preventing a suicide and while assisting in ECT. Other causes for malpractice suits against nurses include patient falls, failing to follow physician orders or established protocols, medication errors, improper use of equipment, inadequate discharge planning, failure to remove foreign objects, failure to provide sufficient monitoring, and failure to communicate. Box 8-7 describes three cases involving psychiatric nurses.

Legal Responsibilities. The nurse is responsible for reporting pertinent information to co-workers involved in the patient's care. The degree of nursing care depends on the patient's condition, with seriously ill patients demanding a higher degree of care to protect them from injury and self-destruction.

The nurse should record all patient and family education, such as explaining the food precautions needed when

BOX 8-6 COMMON AREAS OF LIABILITY IN PSYCHIATRIC SERVICES

- Sexual contact with a patient
- Patient suicide
- Failure to diagnose
- Problems related to electroconvulsive therapy
- Misuse of psychoactive prescription drugs
- Breach of confidentiality
- Failure to refer a patient
- Failure to obtain informed consent
- Inadequate supervision of trainees and employees
- Failure to warn potential victims
- Failure to report abuse

BOX 8-7 SELECTED LITIGATION INVOLVING PSYCHIATRIC NURSES

Case 1: Valentine v Strange (597 F. SUPP. 1316-VA.)

Problem: Nurses were sued when psychiatric patient set self on fire.

Facts: Despite two previous attempts to burn herself, the health care providers permitted the patient to keep her cigarettes and lighter. Patient subsequently set fire to her clothing and suffered third-degree burns.

Legal lesson: The failure of health care professionals to take precautions in the face of imminent danger to the life of an involuntarily committed patient constitutes a violation of liberty interests protected by the due process clause of the Fourteenth Amendment.

Case 2: Delicata v Bourlesses (404 N.E. 2ND 667-MASS.)

Problem: Nursing psychiatric assessment disagreed with the psychologist's assessment.

Facts: A nursing assessment indicated that a depressed patient should be closely supervised as being potentially suicidal. An evaluation by the staff psychologist advised that suicidal precautions were not necessary. The patient subsequently killed herself in a locked bathroom.

Legal lesson: Medical orders by a staff psychiatrist or an evaluation by a staff psychologist must be questioned when there is a change or deterioration in a patient's condition. Nursing assessments should include the evaluation of such changes in the patient's apparent physical and psychological condition. The responsibility of nursing assessment includes the necessity for making appropriate nursing judgments and implementing nursing actions based on these nursing assessments.

Case 3: Vattimo v Lower Bucks Hospital (428 A. 2ND 765-PA.)

Problem: Patient required restraint and supervision by psychiatric nurses.

Facts: A patient with a psychotic fascination with fire set fire to his hospital room, resulting in the death of the other occupant. The patient had been diagnosed as a paranoid schizophrenic, and staff had been warned of his preoccupation with fire.

Legal lesson: The hospital was required to exercise reasonable care under the circumstances, that is, to restrain, supervise, and protect mentally ill patients.

taking monoamine oxidase inhibitor (MAOI) medication. Such a note would provide a good defense against a possible lawsuit if the patient were to violate dietary restrictions and become ill.

A psychiatric nurse can follow a number of preventive measures to avoid possible lawsuits:

- Implement nursing care that meets the *Psychiatric–Mental Health Nursing: Scope and Standards of Practice* as described by the American Nurses Association (2007) (Chapter 11).
- Know the pertinent laws of the specific state in which the nurse practices, including the rights and duties of the nurse and the rights of the patients.
- Stay current with advances and new knowledge in the field.
- Keep accurate and concise nursing records.
- Maintain the confidentiality of patient information.
- Maintain current malpractice liability insurance coverage.
- Consult a lawyer if any questions arise.

Nurse as Employee

The role of the nurse as employee involves the practitioner's rights and responsibilities in relation to employers, partners, consultants, and other professional colleagues. These are the basis of the nurse's economic security, professional future, and peer relationships.

As employees, nurses have the responsibility to supervise and evaluate those under their authority for the quality of care given. They also must observe their employer's rights and responsibilities to patients and other employees, fulfill the obligations of the contracted service, inform the employer of circumstances and conditions that impair the quality of care, and report negligent care by others. This includes the legal duty to communicate any concerns about other nurses and other mental health providers.

Critical Reasoning You have seen a colleague sexually touching a patient on the unit. What should you do based on your legal, ethical, and professional obligations?

In return, nurses can expect certain rights from their employer. These include consideration for service, adequate working conditions, adequate and qualified assistance when necessary, documented grievance procedures, and the right to respect all their other rights and responsibilities.

Critical Reasoning You arrive for work one morning and are told that you and an aide are the only staff assigned to work the day shift on a 25-bed closed acute psychiatric unit. Based on your legal roles, rights, and responsibilities, how should you respond?

Nurse as Citizen

The third role that the nurse plays is that of citizen. This role is significant because all other roles, rights, responsibilities, and privileges are based on the inherent rights of U.S. citizenship: civil rights, property rights, right to protection from harm, right to a good name, and right to due process.

These rights form the foundation for the nurse's other legal relationships. Unfortunately, the best interests of the patient, nurse, and employer do not always coincide. Conflict can occur when, for example, the nurse's right to live and work without threat to personal security is violated by a patient who harms the nurse, as is evident in the following clinical example.

CLINICAL EXAMPLE

A psychotic patient who has hallucinations that are adequately controlled with psychotropic medications but who refuses to take them was recently admitted to a locked psychiatric unit. Before intervening the staff considered the following possibilities:

- Failing to medicate may deny the patient's right to treatment.
- Failing to medicate the patient could have harmful side effects, such as the unnecessary and possibly irreversible continuation of illness.
- Failing to medicate the patient may lead to a psychotic episode and result in injury to self, other patients, or the staff.
- Failing to medicate the patient may lead to a psychotic episode but no violence.
- Medicating the patient in the absence of an emergency situation and without a clear threat of violence violates the patient's right to refuse treatment.

The staff decided not to medicate the patient. When the night nurse checked on the patient in his room that evening, he struck the nurse in the face, resulting in severe bruises and the loss of several teeth. This development leads to new questions:

- Was the patient competent and legally liable for his actions?
- What were the circumstances of the incident?
- Was the nurse sufficiently aware of the potential hazard, and, if so, was she responsible for assuming the risk?
- Was staffing adequate to discourage, respond to, and control a potentially violent situation?
- Was there a provision in the unit for potentially violent patients, and, if so, why was it not used for this patient?
- Was the nurse able to sue the patient for assault and battery?

Obviously, there are no simple solutions to such clinical dilemmas, yet they are very real. The best answer may be to focus on prevention. This requires knowledge of legislation, rights, responsibilities, and potential conflicts.

In addition, professional nursing judgment requires examining the ethical context of nursing care, the possible consequences of nurses' actions, and practical alternatives. Only then do rights and responsibilities become meaningful.

CHAPTER IN REVIEW

- The legal and ethical context of care is important for all psychiatric nurses because it focuses concern on the rights of patients and the quality of care they receive.
- An ethic is a standard of behavior or a belief valued by an individual or group. An ethical dilemma exists when moral claims conflict with one another. Ethical dilemmas unique to psychiatric nursing often fall under the umbrella issue of behavior control.
- The two types of admission to a psychiatric hospital are voluntary and involuntary commitment. Voluntary admission indicates that the patient acknowledges problems in living, seeks help in coping with them, and will probably actively participate in finding solutions.
- Involuntary admission or commitment means that the patient did not request hospitalization and may have opposed it or was indecisive and did not resist it. Most laws permit commitment of the mentally ill on the following three grounds: dangerous to self or others, mentally ill and in need of treatment, and unable to provide for own basic needs.
- Most mentally ill people are not dangerous to themselves or others. People with mental illness who may be more dangerous include those with a history of violent behavior, psychosis, noncompliance with medications, current substance abuse, and antisocial personality disorder.
- The patient who is voluntarily admitted to the hospital can leave at any time. An involuntarily committed patient has lost the right to leave the hospital as desired.
- Outpatient commitment is the process by which the courts can order patients committed to a course of outpatient treatment specified by their clinicians.
- Psychiatric patients have many personal and civil rights. They should be informed of these rights, and hospitals must honor them.
- The right to communication allows patients to visit and hold telephone conversations in privacy and send unopened letters to anyone of their choice, including judges, lawyers, families, and staff.
- The patient may bring clothing and personal items to the hospital, taking into consideration the amount of storage space available. The hospital is not responsible for their safety, and valuable items should be left at home.
- Incompetence is a legal term and not a medical term. To prove incompetence in court, it must be shown that the person has a mental disorder; this disorder causes a defect in judgment; and this defect makes the person incapable of handling personal affairs.
- All emotionally ill or mentally retarded children have the right to education.
- Habeas corpus is an important constitutional right that provides for the speedy release of any person who claims to be detained illegally.
- Every psychiatric professional is responsible for protecting a patient's right to confidentiality, including even the knowledge that a person is in treatment or in a hospital.
- HIPAA provides patients with access to their medical records and more control over how their personal health information is used and disclosed. The physical record itself is the property of the treatment facility or therapist, but the information contained in the record belongs to the patient.
- Testimonial privilege between health professionals and patients exists only if established by law. It varies greatly among professions, even within the same state. A minority of the states allow privilege between nurses and patients.
- When a therapist is reasonably certain that a patient is going to harm someone, the therapist has the responsibility to breach the confidentiality of the relationship and warn or protect the potential victim.
- Informed consent means that a clinician must give the patient a certain amount of information about the proposed treatment and must obtain the patient's consent, which must be informed, competent, and voluntary. It should be obtained for all psychiatric treatments, including medication, somatic therapies, and experimental treatments.
- In determining the right to treatment, the courts defined three criteria for adequate treatment: a humane psychological and physical environment, a qualified staff with a sufficient number of members to administer adequate treatment, and individualized treatment plans.
- The right to refuse treatment includes the right to refuse involuntary hospitalization.
- The goal of the right to treatment in the least restrictive setting is to evaluate the needs of each patient and maintain the greatest amount of personal freedom, autonomy, dignity, and integrity in determining treatment. This right applies to both hospital-based and community programs.
- The most important factors in ensuring patients' rights are the attitude, knowledge, and commitment of the health care provider.
- Three sets of criteria are used in the United States to determine the criminal responsibility of an offender who is mentally ill: the M'Naghten Rule, the Irresistible Impulse Test, and the American Law Institute's Test.
- The psychiatric nurse has three roles in performing professional and personal duties: provider of services, employee or contractor of services, and private citizen.
- Malpractice involves the failure of professionals to provide the proper and competent care that is given by members of their profession, resulting in harm to the patient.

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CHAPTER

9

Policy and Advocacy in Mental Health Care

Mona Shattell and Gail Stuart

I do not want to talk about what you understand about this world.
I want to know what you will do about it.
I do not want to know what you hope.
I want to know what you will work for.
I do not want your sympathy for the needs of humanity.
I want your muscle.

Robert Fulghum

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the need for mental health care from global and national perspectives.
2. Examine policy and legislation related to mental health and substance use services including access to care, parity, and protection of patients' rights.
3. Evaluate areas for mental health advocacy.
4. Implement advocacy strategies to improve mental health care.

Policy affects every aspect of a person's life and wellbeing, including the way a society organizes its health care system, how it finances it, the priorities of care it establishes, and the resources it makes available to individuals, families, and communities to promote and preserve health. The best interventions are of little benefit to patients if they cannot gain access to them.

Nowhere is this more important than in the area of mental health care. Each day, policies shape, support, challenge, and block how well the mental health care needs of individuals, families, and communities are met. **Competent psychiatric nurses need to understand mental health policies and the advocacy role they can play in the broader mental health care environment.**

A COMPELLING NEED

The Global View

Mental illnesses are significant worldwide health problems. **The World Health Organization's (WHO) global burden of disease study revealed that mental disorders are the second most disabling category of illnesses around the world** (Murray & Lopez, 1996). The study compared a range of physical and mental disorders to determine their contribution to the overall burden of disease. The data showed the following:

- Depression was the number one psychiatric cause of disability in the world.

- Four other psychiatric disorders were among the top 10: alcohol abuse, bipolar disorder, schizophrenia, and obsessive-compulsive disorder.
- Depression ranked second in the United States as a cause of disability.
- Depression was projected to rank second in the world as a cause of disability by 2020.

This study raised a global awareness of the impact that mental illnesses have on the everyday lives of people around the world.

The National View

In 2009 there were an estimated 20%, or 45 million, adults ages 18 or older in the United States with any mental illness in the past year. The percentage having serious mental illness in the past year was about 5%, or 11 million adults (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010).

Unfortunately, many of these persons never receive treatment. Barriers to receiving mental health care are presented in Figure 9-1. For individuals with mental illness who received treatment, 20% quit before completing treatment recommendations (Olfson et al, 2009). Yet untreated and mistreated mental illness costs American business, government, and taxpayers an estimated $113 billion each year.

Critical Reasoning Given that mental illness is so prevalent, why do you think there are so many barriers to adequate and appropriate mental health care?

Four important reports released in the United States are having an impact on the delivery of mental health care. The most recent is *Healthy People 2020,* which identifies a list of leading health indicators that reflect the major public health concerns in the United States (U.S. Department of Health and Human Services [USDHHS], 2010). Those related to mental health include tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, and access to health care.

For each of the leading health indicators, specific objectives derived from *Healthy People 2020* have been identified. The objectives related to mental health are presented in Box 9-1, providing a snapshot of the mental health issues in the United States.

The second national report is *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (Institute of Medicine [IOM], 2006). This report describes a multifaceted and comprehensive strategy for ensuring access, improving quality, and expanding mental health and substance abuse treatment services.

The third was the report from the New Freedom Commission on Mental Health (NFCMH), *Achieving the Promise: Transforming Mental Health Care in America* (NFCMH, 2003). The commission was formed to address the problems in the mental health service delivery system that allow Americans to fall through the system's "cracks."

Critical Reasoning Why are the "cracks" in the mental health care system so large and what can be done to narrow them?

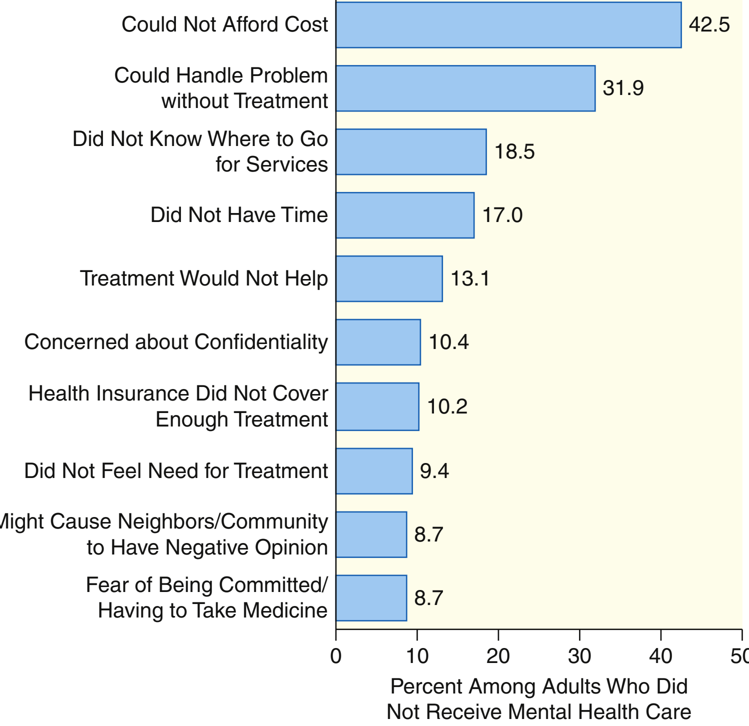


FIG 9-1 Reasons for not seeking treatment. (From Substance Abuse and Mental Health Services Administration: *Results from the 2009 national survey on drug use and health: mental health findings,* Series H-39, HHS Pub. No. SMA 10-4609, Rockville, Md, 2010, Office of Applied Studies, NSDUH.)

The commission found that the current system is unintentionally focused on managing disabilities associated with mental illness rather than promoting recovery. This is because of fragmentation, gaps in care, and uneven quality in mental health services. **The commission thus recommended a focus on promoting recovery and building resilience—the ability to withstand stresses and life challenges** (Chapters 12 and 14).

Six goals and a series of recommendations for federal agencies, states, communities, and providers nationwide were identified. These are listed in Box 9-2.

The fourth report, published in 1999, was the first issued by a U.S. surgeon general on the topic of mental health and mental illness, *Mental Health: A Report of the Surgeon General* (USDHHS, 1999). This landmark document concluded the following:

- **Mental health is fundamental to health.**
- **Mental disorders are real health conditions that have an immense impact on individuals and families.**
- **The efficacy of mental health treatments is well documented.**
- **A range of treatments exists for most mental disorders.**
- **People should seek help if they have a mental health problem or think that they have symptoms of a mental disorder.**

These studies and reports underscore the critical importance of mental health care, and through improved policies and legislation, they help advocate for a more effective and efficient mental health delivery system.

BOX 9-1 *HEALTHY PEOPLE 2020—* OBJECTIVES RELATED TO MENTAL HEALTH AND MENTAL ILLNESS

Mental Health Status Improvement

- Reduce the suicide rate.
- Reduce suicide attempts by adolescents.
- Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight.
- Reduce the proportion of persons who experience major depressive episodes (MDEs).

Treatment Expansion

- Increase the proportion of primary care facilities that provide mental health treatment on-site or by paid referral.
- Increase the proportion of children with mental health problems who receive treatment.
- Increase the proportion of juvenile residential facilities that screen admissions for mental health problems.
- Increase the proportion of persons with serious mental illness (SMI) who are employed.
- Increase the proportion of adults with mental disorders who receive treatment.
- Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.
- Increase depression screening by primary care providers.
- Increase the proportion of primary care physician office visits that screen adults ages 19 years and older for depression.
- Increase the proportion of homeless adults with mental health problems who receive mental health services.

Retrieved July 2011 from www.healthypeople.gov/2020/topicsobjectives2020/.

POLICY AND LEGISLATION

Access is the degree to which services and information about health care are easily obtained. It is a critically important part of an effective mental health care delivery system. An ideal comprehensive health care system would provide the full array of high-quality, community-based, culturally and linguistically competent, integrated mental health and substance abuse services, regardless of ability to pay, including access to the full range of the most effective medications and treatments. It would have multiple points of entry for treatment, including direct access through self-referral, by a wide variety of providers.

Currently, two thirds of the people who seek mental health care are treated by primary care providers (Chapter 34). However, many who need care do not receive it, from either a primary care or a specialty provider. The major reason for not receiving treatment is cost. Unmet needs for treatment are greatest in traditionally underserved groups, including the elderly, racial and ethnic minorities, those with low incomes, those without insurance, and residents of rural areas (Giled and Frank, 2009; Garfield et al, 2011).

When access to mental health care is made difficult, the overall costs of general medical care increase because those with behavioral health problems are frequent users of medical services. For example, people with panic disorder typically are seen by 10 different medical care providers before they are properly diagnosed.

Some access problems apply to the entire health care system, such as the lack of providers in rural areas and the absence of care for people who lack health insurance. Other problems are unique to mental health care. These include the stigma associated with seeking care, the lack of knowledge about how to find the right clinician for a highly personal problem, and the shortage of general medical settings to adequately respond to mental health and substance use disorders. **A significant barrier to access is the major decline in the states' funding of mental health services** (Figure 9-2).

> **Critical Reasoning** Why do you think that most mental health care is given in primary care settings? Do you think primary care providers are prepared to give this type of care?

Persons with serious mental illness are more likely to be uninsured, and even insured persons often receive no treatment or inadequate mental health treatment because of policies and societal values that are discriminatory (Khaykin et al, 2010; Compton et al, 2011). Some policies and laws have been enacted that attempt to address these issues.

BOX 9-2 GOALS AND RECOMMENDATIONS IN A TRANSFORMED MENTAL HEALTH SYSTEM

Goal 1: Americans Understand that Mental Health Is Essential to Overall Health

Recommendations

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

1.2 Address mental health with the same urgency as physical health.

Goal 2: Mental Health Care Is Consumer and Family Driven

Recommendations

2.1 Develop an individualized plan of care for every adult with a serious mental illness and every child with a serious emotional disturbance.

2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

2.3 Align relevant federal programs to improve access and accountability for mental health services.

2.4 Create a comprehensive state mental health plan.

2.5 Protect and enhance the rights of people with mental illness.

Goal 3: Disparities in Mental Health Services Are Eliminated

Recommendations

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas.

Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

Recommendations

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Goal 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated

Recommendations

5.1 Accelerate research to promote recovery and resilience and, ultimately, to cure and prevent mental illness.

5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

5.3 Improve and expand the workforce, providing evidence-based mental health services and supports.

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Goal 6: Technology Is Used to Access Mental Health Care and Information

Recommendations

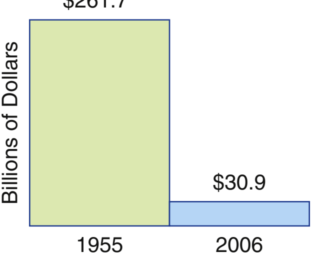
6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

6.2 Develop and implement integrated electronic health record and personal health information systems.

From New Freedom Commission on Mental Health (NFCMH): *Achieving the promise: transforming mental health care in America,* final report, DHHS Pub. No. SMA-03-3832, Rockville, Md, 2003, U.S. Department of Health and Human Services.

Insurance coverage for mental health care has not been equal to that for physical illnesses. Persons with mental illness who had health insurance usually had to pay higher premiums and co-pays, had higher deductibles, and had drastic limits on outpatient and inpatient mental health care compared to coverage for non–mental illness, that is, other physical illnesses.

> **Critical Reasoning** Do you know what coverage your insurance provides for mental and substance use disorders? Check your policy for inpatient, outpatient, partial hospitalization, and home care benefits. Compare these benefits with those you receive for medical and surgical illnesses. If the coverages are not similar, write a letter to your insurance company that addresses this disparity, and request a response.



* In 1955, the year that the patient census in state mental hospitals was at its peak, state mental health spending was $8 billion (the equivalent of $261.7 in current dollars, when adjusted fpr population growth and medical inflation). By 2006, state spending dropped to less than 12% of the total in 1955.

FIG 9-2 Declining commitment of state dollars to mental health. (Graph based on data from NRI FY2005 State Mental Health Agency Revenues and Expenditures: *Key findings,* www.nri-inc.org/projects/Profiles/RevExp2005/keyfinds2005.pdf.)

There have been two main policy approaches to equalizing care: mandated coverage for mental health care and mental health parity.

- **Mandated coverage for mental health care** means that if an employer offers health insurance for employees, both physical illnesses and mental illnesses must be covered. However, these levels of coverage were not equal; that is, coverage for mental health care was extremely limited compared to the coverage for physical illness, hence the need for mental health parity policies.
- **Mental health parity** policies help ensure that insurance coverage for mental illnesses is equal to that for physical illnesses. Mental health advocates who fought for appropriate and fair mental health treatment have long pursued mental health parity. It was only recently, in 2010, that this has become a reality.

Mental Health Parity Act of 1996

The Mental Health Parity Act of 1996 provided equal lifetime and annual limits. Before this act was passed, persons with mental illness who had health insurance typically had an annual limit of $5000 (compared to treatment of physical illnesses that had no annual limit) and a lifetime limit of $50,000 (compared to treatment of physical illnesses that had a $1,000,000 lifetime limit). The Mental Health Act of 1996, however, excluded treatment for substance use disorders. It also failed to mandate mental health coverage, or to address deductibles, co-pays, and out-of-pocket limits.

> **Critical Reasoning** Why do you think the United States has struggled with ensuring mental health parity?

Mental Health and Addiction Equity Act of 2008 (Federal Mental Health Parity Law)

The Mental Health and Addiction Equity Act of 2008, which took effect in 2010, was initially introduced by former Senator Pete Domenici, Republican-New Mexico, and the late Senator Paul Wellstone, Democrat-Minnesota. **The Act is a federal law that marks a historic end to insurance coverage discrimination for persons with mental illness.** The Act ended the annual cap on number of visits for mental health treatment and it required insurance coverage for mental health care to equal that for physical health care, if the insurance plan offered mental health care. This Act did not mandate mental health care coverage; it did not state which mental illnesses are covered nor did it specify what is covered. In addition, although it was a significant and important win for mental health advocates, it did not address mental health care for persons without health insurance.

Patient Protection and Affordable Care Act of 2010 (Health Reform Law)

The Patient Protection and Affordable Care Act of 2010, formerly known informally as "health care reform," expanded affordable health coverage to persons who were previously uninsured and to small businesses. It also reformed the insurance industry by eliminating the formerly common practice of excluding preexisting conditions from coverage. Specific benefits for persons with mental illness are listed in Box 9-3.

BOX 9-3 PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (HEALTH REFORM LAW): IMPACT ON MENTAL HEALTH CARE

- Includes mental health and substance use disorders in an "essential benefits package."
- Creates incentives to coordinate primary care and mental health and addiction services.
- Ensures inclusion of mental illness as a chronic illness in the creation of "health homes."
- Prohibits the denial of coverage because of preexisting illness.
- Expands treatment for mental illness and substance use disorders to include medications, rehabilitation, and preventive and wellness services.
- Allows access to wellness services including annual wellness visits.
- Provides for community education campaigns.
- Supports interprofessional mental health and addiction services training programs.
- Increases community-based care.
- Allows young adults to stay on their parent's insurance until they are 26 years old.

These new laws raise issues of the need for ongoing education about mental health being central to physical health, and the opportunity for policy action to reverse health disparities. Each law has strengths and limitations in relation to access, cost, quality, and type of approved provider, including nurses (Shern et al, 2008; Aggarwai et al, 2010; Druss and Bornemann, 2010; Smaldone and Cullen-Drill, 2010).

In addition to access to care, policies and legislation have been passed that focus on protecting patients' rights.

Protection and Advocacy Act

Under the Protection and Advocacy for Mentally Ill Individuals Act of 1986, all states must designate an agency that is responsible for protecting the rights of persons with mental illness. **A primary mission of the agency is to investigate reported incidents of abuse, neglect, and civil rights' violations of persons with mental illness who live in institutions.** The following areas of advocacy help maximize the fulfillment of patients' rights:

- Educating the mental health staff on policies and procedures that recognize and protect patients' rights
- Establishing an additional procedure to permit the speedy resolution of problems, questions, or disagreements that occur based on legal rights
- Providing access to legal services when patients' rights have been denied

In addition to representing individuals, protection and advocacy programs provide referral and information services, public education, outreach, training, and class-action representation. As mental health systems change and more patients are treated in outpatient settings, access to protection and advocacy services for people living in the

community is becoming increasingly important, and psychiatric nurses have the opportunity to participate in these initiatives.

Americans with Disabilities Act

The Americans with Disabilities Act (ADA), passed in 1990, protects more than 44 million Americans with physical or mental disabilities from discrimination in jobs, public services, and accommodations. **It prohibits discrimination against people with physical and mental disabilities in hiring, firing, training, compensation, and advancement in employment.** Employers are prohibited from asking job applicants whether they have a disability, and medical examinations and questions about disability may be required only if the concerns are job related and necessary (Petrila, 2009).

Each of these prohibitions has major implications for people with psychiatric disabilities; however, because the disability is often not obvious, and because of widespread stigma and discrimination, many people choose not to identify themselves as disabled. If they do, they have concern that employers and co-workers will assume that any work or personal difficulties they have are related to the psychiatric disability. Thus discrimination and unintended negative consequences in psychiatric disability coverage are potential outcomes of the ADA.

> **Critical Reasoning** Given the recognized significance of mental illnesses, why do you think so much stigma surrounds them?

Although the Act has produced some encouraging advances in job placement, education, and training, the majority of people with psychiatric disabilities remain unemployed. Although the ADA provides a cultural and legal mandate to include people with disabilities in the social and economic mainstream, it will not totally eliminate the myths, fears, and discrimination faced by people with disabilities. However, it does contribute to the educational efforts needed to combat widespread biases and misperceptions about people with disabilities, including mental illness.

> **Critical Reasoning** Early in the semester, one of your friends shared with you that she has been diagnosed with bipolar disorder and has been successfully stabilized with treatment. One day she arrives to class agitated and hyperverbal. How might you interpret this behavior? Would your interpretation be different if she had not shared her psychiatric history with you?

Advance Directives

Psychiatric advance directives were established as a result of the Patient Self-Determination Act (PSDA) of 1990. **They are documents, written while a person is competent, that specify how decisions about treatment should be made if the person becomes incompetent**. Correctly implemented they can (Mahon, 2010):

- Promote individual autonomy, empowerment and recovery from mental illness.
- Enhance communication between individuals and their family, friends and healthcare providers.
- Protect people from ineffective, unwanted and possibly harmful intervention.
- Help in preventing crises and the resulting use of involuntary treatment including seclusion and restraint.

The Bazelon Center for Mental Health Law (2011) has sample forms or templates that can be used to prepare such a psychiatric advance directive.

Psychiatric advance directives are particularly appropriate for persons with mental illness who may alternate between periods of competence and incompetence. For example, psychiatric advance directives could formalize a patient's wishes about forced medication, treatment approach, treatment setting, methods for handling emergencies, persons who should be notified, and willingness to participate in research studies.

Federal regulations require all facilities that receive Medicare or Medicaid reimbursement inform patients, including psychiatric patients, at the time of admission about their rights under state law to sign advance directives. To date, advance directives have not had a major impact on psychiatric treatment. However, potential effects of mental health advance directives include enhanced consumer empowerment; improved functioning; better communication among consumers, family members, and providers; increased tolerance for consumer autonomy in community mental health agencies; and reduced use of hospital services and court proceedings (Wilder et al, 2010).

Nurses and other mental health providers should be informed about the intended benefits and limitations of psychiatric advance directives so that they can encourage persons with mental illness to create these documents. In addition, values and policies need to more consistently recognize and honor patients' treatment preferences as specified in the directives.

> **Critical Reasoning** Does your psychiatric setting inform patients about signing an advance directive? If so, ask some patients if they were told about it and what it means to them.

Mental Health Courts

Congress first authorized the federal Mental Health Courts program in 2000 to assist states and communities in creating innovative approaches to divert offenders into treatment programs and ease the burden on the criminal justice and corrections systems. **Mental Health Courts keep people who have severe and persistent mental illness and commit minor offenses from being incarcerated in jails and prisons and allow them to receive treatment instead.** However, there is great variability in the type and quality of services

provided. These courts, which are federally funded, must do the following:

- Continue to supervise cases for up to 1 year after the individual's court date.
- Provide specialized training for law enforcement and judicial personnel to address the mental health needs of offenders.
- Provide inpatient and outpatient treatment that may result in the dismissal of charges or reduced sentences for the individual.
- Coordinate mental health treatment plans and social services for the individual, including housing, job placement, and relapse prevention.

The purpose of Mental Health Courts is to reduce recidivism among persons with mental illness, decrease the use of jails to warehouse persons with mental illness, and increase public safety. Given the number of persons with mental illness in the criminal justice system, it is hoped that this federal program may provide more compassionate and appropriate care to these individuals.

ADVOCACY BY NURSES

Every day, the policy and legislative environment in which nurses practice is changing. Psychiatric nurses need to be knowledgeable about current policies and legislation affecting mental health and substance use care. However, knowledge is not enough. **Nurses must mobilize and become advocates for the needs and rights of this vulnerable population.** They must focus their knowledge about mental health and substance use services and advocate for quality and equitable access to care for all individuals (Delaney, 2010; Halter, 2011).

Nursing advocacy can be categorized into four areas relevant to mental health: patient advocacy, issues' advocacy, community and public health advocacy, and professional advocacy (Priest, 2012).

Patient Advocacy

Nurses need to advocate for individual patients within the medical establishment for appropriate, effective, and quality mental health and addiction care. Patients with serious and persistent mental illness are particularly vulnerable because these individuals, who also have physical health problems, often are untreated, undertreated, or mistreated because of stigmatization, discrimination, or fear (Gaillard et al, 2009). This can result in poor care delivered to the mentally ill by nurses and other staff on medical-surgical units or in emergency departments. Such behavior is not acceptable, and all nurses should be advocates for the appropriate treatment of these individuals, both in the health care delivery system and in the community. Nurse advocacy for a patient is seen in the following clinical example.

CLINICAL EXAMPLE

Mr. K was admitted to the inpatient/acute care psychiatric unit because he had attempted to kill himself. He was on the unit for 2 days and presented with depressed mood, poor appetite, and limited social interaction. The patient expressed ambivalence about acting on his suicidal thoughts, at times denying and at times endorsing these feelings. On the third day the patient denied suicidal ideation. The physician wanted to discharge him because Mr. K was no longer actively suicidal. The nurse realized that he had no support system in the community. She believed that the patient needed more time on the inpatient unit and advocated on his behalf by stating her case to the physician and treatment team. Based on her thorough assessment of Mr. K's risk and protective factors, the physician and team agreed that Mr. K was not ready for discharge.

Issues' Advocacy

Issues' advocacy can impact a broad range of individuals. There are many issues related to mental health, mental illness, and mental health treatment that are advocacy opportunities for nurses. **Coalitions of nurses, other health care providers, community leaders, consumers, and family members advocate through public policy and legislative processes.**

Some current advocacy issues include enhancing the recovery model and patient self-determination, reducing stigma and discrimination, increasing self-determination and decreasing restrictiveness (especially as it relates to seclusion and restraint policies), and examining laws regarding involuntary commitment, forced medications, and competency. Conducting research in basic and applied science related to mental health and illness, evidence-based practices, and program implementation are other advocacy issues.

Critical Reasoning Select one of the issues related to mental health care and identify two activities that you could do to make a difference.

Community and Public Health Advocacy

Community and public health advocacy relates to broader social issues such as poverty, homelessness, and the environment. Mental health advocacy areas that have a community or public health focus include access to mental health care and services, universal health insurance, mental illness prevention (e.g., through strengthening families and communities), community integration and challenges of persons with severe and persistent mental illness, employment, housing and homelessness, and conducting research in basic and applied science related to mental health and illness, community and public health evidence-based practices, and community and public health program implementation.

Table 9-1 lists resource websites for community and public health organizations and agencies that advocate for mental health. Community and public health advocacy is seen in the following clinical example.

TABLE 9-1 COMMUNITY AND PUBLIC HEALTH ORGANIZATIONS AND AGENCIES WITH ADVOCACY ACTIVITIES

ORGANIZATION OR AGENCY	WEBSITE
Bazelon	www.bazelon.org/
National Mental Health America	www.nmha.org/
Substance Abuse and Mental Health Services Administration (SAMSHA)	www.samhsa.gov/
National Alliance on Mental Illness (NAMI)	www.nami.org/

CLINICAL EXAMPLE

In 2007, in the School of Nursing at the University of North Carolina at Greensboro, sophomore nursing student Linsey Hudson and junior nursing student Elizabeth Nemitz, faculty advisors Mona Shattell and Deb Stanford, and a small group of students and faculty founded a new student organization called *Health and Social Justice (HSJ)*. The purpose of HSJ was to connect its members to the larger community through participatory learning and education. HSJ sought to raise awareness around social inequality and its effects on health care. HSJ has been actively involved in 'Food Not Bombs' Health Days, held monthly at a public library. During the Health Days HSJ offered blood glucose level and blood pressure testing, as well as friendship to Greensboro's vulnerable and homeless populations. Members have also been active in the Farm Labor Organizing Committees' campaign that encouraged RJ Reynolds to provide farm laborers with health insurance. HSJ conducted film screenings such as Michael Moore's *SICKO* and Spike Lee's *When the Levees Broke: An American Tragedy;* round table discussions on topics such as universal health care and health care disparities; and a Listening Project that aimed to listen to Greensboro's most vulnerable populations to gain insight into how the health care system affects these individuals. HSJ was open to all students, faculty, and staff regardless of discipline, school, or department. Alumni and community members were also welcome.

Professional Advocacy

Advocacy for the nursing profession or the discipline of nursing is professional advocacy. Examples of professional advocacy include promoting workplace advocacy for safer work environments, working to enact the full scope of advanced psychiatric nursing practice through lobbying state boards of nursing and state legislatures, addressing the shortage of the behavioral health workforce, integrating physical/medical health care and mental health care, and conducting research in applied science related to mental health nursing, evidence-based practices, and program implementation. An example of this is advocating for a workplace safety program that focuses on appropriate staffing of inpatient psychiatric units and adequate physical design of such units to improve patient and staff safety. Table 9-2 lists professional nursing organizations that conduct professional advocacy activities related to mental health nursing.

TABLE 9-2 PROFESSIONAL NURSING ORGANIZATIONS WITH ADVOCACY ACTIVITIES

PROFESSIONAL NURSING ORGANIZATION	WEBSITE
American Psychiatric Nurses Association	www.apna.org
International Society of Psychiatric-Mental Health Nurses	www.ispn-psych.org/
International Nurses Society on Addictions	www.intnsa.org/home/
American Nurses Association	www.nursingworld.org/

Advocacy Strategies

Advocacy Is a Personal and Professional Call to Action.

Every nurse should be asked, "What are you doing to advocate for the health and quality of life of your patients?" There are many areas of opportunity. Advocacy on a personal level can be profound.

Fight the Stigma. **Words are powerful and everyday language can be stigmatizing to people with mental illness.** For example, when referring to someone with a mental illness, the phrase "persons with mental illness" is better than "mentally ill persons" because it puts the "person" first (before the mental illness). People with mental illness should be seen as human beings before all else (Shattell, 2009).

Another example is referring to someone as their illness: "schizophrenic" instead of a "person with schizophrenia." One never hears people called "cancers" or "pneumonias." So too, words like "retards," "mental," "loony," "kooks," and "psycho" are offensive to many. Even using a casual phrase when bored or when wanting something to end (like a boring lecture), you say, "I'm just going to slit my wrists" is insensitive to someone who has attempted suicide. One never knows the experiences of others. Awareness of and changing personal language is one form of advocacy.

Share Your Personal Experience with Mental Illness. Mental health and substance use problems touch the lives of everyone. **Consider sharing your personal experience with your friends and colleagues.** It normalizes the issue and can empower others. This is seen in the personal story of recovery and self-identification described in Box 9-4.

Influence Public Opinion and the Legislature. Nurses should never underestimate their potential impact on others. **There are more than 3 million registered nurses in the United States and their political power could be great**

BOX 9-4 A PERSONAL STORY OF RECOVERY AND SELF-IDENTIFICATION

When I was thinking about recovery and how it has impacted my nursing practice, I came across a definition attributed to William Anthony from the Boston Center for Psychiatric Rehabilitation. There is a line in that definition that really spoke to me: "It [recovery] is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness."

Now in my 50s, I have been battling mental illness all of my adult life. There have been many limitations posed by my illness, but despite those, I have managed to carve out a successful career, enjoy a happy marriage, and raise two healthy children. It has only been recently, however, that I have considered myself in recovery.

I currently teach in an associate degree program in nursing but worked before that as a psychiatric nurse. The entire time I worked as a psychiatric nurse, I never let myself identify with "those people," i.e., the patients. I was somehow "above" them, and as I realized much later, I held much the same stigma toward them as the general public. It was not until I came to terms with this that I really began to recover.

The turning point came during my time as a nurse educator. I have always used guest speakers as a teaching tool. People living with a particular illness make much more of an impression on students than reading a textbook. If I had diabetes, for example, I would have shared that with students because it would have put a face on an illness. I was hesitant to tell students that I have bipolar disorder for fear of a negative reaction from them and from my colleagues. I also had to admit to myself that I was embarrassed by having the disorder.

Around the time that I was debating whether to tell my students, I became active with the National Alliance on Mental Illness (NAMI). NAMI really helped me to see that I was someone who was contributing to society and had overcome the adversities posed by having a mental illness. My experience should be a source of pride, not shame. Armed with newfound pride, I decided that I was wrong in teaching about the evils of stigma while hiding the fact that I had a mental illness. With the support of my department chair, I made the leap. I don't share details with students, but I simply say that I have bipolar disorder. I tell them that I am sharing this fact because I want them to see someone in recovery. The reaction from students and my colleagues has been very positive. Students have said it made them question their assumptions about mental illness. One student told another faculty member that she went back into treatment because of my disclosure.

I have also incorporated recovery into my teaching by having other guest speakers who then share their journeys of recovery. As a result, students no longer just see the negative side of having a mental illness. They see people who exemplify the definition of recovery, i.e., those who are "living a satisfying, hopeful, and contributing life" despite the challenges posed by mental illness.

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University of Cincinnati,
Blue Ash College

if fully realized. As a citizen with specialized knowledge of illness, health, and health care, nurses can influence public policy through the following actions:

- Vote in all elections.
- Send e-mails/letters to legislators.
- Join "Action Alert" listserves for causes related to mental health.
- Make in-person visits to your legislators.
- Speak out for the rights of your patients and their families.
- Write letters to the editor of your local newspaper.
- Participate on community boards.
- Join professional nursing organizations/associations or student organizations.
- Volunteer for nonprofit organizations.

Psychiatric nurses must continue to be patient advocates and help to create an environment that is ethical and respectful of consumers who have psychiatric and mental health, and addiction services, needs. More than 80,000 psychiatric nurses are employed in mental health facilities in the United States (Manderscheid and Berry, 2007). Working together, psychiatric nurses can have a significant impact on the mental health and addiction care delivery system, and the policies and legislation that guide them.

CHAPTER IN REVIEW

- Competent psychiatric nurses need to understand mental health policies and the advocacy role they can play in the broader mental health care environment.
- The World Health Organization's (WHO) Global Burden of Disease Study revealed that mental disorders are the second most disabling category of illnesses around the world.
- In 2009 there were an estimated 20%, or 45 million adults ages 18 or older in the United States with any mental illness in the past year. The percentage having serious mental illness in the past year was about 5%, or 11 million adults.
- Four reports released in the United States concluded the following: mental health is fundamental to health; mental disorders are real health conditions that have an immense impact on individuals and families; the efficacy of mental health treatments is well documented; a range of treatments exists for most mental disorders; and people should seek help if they have a mental health problem or think that they have symptoms of a mental disorder.

CHAPTER IN REVIEW—cont'd

- An ideal comprehensive health care system would provide the full array of high-quality, community-based, culturally and linguistically competent, integrated mental health and substance abuse services, regardless of ability to pay, including access to the full range of the most effective medications and treatments. It would have multiple points of entry for treatment, including direct access through self-referral, by a wide variety of providers.
- Currently, two thirds of the people who seek mental health care are treated by primary care practitioners. Many who need care do not receive it, from either a primary care or a specialty provider. The principal reason for not receiving treatment is cost.
- Persons with serious mental illness are more likely to be uninsured, and even those persons who have health insurance often receive no treatment or inadequate mental health treatment because of policies and societal values that are discriminatory.
- There have been two main policy approaches to equalizing care: mandated coverage for mental health care and mental health parity.
- Mandated coverage for mental health care means that if an employer offers health insurance for employees, both physical illnesses and mental illnesses must be covered.
- Mental health parity policies help ensure that insurance coverage policies for mental illnesses are equal to those for physical illnesses. Only in 2010 has this become a reality.
- The Mental Health and Addiction Equity Act of 2008 (Federal Mental Health Parity Law) and the Patient Protection and Affordable Care Act of 2010 end insurance coverage discrimination for persons with mental illness. Each law has strengths and limitations in relation to access, cost, quality, and type of approved provider, including nurses.
- Under the Protection and Advocacy for Mentally Ill Individuals Act of 1986, all states must designate an agency that is responsible for protecting the rights of persons with mental illness by investigating reported incidents of abuse, neglect, and civil rights' violations of persons with mental illness who live in institutions.
- The Americans with Disabilities Act (ADA) prohibits discrimination against people with physical and mental disabilities in hiring, firing, training, compensation, and advancement in employment.
- Psychiatric advance directives are documents, written while a person is competent, that specify how decisions about treatment should be made if the person becomes incompetent.
- Mental Health Courts keep people who have severe and persistent mental illness and commit minor offenses from being incarcerated in jails and prisons and allow them to obtain treatment instead.
- Psychiatric nurses must focus their knowledge about mental health and substance use services and advocate for quality and equitable access to care for all individuals.
- Nursing advocacy can be demonstrated in four areas relevant to mental health: patient advocacy, issues' advocacy, community and public health advocacy, and professional advocacy.
- Advocacy is a personal and professional call to action. Every nurse should be asked: "What are you doing to advocate for the health and quality of life of your patients?" There are many areas of opportunity. Advocacy on a personal level can be profound.

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CHAPTER

10

Families as Resources, Caregivers, and Collaborators

Gail W. Stuart

To multiply the harbors does not reduce the sea.

Emily Dickinson

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the components of family assessment, including the use of the genogram.
2. Examine issues related to working with families of the mentally ill, including the competence model of care and psychoeducation.
3. Analyze the benefits and barriers to family involvement in the continuum of care.
4. Discuss how family members of a relative with mental illness are a population at risk.
5. Identify ways to collaborate with family advocacy organizations.

Families are the largest group of caregivers for the mentally ill. Most patients live with or are cared for by their families. **Psychiatric nurses must partner with families as resources, caregivers, and collaborators in their clinical practice.** Past and present family relationships affect a patient's self-concept, behavior, expectations, values, and beliefs. Thus understanding principles of family dynamics and interventions is critically important. Competence in this area will enhance the nurse's ability to:

- Assess the individual's and the family's needs and resources
- Identify problems and strengths displayed by an individual and a family
- Select interventions to promote positive coping strategies and adaptive functioning
- Make decisions related to referrals to other appropriate resources

FAMILY ASSESSMENT

The concept of "family" has evolved from the "two married heterosexual parents with several children of their own" to a variety of extended and creative nontraditional "family systems." Nurses encounter many different types of families in their clinical work. This can challenge the nurse's evaluation skills and perhaps the nurse's own value system. Figure 10-1 presents four dimensions of parent status that can describe families in society: biological ties, marital status, sexual orientation, and gender roles. Although the definitions of family have become more fluid in recent decades, a **family** is usually defined in terms of kinship: individuals joined by marriage or its equivalent or by parenthood.

A broader definition describes **family members as those who by birth, adoption, marriage, or declared commitment share deep, personal connections and are mutually entitled to receive, and obligated to provide, support, especially in times of need.**

Biological Tie

- Both parents biologically related to the child
- One parent biologically related (artificial insemination, surrogate parenting, gay or lesbian families, blended families)
- Neither parent biologically related (adoption)
- Biologically related grandparents fulfilling the parenting role

Marital Status

- Single parent
  By choice: child product of heterosexual union or insemination, or due to adoption
  Result of divorce
- Married parents
  Both biological parents
  One biological parent and one stepparent
  Adoptive parents
- Cohabiting parents
  Heterosexual
  Gay or lesbian

Sexual Orientation

- Heterosexual
- Gay or lesbian

Gender Roles/ Employment Status

- Traditional
- Nontraditional

FIG 10-1 Parent status in the contemporary family.

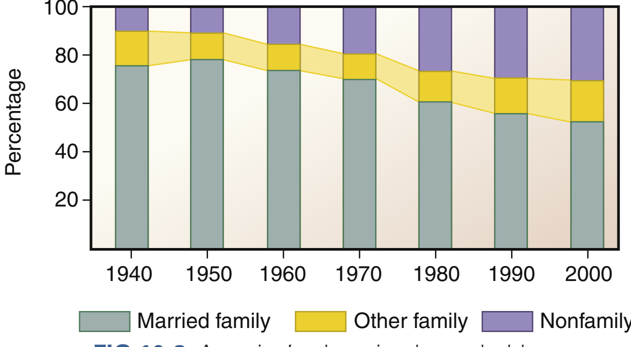

FIG 10-2 America's changing households.

- A **nuclear family** refers to parents and their children.
- An **extended family** includes other people related by blood or marriage.
- A **household** is a residence consisting of an individual living alone or a group of people sharing a common dwelling and cooking facilities.

Over time in the United States, the number of households with married families has declined, whereas the number of nonfamily households has increased (Figure 10-2).

Critical Reasoning Examine the potential problems a nontraditional family may encounter regarding values held by health care providers, neighbors, employers, school systems, churches, and the legal system in your state.

Characteristics of the Functional Family

A well-functioning family can shift roles, levels of responsibility, and patterns of interaction as it experiences stressful life changes. A well-functioning family may, under acute or prolonged stress or increased vulnerability, express maladaptive responses but should be able to rebalance as a system over time. Ultimately, family members remain focused on healthy patterns and established values, and family relationships remain intact. Characteristics of such a family include the following:

- It completes important life cycle tasks.
- It has the capacity to tolerate conflict and to adapt to adverse circumstances without long-term dysfunction or disintegration of family cohesion.
- Emotional contact is maintained across generations and between family members without blurring necessary levels of authority.
- Overcloseness or fusion is avoided, and distance is not used to solve problems.
- Each twosome is expected to resolve the problems between them. Asking a third person to settle disputes or to take sides is discouraged.
- Differences between family members are encouraged to promote personal growth and creativity.
- Children are expected to assume age-appropriate responsibilities and to enjoy age-appropriate privileges negotiated with their parents.
- The preservation of a positive emotional climate is more highly valued than doing what "should" be done or what is "right."
- Within each adult there is a balance of affective expression, careful rational thought, relationship focus, and caregiving; each adult can selectively function in the respective modes.
- There is open communication and interactions among family members.

These functional characteristics represent an ideal family that may be more fictional than real. Most families have some but not all of these elements and still operate with integrity and respect.

Culture

Nurses have a professional responsibility to be aware of and be sensitive to aspects of family structures that are due to social, cultural, and ethnic differences (Box 10-1). Specifically, culture within a family determines the following:

- The definition of family
- The beliefs governing family relationships
- The conflict and tensions in a family and their adaptive or maladaptive responses
- The norms of a family
- The way outside events are perceived and interpreted
- The beliefs regarding when, how, and what type of family interventions are most effective

Critical Reasoning Describe the potential impact on family functioning you might observe among families related to their family configuration: families that include a single parent, an interracial marriage, a homosexual partnership, and a family with several members who have a severe mental illness.

BOX 10-1 SOCIOCULTURAL CONTEXT OF CARE

People caring for an ill family member often turn to religion as a source of solace, strength, and support. Research examining the outcomes of religious coping has generally found that spiritual beliefs among caregivers are linked to enhanced adjustment, including the following (Murray-Swank et al, 2006):

- Better relationships with the care recipients
- Lower levels of depression and enhanced self-esteem
- Better "self-care"
- More positive and hopeful attitudes

Thus collaborative partnerships between mental health professionals and religious and spiritual communities represent a powerful and culturally sensitive resource for meeting the needs of family caregivers of persons with mental illness.

Family History

Family history information usually includes all family members across three generations (McGuinness et al, 2005). It is helpful to use a family genogram as the organizing structure for collecting this information. A three-generation family **genogram** is a structured method of gathering information and graphically showing the factual and emotional relationship data (McGoldrick et al, 2008). A sample genogram is presented in Figure 10-3. Drawing a family genogram in full view of the family on large easel paper or a blackboard broadens the family's focus and facilitates an understanding of the family constellation.

The genogram is usually designed around the patient, and all relatives are included. First-degree relatives include parents, siblings, and children of the patient. Second-degree relatives include grandparents, uncles, aunts, nephews, nieces, and grandchildren. All family members by marriage, partnership, or adoption also are included. The health status of each is noted, as are the relationships between members. The genogram provides an invaluable family map both for discovering individual and family insights and for generating discussions. It can continue to be updated by the family over time.

Critical Reasoning Construct a genogram of your own three-generational family. Ask family members to join you in this project.

Family APGAR

Once the family structure is clear, the nurse can explore roles, relationships, and family dynamics. An evidence-based tool commonly used to assess the patient's satisfaction with relationships in the immediate family is the Family APGAR (Smilkstein, 1978). It measures how the following are shared within the family:

- Adaptation—use of family resources for problem solving when family equilibrium is stressed
- Partnership—sharing of decision making and nurturing responsibilities by family members

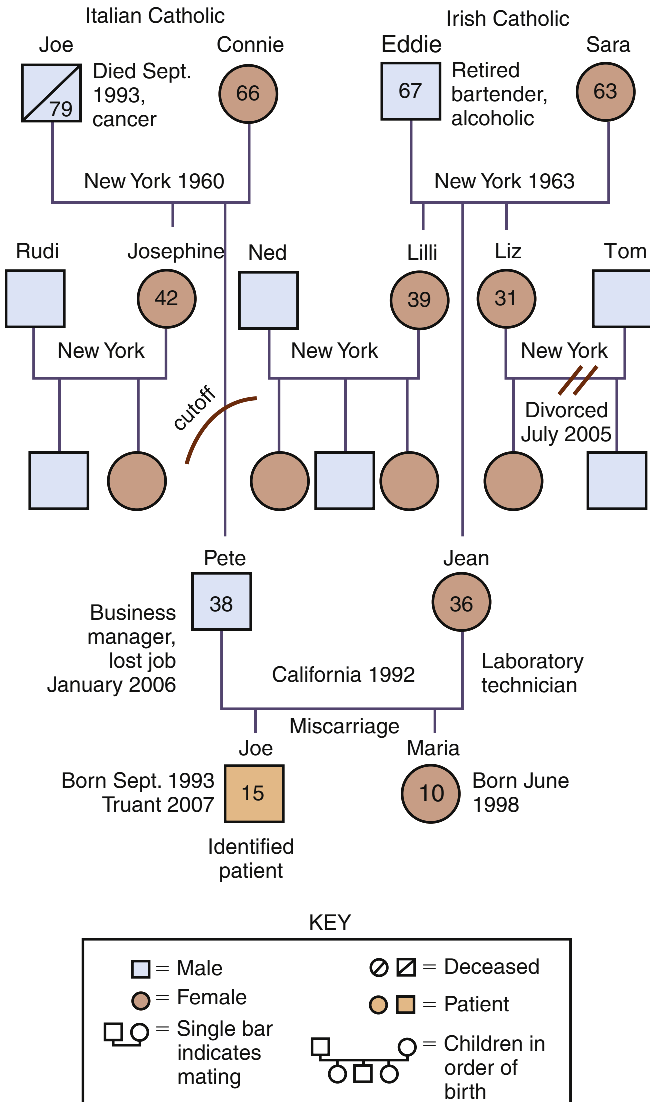

FIG 10-3 Example of a family genogram.

- Growth—physical and emotional maturation and self-fulfilment that is achieved by family members through mutual support and guidance
- Affection—caring or loving relationship that exists among family members
- Resolve—commitment to devote time to other members of the family for physical and emotional nurturing; includes sharing of time, space, and money

Critical Reasoning How would your family score on the APGAR?

WORKING WITH FAMILIES

Partnering with patients' families is an essential part of nursing care. Nurses have always made intuitive observations about family dynamics. Although many nurses have gained additional knowledge and received training in formal

TABLE 10-1 MODELS USED IN WORKING WITH FAMILIES

	PATHOLOGY MODEL	COMPETENCE MODEL
Nature of model	Disease-based medical model	Health-based developmental model
View of families	Pathological or dysfunctional	Competent or potentially competent
Emphasis	Weakness, liabilities, and illness	Strengths, resources, and wellness
Role of professionals	Practitioners who provide psychotherapy	Enabling agents who help families achieve their goals
Role of families	Consumers or patients	Collaborators
Basis of assessment	Clinical pathology	Competencies and competence deficits
Goal of intervention	Treatment of family pathology or dysfunction	Empowerment of families in achieving mastery and control over their lives
Interventions	Psychotherapy	Strengthening of family competencies

From Marsh DT: *Serious mental illness and the family: the practitioner's guide,* New York, 2000, John Wiley & Sons.

family therapy, all nurses must learn how to work with families in everyday nursing practice.

Competence Model

The competence model of care focuses on family strengths, resources, competencies, values, and empowerment instead of dependency. It stresses the importance of treating people as collaborators who are the masters of their own fate and capable of making healthy changes (Marsh, 2000) (Table 10-1).

Using an empowerment model increases the nurse's understanding of familial traits that can help in coping with mental illness. It assesses the positive attributes among family members, offers a blueprint for designing effective interventions for patients and families, and assists in evaluating the outcome of family-oriented services.

Unlike pathology models that may stigmatize and alienate families, the competence model fosters positive alliances between families and health care providers and enhances the delivery of services. The competence model emphasizes the following points:

- Focus is on growth-producing behaviors rather than on treatment of problems or prevention of negative outcomes.
- Promotion and strengthening of individual and family functioning occur by fostering self-efficacy and other adaptive behaviors.
- Definition of the relationship between the help seeker and help giver is based on a cooperative partnership that assumes joint responsibility.
- Assistance is provided that is respectful of the family's culture and congruent with the family's appraisal of problems and needs.
- The family's use of natural support networks is promoted.

It is expected that families will play a major role in deciding what is important to them, what options they will choose to achieve their goals, and whether they will accept help that is offered to them.

Critical Reasoning Watch a popular television show that depicts a family situation. Evaluate the family's level of functioning in terms of culture, competence, and dynamics.

Psychoeducational Programs

Psychoeducational programs for families are designed primarily for education and support. They are the result of the emergence of the family self-help movement in psychiatry and the efforts of such family groups as the National Alliance on Mental Illness (NAMI). These programs are educational and practical in approach. Their aim is to improve the course of the family member's illness, reduce relapse rates, and improve patient and family functioning.

These goals are achieved through **educating the family about the illness, teaching families techniques that will help them cope with symptomatic behavior, and reinforcing family strengths.** In general, a comprehensive program for working with families should include the following:

- **Educational** component that provides information about mental illness and the mental health system
- **Skill** component that offers training in communication, conflict resolution, problem solving, assertiveness, behavioral management, and stress management
- **Emotional** component that provides opportunities for catharsis, sharing, and mobilizing resources
- **Family process** component that focuses on family strategies for coping with mental illness in the family
- **Social** component that increases use of informal and formal support networks

The educational program outlined in Box 10-2 is designed to meet the cognitive and behavioral needs of families. Psychoeducational programs for families should meet a range of needs and provide families with an opportunity to ask questions, express feelings, and socialize with each other and with mental health professionals.

BENEFITS OF FAMILY INVOLVEMENT

There are many benefits to involving families in the care of their loved ones with mental illness. Research confirms that family input in treatment decisions improves patient outcomes, with maximum benefits occurring when the families are supported and educated for these partnership roles (Heru, 2006; Zauszniewski et al, 2009).

Family psychoeducation is an evidence-based practice (Lefly, 2009)**.** It consists of educational, supportive, cognitive,

BOX 10-2 10-WEEK EDUCATIONAL PROGRAM FOR FAMILIES OF THE MENTALLY ILL

Nature and Purpose of Program
Introductions of family members and staff
Purpose and scope of program
Description of treatment program, policies, and procedures
Brief, written survey of specific family needs and requests

The Family Experience
Family burden and needs
The family system
Family subsystems
Life span perspectives

Mental Illness I
Diagnosis
Etiology
Prognosis
Treatment

Mental Illness II
Symptoms
Medication
Diathesis-stress model
Recent research

Managing Symptoms and Problems
Bizarre behavior
Destructive and self-destructive behavior
Hygiene and appearance
Distressing symptoms

Stress, Coping, and Adaptation
The general model
The stressor of mental illness
The process of family adaptation
Increasing coping effectiveness

Enhancing Personal and Family Effectiveness I
Behavior management
Conflict resolution
Communication skills
Problem solving

Enhancing Personal and Family Effectiveness II
Stress management
Assertiveness training
Achieving a family balance
Meeting personal needs

Relationships Between Families and Professionals
Historical context
New modes of family-professional relationships
Barriers to collaboration
Breaking down barriers

Community Resources
The consumer-advocacy movement
Accessing the system
Legal issues
Appropriate referrals

and behavioral strategies of at least 9 months' duration. Providing education for families is a criterion for accreditation by The Joint Commission (TJC). This aspect of care also was identified as a goal in the report of the New Freedom Commission on Mental Health (2003), *Achieving the Promise: Transforming Mental Health Care in America:* **"Mental health care is consumer and family driven."**

Unfortunately, the good intentions promoted at the policy level have not translated well into practice, because family psychoeducation is not consistently offered in mental health systems. A significant gap exists between best practices and usual practices. This remains true currently despite worldwide advocacy for family involvement on the part of international family organizations.

Critical Reasoning Is a family psychoeducation program offered at your clinical facility? If so, attend a session. If not, ask if the facility has considered starting one.

BARRIERS TO FAMILY INVOLVEMENT

The barriers to educating families for involvement in their loved one's treatment include the following:

- **Professional bias** against families based on exposure to family systems theories that suggest families cause or perpetuate the illness
- **Family attitudes** that equate all family interventions with past, unwelcome experiences with family therapy
- **Professional fears** that an alliance with the family will endanger confidentiality and threaten the therapeutic alliance with the patient
- **Administrative restraints** in a managed-cost environment, where services to families (as nonpatients) receive the lowest priority

These barriers are gradually disappearing, but only when issues of treatment and prevention include the family unit and not just the individual patient will they vanish completely (Rose et al, 2004).

The meaning of mental illness to the family and the impact it can have on parents, children, siblings, or a spouse are presented in Box 10-3. To the extent that professional caregivers truly understand the impact of long-term mental illness on the family, the more they will work to involve family members as treatment resources, caregivers, and collaborators and provide them with preventive intervention strategies.

> *Everyone needs to understand that when a family member has a mental illness, you and your loved one are, like Alice in Wonderland, going to fall down the rabbit hole. The world you are entering is overwhelmed by the demand for services and ill equipped to meet your needs. You are up against centuries of bias against you, against the illnesses, against getting organized to do anything about them. What is important here is to recognize system failure and stigma as part of the reality we must deal with. It is also essential to realize how difficult this makes it for our ill*

BOX 10-3 THE MEANING OF MENTAL ILLNESS TO THE FAMILY

When a loved one is stricken with mental illness, every member of the family feels pain. Whether the patient is your mother, father, son, daughter, sister, brother, grandchild, or grandparent, you share in the suffering. But you also have other feelings that confuse and frighten you.

Before the doctors gave you a diagnosis, you probably went through a long period of uncertainty—trying to make sense of what was happening. You were stunned and bewildered. You hoped that the odd behavior and scary talk would stop, that soon things would be back to normal. Instead, maybe a crisis occurred.

In one way or another, your family member was brought in for treatment. Once the diagnosis was made, you began asking questions: "Will my loved one get better and lead a normal life again?" "What have I done wrong?" "Why did this happen to me, to us?"

Your questions and your feelings are quite natural. Your grief, shame, and anger; your sense of helplessness; your hours of anxiety: All are shared by others going through similar experiences. But depending on your relationship to the mentally ill family member, you also have feelings that are not shared by others.

Perhaps it is your child who has fallen ill. Suddenly a promising young person, on the threshold of becoming an adult, takes a sharp turn. Now there is a stranger in your midst. Your once happy and content son or daughter becomes withdrawn, unkempt, and unable to function. He argues, destroys possessions, says and does things that make no sense. You, like other parents, want to protect and nurture your child. When your desire is thwarted, you feel that you have failed. Perhaps you blame him. Such feelings are not unique to parents of mentally ill persons. Parents of children with severe physical illnesses such as cancer or heart disease also tend to blame themselves, to harbor feelings of resentment toward the victim. Because mental illness affects such intensely personal aspects of our being, it is not surprising that parents of mental patients do likewise. Professionals—often unwittingly—may augment your guilt by blaming you for the tragedy.

When it is your spouse who becomes mentally ill, you have special problems. This is, after all, the person you chose to marry: your mate, companion, and lover. Not only do once-shared responsibilities fall solely on you, but you also must try to find help for your spouse. Perhaps help is not welcomed. Without diminishing your partner's status, you must juggle the roles of mother, father, homemaker, and breadwinner all at once.

Other family members may escape the responsibilities that fall to a parent or spouse of the mentally ill person, but they share equally painful feelings. Brothers and sisters are bewildered, hurt, and sometimes ashamed and angry. Grandparents are perplexed and saddened. Adult children find it difficult to assume the role of caretaker when a parent becomes incompetent.

One out of four families has a close relative who is mentally ill. They, like you, typically go through a period of intense searching. Patients, family members, and doctors alike tend to place blame in an effort to identify an event or a person responsible for the breakdown. "Why me?" is an understandable cry.

In time, most families come to accept the illness. Somehow, they find resources to sustain themselves over the rocky period. Many become stronger in the process. When they look back over years of living with chronic mental illness, they almost invariably remember the earliest period as the hardest. They may have been surprised by the amount of energy, resourcefulness, and courage they were able to muster. They come to feel pride in their capacity to face tragedy and conquer defeat.

Although no cure is now known for the more severe, chronic mental illnesses, almost everyone can be helped to live a worthwhile and meaningful life. Caring relatives must continue to hope for improvement, set reasonable expectations, and maintain faith in the patient's recuperative and restorative powers. Realities change. What may have been impossible at one time may become quite possible. There will be regressions, plateaus when all anyone can expect to do is "hang on," without any forward movement.

A short time ago families who had known mental illness for a long time were asked how it had affected them. As might be expected, many reported the negative consequences. But many also saw positive changes in their lives. One mother said she no longer takes life for granted. "I've learned to appreciate the little things in life," she said. "I make it a point to find something to enjoy each day." Other family members reported that they were more compassionate, less judgmental, and more understanding of others. Most had made what they considered a more mature reevaluation of their lives, thereby achieving a truer vision of what really counts. They believed that their lives had become more significant, more basic, and more meaningful.

Most families, in short, found they had wellsprings of strength they never knew they had until they met the great challenge of mental illness.

From Hatfield A: *Coping with mental illness in the family: a family guide,* Arlington, Va, 1986, National Alliance on Mental Illness.

relatives to get the help they deserve and to "rejoin" society (Burland, 2002).

There is a large body of family literature to help nurses understand the family experience of mental illness, sometimes referred to as **family burden** (Muhlbauer, 2008; Marshall et al, 2010). Nurses can read this literature and attend NAMI meetings as members or guests in order to speak directly with NAMI families. The issue of family burden is discussed further in Chapter 14.

Critical Reasoning What situations create stress in your family, and do you receive support from your extended family or the community?

Nurses who take the time to talk with family caregivers about the history of the illness often learn that family members were the first to notice that something was not right. During the early stages of the patient's illness, families are likely to note changes in sleep and appetite, loss of interest in

favorite pastimes, or unexpected interest in religion or philosophy. However, without professional input, they rarely connect these changes with mental illness.

We thought at first he was just having a difficult adolescence. Then we thought he might be into drugs. But mental illness? Not in our family!

When our daughter started sending hundred dollar contributions to TV evangelists, we assumed she was just another born-again Christian.

Usually as the result of a crisis, families are shocked into the realization that they are dealing with something very serious. At this point, if asked, they are often able to provide important diagnostic clues not otherwise available to the psychiatric team. Even further along in treatment, family members who see the patient on a daily basis are often more reliable informants than the patient.

My brother who lives with us was seeing a therapist once each week, and we couldn't figure out why his only treatment was reading books the therapist recommended. He really wasn't reading them because he couldn't concentrate on account of the voices he was hearing most of the time. Finally, I called the therapist and told her what was going on. She was surprised, because my brother hadn't told her he was still hallucinating.

But families have roles other than that of informant, and they have other crucial needs. They may need to unwind by verbally replaying the events that led up to the crisis. They may need to be told they have done the right thing by bringing their loved one to a treatment setting or by calling the police to do this, and they need to be kept informed about what is happening to the patient. These needs are superimposed on basic needs that may not have been met during the emergency, such as the need for rest, food, and drink.

When I brought my husband to the emergency room for a psychiatric evaluation, the nurse allowed me to stay nearby, but out of his sight, because he was yelling at me to get out of there. She listened to my story, kept me informed, and brought me coffee. She helped me through the worst night in my life.

After the immediate crisis has been addressed, nurses should complete their assessment of the mental and physical status of family members. At a minimum, families will need an explanation of the likely diagnosis, the proposed treatment, and a referral to a family support group. Some families may ask for a continuing consultation, and family therapy also may be an option (Chapter 32). In response to the need for continuing support and education, some hospitals have established a family resource center staffed by volunteers and stocked with books, journal articles, videos, and access to mental health websites.

Of all the barriers to collaboration, **confidentiality issues** may well be the most problematic because of the perception that professionals are caught between the patient's right to a confidential therapeutic relationship and the family caregiver's right to information (Chapter 8). However, professionals who believe in the value of collaboration can usually find ways to obtain the patient's permission to communicate with the family.

Failure to include family caregivers in treatment planning that directly involves them not only is unfair but also may precipitate or perpetuate troubled family relationships, such as in the following:

The treatment plan for a 35-year-old, single, pregnant woman who was suffering from depression and addiction to cocaine called for her and the future baby to live in the parents' home after her discharge from the hospital. When the father and mother came in to visit, they were stunned to learn that the discharge date had been moved up, and their daughter would be coming home the following day. They were not prepared for this, resented being excluded from the discharge planning, and wondered if it would be successful.

Even when a treatment plan involves increasing the patient's autonomy and separation from the family, family involvement has advantages. Such a plan is more likely to be carried out if the family members understand the goal, agree with it, and contribute their ideas as to how it can be achieved. Conversely, to drive a wedge between the patient and family could rob a vulnerable person of a family resource that is likely to outlast any single professional resource. Although not all patients with serious mental illness will have family members who are willing or able to provide care, the point is that **family collaboration, support, and education must become the rule, not the exception.**

> **Critical Reasoning** How would you respond to a colleague who says the following? "We have no time to work with families. They just slow us down, and we can't get reimbursed for the time we spend meeting with them."

FAMILIES AS A POPULATION AT RISK

The impact of mental illness is a shattering, traumatic event in the life of a family, and family members are ideal candidates for secondary prevention strategies. They are affected by the resource needs of their ill loved one, including housing and employment. They also face potential stigmatization and reduced social contact themselves, may be at risk for violent victimization, and have concerns about the access and quality of health care their relatives receive (Drapalski et al, 2008; Gerson et al, 2009). Research shows they often have high levels of depression, poorer perceived health, lower levels of psychological well-being, and less marital satisfaction (Gerkensmeyer et al, 2008; Ghosh and Greenberg, 2009).

Parents, siblings, spouses, and children may respond in different ways, but all experience some level of **grief.** In addition, all families experience the **stigma of mental illness** on behalf of their loved one and sometimes by association (McCann et al, 2011).

Aging parents who expected to have an empty nest find themselves in their fifties, sixties, and seventies sharing the nest with adult children who have a mental illness. Not only must their dreams for their children be revised, but these parents must learn to live with loved ones whose moods and behaviors are often baffling and sometimes dangerous. At the same time some families say their lives have been strengthened by such an experience (Sin et al, 2008; Aschbrenner et al, 2010).

We have this terrible feeling of loss and grief for the son we knew. We feel cheated out of watching him mature and flower the way adolescents do as they grow into young adults. When I meet his former classmates who are now working, finishing graduate degrees, or are married, I am always aware that these things are not possible for him, just the same as someone would feel had their son died. Yet this mourning is strange, because our son is not dead at all. He is very much still with us, seemingly eternally childlike, needing care and attention. In the dark soul of the night, I grieve for all of us—for the anguish of the past and the present, and the uncertainty of the future. At the same time, we have emerged from this emotional holocaust as better, stronger, and more tolerant people.

It is not surprising to hear reports of heart attacks or strokes suffered in apparent response to a loved one's relapse, suicide attempt, or encounter with the law. Less dramatic but also unfortunate are the reports of family members who experience depression, couples who separate or divorce, and family members who become addicted to cigarettes, alcohol, or drugs.

Children of mentally ill parents are a particular population at risk (Mason et al, 2007; Donatelli et al, 2010). Living with a mentally ill parent does not necessarily mean that the child will develop the disorder, but it can make growing up more difficult. Although the mechanisms for transmitting psychiatric illness across generations are controversial, many studies support the fact that parental illness affects children. For example, it has been noted that coping with a mentally ill parent may be more difficult than coping with parental loss. These children also feel psychologically vulnerable and fear becoming ill themselves. The major research findings on this topic are as follows:

- Children of mentally ill parents are at greater risk for psychiatric and developmental disorders than are children of well parents.
- The risk to children is greater if the mother rather than the father is the ill parent.
- In studies of depressed versus nondepressed groups, differences in the mother-child interaction are evident as early as 3 months' postpartum.
- Many children with emotionally disturbed parents do not become disordered themselves. The nature of the parent's illness, the child's genetic and constitutional makeup, the family's functional ability, and the availability of healthy attachment figures all play an important role in the mental health of the child.

The effects of caregiving responsibilities of a mentally ill parent on their children are enormous. It can affect a young person's physical, social, emotional, cognitive, and behavioral development (Mechling, 2011). These children are often forced to assume a more adult role for which they are not prepared. They may experience difficulty in school, and more restricted social networks of friends.

For these reasons, psychiatric nurses need to focus more attention on the children of mentally ill parents. They should assess parenting problems whenever parents with children at home are hospitalized for psychiatric care. They also can implement psychoeducational, preventive nursing interventions that will enhance mental health in high-risk children and families (Chapter 12).

Well siblings are another vulnerable group who can experience problems in living (Friedrich et al, 2008). Siblings and offspring may have problems as adults because they had less parental attention than they needed as children and adolescents. When the emotional and financial resources are devoted disproportionately to the son or daughter with the illness, less is available for the siblings. They may be resentful but unable to express their resentment because of survivor's guilt. Some siblings detach from the family. Others remain involved, often at the expense of career and marriage options.

Health professionals who are very knowledgeable about the effects of childhood trauma in general terms are often unaware of the specific difficulties faced by children growing up in families preoccupied by mental illness. Despite the known genetic risks for the offspring of parents with mental illness, these children are underserved in the mental health system.

This lack of service results in part from the fact that women in treatment for serious mental illnesses often do not reveal that they have children, for fear that they will be removed from their care. Consequently, offspring and siblings may present for treatment years later, exhibiting problems with identity, self-esteem, relationships, and dependence on the approval of others. On the other hand, children raised in the shadow of mental illness can achieve success in life. Many siblings and offspring become members of the helping professions.

Ways in which professionals can help young people living in families with mental illness include the following:

- Become informed about the family's experience of mental illness.
- Strengthen and support the family system.
- Reach out to the children and siblings as early as possible, and assure them they are not to blame.
- Address the needs of young family members in an age-appropriate manner.
- Enlist the help of teachers, principals, guidance counselors, and school psychologists.
- Assure them that their needs matter, and support their goals.
- Offer counseling for those who are experiencing particular difficulty.

Critical Reasoning What personal and social impact do you think stigma has on the siblings of those who are mentally ill?

BUILDING BRIDGES

In the late 1980s NAMI's Curriculum and Training Network offered a program to train two persons from each state affiliate as "family education specialists." Later, a 12-week curriculum known as the NAMI Family-to-Family Education Program was written (Box 10-4). This peer-taught program has been presented free of charge to more than 70,000 families across the United States. Many family members trained to teach the course have a nursing background. To make this unique referral resource better known to mental health professionals, the *Clinician's Guide to the NAMI Family-to-Family Education Program* was written (Weiden, 1999).

NAMI and the Human Interaction Research Institute of Los Angeles identified seven competencies that professionals need in order to involve families as partners in treatment. Psychiatric nurses should assess the extent to which they practice these skills (Box 10-5). The American Psychiatric Nurses

BOX 10-4 NAMI FAMILY-TO-FAMILY EDUCATION PROGRAM

Class 1. Introduction. Special features of the course; emotional reactions to the trauma of mental illness; your goals for your family member with mental illness

Class 2. Schizophrenia, Major Depression, Mania, Schizoaffective Disorder. Diagnostic criteria; characteristic features of psychotic illnesses; keeping a Crisis File

Class 3. Mood Disorders and Anxiety Disorders. Types and subtypes of depression and bipolar disorder; causes of mood disorders; diagnostic criteria for panic disorder and obsessive-compulsive disorder

Class 4. Basics About the Brain. Functions of key brain areas; research on functional and structural brain abnormalities; chemical messengers in the brain; genetic research; the biology of recovery; *NAMI Science and Treatment* video

Class 5. Problem Solving Skills Workshop. How to define a problem; sharing our problem statements; solving the problem; setting limits

Class 6. Medication Review. How medications work; basic psychopharmacology of mood disorders, anxiety disorders, and schizophrenia; side effects; key treatment issues; stages of adherence to medications; early warning signs of relapse

Class 7. Inside Mental Illness. The subjective experience of coping with a brain disorder; maintaining self-esteem and positive identity; gaining empathy for your relative's psychological struggle to protect one's integrity despite mental illness

Class 8. Communication Skills Workshop. How illness interferes with the capacity to communicate; learning to be clear; how to respond when the topic is loaded; talking to the person behind the symptoms

Class 9. Self-Care. Learning about family burden; handling feelings of anger, entrapment, guilt, and grief; how to balance our lives

Class 10. The Vision and Potential of Recovery. Learning about key principles of rehabilitation and model programs of community support; a firsthand account of recovery

Class 11. Advocacy. Challenging the power of stigma in our lives; learning how to change the system; the NAMI Campaign to End Discrimination; meet a NAMI advocate

Class 12. Review, Sharing, and Evaluation. Certification ceremony. Celebration!

NAMI, National Alliance on Mental Illness.

BOX 10-5 FAMILY INVOLVEMENT COMPETENCIES FOR MENTAL HEALTH PROFESSIONALS

Developing a Collaboration with the Family
Make a positive first contact.
Identify family's needs.
Address confidentiality.

Offering Information on Mental Illness
Diagnosis, etiology, prognosis, treatments
Long-term course of serious mental illness
Educational sessions

Enhancing Family Communication and Problem Solving
Teach principles of effective communication.
Teach problem-solving strategies.

Helping With Service System Use
Help access entitlements, support, and rehabilitation.
Explain the roles of different mental health providers.
Establish needed linkages.
Translate the language of mental health services.
Help access crisis services.
Help access housing.

Helping Family Members Meet Own Needs
Help family members access support services.
Understand burden and grief.
Assess for stress-related disorders.
Offer services or referrals.
Encourage self-care.
Encourage advocacy.

Addressing Special Issues Concerning the Patient
Treatment is not working.
Illness is of recent onset.
Patient has multiple diagnoses.
Patient is in jail.
Patient refuses treatment.

Addressing Special Issues Concerning the Family
The family does not speak English.
The family is very important or of high status in the community.
The family belongs to an ethnic minority.
The family is missing.
The family is disinterested.

Modified from Glynn S et al: *Involving families in mental health services: competencies for mental health workers,* Los Angeles, 1997, Human Interaction Research Institute.

Association (APNA) also has formed a working alliance with NAMI for the purpose of jointly promoting public policy pertaining to mental health/illness issues. APNA testified before Congress on behalf of NAMI's policy on the limitations on the use of restraints and seclusion, resulting in legislation protecting patients from their inappropriate use. This is but one example of the potential impact that joint advocacy between nursing and family organizations can have on the field.

CHAPTER IN REVIEW

- Families are the largest group of caregivers for the mentally ill. Nurses need to partner with families as resources, caregivers, and collaborators in their clinical practice.
- Competence in working with families will enhance the nurse's assessment of the individual's and the family's needs and resources and the selection of interventions that promote adaptive functioning.
- A well-functioning family can shift roles, levels of responsibility, and patterns of interaction as it experiences stressful life changes, rebalancing as a system over time.
- Nurses have a professional responsibility to be aware of and be sensitive to aspects of family structures that are due to social, cultural, and ethnic differences.
- Information about family history generally includes all family members across three generations. It is helpful to use a family genogram as the organizing structure for collecting this information.
- The competency model used in working with families values empowerment instead of dependency and stresses the importance of treating people as collaborators who are the masters of their own fate and capable of making healthy changes.
- Psychoeducational programs are educational and practical. They focus on improving the course of the family member's illness, reducing relapse rates, and enhancing patient and family functioning. This is achieved by educating the family about the illness, teaching families techniques that will help them cope with symptomatic behavior, and reinforcing family strengths.
- Family psychoeducation is an evidence-based practice that includes educational, supportive, cognitive, and behavioral components of at least 9 months' duration.
- Barriers to family involvement are gradually disappearing; however, only when issues of treatment and prevention include the family unit and not just the individual patient will they disappear completely.
- Of all the barriers to collaboration, confidentiality issues may be the most problematic because of the perception that professionals are caught between the patient's right to a confidential therapeutic relationship and the family caregiver's right to information. Skilled clinicians find a way to address this issue.
- The impact of mental illness is a traumatic event in the life of a family and family members are ideal candidates for secondary prevention strategies.
- Despite the known genetic risks for the offspring of parents with mental illness, these children are underserved in the mental health system.
- Collaboration between psychiatric nurses and families (and psychiatric nursing organizations and family advocacy groups) can reap rich rewards in terms of advancing prevention, treatment, and recovery in the field.

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CHAPTER 11

Implementing the Nursing Process: Standards of Practice and Professional Performance

Gail W. Stuart

The professional motive is the desire and perpetual effort to do the thing as well as it can be done, which exists just as much in the Nurse, as in the Astronomer in search of a new star, or in the Artist completing a picture.

Florence Nightingale

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the nursing process and the challenges it presents for those working with psychiatric patients.
2. Analyze the conditions and behaviors of the psychiatric nurse for each of the Standards of Practice.
3. Describe how accountability and autonomy relate to the psychiatric nurse's professional role responsibilities.
4. Analyze the conditions and behaviors of the psychiatric nurse for each of the Standards of Professional Performance.

By establishing a therapeutic nurse–patient relationship and using the nursing process, the nurse promotes the patient's mental health and well-being. This chapter discusses the Standards of Practice and the Standards of Professional Performance as described in *Psychiatric–Mental Health Nursing: Scope and Standards of Practice* (ANA, 2007).

- **The Standards of Practice describe what the psychiatric nurse does.**
- **The Standards of Professional Performance describe the context in which the psychiatric nurse performs these activities.**

Neither set of standards stands alone. Together they complete the picture of contemporary psychiatric nursing practice.

THE NURSING PROCESS

The **nursing process** is an interactive, problem-solving process and a systematic and individualized way to achieve the outcomes of nursing care. The nursing process respects the individual's autonomy and freedom to make decisions and be involved in nursing care. The nurse and patient are partners in a relationship built on trust and directed toward maximizing the patient's strengths, maintaining integrity, and promoting adaptive responses to stress. A nurse uses the nursing process with individuals, families, and groups at any point on the health-illness continuum. The needs of the patient will determine whether this process is directed toward primary, secondary, or tertiary prevention.

When used with psychiatric patients, the nursing process can present unique challenges. Mental health problems may be vague and elusive, not tangible or visible like many physiological illnesses. Many psychiatric patients may be unable to describe their problems. They may be withdrawn, highly anxious, or out of touch with reality. Their ability to participate in the problem-solving process also may be limited if they see themselves as powerless victims or if their illness impairs them from fully engaging in the treatment process.

It is essential that the nurse and the patient become partners in the problem-solving process. Nurses may be tempted to exclude patients, particularly if they resist becoming involved, but this should be avoided for two reasons. First, learning is most effective when patients participate in the learning experience. Second, by including patients as active participants in the nursing process, nurses help restore their sense of control over life and their responsibility for action. They reinforce the message that patients, whether they have an acute crisis or a serious and persistent mental illness, can choose either adaptive or maladaptive coping responses.

Most importantly, **only if a nurse establishes a true partnership with a patient can problems fully be identified and an effective treatment plan developed**. Most issues related to patient compliance are a result of a poor therapeutic alliance and a lack of mutually developed treatment goals and strategies.

STANDARDS OF PRACTICE

The phases of the nursing process as described by the Standards of Practice in *Psychiatric–Mental Health Nursing: Scope and Standards of Practice* are assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. **Validation is part of each step, and all phases may overlap or occur simultaneously.** The nursing conditions and nursing behaviors related to each of these phases are shown in Figure 11-1. Each of these phases, as it applies to psychiatric nursing practice, is now described.

> **Critical Reasoning** Some depressed patients are discouraged and disheartened by their illness. As a result, it may be difficult to engage them in the treatment process. What strategies might you use to develop a therapeutic alliance with them?

ASSESSMENT

Standard 1: Assessment

The psychiatric–mental health registered nurse collects comprehensive health data that are pertinent to the patient's health or situation.

Rationale

The assessment interview, which requires linguistically and culturally effective communication skills, interviewing, behavioral observation, record review, and comprehensive assessment of the patient and relevant systems, enables the psychiatric–mental health nurse to make sound clinical judgments and plan appropriate interventions with the patient.

Key Elements

Identify the patient's reason for seeking help.

Assess for risk factors related to the patient's safety, including potential for the following:

- Suicide or self-harm
- Assault or violence
- Substance abuse withdrawal
- Allergic reaction or adverse drug reaction
- Seizure
- Falls or accidents
- Elopement (if hospitalized)
- Physiological instability

Complete a biopsychosocial assessment of patient needs related to this treatment encounter, including the following:

- Patient and family appraisal of health and illness
- Previous episodes of psychiatric care in self and family
- Current medications
- Physiological coping responses
- Mental status coping responses

Coping resources, including motivation for treatment and functional supportive relationships

- Adaptive and maladaptive coping mechanisms
- Psychosocial and environmental problems
- Global assessment of functioning
- Knowledge, strengths, and deficits

In the assessment phase, information is obtained from the patient in a direct and structured manner through observations, interviews, and examinations. An assessment tool or nursing history form can provide a systematic format that becomes part of the patient's written record. It should include the mental status examination (see Chapter 6).

The nurse also should use the most appropriate behavioral rating scales. These can help define current pretreatment aspects of the patient's problems, increase the patient's involvement in treatment, document the patient's progress over time and the efficacy of the treatment plan, and compare the patient's responses with those of groups of people with the same illness. This information can help formulate diagnoses and treatment plans, as well as document clinical outcomes of care.

The patient data identified in Standard 1 relate to all parts of the Stuart Stress Adaptation Model used in this text: predisposing factors, precipitating stressors, appraisal of stressors, coping resources, coping mechanisms, and coping responses as described in Chapter 3. The baseline data should include both content and process, and the patient is the ideal source of validation. The nurse should select a private place, free from noise and distraction, in which to interview the patient.

Interviewing is a goal-directed method of communication. It is required in a formal admission procedure and should be focused but open ended, progressing from general to specific and allowing spontaneous patient self-expression. The nurse's role is to maintain the flow of the interview and to listen to the verbal and nonverbal messages conveyed by the patient. Nurses also must be aware of their responses to the patient.

Although the patient should be regarded as the primary source of validation, the nurse should be prepared to talk with family members or other people knowledgeable about the patient. This is particularly important when the patient is unable to provide reliable information because of the symptoms of the psychiatric illness. The nurse also might consider using a variety of other information sources, including the patient's health care record, nursing rounds, change-of-shift reports, nursing

ASSESSMENT

NURSING CONDITIONS
- Self-awareness
- Accurate observations
- Therapeutic communication
- Responsive dimensions of care

NURSING BEHAVIORS
- Establish nursing contract
- Obtain information from patient and family
- Validate data with patient
- Organize data

DIAGNOSIS

NURSING CONDITIONS
- Logical decision making
- Knowledge of normal parameters
- Inductive and deductive reasoning
- Sociocultural sensitivity

NURSING BEHAVIORS
- Identify patterns in data
- Compare data with norms
- Analyze and synthesize data
- Problems and strengths identified
- Validate problems with patient
- Formulate nursing diagnosis
- Set priorities of problems

OUTCOMES IDENTIFICATION

NURSING CONDITIONS
- Critical thinking skills
- Partnership with patient and family

NURSING BEHAVIORS
- Hypothesizing
- Specify expected outcomes
- Validate goals with patient

PLANNING

NURSING CONDITIONS
- Application of theory
- Respect for patient and family

NURSING BEHAVIORS
- Prioritize goals
- Identify nursing activities
- Validate plan with patient

IMPLEMENTATION

NURSING CONDITIONS
- Past clinical experiences
- Knowledge of research
- Responsive and action dimensions of care

NURSING BEHAVIORS
- Consider available resources
- Implement nursing activities
- Generate alternatives
- Coordinate with other team members

EVALUATION

NURSING CONDITIONS
- Supervision
- Self-analysis
- Peer review
- Patient and family participation

NURSING BEHAVIORS
- Compare patient's responses and expected outcome
- Review nursing process
- Modify nursing process as needed
- Participate in quality improvement activities

FIG 11-1 Nursing conditions and behaviors related to psychiatric nursing standards of practice.

care plan, and evaluation by other health professionals, such as psychologists, social workers, or psychiatrists.

> **Critical Reasoning** A patient admitted to your unit is not willing to communicate with you about the problems he is experiencing or his medical or psychiatric history. He also tells you that he does not want you to talk with his family members who brought him to the hospital. Given your understanding of patient confidentiality, what should you do?

DIAGNOSIS

Standard 2: Diagnosis

The psychiatric–mental health registered nurse analyzes the assessment data to determine diagnoses or problems, including level of risk.

Rationale

The basis for providing psychiatric–mental health nursing care is the recognition and identification of patterns of response to actual or potential psychiatric illnesses, mental health problems, and potential comorbid physical illnesses.

Key Elements

Diagnoses should reflect adaptive and maladaptive coping responses based on nursing frameworks such as those of NANDA International (NANDA-I).

Diagnoses should incorporate health problems or disease states such as those identified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association [APA], 2000) and the *International Classification of Diseases and Related Health Problems* (World Health Organization [WHO], 1992).

Diagnoses should focus on the phenomena of concern to psychiatric–mental health nurses as described in Box 11-1.

After collecting all data, the nurse compares the information with documented norms of health and adaptation. **Because standards of behavior are culturally determined, the nurse should consider both the patient's individual characteristics and the characteristics of the larger social group to which the patient belongs**. The nurse then analyzes the data and derives a **nursing diagnosis.** A nursing diagnosis is a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes (NANDA, 2009).

The subject of nursing diagnoses is the patient's behavioral response to stress. This response may lie anywhere on the coping continuum from adaptive to maladaptive. Phenomena of concern to psychiatric nurses are listed in Box 11-1.

Nursing interventions are based on the nursing assessment as well as the medical evaluation to ensure a coordinated plan of treatment. Therefore, when formulating nursing diagnoses and using the nursing process, nurses also should be familiar with medical diagnoses and treatment plans.

A **medical diagnosis** is the health problem or disease state of the patient. In the medical model of psychiatry the **health problems are mental disorders or mental illnesses that are classified in the *DSM-IV-TR*, which describes the symptoms of mental disorders** (APA, 2000). Specific diagnostic criteria are provided for each mental disorder but causes of the disorders are not discussed.

> **Critical Reasoning** If nurses are to be familiar with *DSM-IV-TR* medical diagnoses, should physicians be similarly knowledgeable about NANDA diagnoses?

OUTCOMES IDENTIFICATION

Standard 3: Outcomes Identification

The psychiatric–mental health registered nurse identifies expected outcomes for a plan individualized to the patient or to the situation.

Rationale

Within the context of providing nursing care, the ultimate goal is to influence mental health outcomes and improve the patient's health status.

BOX 11-1 PHENOMENA OF CONCERN FOR PSYCHIATRIC–MENTAL HEALTH NURSES

- Promotion of optimal mental and physical health and well-being and prevention of mental illness
- Impaired ability to function related to psychiatric, emotional, and physiological distress
- Alterations in thinking, perceiving, and communicating because of psychiatric disorders or mental health problems
- Behaviors and mental states that indicate potential danger to self or others
- Emotional stress related to illness, pain, disability, and loss
- Symptom management, side effects to toxicities associated with self-administered drugs, psychopharmacological intervention, and other treatment modalities
- The barriers to treatment efficacy and recovery posed by alcohol and substance abuse and dependence
- Self-concept and body image changes, developmental issues, life process changes, and end-of-life issues
- Physical symptoms that occur along with altered psychological status
- Psychological symptoms that occur along with altered physiological status
- Interpersonal, organizational, sociocultural, spiritual, or environmental circumstances or events that have an effect on the mental and emotional well-being of the individual and family or community
- Elements of recovery, including the ability to maintain housing, employment, and social support, that help individuals reengage in seeking meaningful lives
- Societal factors such as violence, poverty, and substance abuse

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Key Elements

Outcomes should be mutually identified with the patient.
Outcomes should be identified as clearly and objectively as possible.
Well-written outcomes help nurses determine the effectiveness and efficiency of their interventions.
Before defining expected outcomes, the nurse must realize that patients often seek treatment with goals of their own.

Patient outcomes may include relieving symptoms or improving functional ability. Sometimes a patient cannot identify specific goals or may describe them in general terms. Translating nonspecific concerns into specific goal statements is not easy. The nurse must understand the patient's coping responses and the factors that influence them.

- The patient may view a personal problem as someone else's behavior. This may be the case of a father who brings his adolescent son in for counseling. The father may view the son as the problem, whereas the adolescent may feel his only problem is his father. One approach to this situation is to focus help on the person who brought the problem into treatment because he "owns" the problem at that moment. The nurse might suggest, "Let's talk about how I could help you deal with your son. A change in your response might lead to a change in his behavior also."
- The patient may express a problem as a feeling, such as "I'm lonely" or "I'm so unhappy." Besides trying to help the patient clarify the feeling, the nurse might ask, "What could you do to make yourself feel less alone and more loved by others?" This helps patients see the connection among their actions, thoughts, and feelings and increase their sense of responsibility for themselves.
- The patient's problem may be one of lacking a goal or an idea of exactly what is desired from life. In this case it might be helpful for the nurse to point out that values and goals are not magically discovered but must be created by people for themselves. The patient can then actively explore ways to construct goals or adopt the objectives of a social, service, religious, or political group with whom the patient identifies.
- The patient's problem may be a choice conflict. This is especially common if all the choices are unpleasant, unacceptable, or unrealistic. An example is a couple who wants to divorce but does not want to see their child hurt or suffer the financial hardship that would result. Although undesirable choices cannot be made desirable, the nurse can help patients use the problem-solving process to identify the full range of alternatives available to them.

The patient's goals may be inappropriate, undesirable, or unclear. However, the solution is not for the nurse to impose goals on the patient. Even if the patient's desires seem to be against self-interests, the most the nurse can do is reflect the patient's behavior and its consequences. If the patient then asks for help in setting new goals, the nurse can help. **Mutually identifying goals and expected outcomes is an essential step in the therapeutic process.**

In this process a well-intentioned nurse sometimes overlooks the patient's goals and develops a treatment plan leading to an outcome that the nurse thinks is better. However, this is a mistake because the experience of working cooperatively with the nurse to identify mutually acceptable goals is extremely valuable. If the patient does not share the nurse's goals, it is best to wait until the patient agrees on its importance. If this is not done the patient is not likely to adhere to the treatment plan and will be seen as noncompliant.

Once overall goals are agreed on, the nurse must state them explicitly. Expected outcomes are derived from diagnoses, guide later nursing actions, and enhance the evaluation of care. Each goal is stated as an observable behavior and includes the period of time in which it is to be accomplished and any other conditions. Expected outcomes can be documented using standardized classification systems, such as the Nursing Outcomes Classification (NOC) (Moorhead et al, 2008). Long- and short-term goals should contribute to the expected outcomes. Following is a sample expected outcome and long- and short-term goals:

Expected outcome: Patient will be socially engaged in the community.

Long-term goal: The patient will travel about the community independently within 2 months.

Short-term goals:

- At the end of 1 week, the patient will sit on the front steps at home.
- At the end of 2 weeks, the patient will walk to the corner and back home.
- At the end of 3 weeks, the patient, accompanied by the nurse, will walk in the neighborhood.
- At the end of 4 weeks, the patient will walk in the neighborhood alone.
- At the end of 6 weeks, the patient will drive her car in the neighborhood.
- At the end of 8 weeks, the patient will drive to the mall and meet a friend for dinner.

In writing goals, psychiatric nurses should remember that they can be classified into the "ABCs," or three domains, of knowledge:

1. **Affective (feeling)**
2. **Behavioral (psychomotor)**
3. **Cognitive (thinking)**

Correctly identifying the domain of the expected outcome is very important in planning nursing interventions. Some psychiatric nurses place all their emphasis on outcomes related to learning new information (cognitive). They forget about the equally important needs of patients to acquire new values (affective) and to master new skills (behavior).

For example, it would be of limited help to teach a patient about medication if the patient did not value taking medications based on a personal belief system or previous life experiences. It would be equally unsuccessful to engage in medication education if the patient did not know how to take public transportation to fill the prescription.

Finally, it is important to explore with the patient the cost/benefit effect of all identified goals, that is, what is being given up (cost) versus what is being gained (benefit) from attaining the goal. This can be thought of as exploring advantages, or positive effects, and disadvantages, or negative effects.

Patients are not likely to commit themselves to a goal or to work toward attaining a goal if the stakes are too high or the payoffs too low. Exploring advantages and disadvantages helps the patient anticipate what price will be paid to achieve the goal and then decide if the change is worth the cost to oneself or significant others. Sometimes it is helpful to write these down in the form of two columns (advantages and disadvantages) that can be added to or changed at any time.

PLANNING

Standard 4: Planning

The psychiatric–mental health registered nurse develops a plan that prescribes strategies and alternatives to attain expected patient outcomes.

Rationale

A plan of care is used to guide therapeutic interventions systematically, document progress, and achieve the expected patient outcomes.

Key Elements

The plan of nursing care must always be individualized for the patient.

Planned interventions should be based on current evidence in the field and contemporary clinical psychiatric–mental health nursing practice.

Planning is done in collaboration with the patient, the family, and the health care team.

Documentation of the plan of care is an essential nursing activity.

One of the most important tasks for the nurse and patient is to assign priorities to the goals. **Those goals related to protecting the patient from self-destructive impulses always receive top priority.** Because the nursing care plan is dynamic, priorities are constantly changing. If the focus is always on the patient's behavioral responses, priorities can be modified as the patient changes. **If the goal answers the question of what, the plan of care answers the questions of how and why.** Once again, the patient's active involvement leads to a more successful care plan.

After writing a tentative care plan, the nurse must validate this plan with the patient. This communicates to the patient a sense of self-responsibility for getting well. The patient can tell the nurse that a proposed plan is unrealistic based on financial status, lifestyle, value system, culture or, perhaps, personal preference. Usually several approaches to a patient's problem are possible. Choosing the one most acceptable to the patient improves the chances for success. Failure to reach a goal through one plan can lead to the decision to adopt a new approach or re-evaluate the goal.

IMPLEMENTATION

Standard 5: Implementation

The psychiatric–mental health registered nurse implements the identified plan.

Rationale

In implementing the plan of care, psychiatric–mental health nurses use a wide range of interventions designed to prevent mental and physical illness and to promote, maintain, and restore mental and physical health. Psychiatric–mental health nurses select interventions according to their level of practice.

At the basic level nurses may select counseling, milieu therapy, promotion of self-care activities, intake screening and evaluation, psychobiological interventions, health teaching, case management, health promotion and health maintenance, crisis intervention, community-based care, psychiatric home health care, telehealth, and a variety of other approaches to meet the mental health needs of patients.

In addition to the intervention options available to the basic-level psychiatric–mental health nurse, at the advanced level the advanced practice registered nurse in psychiatric–mental health (APRN-PMH) may provide consultation, engage in psychotherapy, and prescribe pharmacological agents where permitted by state statutes or regulations.

Key Elements

Nursing interventions should reflect a holistic, biopsychosocial approach to patient care.

Nursing interventions are implemented in a safe, efficient, and caring manner.

The level at which a nurse functions and the interventions implemented are based on the nursing practice acts in one's state, the nurse's qualifications (including education, experience, and certification), the caregiving setting, and the nurse's initiative.

Standard 5A: Coordination of Care

The psychiatric–mental health registered nurse coordinates care delivery.

Standard 5B: Health Teaching and Health Promotion

The psychiatric–mental health registered nurse employs strategies to promote health and a safe environment.

Standard 5C: Milieu Therapy

The psychiatric–mental health registered nurse provides, structures, and maintains a safe and therapeutic environment in collaboration with patients, families, and other health care clinicians.

Standard 5D: Pharmacological, Biological, and Integrative Therapies

The psychiatric–mental health registered nurse incorporates knowledge of pharmacological, biological, and complementary interventions with applied clinical skills to restore the patient's health and prevent further disability.

Advanced-Practice Interventions 5E to 5G

The following interventions (5E to 5G) may be performed only by the APRN-PMH.

Standard 5E: Prescriptive Authority and Treatment

The psychiatric–mental health advanced practice registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.

Standard 5F: Psychotherapy

The psychiatric–mental health advanced practice registered nurse conducts individual, couples, group, and family psychotherapy using evidence-based psychotherapeutic frameworks and nurse-patient therapeutic relationships.

Standard 5G: Consultation

The psychiatric–mental health advanced practice registered nurse provides consultation to influence the identified plan, enhance the abilities of other clinicians to provide services for patients, and effect change.

The standards of practice for implementation are detailed and explicit. The standards identify the range of activities psychiatric nurses use. Information related to each of these implementation standards appears in various chapters throughout this text. Implementation is the actual delivery of nursing care to the patient and the patient's response to that care.

Nursing interventions should be based on evidence of the effectiveness of the treatment. The use of a standardized classification system of interventions that nurses perform, such as the Nursing Interventions Classification (NIC) (Bulechek et al, 2008), is useful for clinical documentation, communication of care across settings, integration of data across systems, effectiveness research, productivity measurement, competency evaluation, and reimbursement.

The psychiatric nurse helps the psychiatric patient do two things: develop insight and change behavior. These two areas for nursing intervention correspond with the responsive and action dimensions of the nurse–patient relationship described in Chapter 2.

Insight is the patient's development of new emotional and cognitive understandings. However, **knowing something on an intellectual level *does not* necessarily lead to a change in behavior.** Another step is needed. Patients must decide whether they will continue to use maladaptive coping mechanisms or adopt new, adaptive, and constructive approaches to life.

The first step in helping a patient translate insight into action is to build incentives to abandon old, maladaptive patterns of behavior. The nurse should help the patient see the negative consequences of current actions and that they do more harm than good. **The patient will not learn new patterns until the motivation to change is greater than the motivation to stay the same.** This is the idea behind **motivational interviewing** described in Chapter 2 and 27.

The nurse should encourage the patient's desires for mental health, emotional growth, and freedom from suffering. The nurse also should continue to motivate and support patients as they test new, adaptive behaviors and coping mechanisms. Many of the patient's maladaptive patterns have built up over years. The nurse cannot expect the patient to change them in a matter of days or weeks. The nurse must help the patient evaluate these new patterns, integrate them into life experiences, and practice problem solving to prepare for future experiences.

A final issue for the psychiatric nurse to consider in the implementation process is that there are four possible treatment stages:

- Crisis
- Acute
- Maintenance
- Health promotion

The nursing goal, assessment, intervention, and expected outcome vary with each stage, as described in Chapter 3. It is critically important for psychiatric nurses to determine the patient's stage of treatment and then implement nursing activities that target the treatment goal in the most cost-effective and efficient manner.

> **Critical Reasoning** Graduating nursing students are sometimes advised to work in a medical-surgical setting before going into psychiatry so that they can learn "basic nursing skills." Why is this suggestion no longer valid given the types of treatments and range of settings in which psychiatric patients now receive care?

EVALUATION

Standard 6: Evaluation

The psychiatric–mental health registered nurse evaluates progress toward attainment of expected outcomes.

Rationale

Nursing care is a dynamic process involving change in the patient's health status over time, giving rise to the need for data, different diagnoses, and modifications in the plan of care. Therefore, evaluation is a continuous process of appraising the effect of nursing and the treatment regimen on the patient's health status and expected outcomes.

Key Elements

Evaluation is an ongoing process.
Patient and family participation in evaluation is essential.
Goal achievement should be documented and revisions in the plan of care should be implemented as appropriate.

Evaluation is a mutual process based on the patient's and family's previously identified goals and their satisfaction with the processes and outcomes of care. Patients, families, and psychiatric nurses often have different views of treatment and the effectiveness of care. It is therefore critical that psychiatric nurses have a systematic and objective way to learn from patients and families which aspects of the nursing care provided were helpful and what additional nursing actions may have further helped them.

Often, progress with psychiatric patients is slow and occurs in small steps rather than dramatic leaps. Realizing that progress has been made can produce growth and inspire new hope in both the patient and the nurse.

STANDARDS OF PROFESSIONAL PERFORMANCE

The conditions and behaviors related to each standard of professional performance are shown in Figure 11-2. The Standards of Professional Performance apply to self-definition, self-regulation, accountability, and autonomy for practice by psychiatric nurses, both individually and as a group. Each of these standards is discussed here.

QUALITY OF PRACTICE	
NURSING CONDITIONS	**NURSING BEHAVIORS**
Personal and professional integrity Openness to inquiry Critical thinking skills	Identify improvement opportunities Collect and analyze relevant data Formulate a planned approach for improvement Implement suggested changes

EDUCATION	
NURSING CONDITIONS	**NURSING BEHAVIORS**
Intellectual curiosity Desire for professional growth Access to new information	Seek out new knowledge and learning experiences Apply new information in clinical practice Demonstrate increasing mastery of nursing

PROFESSIONAL PRACTICE EVALUATION	
NURSING CONDITIONS	**NURSING BEHAVIORS**
Self-awareness Acceptance of feedback from others Desire to improve professional performance	Engage in ongoing supervision Participate in peer review activities Use information to improve clinical practice

COLLEGIALITY	
NURSING CONDITIONS	**NURSING BEHAVIORS**
Respect for nursing peers Value reciprocal interactions	Share ideas with others Give feedback positively and constructively Actively support fellow nurses

FIG 11-2 Nursing conditions and behaviors related to the psychiatric nursing standards of professional performance.

Continued

QUALITY OF PRACTICE

Standard 7: Quality of Practice

The psychiatric–mental health registered nurse systematically enhances the quality and effectiveness of nursing practice.

Rationale

The dynamic nature of the mental health care environment and the growing body of psychiatric nursing knowledge and research provide both the impetus and the means for the psychiatric–mental health nurse to be competent in clinical practice, to continue to develop professionally, and to improve the quality of patient care.

Key Elements

The nurse should be open to critically analyzing the caregiving process.

The patient and family should be partners with the nurse in the evaluation of care activities.

Improving the quality of care provided goes beyond discussion and analysis to actually implementing actions that will improve practice.

> **Critical Reasoning** Describe how quality is related to patient safety and clinical effectiveness in the psychiatric setting.

Psychiatric nurses participate in the organizational evaluation of overall patterns of care through a variety of **quality improvement** or **process improvement activities.** In these activities, the focus is not on the nurse but on the patient, the overall program of care, and health-related outcomes of care. Specific objectives include the following:

- Continuous improvement of customer satisfaction
- Continuous improvement of patient outcomes
- Efficient use of resources
- Adherence to professional and regulatory standards

COLLABORATION

NURSING CONDITIONS
- Positive self-concept
- Clear sense of professional identity and accountability
- Ability to work with others in a cooperative manner

NURSING BEHAVIORS
- Assertively contribute one's professional expertise
- Share planning and decision making with others
- Make referrals when appropriate

ETHICS

NURSING CONDITIONS
- Ability to engage in introspection
- Sensitivity to social and moral issues
- Commitment to the value clarification process

NURSING BEHAVIORS
- Guide practice by the *Code for Nurses*
- Practice with legal and ethical responsibility
- Act as patient and family advocate

RESEARCH

NURSING CONDITIONS
- Quest for new knowledge or answers to questions
- Acute observational and analytical skills
- Persistence and attention to detail

NURSING BEHAVIORS
- Review reports of nursing research
- Generate questions and identify clinical problems
- Implement research findings in practice

RESOURCE UTILIZATION

NURSING CONDITIONS
- Knowledge of the political and economic environment
- Ability to evaluate costs and benefits of treatment
- Skill in negotiating and accessing resources

NURSING BEHAVIORS
- Fact-based decision making
- Cost-effective allocation of resources
- Patient advocacy on an individual and collective basis

LEADERSHIP

NURSING CONDITIONS
- Professional self-efficacy
- Creativity, flexibility, and openness to change
- Commitment to improving the current system

NURSING BEHAVIORS
- Professional assertiveness
- Thoughtful risk-taking
- Teach and mentor others
- Participate in organizational/system governance

FIG 11-2, cont'd Nursing conditions and behaviors related to the psychiatric nursing standards of professional performance.

Psychiatric nurses play essential roles in identifying opportunities for improvement, collecting data for analysis of the current process, evaluating the effectiveness of the new processes, and representing nursing's perspective to the improvement team.

> **Critical Reasoning** Find out about a quality improvement project that is currently underway in your clinical facility. Does it relate to patient satisfaction, health outcomes, use of resources, or adherence to standards?

EDUCATION

Standard 8: Education

The psychiatric–mental health registered nurse attains knowledge and competency that reflect current nursing practice.

Rationale

The rapid expansion of knowledge pertaining to basic and behavioral sciences, technology, information systems, and research requires a commitment to learning throughout the psychiatric–mental health

nurse's professional career. Formal education, continuing education, independent learning activities, and experiential and other learning activities are some of the means the psychiatric–mental health nurse uses to enhance nursing expertise and advance the profession.

Key Elements

Professional learning should be regarded as a lifelong process.
The nurse should pursue a variety of educational opportunities.
New knowledge should be translated into professional nursing practice.

Psychiatric nurses are expected to engage in a continuous learning process to keep up with emerging knowledge. They may do this in the following ways:

- Formal educational programs
- Continuing education programs
- Independent learning activities
- Lectures, conferences, and workshops
- Credentialing
- Certification

Reading journals and textbooks and collaborating with colleagues are other important ways to remain current with expanding areas of knowledge. Journals that relate to psychiatric nursing practice include *Archives of Psychiatric Nursing, Journal of the American Psychiatric Nurses Association, Journal of Psychosocial Nursing, Journal of Child and Adolescent Psychiatric Nursing, Issues in Mental Health Nursing,* and *Perspectives in Psychiatric Care*. A major resource for psychiatric nurses is the Internet, which allows nurses access to information from around the globe.

PROFESSIONAL PRACTICE EVALUATION

Standard 9: Professional Practice Evaluation

The psychiatric–mental health registered nurse evaluates one's own practice in relation to the professional practice standards and guidelines and relevant statutes, rules, and regulations.

Rationale

The psychiatric–mental health nurse is accountable to the public for providing competent clinical care and has inherent responsibility as a professional to evaluate the role and performance of psychiatric–mental health nursing practice according to standards established by the profession.

Key Elements

Supervision should be viewed as an essential and ongoing aspect of one's professional life.
The nurse should strive to grow and develop professional knowledge, skills, and expertise.

Professional practice evaluation for the psychiatric nurse is generally provided in two ways: administrative and clinical. **Administrative performance appraisal** involves the review, management, and regulation of competent psychiatric nursing practice. It involves a supervisory relationship in which a nurse's work performance is compared with role expectations in a formal way, such as in a nurse's annual performance evaluation. Administrative performance evaluations should identify areas of competency and areas for improvement.

Clinical performance appraisal is guidance provided through a mentoring relationship and clinical supervision with a more experienced, skilled, and educated nurse. **Clinical supervision** is a support mechanism for practicing professionals within which they can share clinical, organizational, developmental, and emotional experiences with another professional in a secure, confidential environment to enhance knowledge and skills. Psychiatric nurses are aware of the need for ongoing mentorship to improve their nursing practice. Clinical supervision reviews one's clinical care and also can serve as a support system for the nurse.

In many ways the process of supervision parallels the nurse-patient relationship. Both involve a learning process that takes place in the context of a meaningful relationship that facilitates positive change. Self-exploration is a critical element of both. The supervisor should provide the same responsive and action dimensions present in the nurse–patient relationship to help supervised nurses be most effective.

The common types of supervision are as follows:

- **Dyadic,** or one-on-one supervision, in which the supervisor meets individually with the nurse being supervised
- **Group** supervision, in which several supervised nurses meet for a shared session with the supervisory nurse
- **Peer review,** in which nurses meet with nurse colleagues without a supervisor to evaluate their clinical practice

All have the same purpose of exploring problem areas and maximizing the strengths of those being supervised.

Despite its intensity, **supervision is not therapy.** The essential difference between the two is a difference of purpose. **The goal of supervision is to teach psychotherapeutic skills.** The goal of therapy is to change a person's way of coping to help the person to function more effectively. Supervision or consultation is necessary for the practicing psychiatric nurse. Although it is essential for novices, it is equally important for experienced practitioners. Finally, supervision is only as helpful as the skill of the supervisor, the openness of the supervised nurse, and the motivation of both to learn and grow.

COLLEGIALITY

Standard 10: Collegiality

The psychiatric–mental health registered nurse interacts with and contributes to the professional development of peers and colleagues.

Rationale

The psychiatric–mental health nurse is responsible for sharing knowledge, research, and clinical information with colleagues, through formal and informal teaching methods, to enhance professional growth.

Key Element

The nurse should regard other nurses as colleagues and partners in caregiving. Mentorship within nursing is important both to nurses as individuals and to the nursing profession as a whole.

Collegiality requires that nurses view their nurse peers as collaborators in the caregiving process who are valued and respected for their unique contributions, regardless of educational, experiential, or specialty background. It suggests that nurses view themselves as members of an organized professional group or unit and that **nurses trust, support, and demonstrate commitment to other nurses**.

Nurses need to work together as colleagues to blend their various skills and abilities in creating a better health care system and enhancing the quality and quantity of psychiatric nursing services provided. One way to do this is for psychiatric nurses to join a professional nursing organization. The largest psychiatric nursing organization that is open to nursing students and psychiatric nurses of all educational and experiential backgrounds is the American Psychiatric Nurses Association (APNA). Information about joining is available on their website: www.apna.org.

> **Critical Reasoning** You approach a colleague about joining APNA, but she tells you that she does not have the money to join a nursing organization. You know that membership in APNA costs less than $3 per week and it includes a subscription to the *Journal of the American Psychiatric Nurses Association*. How would you respond?

COLLABORATION

Standard 11: Collaboration

The psychiatric–mental health registered nurse collaborates with patients, family, and others in the conduct of nursing practice.

Rationale

Psychiatric–mental health nursing practice requires a coordinated, ongoing interaction between consumers and clinicians to deliver comprehensive services to the patient and the community. Through the collaborative process, different abilities of health care clinicians are used to identify problems, communicate, plan and implement interventions, and evaluate mental health services.

Key Elements

Respect for others grows out of respect for self.

Nurses should be able to clearly articulate their professional abilities and areas of expertise to others.

Collaboration involves the ability to negotiate and formulate new solutions with others.

Collaboration is the shared planning, decision making, problem solving, goal setting, and assumption of responsibilities by individuals who work together cooperatively and with open communication. Three key ingredients are needed for collaboration:

1. Active and assertive contributions from each person
2. Receptivity and respect for each person's contribution
3. Negotiations that build on the contributions of each person to form a new way of conceptualizing the problem

Psychiatric nurses have many potential collaborators, including patients and families, interdisciplinary colleagues, and nursing peers (Figure 11-3). Each of these groups allows the psychiatric nurse an opportunity to solve problems in new ways and thus better plan and implement nursing care. Most organized mental health settings use an interdisciplinary or interprofessional team approach, which requires highly coordinated and often interdependent planning based on the separate and distinct roles of each team member (Table 11-1).

It is important for nurses to maintain their professional identity and integrity when they collaborate with other professionals. Within the health care setting, psychiatric nurses must determine whether they as a group are ready to engage in collaborative practice. Questions that should be considered include the following:

- Can psychiatric nurses define, describe, and appropriately defend psychiatric nursing roles and functions?
- Is the psychiatric nursing leadership ready for collegial practice?
- Are psychiatric nursing roles and functions appropriate for nurses' education, experience, and expertise?
- Is nurse staffing appropriate in numbers, patterns, and ratios?
- Are the other disciplines prepared for and supportive of collaboration?
- Is the organizational climate conducive to collaboration?

With positive answers to these questions, psychiatric nurses should be able to implement collaborative practice.

> **Critical Reasoning** Many people think that there are more *collaborative* interdisciplinary relationships in psychiatry than in other specialty areas because of the nature of the work. Others believe that there is more interdisciplinary *conflict* in psychiatry because roles overlap and boundaries are often unclear. What do you think based on your observation of the mental health care team?

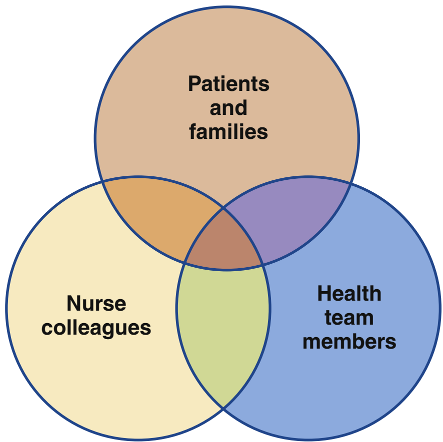

FIG 11-3 Collaborative relationships for psychiatric nurses.

TABLE 11-1 **MENTAL HEALTH PERSONNEL, TRAINING, AND ROLES**

PERSONNEL	TRAINING	ROLE/FUNCTION
Psychiatric nurse	Registered nurse (RN) with specialized training in the care and treatment of psychiatric patients; may have an AD, BS, MS, DNP, or PhD degree	Biopsychosocial nursing care of patients and families and their milieu
Psychiatrist	Medical doctor (MD) with internship and residency training in psychiatry	Medical diagnosis and treatment of patients with psychiatric disorders
Social worker	May have a BS, MSW, or PhD degree with specialized training in mental health settings	Family casework and community placement of patients
Psychologist	Has a PhD or PsyD degree with research and clinical training in mental health	Psychological assessments, testing, and treatments
Activity therapist	May have a BS degree with training in mental health settings	Recreational, occupational, and activity programs
Case worker	Has varying degrees of training and usually works under supervision	Helps patients to be maintained in the community and receive needed services
Substance abuse counselor	Has varying degrees of training in alcohol and substance use disorders	Evaluates and treats patients with substance use problems
Peer counselor	Self-identified as a consumer who is receiving or has received mental health services and is well grounded in their own mental health recovery; may or may not have formal training	Helps consumers identify goals and receive services that promote recovery and resiliency

ETHICS

Standard 12: Ethics

The psychiatric–mental health registered nurse integrates ethical provisions in all areas of practice.

Rationale

The public's trust and its right to humane psychiatric–mental health care are upheld by professional nursing practice. Ethical standards describe a code of behaviors to guide professional practice. People with psychiatric–mental health needs are an especially vulnerable population. The foundation of psychiatric–mental health nursing practice is the development of a therapeutic relationship with the patient. Boundaries need to be established to safeguard the patient's well-being.

Key Elements

Nurses should be sensitive to the social, moral, and ethical environment in which they practice.

Patient and family advocacy is a core aspect of nursing practice.

Ethical conduct is essential to the nurse–patient relationship.

Ethical considerations combine with legal and therapeutic issues to affect all aspects of psychiatric nursing practice. The legal and ethical context of psychiatric nursing care is discussed in Chapter 8. Boundary violations related to the nurse–patient relationship are described in Chapter 2. The American Nurses Association (2001) has a code of ethics for nurses. It emphasizes that the nurse's primary commitment is to the patient and expands the ethical perspective of nurses to include the health care system and duties of the nurse to oneself.

RESEARCH

Standard 13: Research

The psychiatric–mental health registered nurse integrates research findings into practice.

Rationale

Nurses in psychiatric–mental health nursing are responsible for contributing to the further development of the field of mental health by participating in research. At the basic level of practice, the psychiatric–mental health nurse uses research findings to improve clinical care and identifies clinical problems for research study. At the advanced level, the psychiatric–mental health nurse engages and/or collaborates with others in the research process to discover, examine, and test knowledge, theories, and creative approaches to practice.

Key Elements

Research links nursing theory and practice and is essential to the development of a profession.

Outcome research helps to establish the value of nursing in an era of health care reform.

The progression of observing from practice, theorizing, testing in research, and modifying practice is an essential part of psychiatric nursing. The clinical problems are many, and as nurses gain the skills and experience to validate their work scientifically, they can make a significant contribution to psychiatric theory and practice through research. Actively involving consumers and families in psychiatric research can improve the quality of research and clinical outcomes. In this process the role of the nurse is one of patient advocate and educator. The nature and process of outcomes research and evidence-based practice are discussed in Chapter 4.

RESOURCE UTILIZATION

Standard 14: Resource Utilization

The psychiatric–mental health registered nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.

Rationale

The patient is entitled to psychiatric–mental health care that is safe, effective, and affordable. As the cost of health care increases, treatment decisions must be made in such a way as to maximize resources and maintain quality of care. The psychiatric–mental health nurse seeks to provide cost-effective, quality care by using the most appropriate resources and delegating care to the most appropriate, qualified health care clinician.

Key Elements

Nurses play a critical role in integrating and coordinating health care services.
Nurses should be fiscally accountable for the care they provide.
Resources should be allocated based on cost/benefit analyses and documented expected outcomes.

Resource use is one of the most important aspects of psychiatric nursing practice. Discussing the costs and benefits of treatment options with patients, families, providers, and reimbursers is an essential part of the professional psychiatric nursing role. To meet this performance standard, psychiatric nurses need to request and obtain both cost and outcome information related to tests, consultations, evaluations, therapies, and continuum of care alternatives. **Nurses need to assume an active role in questioning, advising, and advocating for the most cost-effective use of resources.**

Critical Reasoning Psychiatric nurses must become increasingly cost and outcome conscious. Identify three commonly ordered tests for psychiatric patients. Find out how much they cost, and analyze how helpful they are in planning treatment.

LEADERSHIP

Standard 15: Leadership

The psychiatric–mental health registered nurse provides leadership in the professional practice setting and the profession.

Rationale

Psychiatric nurses have a responsibility to demonstrate leadership by working for greater professional accountability and autonomy for nurses through a negotiated process with their peers, other health care providers, administrators, consumers, and society at large, with the ultimate goal of improving patient care.

Key Elements

An inherent part of nurses' role should be focused on the growth and success of their profession, their peers, and the care provided in their practice setting.
Mentorship and team building are skills to be cultivated.
Advocacy and participation in key governance groups are the best way to effect change.

The standard of leadership is one of the most important, since it requires psychiatric nurses to think beyond their immediate caregiving responsibilities to the way in which they can impact the broader health care environment. Their interactions with other nurses and providers, health care administrators, and the public define them and reflect on their profession.

Nurses who have a positive regard for themselves, their knowledge, and their skills will reach out to mentor and teach others, including new nursing students, trainees, and professional colleagues. They will be open to new ideas and see every problem as an opportunity for new learning. They also will understand that true change comes about through active participation on influential committees, boards, and decision-making bodies. They will therefore be both active and proactive in sharing their understandings, challenging existing ways of thinking, and demonstrating leadership on behalf of their profession and the patients whom they serve.

Box 11-2 provides a case study of the use of the nursing process with a psychiatric patient.

BOX 11-2 CASE STUDY

This case study describes the use of the nursing process with a psychiatric patient. It shows the interrelationship of the phases of the nurse-patient relationship, the therapeutic partnership, and various activities as the nurse works with the patient to foster adaptive coping behavior and more integrated functioning.

Assessment

Ms. G came to the psychiatric outpatient department of the local hospital requesting treatment with a female therapist. The advanced practice psychiatric nurse agreed to perform the initial screening and evaluation and consider serving as her primary therapist.

To collect the initial data, the nurse followed the admission format required by the department. A description of the presenting problem revealed that Ms. G was a 29-year-old single woman who was neat in appearance and markedly overweight. She reported feelings of "confusion and depression" and said that superficially she appeared "outgoing and friendly and played the role of a clown." In reality, however, she said she had few close friends, felt insecure about herself, felt unsuccessful in her job, and believed she "overanalyzed her problems." She said she had feelings of worthlessness and loss of pleasure in her daily activities on and off for the past 2 years.

Additional information was gathered about other significant areas of her life. Her psychosocial history revealed a disrupted family situation. Her mother died of tuberculosis when she was 11 years of age. Her father, 73 years old, was alive but had been an alcoholic for as long as Ms. G could remember. She had one sister, 20 years old, who married at age 16 and was now divorced. She also had one stepsister, 45 years old, who was married, had two adopted sons, and lived out of state.

BOX 11-2 CASE STUDY—cont'd

In giving this family information, Ms. G revealed that her stepsister was her natural mother, but she had continued to call her father's wife "mother." After her "mother" died, her stepsister took over the house. However, 2 years later this stepsister married and moved out of state. Ms. G reported feeling closest to this stepsister and felt abandoned when she left. Ms. G then took charge of the house until 14 years of age, when her father placed her and her younger sister in a group home, where she had difficulty making friends.

Ms. G completed high school and college. In college she had four good friends who were all married now. Her only close heterosexual relationship was in high school, and this boyfriend eventually married her best friend. Since that time she had never dated and stated she had no desire to marry. After college she obtained a job as a "girl Friday" for a law firm and was very happy there. She then saw the opportunity to make more money as a waitress and switched jobs. She currently works at a restaurant, and her schedule involves day and night rotations and weekend shifts. She expressed dissatisfaction with many aspects of her job but she could not think of alternatives to it. Her goal in life was to have a fulfilling career. She lived alone. Her best friend was her immediate supervisor at work. She currently had no male friends and only two other female acquaintances.

Pertinent medical history included a major weight problem. She was 36 kg (80 pounds) overweight and extremely conscious of it. She viewed her body negatively and believed others also were "repulsed" by her weight. She recently recovered from infectious hepatitis. She drank an occasional beer when out with friends (once or twice a month), denied any drug use, and smoked three fourths of a pack of cigarettes per day.

Diagnosis

The psychiatric nurse agreed to work with Ms. G as her primary therapist. At their next meeting they set a contract for working together and a fee for treatment. They explored Ms. G's expressed guilt over seeking help, the reason for her request for a female therapist, their mutual roles, and the confidential nature of the relationship. The nurse also shared with Ms. G the maladaptive coping responses she had noted and the inferences she had made. They discussed these areas, and the following nursing diagnoses were identified:

1. Chronic low self-esteem related to childhood rejection and unrealistic self-ideals, as evidenced by feelings of worthlessness
2. Social isolation related to ambivalence regarding male–female relationships and lack of socialization skills, as evidenced by lack of close friends
3. Ineffective role performance related to job dissatisfaction with working hours and nature of the work, as evidenced by feeling unsuccessful in her job
4. Disturbed body image related to weight control problem, as evidenced by negative feelings

Ms. G's *DSM-IV-TR* diagnosis was identified as dysthymia, a mood disorder.

Outcomes Identification

They mutually agreed to work on her problem areas in weekly therapy sessions. After 3 months they would evaluate the achievement of the following expected outcomes: consistently positive self-esteem; substantial social involvement; enhanced role performance; and improved body image. These expected outcomes would be met through the attainment of the following goals:

1. Ms. G will describe her expectations of the therapeutic process and her commitment to it.
2. Aspects of Ms. G's self-ideal will be identified and realistically evaluated.
3. Cognitive distortions influencing her self-concept and negative, stereotyped self-perceptions will be analyzed.
4. Interpersonal relationships will be examined to include her patterns of relating, her expectations of others, and specific areas of difficulty.
5. Alternative employment opportunities will be identified.
6. The advantages and disadvantages of a job change will be compared.

Planning

In discussing these areas they agreed that nursing diagnosis 1 was a central one and problems 2, 3, and 4 directly contributed to her low self-esteem. Her coping mechanisms included intellectualization and denial, and she compensated for her self-doubts by an outward appearance that was social, joking, and friendly, yet superficial. Her strengths were her ability to analyze events, her openness to new ideas, the resource people available to her in her immediate environment, and her genuine sense of humor.

Implementation

Because they were in the introductory phase of the relationship, many of the goals involved areas needing further assessment. During this phase of treatment, Ms. G displayed much anxiety, testing behavior, and ambivalence, and the nursing actions were focused on promoting respect, openness, acceptance, and minimizing her anxiety. Through the nurse's use of empathic understanding, Ms. G became less jovial and superficial and began to gain some intellectual insight into her behavior. With guidance she began to appraise her own abilities, became more open in expressing feelings, and was able to examine her thoughts and beliefs about herself.

She feared intimate personal involvement and could not tolerate physical closeness. The nurse incorporated this into nursing actions by initially minimizing confrontation, setting limits on anxiety-producing topics, and arranging the office seating to allow the patient to select her distance from the nurse. As they discussed the patient's relationships, the nurse confronted her with the dependent role she played and the unrealistic expectations she placed on others in the exclusiveness and amount of time she demanded from them. Her pattern of relating also was a problem in that she elicited a sympathetic response and then used it to meet her own needs. She had great difficulty with mutuality and autonomy in relating to others. She was inexperienced in heterosexual relationships and missed many of the normal adolescent growth experiences in this area.

Finally, she had much emotion and fear vested in her family of origin. The only trusting relationship Ms. G could recall was with her stepsister-mother. When this stepsister abruptly left home to marry, Ms. G took this as a personal rejection. She had since isolated herself from her family and continued

BOX 11-2 CASE STUDY—cont'd

to blame herself for her rejection by others, thus lowering her self-esteem and ability to trust others.

At the end of 2 months Ms. G was being considered for a promotion at work to hostess but, on the basis of an evaluation by her best friend and supervisor, was rejected for it. This precipitated a suicide attempt. At this point the issue of her safety and trust within the relationship became critical, as well as her inability to express anger because she feared rejection. The nurse became more active in helping Ms. G modify her negative thoughts, setting limits on her self-destructive behavior, and suggesting alternatives. Ms. G then revealed that her relationship with her friend-supervisor was also a sexual one, and she expressed fears of homosexuality and loss of identity.

In later sessions, Ms. G's relationship with this friend became a critical therapeutic issue because it reflected many of her conflicts. The therapy process was a threat to the unhealthy parts of this relationship, and during the course of therapy Ms. G decided she needed to choose between maladaptive behaviors and more growth-producing options. The nurse-patient relationship had now moved into the working phase, where focus was placed on specifics, and problem-solving activities began. After 3 months the nursing diagnoses were reevaluated to include the following:

1. Risk for self-directed violence related to perceived rejection by friend, as evidenced by suicide attempt
2. Disturbed personal identity related to childhood rejection and unrealistic self-ideals, as evidenced by self-statements
3. Social isolation related to inability to trust, lack of socialization skills, and feelings of inadequacy, as evidenced by relationship patterns
4. Powerlessness related to fear of rejection by others, as evidenced by perceived lack of control over life events
5. Ineffective role performance related to job dissatisfaction with working hours and nature of the work, as evidenced by feeling unsuccessful in her job

At this time the nurse sought consultation as her plan of care evolved. Neither medication nor hospitalization was indicated. These formulations were shared with Ms. G, who contracted for safety with the nurse, and together they collaborated about her future progress. They agreed to focus on changing Ms. G's maladaptive behavior by exploring her dysfunctional thoughts, feelings, and behaviors and helping her learn more productive coping strategies. Ms. G was now ready to commit herself to the work of therapy and interpersonal change, and she began to assume increased responsibility for this therapeutic work.

Because her self-ideal was unrealistically high, specific short-term goals became essential. The relationship was focused on through the use of immediacy and became a model for examining many of her conflicts. This proved to be an excellent learning opportunity as Ms. G and the nurse dealt with resistance, transference, and countertransference reactions. During the next couple of months Ms. G made much progress, including the following changes:

1. She moved into an apartment with another girlfriend.
2. She left her previous job and resumed working in an office, where she received more personal satisfaction and a work schedule that allowed her to increase her social activities.
3. She began a diet regimen.
4. She participated in additional activities, such as a dancing class and a health spa.
5. She learned to verbalize her anger more freely with the nurse, friends, and others at work. This included discussing the many relationships in her past that were terminated without her agreement and in which she had internalized her anger.
6. She contacted her stepsister-mother and visited her. This was an important therapeutic goal because it allowed her to review her early experiences and provided her with actual feedback from those involved. Consequently, many of her misperceptions became evident and open to exploration in therapy.
7. She was able to admit her ambivalent feeling about her friend-supervisor and discuss the negative aspects of the relationship.
8. She stopped further sexual contact with the friend-supervisor because she felt exploited. Over time the nature of this relationship changed, and it eventually became a casual acquaintance.
9. She learned about the variety of sexual feelings and responses and saw her needs in this area as appropriate developmental tasks. She became open to evaluating both heterosexual and homosexual expressions of her own sexual feelings.
10. Her perception of personal space changed, and her tolerance for physical closeness increased.
11. She developed new male and female friends and socialized with them.

Evaluation

The terminating phase of the relationship began after about 5 months. At that time Ms. G was independently solving problems, and, in therapy, the nurse primarily validated and supported her thinking. She was now receiving and accepting positive feedback from others, had lost 9 kg (20 pounds), was continuing to diet, was planning future career goals, and had more satisfactory interpersonal relationships with both men and women. The mutual goals for therapy had been met.

Terminating was difficult because of the close, trusting bond that had developed between them. The nurse had feelings of pleasure in Ms. G's growth, as well as personal satisfaction in her effectiveness as therapist. Ms. G openly described her feelings about terminating and raised the question of a possible social relationship between them. Over the course of the sessions she came to realize that the premise of the relationship was therapy and changing patterns of relating would not be feasible or desirable. Most important, she had control over terminating this relationship and the opportunity to work through it in a positive way.

CHAPTER IN REVIEW

- The Standards of Practice describe what the psychiatric nurse does. The Standards of Professional Performance describe the context in which the psychiatric nurse performs these activities.
- In the assessment phase, information is obtained from the patient in a direct and structured manner through observations, interviews, and examinations. Patient data collected at this time relate to all of the components of the Stuart Stress Adaptation Model used in this text: predisposing factors, precipitating stressors, appraisal of stressors, coping resources, coping mechanisms, and coping responses.
- The subject of nursing diagnoses is the patient's behavioral response to stress. This response may lie anywhere on the coping continuum from adaptive to maladaptive.
- Mutually clarifying goals and identifying expected outcomes are an essential step in the therapeutic process.
- The nursing care plan applies theory and research from nursing and related biological, behavioral, and social sciences to the unique responses of the individual patient.
- The nurse helps the psychiatric patient do two things: develop insight and change behavior. It is important for psychiatric nurses to determine the patient's stage of treatment and then implement nursing activities that target the treatment goal in the most cost-effective and efficient manner.
- Evaluation is a continuous, active process that begins early in the relationship and continues throughout.
- The Standards of Professional Performance apply to self-definition, self-regulation, accountability, and autonomy for practice by psychiatric nurses, both individually and as a group.
- Psychiatric nurses actively participate in the formal organizational evaluation of overall patterns of care through a variety of quality improvement or process improvement activities.
- Psychiatric nurses are expected to engage in a continuous learning process to keep up with rapidly emerging knowledge in the field.
- Professional practice evaluation for the psychiatric nurse can be administrative and clinical. Administrative performance appraisal involves the review, management, and regulation of competent psychiatric nursing practice. Clinical performance appraisal is guidance provided through a mentoring relationship and clinical supervision by a more experienced, skilled, and educated nurse.
- Collegiality requires that nurses view their nurse peers as collaborators in the caregiving process who are valued and respected for their unique contributions, regardless of educational, experiential, or specialty background.
- Collaboration is the shared planning, decision making, problem solving, goal setting, and assumption of responsibilities by individuals who work together cooperatively and with open communication.
- Ethical considerations combine with legal and therapeutic issues to affect all aspects of psychiatric nursing practice.
- As nurses gain the skills and experience to validate their work scientifically, they can make a significant contribution to psychiatric theory and practice through research.
- Nurses need to assume an active role in questioning, advising, and advocating for the most cost-effective use of resources.
- Psychiatric nurses have a responsibility to demonstrate leadership in the practice setting through a negotiated process with their peers, other health care providers, administrators, consumers, and society at large, with the ultimate goal of improving patient care.

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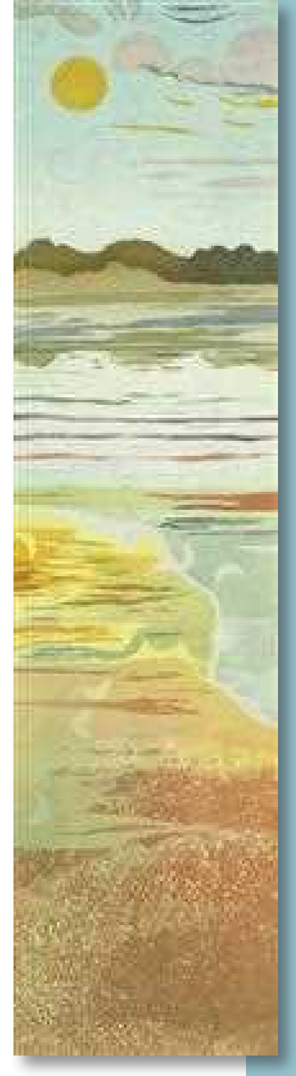
UNIT 2

Continuum of Care



CHAPTER

12

Prevention and Mental Health Promotion

Gail W. Stuart

What is this thing called health? Simply a state in which the individual happens transiently to be perfectly adapted to his environment. Obviously, such states cannot be common, for the environment is in constant flux.

H.L. Mencken, The American Mercury, March 1930

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the aims and activities of mental health promotion and mental illness prevention.
2. Compare and contrast the public health, medical, and nursing models of primary prevention.
3. Assess the vulnerability of various groups to developing maladaptive coping responses.
4. Analyze the levels of intervention and activities related to the following primary prevention nursing interventions: health education, environmental change, social support, and stigma reduction.
5. Assess the importance of evaluation of the nursing process when applied to primary prevention.

Mental and emotional well-being is essential to overall health. In *Healthy People 2020* (Healthy People Gov, 2011), mental health is defined in a positive way:

> Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society.

For too long the major emphasis in the United States has been on the treatment rather than on the prevention of mental disorders and promotion of mental health. Only recently is prevention emerging as a major force in health care. One of the reasons it is gaining momentum is because the health care system is beginning to provide some economic incentive for preventing illness rather than treating it. Another reason is that it has been found that **good mental health improves the quality of life for people with physical illnesses and may contribute to longer life in general** (New Freedom Commission on Mental Health [NFCMH], 2003; Centers for Disease Control and Prevention, 2011).

PROMOTION AND PREVENTION

Mental health promotion and mental illness prevention are distinct but interrelated concepts. The distinction between health promotion and illness prevention is in their targeted outcomes.

- **Mental health promotion** aims to promote positive mental health by increasing psychological well-being, competence, and resilience and by creating supporting living conditions and environments.
- **Mental illness prevention** has as its goal the reduction of symptoms and ultimately of mental disorders. It uses mental health promotion strategies as one of the means to achieve these goals.

Mental health promotion, when aiming to enhance positive mental health in the community, may also have the secondary outcome of decreasing the incidence of mental disorders. Thus, prevention and promotion strategies often involve similar activities and produce different but complementary outcomes.

Mental Health Promotion

The idea of promoting mental health in general is attractive. Promotion sounds optimistic and positive. It is consistent with the idea of self-help and being self-responsible for health. It implies changing human behavior and draws on a holistic approach to health.

The aims of mental health promotion are to enhance an individual's ability to:

- **Achieve developmentally appropriate tasks**
- **Acquire a sense of self-esteem, mastery, well-being, and social inclusion**
- **Strengthen one's ability to cope with adversity**

Mental health promotion considers mental health as a resource, as a value on its own, and as a basic human right essential to social and economic development. Mental health promotion aims to have an impact on the social determinants of health in order to increase positive mental health, reduce inequalities, build social capital, and narrow the gap in health expectancy between groups (World Health Organization [WHO], 2004). Mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles.

> **QUALITY AND SAFETY ALERT**
>
> - A climate that respects and protects basic civil, political, socioeconomic, and cultural rights is fundamental to mental health promotion.

Positive mental health allows people to realize their full potential, cope with the stresses of life, work productively, and make meaningful contributions to their communities. Early childhood experiences have lasting consequences later in life. Fostering emotional well-being from the earliest stages of life helps build a foundation for overall health and well-being.

There is solid research evidence indicating that anxiety, mood (e.g., depression), and impulse control disorders are associated with a higher probability of risk behaviors (e.g., tobacco, alcohol and other drug use, risky sexual behavior), intimate partner and family violence, many other chronic and acute conditions (e.g., obesity, diabetes, cardiovascular disease, HIV/sexually transmitted infections [STIs]), and premature death. Thus, the National Prevention Strategy (Healthy Care Gov, 2011) has identified the following four priorities for mental and emotional well-being:

1. Promote positive early childhood development, including positive parenting and violence-free homes.
2. Facilitate social connectedness and community engagement across the life span.
3. Provide individuals and families with the support necessary to maintain positive mental well-being.
4. Promote early identification of mental health needs and access to quality services.

Mental Illness Prevention

Prevention is often described with slogans such as "An ounce of prevention is worth a pound of cure" or "Curing is costly; prevention is priceless." Preventive interventions work by focusing on reducing risk factors and enhancing protective factors associated with mental illness (Beardslee et al, 2011).

The aims of mental illness prevention are to reduce the:

- **Incidence, prevalence, and recurrence of mental disorders**
- **Time spent with symptoms**
- **Risk factors for developing a mental illness**
- **Impact of the illness in the affected person, their families, and the society**

A study by the National Research Council and the Institute of Medicine (2009) reviewed the research on the prevention of mental disorders and substance abuse among young people and recommended multiple strategies for enhancing the psychological and emotional well-being of young people. Research demonstrates the value of:

- **Strengthening families** by teaching effective parenting skills, improving communication, and helping families deal with potential problems (such as substance use), disruptions (such as divorce), and adversities (such as parental mental illness or poverty).
- **Strengthening individuals** by building resilience and skills and improving cognitive processes and behaviors.
- **Promoting mental health in schools** by offering support to children encountering serious stresses; modifying the school environment to promote socially adaptive behavior; developing students' skills at decision making, self-awareness, and conducting relationships; and coping with potential violence, aggressive behavior, and substance use.
- **Promoting mental health through health care and community programs** by promoting and supporting socially adaptive behavior, teaching coping skills, and targeting modifiable lifestyle factors that can affect behavior and emotional health, such as sleep, diet, activity and physical fitness, sunshine and light, and television and computer use.

Figure 12-1 shows the developmental phases and the related opportunities for preventive intervention strategies. Box 12-1 lists mental health prevention recommendations made by *Healthy People 2020* and the U.S. Preventive Services Task Force 2010-2011.

The time has come for health care in general and psychiatric care in particular to focus on promoting mental health and preventing mental illness whenever possible. The ability to prevent the development of a psychiatric illness would benefit individuals, families, communities, and society.

Thus, prevention activities in psychiatric nursing care have five basic aims:

- **To increase resilience**
- **To identify and reduce risk factors for illness**

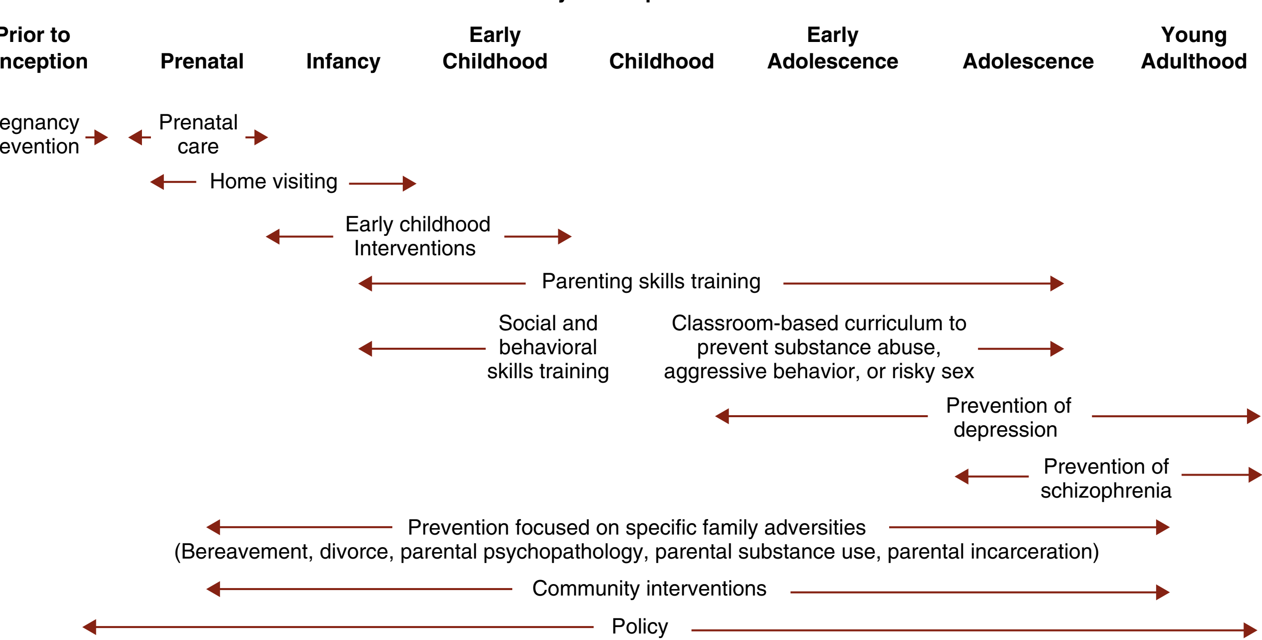


FIG 12-1 Preventive interventions by developmental stage. (From National Research Council and Institute of Medicine, Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: *Preventing mental, emotional and behavioral disorders among young people: progress and possibilities*, Washington DC, 2009, National Academies Press.)

BOX 12-1 U.S. MENTAL HEALTH PREVENTION RECOMMENDATIONS

***Healthy People 2020* Recommendations**

- Reduce the suicide rate.
- Reduce suicide attempts by adolescents.
- Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight.
- Reduce the proportion of persons who experience major depressive episodes (MDEs).

U.S. Preventive Services Task Force 2010-2011 Recommendations

- Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women
- Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up
- Clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products

From U.S. Department of Health and Human Services (USDHHS): *Healthy people 2020*, Washington, DC, 2010, U.S. Government Printing Office. Healthy People Gov: http://www.healthypeople.gov/2020/topicsobjectives2020/; U.S. Preventive Services Task Force: *The guide to clinical preventive services*. Accessed July 2011 at http://www.uspreventiveservicestaskforce.org/recommendations.htm.

- **To help people cope with stressors adaptively**
- **To change the resources and policies of the environment so that they do not cause stress but rather enhance people's functioning**
- **To increase positive outcomes**

Critical Reasoning The terms *health promotion* and *illness prevention* are often used interchangeably. In what ways do they overlap, and how do they differ?

Models of Prevention. There are three models of prevention: the public health model, medical model, and nursing model. Each makes a contribution to the field.

Public Health Prevention Model

In the public health prevention model, **the "patient" is the community** rather than the individual, and the focus is on the amount of mental health or illness in the community as a whole, including factors that promote or inhibit mental health (Power, 2009). **The emphasis in the public health model is on reducing the risk of mental illness for an entire population by providing services to high-risk groups.** Use of the public health model requires that mental health professionals be familiar with skills such as community needs assessment, identifying and prioritizing target or high-risk groups, and intervening with treatments such as consultation, education, and crisis intervention.

Critical Reasoning Do you believe it is possible to prevent mental illness in an individual or a community?

Community Needs Assessment. In the public health model, services are developed and delivered based on a culturally sensitive assessment of community needs. Because it is not possible to interview each person in the community to identify mental health needs, four techniques are used to estimate service needs:

- **Social indicators** infer need for service from descriptive statistics found in public records and reports, especially statistics that are highly correlated with poor mental health outcomes. Examples of statistics most commonly used are income, race, marital status, population density, crime, and substance abuse.
- **Key informants** are people knowledgeable about the community's needs. Typical key informants are public officials, clergy, social service personnel, nurses, and primary care physicians.
- **Community forums** invite members of the community to a series of public meetings where they can express their ideas and beliefs about mental health needs in their community.

Epidemiological studies examine the incidence and prevalence of mental disorders in a defined population. **Incidence** is the number of **new cases** of a disease or disorder in a population over a specified period. **Prevalence** is the number of **existing cases** of a disease or disorder in the total population at a specified time.

Identifying and Prioritizing High-Risk Groups. When the data from the various community needs assessments are analyzed, specific high-risk groups begin to emerge. For example, socioeconomic data might show that a large number of elderly widows live in the community. Community forums and surveys of key informants may find that there are few services and programs for the elderly, and epidemiological studies might suggest that elderly widows living alone are at high risk for depression. Therefore elderly widows might become a target group for program development and intervention.

Demographic data might show that a community has many preadolescent females, and socioeconomic indicators may suggest that many of these young women live in single-parent households and in poverty. Community forums and surveys of key informants may reveal few recreational and social services for children and adolescents. Epidemiological studies may report high correlations among poverty, single-parent households, and adolescent pregnancy. Therefore, community mental health providers might consider adolescents in this community to be at risk for mental health problems and target them for intervention.

Interventions. The public health model applies three levels of preventive intervention to mental illness and emotional disturbance (Caplan, 1964):

- **Primary prevention** is lowering the incidence of a mental disorder by reducing the rate at which new cases of a disorder develop.
- **Secondary prevention** involves decreasing the prevalence of a mental disorder by reducing the number of existing cases through early case finding, screening, and prompt, effective treatment.
- **Tertiary prevention** attempts to reduce the severity of a mental disorder and its associated disability through rehabilitative activities.

Each of these levels of intervention has implications for psychiatric nursing practice.

- **Primary prevention** is the focus of this chapter.
- **Secondary prevention** is addressed in Chapter 13, "Crisis and Disaster Intervention."
- **Tertiary prevention** is described in Chapter 14, "Recovery Support."

Critical Reasoning Describe the characteristics of a group that was at high risk for developing mental illness in the community in which you grew up.

Medical Prevention Model

The medical prevention model focuses on biological and brain research to discover the specific causes of mental illness, with primary prevention activities focused on the prevention of illness in the **individual patient.** This model consists of the following steps:

1. Identify a **disease** that warrants the development of a preventive intervention program. Develop reliable methods for its **diagnosis** so that people can be divided into groups according to whether they do or do not have the disease.
2. Through use of a series of epidemiological and laboratory studies, identify the most likely **cause** of the disease.
3. Launch and evaluate an experimental preventive intervention program based on the results of those studies.

This model has been effective for controlling many communicable diseases, such as smallpox, typhus, malaria, diphtheria, tuberculosis, rubella, and polio, and nutritional diseases, such as scurvy, pellagra, rickets, kwashiorkor, and endemic goiter.

It also has proved useful for preventing a variety of mental disorders caused by poisons, chemicals, licit or illicit drugs, electrolyte imbalances, and nutritional deficiencies. All these diseases have one thing in common: a known necessary, but not always sufficient, causative factor.

Critical Reasoning Identify one psychiatric disorder that could be lessened or managed effectively by having the medical prevention model applied to it.

Nursing Prevention Model

The nursing prevention model stresses the importance of promoting mental health and preventing mental illness by focusing on resilience, risk factors, protective factors, vulnerability, and human responses. In the nursing prevention model, the "patient" may be an individual, family, or community. It is based

on the understanding that mental disorders are the result of many causes, requiring that mental illness prevention be thought of as the promotion of resilience and adaptive coping responses and the prevention of maladaptive responses to life stressors.

Stressors can include one-time events, such as a divorce, or long-standing conditions, such as marital conflict. They can reflect either an acute health problem or a chronic health problem. For example, the following categories of maladaptive responses can arise from alcohol abuse:

- Acute health problems, such as overdose or delirium tremens
- Chronic health problems, such as cirrhosis of the liver
- Casualties, such as accidents on the road, in the home, or elsewhere, and suicide
- Violent crime and family abuse
- Problems of demeanor, such as public drunkenness and use of alcohol by teenagers
- Default of major social roles (work or school and family roles)
- Problems of feeling state (demoralization, depression, and experienced loss of control)

The nursing prevention model assumes that problems are multicausal, that everyone is vulnerable to stressful life events, and that any disability or problem may arise as a consequence.

For example, four vulnerable people can face a stressful life event, such as the ending of a marriage or the loss of a job. One person may become severely depressed, the second may be involved in an automobile accident, the third may begin to drink heavily, and the fourth may develop coronary artery disease.

The nursing model of prevention is based on the application of the nursing process and incorporates the following aspects:

- **Assessment:** identify risk and protective factors and stressors that may result in maladaptive responses
- **Planning:** identify ways to build resilience, enhance coping and minimize the negative consequences of the stressors
- **Implementation:** apply selected nursing interventions aimed at enhancing adaptation
- **Evaluation:** determine the effectiveness of the nursing interventions based on short- and long-term outcomes, use of resources, and comparison with other prevention strategies

Critical Reasoning Analyze the problem of child abuse from the nursing prevention perspective.

ASSESSMENT

Risk Factors and Protective Factors

Risk factors are those predisposing characteristics that, when present, make it more likely that the person will develop a disorder. Some risk factors are fixed, such as one's genetics and family history, whereas others can be changed, such as lack of social support and inability to read. Current research is focusing on the interplay among biological, psychosocial, and environmental risk factors and how they can be modified to eventually prevent a biological risk factor, such as the genes that may contribute to developing a mental illness, from being expressed.

Protective factors are the coping resources and coping mechanisms that can improve a person's response to stress, resulting in adaptive behavior. These factors exist in the individual, family, and community. They can have a powerful buffering effect on the influence of risk factors.

QUALITY AND SAFETY ALERT

- The concepts of risk and protective factors are central to evidence-based prevention programs.

Target Populations

Three types of preventive interventions based on target populations have been identified (Mrazek and Haggerty, 1994):

1. **Universal:** targeted to the general population group without consideration of risk factors
2. **Selective:** targeted to individuals or groups with a significantly higher risk of developing a particular disorder
3. **Indicated:** targeted to high-risk individuals identified as having symptoms foreshadowing a specific mental disorder or biological markers indicating predisposition for the disorder

Knowledge of normal growth and development is essential for assessing a person's functioning and for being able to intervene with preventive nursing interventions. The nurse should be familiar with normative stages, tasks, and parameters. This will help the nurse understand what issues the person has faced in the past and what challenges lie ahead. In addition to understanding the person's development, the nurse must know about the family cycle because many nursing interventions are directed at the family, from mobilizing their support of a patient to modifying dysfunctional family patterns.

Assessment in primary prevention involves identifying individuals and groups of people who are vulnerable to developing mental disorders or who may display maladaptive coping responses to specific stressors or risk factors. In this process, it is important for the nurse to realize that not all people in these groups are at equal risk. What these groups share is the experience of a life event, stressor, or risk factor that represents a loss of some kind or places an excessive demand on one's ability to cope. The more clearly the subgroup can be defined, the more specifically the prevention strategies can be researched, identified, and implemented.

Critical Reasoning Identify three groups of people vulnerable to the development of psychiatric illness: one based on biological factors, one based on psychological factors, and one based on sociocultural factors.

PLANNING AND IMPLEMENTATION

The Stuart Stress Adaptation Model presented in Chapter 3 is a useful tool for the nurse that can help in planning strategies for primary prevention. **The overall nursing goal**

is to promote constructive coping mechanisms and maximize adaptive coping responses. Thus prevention strategies should be directed toward influencing predisposing factors, precipitating stressors, appraisal of stressors, coping resources, and coping mechanisms through the following interventions:

- **Health education**
- **Environmental change**
- **Social support**
- **Stigma reduction**

In each of these areas, the nurse can focus on decreasing risk factors or increasing protective factors. Further, a single intervention can affect many parts of a person's life. For example, an environmental change, such as changing jobs, can affect an individual's predisposition to stress, decrease the amount of stress, change the appraisal of the threat, and perhaps increase financial or social coping resources.

Health Education

The health education strategy of primary prevention in mental health involves the strengthening of individuals and groups through competence building or resilience. It is based on the knowledge that many maladaptive responses are the result of a lack of competence, that is, a lack of perceived control over one's own life and the lowered self-esteem that results.

Competence building is also referred to as **resilience.** The report of the New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (NFCMH, 2003), offers this definition of resilience:

> Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses—and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by positive individual traits, such as optimism, good problem-solving skills, and treatments (Kobau et al, 2011). Closely knit communities and neighborhoods are also resilient, providing supports for their members.

Competence building or resilience may be the single most important preventive strategy. A competent individual or community is aware of resources and alternatives, can make informed decisions about issues, and can cope adaptively with problems. Coping in the face of adversity involves emotional intelligence and resilience, both of which can be developed through support and education (Luthar, 2008). Other clinical strategies include early intervention and promoting a social and familial climate, self-esteem, support building, and social/life and vocational skills. Four categories of resilience strengths are presented in Box 12-2.

Self-Efficacy. **Self-efficacy** is a belief in one's personal capabilities. It is the idea that a person has control over the events in life and that one's actions will be effective. **A high level of self-efficacy has been shown to positively affect one's thoughts, motivation, mood, and physical health** (Bandura, 1997).

People with a low sense of efficacy tend to avoid difficult tasks. They have low aspirations and weak commitment to their goals. They turn inward on their self-doubts instead of thinking about how to perform successfully. When faced with stress, they dwell on obstacles and their personal deficiencies. They give up in the face of difficulty, recover slowly from setbacks, and easily fall victim to depression.

In contrast, people with a high self-efficacy approach difficult tasks as challenges to be mastered rather than threats to be avoided. They are deeply interested in what they do, set high goals, and maintain strong commitments. This outlook sustains motivation, reduces stress, and lowers vulnerability to depression. **Preventive interventions related to health education can help people take control of their lives and start a process of self-change guided by a sense of resiliency and personal efficacy.**

> **Critical Reasoning** How is the concept of competency similar to the concept of positive mental health?

BOX 12-2 RESILIENCE STRENGTHS IN INDIVIDUALS, FAMILIES, AND COMMUNITIES

SOCIAL COMPETENCE	PROBLEM SOLVING	AUTONOMY	SENSE OF PURPOSE
Responsiveness	Planning	Positive identity	Goal direction
Communication	Flexibility	Internal locus of control	Achievement motivation
Empathy	Resourcefulness	Initiative	Educational aspirations
Caring	Critical thinking	Self-efficacy	Special interests
Compassion	Insight	Mastery	Creativity
Altruism		Adaptive distancing	Imagination
Forgiveness		Resistance	Optimism
		Self-awareness	Hope
		Mindfulness	Faith
		Humor	Spirituality
			Sense of meaning

From Bernard B: *Fostering resiliency in kids: Protective factors in the family, school, and communities,* Portland, OR, 1991, Northwest Regional Educational Laboratory; Bernard B: *Resiliency: What we have learned,* San Francisco, 2004, WestEd.

Types of Interventions. Health education related to competence building or increasing self-efficacy can include four types of interventions:

1. **Increasing awareness of issues and events related to health and illness, including normal developmental tasks and problems.**
2. **Increasing understanding of potential stressors, possible outcomes (both adaptive and maladaptive), and alternative coping responses.**
3. **Increasing knowledge of where and how to obtain needed resources.**
4. **Increasing the abilities of the individual or group by improving such coping skills as problem solving, communication skills, tolerance of stress and frustration, motivation, hope, anger management, and self-esteem.**

Programs and Activities. Mental health education can take place in any setting, can have a formal or informal structure, can be directed toward individuals or groups, and can be related to predisposing factors or potential stressors. Health education activities identified by the Nursing Intervention Classification (NIC) system (Bulechek et al, 2008) are listed in Box 12-3.

Health education directed toward strengthening an individual's predisposition to stress can take various forms. Growth groups may be formed for parents that focus on

BOX 12-3 HEALTH EDUCATION ACTIVITIES

Definition

Developing and providing instruction and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities.

Activities

- Target high-risk groups and age ranges that would benefit most from health education.
- Target needs in *Healthy People 2020* or other local, state, and national needs.
- Identify internal or external factors that may enhance or reduce motivation for healthy behavior.
- Determine personal context and sociocultural history of individual, family, or community health behavior.
- Determine current health knowledge and lifestyle behaviors of individual, family, or target group.
- Assist individuals, families, and communities in clarifying health beliefs and values.
- Identify characteristics of target population that affect selection of learning strategies.
- Prioritize identified learner needs based on patient preference, skills of nurse, resources available, and likelihood of successful goal attainment.
- Formulate objectives for health education program.
- Identify resources (e.g., personnel, space, equipment, money) needed to conduct program.
- Consider accessibility, consumer preference, and cost in program planning.
- Strategically place attractive advertising to capture attention of target audience.
- Avoid use of fear or scare techniques as strategy to motivate people to change health or lifestyle behaviors.
- Emphasize immediate- or short-term positive health benefits to be received by positive lifestyle behaviors rather than long-term benefits or negative effects of noncompliance.
- Incorporate strategies to enhance the self-esteem of target audience.
- Develop educational materials written at a readability level appropriate to target audience.
- Teach strategies that can be used to resist unhealthy behavior or risk taking rather than give advice to avoid or change behavior.
- Keep presentation focused, short, and beginning and ending on main points.
- Use group presentations to provide support and lessen threat to learners experiencing similar problems or concerns as appropriate.
- Use peer leaders, teachers, and support groups in implementing programs to groups less likely to listen to health professionals or adults (e.g., adolescents) as appropriate.
- Use lectures to convey the maximum amount of information when appropriate.
- Use group discussions and role playing to influence health benefits, attitudes, and values.
- Use demonstrations/return demonstrations, learner participation, and manipulation of materials when teaching psychomotor skills.
- Use computer-assisted instruction, television, interactive video, and other technologies to convey information.
- Use teleconferencing, telecommunications, and computer technologies for distance learning.
- Involve individuals, families, and groups in planning and implementing plans for lifestyle or health behavior modification.
- Determine family, peer, and community support for behavior conducive to health.
- Utilize social and family support systems to enhance effectiveness of lifestyle or health behavior modification.
- Emphasize importance of healthy patterns of eating, sleeping, exercising, and so on to individuals, families, and groups who model these values and behaviors to others, particularly children.
- Use variety of strategies and intervention points in educational program.
- Plan long-term follow-up to reinforce health behavior or lifestyle adaptations.
- Design and implement strategies to measure patient outcomes at regular intervals during and after completion of program.
- Design and implement strategies to measure program and cost-effectiveness of education, using these data to improve the effectiveness of subsequent programs.
- Influence development of policy that guarantees health education as an employee benefit.
- Encourage policy where insurance companies give consideration for premium reductions or benefits for healthful lifestyle practices.

From Bulechek GM, Butcher HK, Dochterman JM: *Nursing interventions classifications (NIC),* ed 5, St Louis, 2008, Mosby.

parent-child relations, normal growth and development, or effective methods of child rearing. Groups of children or adolescents can discuss peer relationships, sexuality, or potential problem areas, such as drug abuse or promiscuity. Employee groups can discuss career burnout and related issues.

A more activity-centered educational program also can be initiated, such as Outward Bound, which helps the individual discover that step-by-step competence can be expanded to master new, unexpected, and potentially stressful situations in an adaptive way. Another example is the Nurse-Family Partnership, an evidence-based nurse home visitation program that improves the health, well-being, and self-sufficiency of low-income, first-time parents and their children (www.nursefamilypartnership.org).

Probably the most common type of health education program is one that helps the individual cope with a specific potential stressor. For example, families about to experience marital separation are vulnerable to emotional problems, physical complaints, and increased use of health care services. Such families may be offered educational and supportive group intervention aimed at enhancing their ability to cope. Education groups can similarly be offered to those experiencing retirement, bereavement, or any other stress.

Parent education classes are a well-known example of anticipatory guidance that can be offered to high-risk groups. Although raising children is considered an important responsibility, relatively little attention has been directed to the belief that effective parenting is not an innate ability. Possibly one of the most beneficial results of parent education is the acknowledgment that all parents become frustrated, angry, and ambivalent toward their children.

Parent education goes beyond acknowledging feelings and includes learning and practicing alternative ways of interacting with children. During these classes, situations are anticipated, and discussions focus on identifying potential crisis situations and dealing with them through simulated encounters, such as role playing. Education to promote mental health can thus address the needs of both children and parents as family roles shift and respond to societal change.

Critical Reasoning Attend one of the self-help groups in your community. Describe the specific ways in which it promoted the mental health of those who attended.

Environmental Change

Prevention activities involving environmental change involve the modification of an individual's or group's immediate environment or the modification of the larger social system. Such changes are particularly appropriate when the environment has become a source of new demands being made on the person, when it is not nurturing the person's developmental needs, or when it does not provide positive reinforcement.

Many environmental changes may promote mental health, including changes in economic, work, housing, or family situations. Economically, resources for financial aid or assistance in budgeting and money management may be obtained. Making changes in the work environment may be facilitated by vocational testing, guidance counseling, education, or retraining that can then result in a change in the work environment, even a completely different job. For an adolescent, a homemaker, or an older adult, this can mean starting a new career.

Changes in housing can involve moving to new quarters, which may mean leaving family and friends or returning to them, improvements in existing housing, or the addition or subtraction of co-inhabitants, whether they are family, friends, or roommates. Environmental changes that may benefit the entire family include obtaining child care; enrolling in a nursery school, grade school, or camp; or gaining access to recreational, social, religious, or community facilities.

The potential benefit of all these changes should be understood by psychiatric nurses. They can promote mental health by increasing coping resources, modifying the nature of stressors, and increasing positive, rewarding, and self-enhancing experiences.

Organizations and Politics.

Nurses also can effect environmental changes at a larger organizational and political level by advocacy and influencing health care structures and policies (see Chapter 9). Nurses might become involved in training community nonprofessional caregivers to increase the social supports available to vulnerable groups. Another approach would be to become involved in health-related issues in one's community through volunteering or serving on boards.

If nurses believe that their profession makes a valuable contribution to health promotion, they should document the cost-effectiveness and quality of nursing care, lobby for greater patient access by nurses, and seek adequate compensation and reimbursement for nursing services. Many of these goals can be obtained if nursing has greater participation in the decision-making structures of health care institutions, such as hospital boards, advisory groups, health system agencies, and legislative bodies.

Involvement in community planning and development can affect many different areas. For instance, a community may be better able to meet the needs of the elderly in regard to educational opportunities, recreational programs, and access to social support networks by implementing telephone or transportation services. Also, the stress associated with environmental pollutants, such as chemicals and radiation, can be addressed at the community level.

Some environmental changes require involvement at the national level. For example, efforts to effect change may be directed toward modifying the media's portrayal of violence, enforcing laws on drunk driving, enacting gun control legislation, providing access to family planning services, fighting against rape, and advocating changes in child-rearing practices, including the provision of day care centers, flex-time, and paternity leave by more businesses.

Of course, many aspects of the broader social system are in need of change, including racism, sexism, ageism, poverty, and inadequate housing and education. The dilemma is that

global problems such as these are too broad, pervasive, and diffuse to be adequately addressed, let alone resolved. **For any future prevention strategies to be successful, they will need to document three things:**

1. **Ways in which a particular group is vulnerable to a specific stressor**
2. **How the proposed prevention program will be beneficial and cost-effective**
3. **The degree to which the program can succeed and be sustained over time**

Critical Reasoning What legislation in your state is being considered that pertains to mental health care? What is your position on it, and how can you influence its chances for passage?

Social Support

As a primary prevention strategy, supporting social systems means strengthening the social supports in place to enhance their protective factor and developing ways to buffer or cushion the effects of a potentially stressful event. Support system enhancement activities identified by the NIC system (Bulechek et al, 2008) are listed in Box 12-4. Social support systems can be helpful in emphasizing the strengths of individuals and families and in focusing on health rather than illness.

Social support influences all of the following:

- Encouraging health promotion behavior
- Helping people seek assistance earlier
- Improving the functioning of the immune system or other biological processes
- Reducing the occurrence of potentially stressful events
- Fostering the ability to cope with stressful events
- Helping one to deal with chronic mental and physical illness

People with poor social support—whether it is defined by the number of social contacts, the satisfaction derived from them, or a combination of the two—have a higher risk of dying from all causes.

How can the goal of maximizing social support systems be achieved? First, the amount of social support needed by a high-risk group must be determined and compared with the amount of social support available. The need for social support is influenced by predisposing factors, the nature of the stressors, and the availability of other coping resources, such as economic assets, individual abilities and skills, and defensive techniques. The availability of social supports is also influenced by age, gender, socioeconomic status, the nature of the stressor, and the characteristics of the environment.

Acute episodic stressors tend to elicit more intense support, whereas support resources for chronic problems tend to fade away. Also, changes or stressors viewed in a positive way by the individual's social network, such as the birth of a baby or a promotion, may generate a great deal of support, whereas a negative event, such as a divorce, might stimulate little support. Finally, the amount and type of social support that meet one need may not meet another.

BOX 12-4 NIC INTERVENTIONS RELATED TO SUPPORT SYSTEM ENHANCEMENT

Definition

Facilitation of support to patient by family, friends, and community.

Activities

- Assess psychological response to situation and availability of support system.
- Determine adequacy of existing social networks.
- Identify degree of family support.
- Identify degree of family financial support.
- Determine support systems currently used.
- Determine barriers to using support systems.
- Monitor current family situation.
- Encourage the patient to participate in social and community activities.
- Encourage relationships with persons who have common interests and goals.
- Refer to a self-help group as appropriate.
- Assess community resource adequacy to identify strengths and weaknesses.
- Refer to a community-based promotion/prevention/treatment/rehabilitation program as appropriate.
- Provide services in a caring and supportive manner.
- Involve family/significant others/friends in care and planning.
- Explain to concerned others how they can help.

From Bulechek GM, Butcher HK, Dochterman JM: *Nursing interventions classifications (NIC),* ed 5, St Louis, 2008, Mosby.

Types of Interventions. Social support can be used to design and implement interventions in primary prevention. Four types of interventions are possible:

1. **Social support patterns can be used to assess communities and neighborhoods to identify problem areas and high-risk groups.** Not only will information about the quality of life be gained but also the social isolation of a particular group may become apparent, as may central individuals who can be enlisted to help develop community-based programs.
2. **Links can be improved between community support systems and formal mental health services.** Often mental health professionals are not aware of or comfortable with the existence or functioning of community support systems. They should be taught how to use and mobilize community resources and social support systems. All health care providers need to be able to recognize when patients are in need of social support and to provide them with access to appropriate community support systems.
3. **Naturally existing caregiving networks can be strengthened.** Health professionals can provide information and support to informal caregivers in the community, who serve a very important and somewhat different function than more formalized and organized support systems. Informal support systems provide the following:
   - A natural training ground for the development of problem-solving skills

BOX 12-5 CHARACTERISTICS OF SELF-HELP GROUPS

- Supportive and educational in nature rather than therapeutic
- Based on shared experiences and the premise that the individual is not alone
- Focused on a single life-disrupting event
- Purpose: to support personal responsibility and change
- Anonymous and confidential in nature
- Voluntary membership
- Members lead the group and implement principles of self-governance
- Nonprofit orientation

- A medium in which people grow and develop by learning to direct the process of change for themselves
- A supportive milieu that capitalizes on the strength of existing ties among people in communities, rather than fragmenting intact social units on the basis of diagnosed needs or specialized services

4. **Individuals and groups can be helped to develop, maintain, expand, and use their social networks.** For example, network therapy involves bringing together all the important members of the family's kin and friendship network. The focus is then on tightening bonds within the network and breaking dysfunctional patterns. For families who are isolated and whose networks are depleted, there may not be enough network members available for such a strategy. In this case arranging for the use of mutual support groups may be effective.

Informal Support Groups. There are many informal support groups, including church groups, civic organizations, clubs, women's groups, or work and neighborhood support groups. Self-help groups are becoming more common as members organize themselves to solve their own problems. The members all share a common experience, work together toward a common goal, and use their strengths to gain control over their lives. Such groups are also forming on the Internet.

The processes involved in self-help groups are social affiliation, learning self-control, modeling methods to cope with stress, and acting to change the social environment. Characteristics of self-help groups are listed in Box 12-5.

Self-help groups such as Alcoholics Anonymous, Weight Watchers, Parents Without Partners, Recovery, and Parents Anonymous are familiar to the public. They have shown their ability to promote adaptive responses among people experiencing stress, such as the grief reactions of widows and of parents of children who died of sudden infant death syndrome.

Because self-help groups use a variety of stress coping methods and have differing membership criteria, each group should be assessed individually for its general effectiveness and appropriateness for particular individuals and families. Some areas for the nurse to assess before recommending involvement in a self-help group are presented in Box 12-6.

Working with naturally occurring, informal support systems should be done cautiously, however, to minimize undesirable consequences. The nurse should attempt to create the least amount of disruption possible and not suppress the natural helping behaviors of informal caregivers.

BOX 12-6 ASSESSMENT GUIDELINES FOR RECOMMENDING SELF-HELP GROUPS

Questions for the Group
- What is its purpose?
- Who are the group members and leaders?
- What are the beneficial aspects of the group?
- For whom would the group not be suitable?
- What problems are inherent in the group?
- Is the group effective in preventing further emotional distress?

Questions for the Potential Member
- How does the person feel about attending a self-help group?
- How compatible is the group with the individual's approach to the problem?
- How accessible is the group to the potential member?

Finally, although supporting social supports is an effective intervention, it is not limited to primary prevention activities. Rather, all nurses in all settings can use this strategy as a way of providing holistic care to maximize the health of individuals, families, and groups.

Stigma Reduction

An important aspect of mental health promotion involves activities related to dispelling myths and stereotypes associated with vulnerable groups, providing knowledge of normal parameters, increasing sensitivity to psychosocial factors affecting health and illness, and enhancing the ability to give sensitive, supportive, and humanistic health care.

Stigma is defined as a mark of disgrace or discredit that is used to identify and separate out people whom society sees as deviant, sinful, or dangerous. Misperceptions about vulnerable subgroups of the population must be corrected. In the report of the New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (NFCMH, 2003), stigma is defined as a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness.

For the psychiatrically ill, stigma is a barrier that separates them from society and keeps them apart from others (Box 12-7). They are the result, in part, of the cultural stigma against mental illness that is prevalent in society. For example, most newspaper stories related to mental illness focus on dangerousness and violence, and these stories most often end up in the front section.

Three types of stigma have been identified (Corrigan and Wassel, 2008):

- **Public stigma**—what the public does to those with mental illness
- **Self-stigma**—when individuals internalize public stigma and harm themselves

BOX 12-7 THE ROOTS OF STIGMA

Stigma is ignorance. Stigma is fear. Stigma is guilt. Stigma is discrimination. Why is something so obviously wrong still so prevalent?

The roots of stigma in our society are stubborn, reaching back to the beginnings of human history. Anyone whose behavior was different was considered dangerous, and so those with mental diseases often became outcasts. With virtually no scientific data to enlighten people, ignorance of mental illness predominated for millennia. Medieval Christianity, for example, moralized about mental illness as an issue of good and evil. A person suffering from profound depression, for example, was assumed to be possessed by the devil and therefore in need of exorcism.

Fast forward to the twenty-first century. Though religious traditions endure through millennia, in our day, it's the police blotter that so often links mental illness to the evil of violence and other threatening behaviors. Reporters write stories from police reports often without real insights into mental illness. Thus we see the resultant newspaper accounts with headlines such as "Schizo Son Smothers His Mom in Queens" (*New York Post*, October 29, 2002).

The news media will always report on the sensational cases far out of proportion to the actual occurrences. The Andrea Yates story, serial murderers, random subway pushers, and the like get lots of ink compared with the millions of mental illness recovery stories that are not considered newsworthy.

Then we're exposed to TV shows and movies that entertain us by often linking mental illness to malevolence. Baby Jane, Norman Bates, and Hannibal Lecter are cultural icons. Cop shows on TV strive for realism, and yet they too can create distortions when their writers are inevitably influenced by newspaper stories generated by the police blotter.

What's the result of our society's steady diet of mass media fed by such cultural and religious beliefs, most of which associate mental illnesses with profound negativity? In a word, stigma.

From *Reintegration today,* Winter 2002, The Center for Reintegration.

- **Label avoidance stigma**—when individuals who are not mentally ill avoid mental health care so as not to be marked with the label

Public stigma can be changed through education and contact. Self-stigma can be addressed by fostering group identity, changing perceived basis of the stigma, and making strategic decisions about disclosing one's own mental health history. Label avoidance stigma can be changed through public education and having contact with those who are in treatment.

QUALITY AND SAFETY ALERT

- Nearly two thirds of people with diagnosable mental disorders do not seek treatment
- Stigma related to mental illness is one of the major barriers that discourages people from seeking needed care.

The impact of this stigma is enormous (Pinto-Foltz and Logsdon, 2008; Pope, 2011; Verhaeghe and Bracke, 2011). Patients and their families often report that the diagnosis of a mental illness is followed by increasing isolation and loneliness as family and friends withdraw (see Chapter 10). Patients feel rejected and feared by others, and their families are met by blame. Stigma against mental illness is a reflection of the cultural biases of society that are shared by consumers and health care providers alike (Box 12-8).

The health repercussions of stigma are as follows:

- Stigma makes people conceal or deny their symptoms.
- Stigma results in delays in treatment.
- Stigma discourages adherence to effective treatments.
- Stigma isolates the individual and family.
- Stigma lowers self-esteem and potential for self-care.
- Stigma limits access to quality health care.
- Stigma negatively affects the attitudes of health care providers.
- Stigma contributes to more severe forms of illness.
- Stigma limits the community's response to illness.

BOX 12-8 CULTURAL CONTEXT OF CARE: AMERICAN ATTITUDES ABOUT MENTAL ILLNESS

- 42% believe that a person with mental illness can be as successful at work as others
- 54% who know someone with a mental illness believe that treatment can help people with mental illnesses lead normal lives
- 84% believe that people with mental illnesses are not to blame for their conditions
- 26% agree that people are generally caring and sympathetic toward individuals with mental illnesses.
- 75% know that depression is a real health problem
- 46% see suicide as a personal or emotional weakness, while 46% see it as a health problem
- 63% believe homicides vastly outnumber suicides—but suicide deaths (more than 30,000 each year) consistently outnumber deaths attributable to homicide (18,000)—with most suicides due to untreated depression
- 94% feel comfortable interacting with someone with diabetes and 92% are comfortable with someone with cancer. In contrast, 63% felt the same way about someone with depression, 45% about someone with bipolar disorder or schizophrenia, 48% about a person who attempted suicide, and 43% about someone struggling with alcohol or drugs.
- 25% of those between the ages of 18 and 24 believe that a person with mental illness can eventually recover

Accessed at http://whatadifference.samhsa.gov/docs/SAMHSA_CDC_Report.pdf. Accessed January 14, 2008, at http://www.nmha.org/go/go/news/10-year-retrospective-study-shows-progress-in-american-attitudes-about-depression-and-other-mental-health-issues.

The stigma, misunderstanding, and fear surrounding mental illness are related to both the people and agencies providing mental health services and the people receiving these services, who are often elderly, poor, or members of social minority groups. Unlike physical illness, which tends to evoke

sympathy and the desire to help, mental disorders tend to disturb people and keep them away.

It is critically important that stigma be overcome. More of the public now embraces a neurobiological understanding of mental illness but this has not translated into a decrease in stigma (Pescosolido et al, 2010; Rusch et al, 2011)). Still there is a growing demand for mental health services in the United States, which is predicted to increase in the coming years.

Reducing stigma must involve programs of public advocacy, public education on mental health issues, and contact with persons with mental illness through schools and other social institutions. Another way to reduce stigma is to find causes and effective treatments for mental disorders.

Stigma reduction initiatives must take place on both individual and community levels. Many organizations have launched campaigns targeted at the general public to combat the stigma and discrimination associated with mental health problems. No study has clearly demonstrated their effectiveness but it appears that they do contribute to modest improvements in public knowledge (Dumesnil and Verger, 2009). Examples of mass approaches to antistigma programs include the following:

- StigmaBusters: a group of the National Alliance on Mental Illness (NAMI) that actively challenges images in the media that are stigmatizing. They work together on the Internet and launch campaigns to protest the stigmatizing portrayals.
- Elimination of Barriers Initiative: a large effort to diminish stigma by educating the public through media such as public service announcements and social marketing.
- In Our Own Voice: a 90-minute standardized contact program in which people with mental illness interact with an audience on the topic of their mental illness. This also is a program of NAMI.
- BringChange2Mind.org is a nonprofit organization started by Glenn Close, whose sister and nephew are mentally ill. The purpose is to provide information that combats stigma and resources to those who are ill.

Finally, it must be understood that everyone encounters stress and that all people are subject to maladaptive coping responses. Mental health professionals can educate the public and teach them that mental health is a continuum and mental illness is caused by a complex combination of factors.

The public needs to realize that mental disorders are not the result of moral failings or limited will power, but rather they are true medical illnesses that respond very well to specific treatments (Insel and Wang, 2010). **Everyone needs to understand that no one is immune to mental illness or emotional problems and that the fear, anxiety, and even anger felt about people who experience these problems may reflect some of our own deepest fears and anxieties.**

Critical Reasoning Have you observed the stigma associated with psychiatric illness in your personal or professional life? If so, what steps have you taken or could you take to overcome it?

BOX 12-9 A FUTURE FOUNDED ON PREVENTION

- Families and children have access to the best available, evidence-based, preventive interventions delivered in their communities in a culturally competent and respectful way.
- Preventive interventions are provided as a routine component of school, health, and community service systems.
- Children and their families have multiple points of entry for preventive services (including schools, health care settings, and youth centers).
- Teachers, child care workers, health care providers, and others are routinely trained to support the emotional and behavioral health of young people and the prevention of mental disorders.
- Families and communities partner in developing and implementing preventive interventions.
- Innovative, evidence-based preventive interventions are rapidly deployed in multiple systems.
- A well-organized public health monitoring system tracks the incidence and prevalence of mental, emotional, and behavioral disorders and directs appropriate resources.

From Beardslee W et al: Prevention of mental disorders, substance abuse, and problem behaviors: a developmental perspective, *Psychiatr Serv* 62:247, 2011.

EVALUATION

When talking about primary prevention, there is a tendency to think in terms of the total elimination of mental illness and stress. These are not realistic goals, and maintaining them can only discourage any possible action. It is possible, however, to set goals of reducing suffering and enhancing the capacity to cope. Box 12-9 captures elements of a future founded on mental health promotion and mental illness prevention.

Clearly, a need exists for the evaluation of programs in primary prevention. In a world of shrinking resources, only programs with proven effectiveness are likely to be supported in the future. It must be demonstrated that the prevention strategy used has both short- and long-term effects that will benefit the individual and society.

Also, it is necessary to determine whether the specific strategy implemented was the most effective, appropriate, and efficient. Considering alternative approaches and comparing clinical and financial outcomes are essential aspects of the evaluation process.

Although preventing all illness is not possible, preventing some particular problems is possible; but many barriers exist that make expansion of prevention activities difficult. When faced with a choice, the needs of the ill consistently take precedence over promoting prevention. This holds true for nurses providing care as well as for the larger society. Yet by being more visionary, both groups could benefit greatly.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Penelope Chase, MSN, MEd, RN, CS

I was changing planes on my way to Boston to attend the reunion of my nursing school. I was traveling alone and looking forward to some anonymity and a time to reflect and rest.

As I approached the check-in counter of the airport, I saw a young woman sitting nearby in the waiting area. The seats on either side of her were empty except for a soft knapsack on her left. She looked as if she were about to burst into tears or change her mind about being here and dash for the exit. I stopped in my tracks to observe her without being aware of deciding to do so.

"Distressed, needs help, emotionally fragile" went through my professional mind, while "don't get involved" went through my personal mind, along with, "You're on vacation. Don't mess it up. Relax, you're not the only one who can help." So I went ahead and checked in. I chose to wait in a seat in the row behind the young woman.

She compared her ticket information with the boarding announcement and sat back in her seat. A moment later, she shifted in her seat and put her hands over her face.

I read a bit in my novel, keeping my peripheral vision and ears attuned in her direction. I had difficulty concentrating on my reading because I was constantly interrupted by imposing, opposing thoughts of "Do something" and "Let it be."

I was still deliberating when my flight was called. The young woman looked at her ticket, got up, and joined the line. I sat and waited until my row number was called. As the flight attendant checked the young woman's boarding pass, she looked carefully at the anguished face and then asked, "Are you okay?" The girl nodded. "Are you sure?" Another nod, but the flight attendant paused in her checking and turned briefly to watch as the girl began walking down the boarding ramp. It was then that I decided how to resolve my professional helper's dilemma. I identified myself to the flight attendant as a psychiatric nurse and said that if there was an emergency, they could call on me. "Oh, you noticed her, too," the woman smiled. "Thank you."

I had just gotten settled in my seat when the flight attendant approached me. "I pulled her up in the computer. It's an emergency flight—a death in the family." "Oh," I said, "loss and grief are one of my specialties. I'd be happy to sit with her if she'd like, but only if she says she'd like someone with her." I suddenly remembered traveling 450 miles, mostly alone, to my younger brother's funeral.

Within a few minutes the flight attendant returned saying, "She said she'd like that." So I took my purse and moved toward the back of the plane. As I approached her seat, the young woman looked up at me. I smiled, introduced myself by name, and said I was the person who would sit with her if that would be all right. She nodded, managed a wan smile, and said, "Thank you."

I was trying to decide what my role would be. I knew I wanted to support her as a psychiatric nurse and a representative of my profession, and I was also aware that in a couple of hours our relationship would be ending. The time limit helped me focus on my goal of simply being available to her as a support.

Realizing that my seat partner was probably in the initial stage of shock in the grief process and thus lacked her usual coping skills, I decided to do a bit of framing for her. "The flight attendant told me you had a death in your family. I'm sorry," I said. "I'm a nurse who works with people who are going through losses. You could talk about it if you want to, or I could just sit here and read my book. It's up to you." I offered her two simple choices.

She sat silently but with slightly changing facial expressions, and I thought she was getting ready to speak. I focused my attention softly on her and waited. "He wasn't supposed to die. He was going to have chemotherapy," she began. As her story unfolded, I listened, asked clarifying questions occasionally, and acknowledged her words and anguish. In between bits of content, I learned that friends of the family and her sister were meeting her at the airport.

At one point she said sadly, "Now he'll never see his grandchildren," and buried her head on my shoulder and sobbed for a little while. After a bit she said, "I think I need to sleep." That sounded like a good idea to me. As she slept, I evaluated what had unfolded and thought about where to go from here. I needed a plan for closure, for termination of the intervention.

I thought of how long she would have to stand in the aisle waiting to get off this big plane. I asked the flight attendant if there were some way the young woman could be one of the first passengers off the plane. We were moved to the first-class section near the door after she awoke. We talked briefly of how she wanted to depart. I let her know I was available to walk off the plane with her if she wanted and that I thought she could manage "just fine" without me as well. "I'll be all right," she said, giving me a hug as we stood up to disembark.

"You don't know how much we appreciate this," the flight attendant said to me with sincere eye contact. I acknowledged her thanks. I motioned for my seatmate to go ahead of me. As we approached the waiting area, I looked questioningly at her to see how she was managing. "I've got it," she said and gave me the thumbs-up sign. I smiled and walked on. I was met by two classmates and felt clear, reflective, and exhilarated. I felt that my clinical skills had positively influenced the outcome. I felt I had acted in a professionally responsible and caring manner. I felt good about being a psychiatric nurse.

CHAPTER IN REVIEW

- Mental and emotional well-being are essential to overall health.
- Mental health promotion aims to promote positive mental health by increasing psychological well-being, competence, and resilience and by creating supporting living conditions and environments.
- Mental illness prevention has as its goal the reduction of symptoms and ultimately of mental disorders. It uses mental health promotion strategies as one of the means to achieve these goals.
- The aims of mental health promotion are to enhance an individual's ability to achieve developmentally appropriate tasks; acquire a sense of self-esteem, mastery, well-being and social inclusion; and strengthen one's ability to cope with adversity.
- The aims of mental illness prevention are to reduce the incidence, prevalence, and recurrence of mental disorders; time spent with symptoms; risk factors for developing a mental illness; and impact of the illness on the affected person, their families, and the society.
- Primary prevention activities in psychiatric nursing care have five basic aims: (1) to increase resilience, (2) to identify and reduce risk factors for illness, (3) to help people cope with stressors adaptively, (4) to change the resources and policies of the environment so that they do not cause stress but rather enhance people's functioning, and (5) to increase positive outcomes.
- In the public health model, the "patient" is the community rather than the individual; the focus is on the amount of mental health or illness in the community as a whole, including factors that promote or inhibit mental health; and emphasis is on reducing the risk of mental illness for an entire population by providing services to high-risk groups.
- Three levels of preventive intervention from the public health model include (1) primary prevention—the lowering of the incidence of a mental disorder or reducing the rate at which new cases of a disorder develop; (2) secondary prevention—decreasing the prevalence of a mental disorder by reducing the number of existing cases through early case finding, screening, and prompt effective treatment; and (3) tertiary prevention—reducing the severity of a mental disorder and associated disability through rehabilitative activities.
- The medical prevention model focuses on biological and brain research to discover the specific causes of mental illness, with primary prevention activities focused on the prevention of illness in the individual patient.
- The nursing prevention model stresses the importance of promoting mental health and preventing mental illness by focusing on risk factors, vulnerability, and human responses. In the nursing prevention model the "patient" may be an individual, family, or community.
- Risk factors are those predisposing characteristics that, if present for a person, make it more likely that the person will develop a disorder. Protective factors are the coping resources and coping mechanisms that can improve a person's response to stress, resulting in adaptive behavior.
- Assessment in prevention involves identifying individuals and groups of people who are vulnerable to developing mental disorders or who may display maladaptive coping responses to specific stressors or risk factors.
- The overall goal of nursing care is to promote constructive coping mechanisms and maximize adaptive coping responses.
- The health education strategy of prevention in mental health involves the strengthening of individuals and groups through competence building or resilience. Preventive interventions related to health education can equip people to take control of their lives and start a process of self-regulated change guided by a sense of resiliency and personal efficacy.
- Various environmental changes may promote mental health, including changes in economic, work, housing, or family situations. Nurses also can effect environmental changes at a larger organizational and political level by influencing health care structures and procedures.
- Supporting social systems means strengthening the social supports in place to enhance their protective factor and developing ways to buffer or cushion the effects of a potentially stressful event.
- Mental health promotion includes activities related to reducing stigma by dispelling myths and stereotypes associated with vulnerable groups, providing knowledge of normal parameters, increasing sensitivity to psychosocial factors affecting health and illness, and enhancing the ability to give sensitive, supportive, and humanistic health care.
- It must be demonstrated that the prevention strategy used has both short-term and long-term effects that will benefit the individual and society. Also, it is necessary to determine whether the specific strategy implemented was the most effective, appropriate, and efficient.

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CHAPTER

13

Crisis and Disaster Intervention

Gail W. Stuart

He knows not his own strength that hath not met adversity.

Francis Bacon, *Of Fortune*

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe a crisis and its characteristics, including crisis responses, types of crises, characteristics of disasters, and crisis intervention.
2. Analyze aspects of the nursing assessment related to crisis and disaster responses.
3. Plan and implement nursing interventions for patients related to their crisis and disaster responses.
4. Develop a patient education plan to cope with crisis.
5. Evaluate nursing care for patients related to their crisis and disaster responses.
6. Describe the settings in which crisis and disaster intervention may be practiced.
7. Discuss modalities of crisis intervention.

Stressful events, or crises, are a common part of life. They may be social, psychological, or biological in nature, and there is often little that a person can do to prevent them. As the largest group of health care providers, nurses are in an excellent position to help promote healthy outcomes for people in times of crisis and disaster (Happell et al, 2009).

Crisis intervention **is a brief, focused, and time-limited treatment strategy that is effective in helping people adaptively cope with stressful events.** Knowledge of crisis and disaster intervention techniques is an important clinical skill for all nurses, regardless of clinical setting or practice specialty.

CRISIS CHARACTERISTICS

A crisis is a disturbance caused by a stressful event or a perceived threat. The person's usual way of coping becomes ineffective in dealing with the threat, causing anxiety. The threat, or precipitating event, usually can be identified. It may have occurred weeks or days before the crisis, and it may or may not be linked in the individual's mind to the crisis state the individual is experiencing. Precipitating events can be actual or perceived losses, threats of losses, or challenges.

Crisis Responses

After the precipitating event, the person's anxiety begins to rise, and three phases of a crisis response emerge:

1. The anxiety activates the person's usual methods of coping. If these do not bring relief, anxiety increases because coping mechanisms have failed.
2. New coping mechanisms are tried or the threat is redefined so that old ones can work. Resolution of the problem can occur in this phase. However, if resolution does not occur, the person goes on to the last phase.
3. The continuation of severe or panic levels of anxiety may lead to psychological disorganization.

In describing the phases of a crisis, it is important to consider the balancing factors shown in Figure 13-1. These

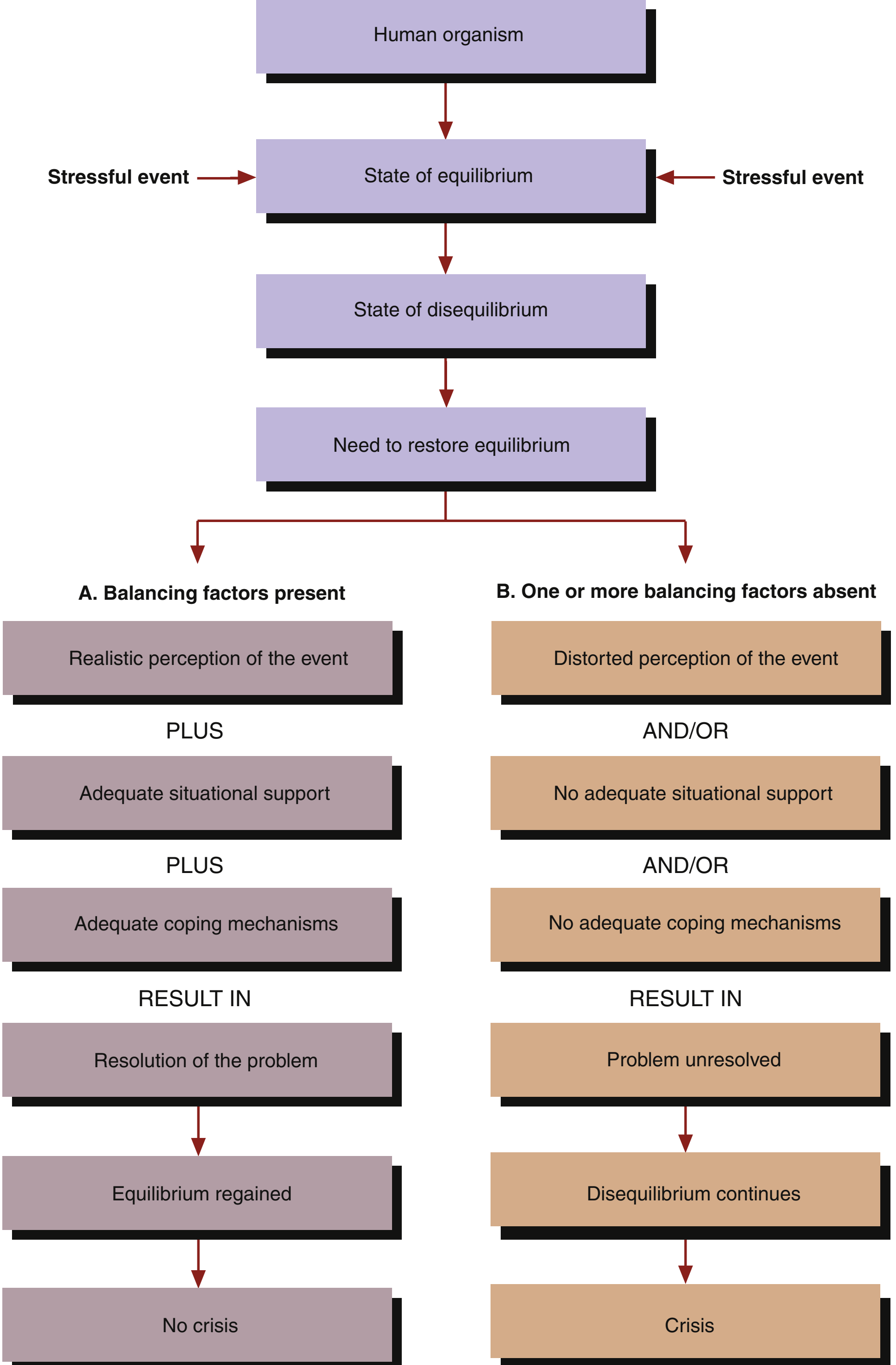


FIG 13-1 Paradigm: the effect of balancing factors in a stressful event. (From Aguilera DC: *Crisis intervention: theory and methodology,* ed 8, St Louis, 1998, Mosby.)

include the individual's perception of the event, situational supports, and coping mechanisms. **Successful resolution of the crisis is more likely if the person has a realistic view of the event; if situational supports are available to help solve the problem; and if effective coping mechanisms are present** (Aguilera, 1998).

The phases of a crisis and the impact of balancing factors are similar to the elements of the Stuart Stress Adaptation Model used in this textbook and described in Chapter 3. However crises are self-limiting. People in crisis are too upset to function at such a high level of anxiety indefinitely. **The time needed to resolve the crisis, whether it is a positive**

solution or a state of disorganization, may be 6 weeks or longer.

It also is important to recognize that periods of intense conflict ultimately can result in increased growth. It is how the crisis is handled that determines whether growth or disorganization will result. Growth comes from learning in new situations. People in crisis feel uncomfortable, often reach out for help, and accept help until they feel that their lives are back to normal. **The fact that crises can lead to personal growth is important to remember when working with patients in crisis.**

> **Critical Reasoning** Think of a crisis you have experienced. Do you feel that the way you handled it made you a better person in some way? If so, how?

Types of Crises. The two types of crises are maturational and situational. Sometimes these crises can occur simultaneously. For example, an adolescent who is having difficulty adjusting to a change in role and body image (maturational crisis) may at the same time undergo the stress related to the death of a parent (situational crisis).

Maturational Crises. **Maturational crises** are developmental events requiring role changes. **Transitional periods during adolescence, parenthood, marriage, midlife, and retirement are key times for the onset of maturational crises.** For example, successfully moving from early childhood to middle childhood requires the child to become socially involved with people outside the family. With the move from adolescence to adulthood, financial responsibility is expected. Both social and biological pressures to change can precipitate a crisis.

The nature and extent of the maturational crisis can be influenced by role models, interpersonal resources, and the response of others. Positive role models show the person how to act in the new role. Interpersonal resources encourage the trying out of new behaviors to achieve role changes.

Other people's acceptance of the new role is also important. The greater the resistance of others, the more stress the person faces in making the changes. Some conflicts related to maturational crises are seen in the clinical examples that follow.

CLINICAL EXAMPLE

Ms. J was a 19-year-old African-American, single, unemployed woman who came to the mental health clinic 1 month after the birth of her first child. Ms. J complained of feeling depressed. Her symptoms included difficulty falling asleep, early-morning awakening, crying spells, a poor appetite, and difficulty in caring for the baby because of fatigue and apathy. The patient lived with her parents and siblings and had never lived on her own. She had always depended on her mother to take care of her. Her mother worked, however, and the patient was totally responsible for her daughter's care each day. Also, Ms. J's mother was angry that she had a child and often refused to care for the baby. The patient's boyfriend, who was the baby's father, had promised to marry her, but he had recently decided he was too young to handle the responsibility of a wife and child. In summary, the young woman who had unmet dependency needs of her own was now a parent and had to meet the dependency needs of her infant. This precipitated a crisis for her.

Selected Nursing Diagnoses
- Ineffective coping related to birth of a child, as evidenced by feelings of depression
- Interrupted family processes related to birth of a grandchild, as evidenced by lack of family support
- Impaired parenting related to being a single mother, as evidenced by difficulty caring for her baby

CLINICAL EXAMPLE

Mr. R was a 67-year-old white, married pharmacist who came to the mental health clinic complaining of anxiety, depression, and insomnia. His symptoms had begun 2 weeks ago when his wife decided that they should move to a retirement community in Florida. He described his wife as a strong, determined woman who was outgoing and charming and made friends easily. He considered himself a quiet, nervous person who was comfortable only with old friends and his two sons and their families. Mr. R, although at retirement age, had continued to work as a pharmacist, doing relief work for a drugstore chain when the regular pharmacists were absent. In moving to Florida, he would lose his pharmacist's license, which was valid only in his state of residence. He expressed difficulty in making the transition from work to retirement. He had fears of becoming directionless and useless. He was anxious about leaving his sons and his friends. The prospect of complete retirement and moving to another state precipitated his distress.

Selected Nursing Diagnoses
- Relocation stress syndrome related to pending retirement, as evidenced by feelings of anxiety
- Interrupted family processes related to conflict about lifestyle changes, as evidenced by inability to plan future

Situational Crises. **Situational crises** occur when a life event upsets an individual's or group's psychological equilibrium. Examples of situational crises include loss of a job, loss of a loved one, unwanted pregnancy, onset or worsening of a medical illness, divorce, school problems, and witnessing a crime.

The loss of a job can result in financial stress, feelings of inadequacy, and marital conflict caused by a family member's anger over the lost job. The loss of a loved one results in bereavement and also can cause financial stress, change in roles of family members, and loss of emotional support. Homelessness is another possible outcome of the loss of a job or a loved one. The onset or worsening of a medical illness causes anticipatory grief and fear of the loss of a loved one. Again, financial stress and change in roles of family members often occur. Divorce is similar to the stress of losing a loved one, except that the crisis can recur with the stress of dealing with the ex-spouse.

An unwanted pregnancy is stressful because it requires decisions to be made about whether to complete the pregnancy or to abort it and whether to keep the baby or place the baby for adoption. If the pregnancy is aborted or adoption occurs, the mother may need to deal with feelings of grief or anger. If the baby is to be kept, changes in lifestyle are required. Finally, being the victim of or witnessing a crime can cause feelings of helplessness, distrust of others, fear, nightmares, and guilt about causing or not stopping the crime.

Situational crises can be accidental, uncommon, and unexpected events including natural and man-made disasters such as fires, tornadoes, earthquakes, hurricanes, or floods. These disrupt entire communities and cause widespread damage. Disasters, such as killings in the workplace or in schools, airplane crashes, suicide bombings, and acts of terrorism, also can precipitate situational crises.

The terrorist attacks of September 11, 2001, in which airplanes were hijacked and flown into the World Trade Center in New York City, presented unprecedented trauma and crisis to people throughout the United States. Entire communities, especially people living in New York City, experienced a sudden and unexpected violent act that resulted in multiple losses and extensive community disruption.

In addition, the safety felt by all people across the United States was affected. One study found that more than half of the people who lived or worked in New York had some emotional sequelae 3 to 6 months after September 11; however, only a small portion of those with severe responses were seeking treatment (DeLisi et al, 2003).

Disaster-precipitated emotional problems can surface immediately, or weeks or even months after the disaster. After the September 11 attack, individuals who lost family members accounted for 40% of mental health visits in the first month but dropped to 5% by 5 months. Uniformed personnel used many more mental health services after the first year (Covell et al, 2006).

Researchers have identified several common characteristics of disasters that are particularly important when discussing emotional distress and recovery. These are listed in Box 13-1.

Disaster responses usually occur in seven phases. These are described in Table 13-1. Individuals and communities progress through these phases at different rates depending on the type of disaster and the degree and nature of disaster exposure. This progression may not be sequential, because each person and each community is unique in the recovery process. **Individual variables such as psychological resilience, social support, and financial resources influence a survivor's capacity to move through the phases.**

Critical Reasoning Some crises, such as obtaining a divorce, develop over time and are of longer duration. Other crises, such as an earthquake, are sudden and unexpected. How do you think the element of time affects the response to crisis?

BOX 13-1 CHARACTERISTICS OF DISASTERS

- ***Intensity of the impact:*** Disasters that result in intense destruction within a short period of time are more likely to cause emotional distress among survivors than are disasters that spread their impact over a longer period of time.
- ***Impact ratio (i.e., the proportion of the community sustaining personal losses):*** When a disaster affects a significant proportion of a community's population, few individuals may be available to provide material and emotional support to survivors.
- ***Potential for recurrence of other hazards:*** The real or perceived threat of recurrence of the disaster or of associated hazards can lead to anxiety and heightened stress among survivors.
- ***Cultural and symbolic aspects:*** Changes in survivors' social and cultural lives and routine activities can be profoundly disturbing. Both natural and human-caused disasters can have symbolic implications.
- ***Extent and types of loss sustained by survivors:*** Property damage or loss, deaths of loved ones, injury, and job loss all affect emotional recovery.

CRISIS INTERVENTION

Crisis intervention is a short-term therapy focused on solving the immediate problem. It is usually limited to 6 weeks. **The goal of crisis intervention is for the individual to return to a precrisis level of functioning.** Often the person advances to a level of growth that is higher than the precrisis level because new ways of problem solving have been learned.

It is important for the nurse to remember that culture strongly influences the crisis intervention process, including the communication and response style of the crisis worker. Cultural attitudes are deeply ingrained in the processes of asking for, giving, and receiving help. They also affect the victimization experience, as seen in Box 13-2, so it is essential to understand and respect the sociocultural context of crisis care. Specific cultural factors to be considered in crisis intervention include the following:

- Migration and citizenship status
- Gender and family roles
- Religious belief systems
- Child-rearing practices
- Use of extended family and support systems
- Housing and living conditions
- Socioeconomic status

The age of the survivors is also important for the nurse to consider when providing crisis intervention. Responses to stressful events differ across the life span. Therefore age-appropriate interventions are most effective in helping survivors return to their previous level of functioning. For example, 4-year-old children may best express themselves through play, whereas adolescents may best work through crisis issues in peer group discussions.

TABLE 13-1 **PHASES OF DISASTER RESPONSE**

PHASE	RESPONSE
Warning or threat phase	Disasters vary in the amount of warning communities receive before they occur from little or no warning to hours or even days of warning. When no warning is given, survivors may feel more vulnerable, unsafe, and fearful of future unpredicted tragedies.
Impact phase	The impact period of a disaster can vary from the slow, low-threat build-up associated with some types of floods to the violent, dangerous, and destructive outcomes associated with tornadoes and explosions. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial effects.
Rescue or heroic phase	In the immediate aftermath, survival, rescuing others, and promoting safety are priorities. For some, postimpact disorientation gives way to adrenaline-induced rescue behavior to save lives and protect property. Although activity level may be high, actual productivity is often low. Altruism is prominent among both survivors and emergency responders.
Remedy or honeymoon phase	During the week to months following a disaster, formal governmental and volunteer assistance may be readily available. Community bonding occurs as a result of sharing the catastrophic experience and the giving and receiving of community support. Survivors may experience a short-lived sense of optimism that the help they will receive will make them whole again. When disaster mental health workers are visible and perceived as helpful during this phase, they are more readily accepted and have a foundation from which to provide assistance in the difficult phases ahead.
Inventory phase	Over time, survivors begin to recognize the limits of available disaster assistance. They become physically exhausted because of enormous multiple demands, financial pressures, and the stress of relocation or living in a damaged home. The unrealistic optimism initially experienced can give way to discouragement and fatigue.
Disillusionment phase	As disaster assistance agencies and volunteer groups begin to pull out, survivors may feel abandoned and resentful. The reality of losses and the limits and terms of the available assistance become apparent. Survivors calculate the gap between the assistance they have received and what they will require to regain their former living conditions and lifestyle. Stressors abound—family discord, financial losses, bureaucratic hassles, time constraints, home reconstruction, relocation, and lack of recreation or leisure time. Health problems and exacerbations of preexisting conditions emerge because of ongoing, unrelenting stress and fatigue.
Reconstruction or recovery phase	The reconstruction of physical property and recovery of emotional well-being may continue for years following the disaster. Survivors have realized that they will need to solve the problems of rebuilding their own homes, businesses, and lives largely by themselves and gradually assume the responsibility for doing so. Survivors are faced with the need to readjust to and integrate new surroundings as they continue to grieve losses. Emotional resources within the family may be exhausted and social support from friends and family may be worn thin.
	When people come to see meaning, personal growth, and opportunity from their disaster experience despite their losses and pain, they are well on the road to recovery. Although disasters may cause profound life-changing losses, they also bring the opportunity to recognize personal strengths and to reexamine life priorities.

From U.S. Department of Health and Human Services: *Training manual for mental health and human service workers in major disasters,* ed 2, Washington, DC, 2000, U.S. Government Printing Office.

BOX 13-2 **SOCIOCULTURAL CONTEXT OF CARE**

Survivors of Katrina

Many of the African-American survivors of Hurricane Katrina in New Orleans were at high risk for physical and mental health problems because of their residence in high-poverty areas, the residential segregation that existed before the storm, and the enormous dislocation that resulted from the hurricane. A study of this population found that survivors who lacked financial resources faced higher risks for general mental health problems and that racial discrimination increased the health-related risk for Katrina survivors. Further, female African-American survivors reported more posttraumatic stress disorder (PTSD) symptoms and worse mental health (Chen et al, 2007). In contrast, support provided by network members enhanced physical and mental health. This study of African-American survivors of Hurricane Katrina highlighted the social inequities in U.S. society and the need to directly address the issues of race, class, and gender inequality in disaster preparation, postdisaster rescue, and recovery mission and rebuilding efforts.

Another study examined the use of mental health services among adult survivors of Hurricane Katrina to evaluate the impact of disasters on persons with existing mental illness who were living in the community. As a result of the storm, entire mental health delivery systems were destroyed, and few Katrina survivors with mental disorders received adequate care (Wang et al, 2007, 2008). The sociocultural, financial, structural, and attitudinal barriers that prevented those with mental illness from obtaining needed treatment also will need to be overcome in future disasters.

BOX 13-3 BEHAVIORS COMMONLY EXHIBITED AFTER A CRISIS

Anger	Irritability
Apathy	Lability
Backaches	Nightmares
Boredom	Numbness
Crying spells	Overeating or undereating
Diminished sexual drive	Poor concentration
Disbelief	Sadness
Fatigue	School problems
Fear	Self-doubt
Flashbacks	Shock
Forgetfulness	Social withdrawal
Headaches	Substance abuse
Helplessness	Suicidal thoughts
Hopelessness	Survivor guilt
Insomnia	Work difficulties
Intrusive thoughts	

Critical Reasoning Describe how sociocultural factors might affect a woman's decision to seek help after being raped.

ASSESSMENT

The first step of crisis intervention is assessment. At this time, data about the nature of the crisis or disaster and its effect on the patient must be collected. From these data an intervention plan will be developed. People in crisis experience many symptoms, including those listed in Box 13-3. Sometimes these symptoms can cause further problems. For example, problems at work may lead to loss of a job, financial stress, and lowered self-esteem.

Crises also can be complicated by old conflicts that resurface as a result of the current problem, making crisis resolution more difficult. For example, a woman who was orphaned at an early age may have more difficulty resolving a crisis precipitated by the work injury of her husband than a woman who had not experienced an earlier loss.

Anger is one of the most understandable responses to a crisis or disaster but it also may be the most difficult one to manage. Anger can be productive if it is channeled in the right way but also can become a serious obstacle to recovery, creating problems for one's physical and mental health, as well as family and community cohesion. Questions that should be considered are as follows:

- Is the anger justified?
- Is the anger purposeful?
- Can the anger be used in a positive way?
- Does the anger pose an immediate threat or danger?

Anger is most common in the "disillusionment phase" noted in Table 13-1. In some cases, it can even pose a danger to the health care responders who have come to assist survivors. Thus, safety issues should be a priority for the nurse in working with patients in crisis.

QUALITY AND SAFETY ALERT

- As a helper, do not sacrifice one's personal safety to establish a relationship.
- Trust your instincts and exit a situation too soon rather than too late.
- Don't run from danger; rather have an exit plan and run to safety.

Although the crisis situation is the focus of the assessment, the nurse may identify more significant and long-standing problems. **Those individuals with preexisting psychological problems may have more postdisaster health problems**. For example, those with serious mental illness will need help in ensuring access to their medications and caregiver stability (Milligan and McGuinness, 2009).

It is important, therefore, to identify which areas can be helped by crisis intervention and which problems must be referred to other sources for further treatment. During this phase the nurse begins to establish a positive working relationship with the patient. A number of balancing factors are important in the development and resolution of a crisis and should be assessed:

- Precipitating event or stressor
- Patient's perception of the event or stressor
- Nature and strength of the patient's support systems and coping resources
- Patient's previous strengths and coping mechanisms

Precipitating Event

To help identify the precipitating event, the nurse should explore the patient's needs, the events that threaten those needs, and the time at which symptoms appear. Four kinds of needs that have been identified are as follows:

1. **Self-esteem** needs are achieved when the person attains successful social role experience.
2. **Role mastery** needs are achieved when the person attains work, sexual, and family role successes.
3. **Dependency** needs are achieved when a satisfying interdependent relationship with others is attained.
4. **Biological function** needs are achieved when a person is safe and life is not threatened.

The nurse determines which needs are not being met and looks for obstacles that might interfere with meeting the patient's needs.

Coping patterns become ineffective and symptoms appear usually after the stressful incident. When did the patient begin to feel anxious? When did sleep disturbances begin? At what point in time did suicidal thoughts start? If symptoms began last Tuesday, ask what took place in the patient's life on Tuesday or Monday. As the patient connects life events with the breakdown in coping mechanisms, an understanding of the precipitating event can emerge.

QUALITY AND SAFETY ALERT

- The safety of the patient is the first priority.
- Only when biological needs of food, shelter and physical integrity are met can other needs be addressed.

Perception of the Event

The patient's perception or appraisal of the precipitating event is very important. In times of disaster, perceptions of the event may be very similar. With other events it may not be so clear. What may seem trivial to the nurse may have great meaning to the patient.

For example, an overweight adolescent girl may have been the only girl in the class not invited to a dance. This may have threatened her self-esteem. A man with two unsuccessful marriages may have just been told by a girlfriend that she wants to end their relationship; this may have threatened his need for sexual role mastery. An emotionally isolated, friendless woman may have had car trouble and been unable to find someone to give her a ride to work. This may have threatened her dependency needs. A chronically ill man who has had a recent relapse of his illness may have had his need for biological functioning threatened.

Themes and surfacing memories of the patient give further clues to the precipitating event. Current issues of concern are often connected to past issues. For example, a female patient who talks about the death of her father, which occurred 3 years ago, may, on discussion, reveal a recent loss of a relationship with a male. A patient who talks about feelings of inadequacy he had as a child because of poor school performance may, on discussion, reveal a recent experience in which his feelings of adequacy on his job were threatened.

Because most crises involve losses or threats of losses, the theme of loss is a common one. In assessment, the nurse looks for a recent event that may be connected to an underlying theme.

Support Systems and Coping Resources

The patient's living situation and supports in the environment must be assessed. Does the patient live alone or with family or friends? With whom is the patient close, and who offers understanding and strength? Is there a supportive clergy member or friend?

Assessing the patient's support system is important in determining who should come for the crisis therapy sessions. It may be decided that certain family members should come with the patient so that the family members' support can be strengthened. If the patient has few supports, participation in a crisis therapy group may be recommended.

Assessing the patient's coping resources also is vital in determining whether hospitalization would be more appropriate than outpatient crisis therapy. If there is a high degree of suicidal or homicidal risk along with weak outside resources, hospitalization may be a safer and more effective treatment.

> **Critical Reasoning** Identify people in your social system that you would turn to in a time of crisis. Compare your list with that of a friend.

Coping Mechanisms

Next, the nurse assesses the patient's strengths and previous coping mechanisms. How has the patient handled other crises? How were anxieties relieved? Did the patient talk out problems? Did the patient leave the usual surroundings for a period of time to think things through from another perspective? Was physical activity used to relieve tension? Did the patient find relief in crying? Besides exploring previous coping mechanisms, the nurse also should note the absence of other possible successful mechanisms.

PLANNING AND IMPLEMENTATION

The next step of crisis intervention is planning; the previously collected data are analyzed, and specific interventions are proposed. Dynamics underlying the present crisis are formulated from the information about the precipitating event.

Alternative solutions to the problem are explored, and steps for achieving the solutions are identified. The nurse decides which environmental supports to engage or strengthen and how best to do this, as well as deciding which of the patient's coping mechanisms to develop and which to strengthen.

This process is outlined in the Patient Education Plan for coping with crisis in Table 13-2. **The expected outcome of nursing care is that the patient will recover from the crisis event and return to a precrisis level of functioning.** A more ambitious expected outcome would be for the patient to recover from the crisis event and attain a higher than precrisis level of functioning and improved quality of life.

Nursing interventions can take place on many levels using a variety of techniques. The four levels of crisis intervention—environmental manipulation, general support, generic approach, and individual approach—represent a hierarchy from the most basic to the most complex (Shields, 1975) (Figure 13-2).

Each level includes the interventions of the previous level, and the progressive order indicates that the nurse needs additional knowledge and skill for implementing high-level interventions. It is often helpful to consult others when deciding which approach to use.

> **QUALITY AND SAFETY ALERT**
> - Individuals who have experienced a crisis can grow from it and function at a higher level afterwards based on the coping skills they learned in dealing with the situation.

Environmental Manipulation

Environmental manipulation includes interventions that directly change the patient's physical or interpersonal situation. These interventions provide situational support or remove stress and include mobilizing the patient's supporting social systems and serving as a liaison between the patient and social support agencies. After a disaster, agencies such as the American Red Cross often provide temporary shelter, food, and clothing.

At other times, unaffected family members may be helpful. For example, a patient who is having trouble coping with her six children may temporarily send several of the children to their grandparents' house. In this situation some stress is reduced. Similarly, a patient having difficulty on the job may take 1 week of sick leave to be removed temporarily from that stress. A patient who lives alone may move in with his

TABLE 13-2 PATIENT EDUCATION PLAN

Coping with Crisis

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Describe the crisis event.	Ask about the details of the crisis, including the following: • A timeline of the crisis • Who was affected • The events of the crisis • Any precipitating events	Patient describes the crisis event in detail.
Explore feelings, thoughts, and behaviors related to the crisis event.	Determine precrisis level of functioning. Discuss patient's perception of the crisis event. Determine acute and long-term needs, threats, and challenges.	Patient discusses precrisis level of functioning and perceptions of the crisis event. Patient's needs are identified.
Identify coping mechanisms.	Ask how stressful events have been handled in the past. Analyze whether these are adaptive or maladaptive for the current crisis event. Suggest additional coping strategies.	Patient identifies adaptive coping mechanisms for the current crisis event.
Develop a plan for coping adaptively with the crisis event.	Reinforce adaptive coping mechanisms and healthy defenses. With the patient, construct a coping plan for the aftermath of the crisis event.	Patient develops a plan for coping with the crisis event.
Assign the patient activities from coping plan.	Review implementation of the coping plan. Help patient generalize coping strategies for use in future crisis events.	Patient reports satisfaction with coping abilities and level of functioning.

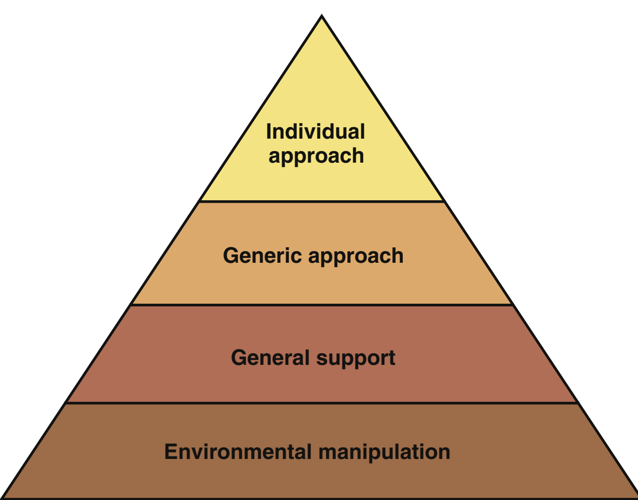


FIG 13-2 Levels of crisis intervention.

closest sibling for several days. Likewise, involving the patient in family or group crisis therapy provides environmental manipulation for the purpose of providing support.

General Support

General support includes interventions that convey the feeling that the nurse is on the patient's side and will be a helping person. The nurse uses warmth, acceptance, empathy, caring, and reassurance to provide this type of support.

Generic Approach

The generic approach is designed to reach high-risk individuals and large groups as quickly as possible. **It applies a specific method to all people faced with a similar type of crisis or disaster.** The expected course of the particular type of crisis is studied and mapped out. The intervention is then set up to ensure that the course of the crisis results in an adaptive response.

Grief is an example of a crisis with a known pattern that can be treated by the generic approach. Helping the patient to overcome ties to the deceased and find new patterns of rewarding interaction may effectively resolve the grief. Applying this intervention to people experiencing grief, especially with a high-risk group such as families of disaster victims, is an example of the generic approach.

Interventions following an acute stress are sometimes referred to as **debriefing.** Originally a military concept, debriefing has been used as a therapeutic intervention to help people recall events and clarify traumatic experiences. Interventions consist of ventilation of feelings within a context of group support, normalization of responses, and education about psychological reactions to traumatic events.

Although debriefing may be effective for some individuals, research evidence does not support the usefulness of psychological debriefing in reducing symptoms after psychological trauma and suggests that it may be harmful (Sijbrandij et al, 2006).

QUALITY AND SAFETY ALERT

- Debriefing is not an evidence-based practice.
- It has not been shown to be an effective psychological intervention.
- Some studies suggest that it actually worsens the trauma symptoms.

Individual Approach

The individual approach is a type of crisis intervention similar to the diagnosis and treatment of a specific problem

in a specific patient. The nurse must understand the specific patient characteristics that led to the present crisis and must use the intervention that is most likely to help the patient develop an adaptive response to the crisis.

This type of crisis intervention can be effective with all types of crises. It is particularly useful in combined situational and maturational crises. The individual approach is also helpful when symptoms include homicidal and suicidal risk. In addition, the individual approach should be applied if the course of the patient's crisis cannot be determined and if resolution of the crisis has not occurred using the generic approach.

Interventions are aimed at facilitating cognitive and emotional processing of the traumatic event and at improving coping. Five core interventions to assist survivors of acute stress are as follows:

- **Restore psychological safety.**
- **Provide information.**
- **Correct misattributions.**
- **Restore and support effective coping.**
- **Ensure social support.**

> **Critical Reasoning** How might each level of crisis intervention be used in a high school after a star player of the football team commits suicide?

Techniques

The nurse should be creative and flexible, trying many different techniques. These should be active, focused, and explorative techniques that can achieve the targeted interventions. Some of these include catharsis, clarification, suggestion, reinforcement of behavior, support of defenses, raising self-esteem, and exploration of solutions.

The intervention must be aimed at achieving quick resolution. The nurse also must be active in guiding the crisis intervention through its various steps. A passive approach is not appropriate because of the time limitations of the crisis situation. A brief description of these techniques follows.

Catharsis is the release of feelings that takes place as the patient talks about emotionally charged areas. As feelings about the events are discussed, tension is reduced. Catharsis is often used in crisis intervention. The nurse explores the patient's feelings about the specific situation, recent events, and significant people involved in the particular crisis.

The nurse asks open-ended questions and repeats the patient's words so that more feelings are expressed. The nurse does not discourage crying or angry outbursts but rather sees them as a positive release of feelings.

Only when feelings seem out of control, such as in cases of extreme rage or despondency, should the nurse discourage catharsis and help the patient concentrate on thinking rather than feeling. For example, if a patient angrily talks of wanting to kill a specific person, it is better to shift the focus to a discussion of the consequences of carrying out the act rather than to encourage free expression of the angry feelings.

Clarification is used when the nurse helps the patient identify the relationship among events, behaviors, and feelings. For example, helping a patient see that it was after being passed over for a promotion that the patient felt too sick to go to work is clarification. Clarification helps the patient gain a better understanding of feelings and how they lead to the development of a crisis.

Suggestion is influencing a person to accept an idea or belief. In crisis intervention the patient is influenced to see the nurse as a confident, calm, hopeful, empathic person who can help. By believing the nurse can help, the patient may feel more optimistic and less anxious.

It is a technique in which the nurse engages patients' emotions, wishes, or values to their benefit in the therapeutic process. Suggestion is a way of influencing the patient by pointing out alternatives or new ways of looking at things.

Reinforcement of behavior occurs when healthy, adaptive behavior of the patient is reinforced by the nurse, who strengthens positive responses made by the patient by agreeing with or positively acknowledging those responses. For example, when a patient who has passively allowed himself to be criticized by the boss later reports being assertive in a discussion with the boss, the nurse can commend the patient on this assertiveness.

Support of defenses occurs when the nurse encourages the use of healthy defenses and discourages those that are maladaptive. Defense mechanisms are used to cope with stressful situations and to maintain self-esteem and ego integrity. When defenses deny, falsify, or distort reality to the point that the person cannot deal effectively with reality, they are maladaptive.

The nurse should encourage the patient to use adaptive defenses and discourage those that are maladaptive. For example, when a patient denies that her husband wants a separation despite the fact that he has told her so, the nurse can point out that she is not facing facts and dealing realistically with the problem. This is an example of discouraging the maladaptive use of the defense mechanism of denial. If a patient who is furious with his boss writes a letter to his boss's supervisor rather than assaulting his boss, the nurse should encourage the adaptive use of the defense mechanism of sublimation.

In crisis intervention, defenses are not attacked but rather are more gently encouraged or discouraged. When defenses are attacked, the patient cannot maintain self-esteem and ego integrity. Also, the immediacy of crisis intervention does not allow enough time to replace the attacked defenses with new ones. Returning the patient to a prior level of functioning is the goal of crisis intervention, not the restructuring of defenses.

Raising self-esteem is a particularly important technique. The patient in a crisis feels helpless and may be overwhelmed with feelings of inadequacy. The fact that the patient has found it necessary to seek outside help may further increase feelings of inadequacy.

The nurse should help the patient regain feelings of self-worth by communicating confidence that the patient can find solutions to problems. The nurse also should convey that the patient is a worthwhile person by listening to and accepting the patient's feelings, being respectful, and praising help-seeking efforts.

Exploration of solutions is essential because crisis intervention is geared toward solving the immediate crisis. The nurse

BOX 13-4 TECHNIQUES OF CRISIS INTERVENTION

***Technique:* Catharsis**
Definition: The release of feelings that takes place as the patient talks about emotionally charged areas
Example: "Tell me about how you have been feeling since you lost your job."
***Technique:* Clarification**
Definition: Encouraging the patient to express more clearly the relationship among certain events
Example: "I've noticed that after you have an argument with your husband you become sick and can't leave your bed."
***Technique:* Suggestion**
Definition: Influencing a person to accept an idea or belief, particularly the belief that the nurse can help and that the person will in time feel better
Example: "Many other people have found it helpful to talk about this and I think you will, too."
***Technique:* Reinforcement of behavior**
Definition: Giving the patient positive responses to adaptive behavior
Example: "That's the first time you were able to defend yourself with your boss, and it went very well. I'm so pleased that you were able to do it."
***Technique:* Support of defenses**
Definition: Encouraging the use of healthy, adaptive defenses and discouraging those that are unhealthy or maladaptive
Example: "Going for a bicycle ride when you were so angry was very helpful because when you returned you and your wife were able to talk things through."
***Technique:* Raising self-esteem**
Definition: Helping the patient regain feelings of self-worth
Example: "You are a very strong person to be able to manage the family all this time. I think you will be able to handle this situation, too."
***Technique:* Exploration of solutions**
Definition: Examining alternative ways of solving the immediate problem
Example: "You seem to know many people in the computer field. Could you contact some of them to see whether they might know of available jobs?"

and patient actively explore solutions to the crisis. Answers that the patient had not thought of before may become apparent during conversations with the nurse as anxiety decreases. For example, a patient who has lost his job and has not been able to find a new one may become aware of the fact that he knows many people in his field of work whom he could contact to get information regarding the job market and possible openings.

These crisis intervention techniques are summarized in Box 13-4. In addition to using these techniques, the crisis worker should have some other particular attitudes toward the care being given in order to be effective.

The crisis worker should see this work as the treatment of choice for people in crisis rather than as a second-best treatment. Assessment of the present problem should be viewed as necessary for treatment, whereas a complete diagnostic assessment should be recognized as being unnecessary. The goal and time limitations of crisis intervention should be kept in mind constantly, and material unrelated to the crisis should not be explored.

The crisis worker must take an active directive role and maintain flexibility of approach. If more complex problems are identified that are not suitable for crisis intervention, the patient should be referred for further treatment. Table 13-3 describes interventions for helping individuals and families cope with stress resulting from crisis.

EVALUATION

The last phase of crisis intervention is evaluation, when the nurse and patient evaluate whether the intervention resulted in a positive resolution of the crisis. Specific questions the nurse might ask include the following:

- Has the expected outcome been achieved, and has the patient returned to the precrisis level of functioning?
- Have the needs of the patient that were threatened by the event been met?

TABLE 13-3 NURSING INTERVENTIONS FOR CRISIS AND DISASTER EVENTS

TARGET AREAS	NURSING INTERVENTIONS
Basic Needs	Provide liaison to social agencies.
Physical Deficits	Attend to physical emergencies. Refer to other health care providers as necessary.
Psychological Effects	
Shock	Attentively listen to telling of the crisis details.
Confusion	Give nurturing support; permit regression.
Denial	Permit intermittent denial; identify patient's primary concern.
Anxiety	Provide structure; enact antianxiety interventions.
Lethargy/heroics	Encourage sublimation and constructive activity.
Protective Factors	
Coping	Encourage patient's favored, adaptive coping mechanisms; emphasize rationalization, humor, sublimation.
Self-efficacy	Support patient's previous successes and belief in own abilities; dilute irrational self-doubts; emphasize power of expectations to produce results.
Support	Add social supports to the patient's world; provide professional support; refer for counseling when necessary; help patient develop new coping strategies.

Modified from Hardin SB: Catastrophic stress. In McBride AB, Austin JK, editors: *Psychiatric–mental health nursing*, Philadelphia, 1996, Saunders.

- Have the patient's symptoms decreased or been resolved?
- Does the patient have adequate support systems and coping resources on which to rely?
- Is the patient using constructive coping mechanisms?
- Is the patient demonstrating adaptive crisis responses?
- Does the patient need to be referred for additional treatment?

The nurse and patient also should review the changes that have occurred. The nurse should give patients credit for successful changes so that they can realize their effectiveness and understand that what they learned from a crisis may help in coping with future crises. If the goals have not been met, the patient and nurse can return to the first step, assessment, and progress through the phases again.

At the end of the evaluation process, if the nurse and patient believe referral for additional professional help would be useful, the referral should be made as quickly as possible. All phases of crisis intervention are presented in the Case Study in Box 13-5.

Critical Reasoning Given that stress is experienced by all people, why aren't all nurses required to be competent in crisis intervention skills, just as they are in cardiopulmonary resuscitation (CPR) skills?

SETTINGS FOR CRISIS AND DISASTER INTERVENTION

Disasters can occur anytime and anywhere. Nurses live and work in settings in which they often see people in crisis. **Hospitalizations of any type are stressful for patients and their families and are precipitating causes of crises.**

The patient who becomes demanding or withdrawn or the spouse who becomes bothersome to the nursing staff is a possible candidate for crisis intervention. The diagnosis of an illness, the limitations imposed on activities, and the changes in body image because of surgery can all be viewed as losses or threats that may precipitate a situational crisis. Simply the stress of being dependent on nurses for care can precipitate a crisis for the hospitalized patient.

Nurses who work in obstetric, pediatric, adolescent, or geriatric settings often observe patients or family members undergoing maturational crises. The anxious new mother, the acting-out adolescent, and the newly retired depressed patient are all possible candidates for crisis therapy. If physical illness is an added stress during maturational turning points, the patient is at an even greater risk.

Emergency department and critical care settings also are flooded with crisis cases. People who attempt suicide, psychosomatic patients, survivors of sudden cardiac arrest, and crime and accident victims are all possible candidates for crisis intervention. If the nurse is not in a position to work with the patient on an ongoing basis, a referral should be made.

Community and home health nurses work with patients in their own environments and can often spot and intervene in family crises. The child who refuses to go to school, the man who resists learning how to give himself an insulin injection, and the family with a member dying at home are possible candidates for crisis intervention. Community health nurses are also in an ideal position to evaluate high-risk families, such as those with new babies, ill members, recent deaths, and a history of difficulty coping.

Finally, nurses in primary care, community health centers, managed care clinics, schools, occupational health centers, long-term care facilities, and home health agencies also may see patients in crisis, such as those experiencing depression, anxiety, marital conflict, suicidal thoughts, illicit drug use, and traumatic responses. **Crisis intervention can be implemented in any setting and should be a competency skill of all nurses, regardless of specialty area.**

MODALITIES OF CRISIS INTERVENTION

Crisis intervention modalities are based on the philosophy that the health care team must be aggressive and go out to the patients rather than wait for the patients to come to them. Nurses working in these modalities intervene in a variety of community settings, ranging from patients' homes to street corners, with great success.

Disaster Responses

As part of the community, nurses are called upon when situational crises and disasters strike the community. Floods, earthquakes, airplane crashes, fires, nuclear accidents, and other natural and unnatural disasters precipitate large numbers of crises. Key concepts that should be understood by all disaster mental health providers are presented in Box 13-6 (DHHS, 2003).

It is important that nurses in the immediate postdisaster period go to places where victims are likely to gather, such as morgues, hospitals, shelters, and areas surrounding the disaster site. Rather than waiting for people to publicly identify themselves as being unable to cope with stress, it is suggested that nurses work with the American Red Cross, talk to people waiting in lines to apply for assistance, go door-to-door, or, at a relocation site, ask people how they are managing their affairs and explore their reactions to stress (Weeks, 2007).

Common psychiatric responses to disaster should be considered when developing plans. These are listed in Box 13-7. **Experts in the field of disaster response suggest that organized plans for crisis response be developed and practiced during nondisaster times** (Sederer et al, 2011).

A study of World Trade Center rescue and recovery workers indicated that disaster preparedness training and shift rotations, which allowed for shorter time worked, may have reduced posttraumatic stress disorder (PTSD) among workers and volunteers. Furthermore, PTSD was significantly higher among those who did not have disaster training and who performed tasks not common for their occupation (Perrin et al, 2007).

Disaster plans are needed for large and small communities so that multiple complex needs can be met and effective triage implemented (Beach, 2010; Culley and Effken, 2010). Specifically, disaster plans need to have a way of identifying

BOX 13-5 CASE STUDY

Assessment

Mr. A is a 39-year-old, medium-build, casually dressed, African-American man who was referred to the mental health clinic by his primary care provider. The patient came to the center alone. The nurse working with Mr. A collected the following data.

The patient worked in a large naval shipyard that was recently scheduled for closing. It was laying off many workers and reassigning others. One month earlier Mr. A was assigned to an area where he had difficulty 2 years ago. The patient believed that the foreman was harassing him as he had done previously.

Two weeks ago the patient had become angry with the foreman and had thoughts of killing him. Instead of acting on these thoughts, Mr. A became dizzy, and his head ached. He requested medical attention but was refused. He then passed out and was taken by ambulance to the dispensary. Since that time Mr. A had a comprehensive physical examination and was found to be in excellent health. He was prescribed diazepam (Valium) on an as-needed basis, which was only slightly helpful. He returned to work for 2 days this week but again felt sick.

Mr. A complained of being depressed, nervous, and tense. He was not sleeping well, was irritable with his wife and children, and was preoccupied with angry feelings toward his foreman. He denied suicidal thoughts but admitted that he felt like killing the foreman. He quickly added that he would really never do anything like that.

He appeared to have good comprehension, above-average intelligence, adequate memory, and some paranoid ideation related to the foreman at work. His thought processes were organized, and there was no evidence of a perceptual disorder. Ego boundary disturbance was evident in the patient's paranoid thoughts. It seemed that the foreman was a difficult man to get along with, but the description of personal harassment was not based on any specifics.

Mr. A was raised by his parents. His father beat him and his siblings often. His mother was quiet and always agreed with his father. The patient had a younger brother and sister and an older sister. The patient and his brother had always been close. The two of them had stopped their father's beatings by ganging up on him and "psyching him out." As a child, Mr. A hung around with a tough crowd and fought frequently. He believed that he could physically overpower others but tried to keep out of trouble by talking to people rather than fighting.

Mr. A had no psychiatric history. His physical health was excellent, and he was taking no medication other than the prescribed Valium. He had a tenth-grade education, and his work record up to this time was good. His interests included bowling and other sports. He had been married for 17 years and had three daughters, ages 16, 13, and 9 years. Mr. A stated that he had a good relationship with his wife and daughters and that both his wife and his brother were strong supports for him.

His usual means of coping were talking calmly with the threatening party and working hard on his job, at home, and in leisure activities. These coping mechanisms failed to work for him at this time, but they had been successful in the past. He had no arrest record and was able to think through his actions rather than act impulsively. Mr. A showed strong motivation for working on his problem. He was reaching out for help and was able to form a therapeutic relationship with the nurse. Although his wife and brother were supportive, he felt a need for outside support because his previous coping skills were not working.

Diagnosis

Mr. A was in a **situational crisis.** The threat or precipitating stress was his job transfer and supervision by a former boss, whom he felt was harassing him. The patient's need for role mastery was not being met because he was not feeling successful at his job. Soon after the transfer, Mr. A's usual means of coping became ineffective and he experienced increased anxiety. His nursing diagnosis was *ineffective coping related to changes at work, as evidenced by physical complaints of dizziness and tension*. His *DSM-IV-TR* diagnosis was *adjustment disorder with mixed anxiety and depressed mood*.

Outcomes Identification and Planning

The **expected outcome** of treatment was for Mr. A to return to his precrisis level of functioning. If possible, he could reach a higher level, having learned new methods of problem solving. The patient showed good potential for growth, and the nurse made a contract with him for crisis intervention. Mutually identified **short-term goals** included the following:

- Mr. A will explore his thoughts and feelings about recent work events.
- Mr. A will not harm his boss.
- Mr. A will describe coping mechanisms that have been successful for him in the past.
- Mr. A will identify three new ways of coping with work stress.
- Mr. A will implement two of the new coping strategies.
- Mr. A will be free of symptoms and function well at work.

Implementation

The level of intervention used by the nurse was the **individual approach,** which includes the generic approach, general support, and environmental manipulation.

Environmental manipulation involved having the patient remain home from work temporarily. Letters were written by the nurse to his employer explaining Mr. A's absence in general terms. Mr. A was encouraged to talk to his wife about his difficulties so that she could understand his anxiety and provide emotional support.

General support was given by the nurse, who provided an atmosphere of reassurance, nonjudgmental caring, warmth, empathy, and optimism. Mr. A was encouraged to talk freely about the problem, and the nurse assured him that his problem could be solved and that he would be feeling better soon.

The **generic approach** was used to decrease the patient's anxiety and guide him through the steps of problem solving. Levels of anxiety were assessed and ways of reducing anxiety and helping the patient tolerate moderate anxiety were identified. The patient was encouraged to use his anxiety constructively to solve his problem and develop new coping mechanisms.

The **individual approach** was used in assessing and treating the specific problems of Mr. A, who was strongly sensitive to mistreatment as a result of early childhood experiences. His emotional response was to strike out physically, as his father had struck out at him. Intellectually, Mr. A knew this would not be good, and his conflict was solved by becoming sick and passing out so that he could not assault his boss. Mr. A's intense anger was recognized, and a high priority was placed on channeling the anger in a positive direction. He stated that he had no intentions of hurting his boss.

BOX 13-5 CASE STUDY—cont'd

The first two meetings were used for data gathering and establishing a positive therapeutic relationship. Through the use of **catharsis** the patient vented angry feelings but did not concentrate on wanting to kill his boss. The nurse used **clarification** to help the patient begin to understand the precipitating event and its effect on him. **Suggestion** was used to allow the patient to see the nurse as one who could help. The nurse told the patient the problem could be worked out by the two of them and that he would soon be feeling better. Mr. A decided to contact several people at work to obtain information about transferring to another department and filing a formal complaint against the foreman. The patient and nurse therefore were **exploring solutions.** The nurse reinforced the patient's use of problem solving by telling him that his ideas about alternative solutions were good ones. Throughout these and other sessions the nurse **raised his self-esteem** by communicating her confidence that he could find solutions to his problems. She listened to and accepted his feelings and treated him with respect. By contacting others at work, the patient also found some supportive people.

During the third session the patient described an incident in which he became furious at a worker in an automobile repair shop. The repairs on the patient's car were repeatedly done incorrectly, and the patient had to keep returning the car. The patient shoved the worker but limited his physical assault to just that. He then felt nervous and jittery. The patient had previously expressed pride in his ability to control his angry feelings and not physically strike out at others. **Suggestion** was used by telling the patient that he showed control in stopping the assault before it had become a full-blown fight and he could continue to do so. During this session the patient spoke of old, angry feelings toward his father. Some of this venting was allowed, but soon thereafter the focus was guided back to the present crisis.

In the fourth session the patient reported no episodes of uncontrollable anger. However, he still put much emphasis on being harassed by others. The nurse questioned the notion that others were out to intentionally harass the patient. Mr. A's defenses were not attacked, but his use of projection was discouraged.

In the fifth session the patient reported that a car tried to run him off the road. At a red traffic light the patient spoke calmly to the offending driver and the driver apologized. The nurse **reinforced this behavior** and **supported his use of sublimation** as a defense. Discussion of termination of the therapy was begun.

In the sixth session Mr. A said that things were going well at work and that he would soon be going to a different department. He also talked about a course he had begun at a community college. He showed no evidence of anxiety, depression, or paranoia and thought he didn't need to come back to the mental health clinic.

Evaluation

The interventions resulted in an adaptive resolution of the crisis. The patient's need for role mastery was being met. He was once again comfortable and successful at work. His symptoms of anxiety, paranoia, dizziness, headaches, passing out, and homicidal thoughts had ended. He no longer felt harassed. His original coping mechanisms were again effective. He was talking calmly to people with whom he was having difficulty, and he was again working hard in a goal-oriented way (his college course).

He had learned new methods of coping, which included talking about his feelings to significant others, following administrative or official avenues of protest, and seeking support. The patient and nurse discussed how Mr. A could use the methods of problem solving he had learned from the experience to help cope with future problems. The expected outcome, return to the precrisis level of functioning, had been attained.

It was also recommended to the patient that he engage in psychotherapy so that he could deal with the old angers that continued to interfere with his life. Mr. A rejected the recommendation and said he would contact the clinic if he changed his mind.

BOX 13-6 KEY CONCEPTS OF DISASTER—MENTAL HEALTH

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma—individual and community.
- Most people pull together and function adequately during and after a disaster, but they are less effective due to the effects of the event.
- Stress and grief in disasters are normal reactions to abnormal situations.
- Many emotional reactions of disaster survivors stem from problems of daily living brought about by the disaster.
- Disaster relief assistance may be confusing to some survivors. They may experience frustration, anger, and feelings of helplessness related to federal, state, and private-sector disaster assistance programs.
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be tailored to the culture of communities where they are provided.
- Mental health workers should set aside traditional methods, avoid mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of the disaster.
- Social support systems are crucial to recovery.

BOX 13-7 COMMON PSYCHIATRIC RESPONSES TO DISASTER

Psychiatric Diagnoses
- Organic mental disorders secondary to head injury, toxic exposure, illness, and dehydration
- Acute stress disorder
- Adjustment disorder
- Substance use disorders
- Major depression
- Posttraumatic stress disorder
- Generalized anxiety disorder

Psychological/Behavioral Responses
- Grief reactions and other normal responses to an abnormal event
- Family violence
- Self-directed violence
- Other-directed violence

BOX 13-8 GUIDING PRINCIPLES FOR CULTURAL COMPETENCE IN DISASTER MENTAL HEALTH

- Recognize the importance of culture and respect diversity.
- Maintain a current profile of the cultural composition of the community.
- Recruit disaster workers who are representative of the community or service area.
- Provide ongoing cultural competence training to disaster mental health staff.
- Ensure that services are accessible, appropriate, and equitable.
- Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks.
- Involve as "cultural brokers" community leaders and organizations representing diverse cultural groups.
- Ensure that services and information are culturally and linguistically competent.
- Assess and evaluate the program's level of cultural competence.

those individuals who are at greatest risk for developing or worsening psychiatric illnesses.

Examples of agencies, organizations, and individuals to be included in disaster planning include hospitals, mental health programs, substance abuse agencies, departments of health, employee assistance programs, housing programs, university-affiliated nurses, and school district nurses. The American Nurses Association has guidance for professionals during disasters, pandemics, and other extreme emergencies that includes ethical principles, emergency preparedness competencies, and specific emergency event care (ANA, 2008).

Nurses providing crisis therapy during large disasters use the generic approach to crisis intervention so that as many people as possible can receive help in a short amount of time. Tragedies such as workplace violence and school shootings may affect fewer people and may at times require the individual approach. The nurse may choose to work with families or groups rather than individuals during situational crises so that people can gain support from others in their family or community who are undergoing stresses similar to theirs.

It is important to prioritize those in need of crisis intervention. At the top of the list are those who have themselves been physically attacked or injured. This is followed by those who suffer immediate and direct loss, such as the families and neighbors of victims. Below that are people who have been less directly affected but have still experienced some significant changes in their lives, such as friends and co-workers of the injured person and rescue workers. Next are those who have not been directly affected but who are particularly sensitive to environmental uncertainty, such as those who are physically and mentally ill. And finally, at the bottom, are the masses of people who have experienced some changes in their lives and feel fear as a result of the disaster.

Providing culturally competent care requires a concerted effort by disaster mental health planners and frontline workers. Successful programs share common practices that are defined by nine guiding principles listed in Box 13-8.

Finally, attention also has been focused on offering support and help to the helpers involved in disasters. Health and mental health professionals who are victims of disasters as well as providers of care during disasters often feel overwhelmed with stress (Adams, 2007; Chaffee, 2006). These care providers describe feelings of concern for their patients and their own families, as well as themselves. **Thus crisis intervention strategies for the caregivers in times of disaster are essential.**

Critical Reasoning Nurses are often called on to help out in times of disaster. What special needs might nurses have in situations where they are both victims and caregivers?

Mobile Crisis Programs

Mobile crisis teams provide frontline interdisciplinary crisis intervention to individuals, families, and communities. The nurse who is a member of a mobile crisis team may respond to a desperate person threatening to jump off a bridge in a suicide attempt, an angry person who is becoming violent toward family members at home, or a frightened person who has barricaded himself in an office building. By defusing the immediate crisis situation, lives can be saved, incarcerations and hospitalizations can be avoided, and people can be stabilized.

Mobile crisis programs throughout the United States vary in the services they provide and the procedures they use. However, they are usually able to provide on-site assessment, crisis management, treatment, referral, and educational services to patients, families, law enforcement officers, and the community at large. Studies of mobile crisis services show favorable outcomes for patients and families, lower hospitalization rates and fewer arrests (Compton et al, 2006; Skeem and Bibeau, 2008).

Critical Reasoning Ask if you can shadow a mobile crisis team in your community for a day. Observe the work they do and share your experience with your peers.

Telephone Contacts

Crisis intervention is sometimes practiced by telephone or Internet communication rather than through face-to-face contacts. When individuals in crisis use the telephone or Internet, it is usually at the peak of their distress. Nurses working for these types of hotlines or those who answer emergency telephone calls or electronic mail may find themselves practicing crisis intervention without having visual cues to rely on. Referrals for face-to-face contact should be made, but often, because of the patient's unwillingness or inability to cooperate, the telephone or Internet remains the only contact. A variety of listening skills must therefore be emphasized in the nurse's role.

Most emergency telephone and Internet services have extensive training programs to teach this specialized type of crisis intervention. Manuals written for the crisis worker include content such as suicide-potential rating scales, community resources, drug information, guidelines for helping the caller or crisis worker discuss concerns, and advice on understanding the limitations of the crisis worker's role.

Group Work

Crisis groups follow the same steps that individual intervention follows. The nurse and group help the patient solve the problem and reinforce the patient's new problem-solving behavior. The nurse's role in the group is active, focal, and present oriented. The group follows the nurse's example and uses similar therapeutic techniques. The group acts as a support system for the patient and is therefore of particular benefit to socially isolated people.

Often the way the patient functions in the group suggests the faulty coping pattern that is responsible for the patient's current problem. For example, a patient's interaction with group members may show that he does not appear to listen to anything said by others. This same patient may be in a crisis because his girlfriend left him because she thought he did not care about her thoughts and feelings. The nurse can comment on the faulty coping behavior seen in the group and encourage group discussion about it.

Nurses practicing on acute psychiatric units also can use crisis intervention in working with patients and families to prepare for discharge and prevent rehospitalization. With the shortened lengths of hospital stays, crisis intervention is often the treatment of choice. The hospitalization itself may be viewed as an environmental manipulation and part of the crisis intervention.

Victim Outreach Programs

Crisis intervention is not considered the appropriate treatment for serious consequences of victimization, such as PTSD or depression. **However, it is very useful as a community support for victims in the immediate aftermath of crime and may provide an important link for referral to more comprehensive services when needed.**

Violent crime has become a global issue, concerning people in every walk of life and in every country. Many victim outreach programs use crisis intervention techniques to identify the needs of victims and then to connect them with appropriate referrals and other resources. Patient concerns such as the personal meaning of the crime, who to tell, and the reaction of others should be discussed. A victim advocate can contact employers regarding the need for temporary time off, can mobilize community resources for food and shelter if necessary, and can arrange for grace periods with debtors to delay payment of bills without penalty until the victim recovers.

Crisis intervention is successful in the immediate aftermath of rape. It uses an integrated framework of outreach, emergency care, and advocacy assistance. Nurses often work in rape crisis centers, where victims commonly are seen immediately after the rape. These victims need thorough evaluation, empathic support, information, and help with the legal system.

Another important issue is that of abusive relationships. Whether the victim is a spouse, a child, a date, an elderly person, or a caregiver, abusive relationships are experienced by people of both genders and of all racial, ethnic, economic, educational, and religious backgrounds. Chapter 38 presents more information regarding care of survivors of violence.

Health Education

Although health education can take place during the entire crisis intervention process, it is emphasized during the evaluation phase. At this time the patient's anxiety has decreased, so better use can be made of cognitive abilities. The nurse and patient summarize the course of the crisis, and the intervention is to teach the patient how to avoid other similar crises.

For example, the nurse helps the patient identify the feelings, thoughts, and behaviors experienced following the stressful event. The nurse explains that if these feelings, thoughts, and behaviors are again experienced, the patient should immediately become aware of being stressed and take steps to prevent the anxiety from increasing. The nurse then teaches the patient ways to use these newly learned coping mechanisms in future situations.

Nurses also are involved in identifying people who are at high risk for developing crises and in teaching coping strategies to help them avoid the development of the crises. For example, coping strategies that can be taught include how to request information, access resources, and obtain support.

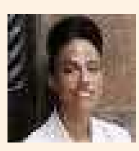
> **Critical Reasoning** Explain how conducting a group on stress management for critical care nurses is an example of health education as crisis intervention.

Finally, members of the public also need education so that they can identify those requiring crisis services, be aware of available services, change their attitudes so that people will feel free to seek services, and obtain information about how others deal with potential crisis-producing problems. Nurses, as health care professionals, have a great opportunity to provide health education and crisis intervention, thus preventing mental illness and promoting mental health.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse: Nurses Remember 9/11

Maria Gatto, New York University, Division of Nursing



A Student's View

The doctor brought us to Firehouse 10, located at Greenwich and Liberty. I stood in amazement, taking in the environment that would be my home for the next few days. There was no front door or wall to the station house because it had been blown out. It was dark, dim, and filthy with thick layers of dust, ash, and debris from the fallout. There were two small tables, one gurney, a coat rack that was fashioned into a makeshift IV pole, hung with a few bags of solution and tubing. There were also a few tanks of oxygen, a defibrillator, and an emergency crash box. Two other people, a retired lawyer turned emergency medical technician (EMT) from Pennsylvania and a medical resident, walked into the station and joined us. We all sat down and looked out. For the first time that day, I really saw what no photograph, news report, or television footage could ever capture.

Ground Zero was a mountain of concrete, mangled steel, dirt, debris, and rubble … absolute devastation and destruction. Silently we sat, exchanging a sober moment. There was nothing for us to do. Or was there?

Hundreds of people were working in a synchronized bucket brigade. A community banded together on their hands and knees trying to clear and unearth anything to bring home to the thousands waiting to celebrate or mourn. Our duty was right there in front of us. We joined the digging effort. On our hands and knees, we dug with a purposeful rhythm. The ground underneath me was very hot, and the air was dense with choking fumes. I filled buckets with dirt and debris. Then signs of what was once a work force of thousands began to appear.

First it was the occasional business card, parts of a day planner with smeared notes, then pieces of a briefcase. This brought me closer to what I feared the most. A shoe—and then the foot. I called out to a rescue worker, a towering man, rough and filthy with the day's events. He placed the remains carefully into a container and walked it down the mountain, cradling it like a baby. I said a silent prayer for this kind man who had just taught me one of the gravest lessons a nurse could learn:

In life we celebrate, in death we respect.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse: Nurses Remember 9/11

Angela Apuzzo, New York University, Division of Nursing

A Faculty's View

This is what I want to tell you about the profession of nursing. Nursing is not a nine-to-five job. It's a way of life that you have pledged yourselves to follow.

In school, professors cram your head with knowledge and nursing diagnoses. We help you develop critical thinking and try to show you how a nurse functions in clinical settings. We give you the tools you need to perform your professional duties. But you have to internalize this knowledge and make it your own.

We are nurses, members of a group that enjoys the highest level of trust of any profession. Patients believe nurses act as their advocates. In turn, we accept them as they are. We leave the security of our own selves and enter into the patients' worlds. When we are truly there, we can see their point of view and are able to help them to achieve healing and wellness.

Here's what I learned from September 11: *keep learning*, for nurses must function in unexpected settings and carry out a wide range of duties; *share yourself*, for it takes a brave heart to open yourself to pain and suffering; *always do your best*, for when you show that you care you are giving the best of clinical nursing.

CHAPTER IN REVIEW

- A crisis is a disturbance caused by a stressful event or a perceived threat. The person's usual way of coping becomes ineffective in dealing with the threat, causing anxiety.
- Successful resolution of the crisis is more likely if the person has a realistic view of the event, if situational supports are available to help solve the problem, and if effective coping mechanisms are present.
- There are two types of crises: maturational and situational.
- Maturational crises are developmental events requiring role changes.
- Situational crises occur when a life event upsets an individual's or group's psychological equilibrium. They include natural and man-made disasters.
- Disaster responses typically occur in seven phases and the nature of the disaster often can determine its mental health impact.
- Crisis intervention is a short-term therapy focused on solving the immediate problem, usually limited to 6 weeks. The goal of crisis intervention is for the individual to return to a precrisis level of functioning. Often the person advances to a level of growth that is higher than the precrisis level because new ways of problem solving have been learned.
- A number of balancing factors are important in the development and resolution of a crisis and should be assessed: precipitating event or stressor; patient's perception of the

CHAPTER IN REVIEW—cont'd

event or stressor; nature and strength of the patient's support systems and coping resources; and patient's previous strengths and coping mechanisms.

- To help identify the precipitating event, the nurse should explore the patient's needs, the events that threaten those needs, and the time at which symptoms appear. Four kinds of needs that have been identified are related to self-esteem, role mastery, dependency, and biological function.
- There are four levels of crisis intervention—environmental manipulation, general support, generic approach, and individual approach—that represent a hierarchy from the most basic to the most complex.
- Environmental manipulation includes interventions that directly change the patient's physical or interpersonal situation. These interventions provide situational support or remove stress.
- Important elements of this intervention are mobilizing the patient's supporting social systems and serving as a liaison between the patient and social support agencies.
- General support includes interventions that convey the feeling that the nurse is on the patient's side and will be a helping person. The nurse uses warmth, acceptance, empathy, caring, and reassurance to provide this type of support.
- The generic approach is designed to reach high-risk individuals and large groups as quickly as possible. It applies a specific method to all people faced with a similar type of crisis.
- The individual approach is a type of crisis intervention similar to the diagnosis and treatment of a specific problem in a specific patient. The nurse must understand the specific patient characteristics that led to the present crisis and must use the intervention that is most likely to help the patient develop an adaptive response to the crisis.
- The nurse should be creative and flexible, trying many different techniques. These should be active, focused, and explorative to carry out the interventions. Some of these include catharsis, clarification, suggestion, reinforcement of behavior, support of defenses, raising self-esteem, and exploration of solutions.
- The nurse should give patients credit for successful changes so that they can realize their effectiveness and understand that what they learned from a crisis may help in coping with future crises.
- Crisis intervention can be implemented in any setting and should be a competency skill of all nurses, regardless of specialty area.
- Crisis intervention modalities are based on the philosophy that the health care team must be aggressive and go out to the patients rather than wait for the patients to come to them. Nurses working in these modalities intervene in a variety of community settings, ranging from patients' homes to street corners.
- As part of the community, nurses are called upon when situational crises and disasters strike the community. Common psychiatric responses to disaster should be considered when developing plans.
- Organized plans for crisis response should be developed and practiced during nondisaster times. Disaster plans need to have a way of identifying those individuals who are at greatest risk for developing or worsening psychiatric illnesses and prioritizing care.
- Providing culturally competent care requires a concerted effort by disaster mental health planners and frontline workers.
- Crisis intervention strategies for the caregivers in times of disaster are essential.
- Mobile crisis programs throughout the United States vary in the services they provide and the procedures they use. However, they are usually able to provide on-site assessment, crisis management, treatment, referral, and educational services to patients, families, law enforcement officers, and the community at large.
- Crisis intervention is sometimes practiced by telephone or Internet communication rather than through face-to-face contacts. When individuals in crisis use the telephone or Internet, it is usually at the peak of their distress.
- Crisis groups follow the same steps that individual intervention follows. The nurse and group help the patient solve the problem and reinforce the patient's new problem-solving behavior.
- Many victim outreach programs use crisis intervention techniques to identify the needs of victims and then to connect them with appropriate referrals and other resources.
- Although health education can take place during the entire crisis intervention process, it is emphasized during the evaluation phase. Nurses are involved in identifying people who are at high risk for developing crises and in teaching coping strategies to avoid the development of the crises. Members of the public also need education so that they can identify those needing crisis services, be aware of available services, change their attitudes so that people will feel free to seek services, and obtain information about how others deal with potential crisis-producing problems.

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CHAPTER

14

Recovery Support

Sandra J. Sundeen

Of equality—as if it harm'd me giving others the same chances and rights as myself—as if it were not indispensable to my own rights that others possess the same.

Walt Whitman, Thought

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Define *recovery* and *rehabilitation* in psychiatric care.
2. Assess the nursing care needs of people in recovery and how families and communities respond to their needs.
3. Plan and implement recovery support of psychiatric nursing interventions with individuals, families, and communities.
4. Examine approaches to evaluate recovery support interventions related to individuals, families, and programs.

It is estimated that 5% of adults in the United States have a serious mental illness. Nurses care for these people in private and public psychiatric hospitals, psychiatric and medical-surgical units in general hospitals, emergency departments, community-based treatment and rehabilitation programs, primary care settings, and patients' homes. As patients alternate between community-based and hospital-based care, nurses in all settings share responsibility for their care.

RECOVERY

Individuals who have serious mental illnesses, with the provision of appropriate and individualized supports, can recover from their illnesses and lead satisfying and productive lives. One of the eight Strategic Initiatives identified in the 2011–2014 plan of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is "Recovery Support" (SAMHSA, 2011). One-third of individuals with severe mental illnesses who receive community mental health services after lengthy stays in a state hospital fully recover, and another third improve significantly (SAMHSA, 2009).

Recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential (USDHHS, 2006). The components of recovery are described in Box 14-1.

Recovery is the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Recovery also involves connectedness, or the capacity for mutual interpersonal relationships, and citizenship, which includes the rights, privileges, and responsibilities of membership in a democratic society (Ware et al, 2007, 2008).

Self-determination is the foundation of person-centered and consumer-driven recovery supports and systems. The

BOX 14-1 COMPONENTS OF RECOVERY

- **Self-Determination:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual who defines personal life goals and designs a unique path toward those goals.
- **Individualized and Person Centered:** There are multiple paths to recovery based on an individual's unique strengths and resiliencies as well as the individual's needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and they are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment an individual gains control of his own destiny and influences the organizational and societal structures in his life.
- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

From Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (USDHHS): *National consensus statement on mental health recovery,* Rockville, MD, 2006, USDHHS, CMHS.

most important aspects of recovery are defined by each individual with the help of mental health care providers and the people who are most important in each person's life. **Having hope plays an essential role in an individual's recovery** (Stuart, 2010).

The individual receives recovery supports through activities identified as **rehabilitation,** which is the process of helping the person return to the highest possible level of functioning. **Psychiatric rehabilitation is a combination of services incorporating social, educational, occupational, behavioral, and cognitive interventions aimed at long-term recovery and maximization of self-sufficiency.**

It grew out of a need to create opportunities for people diagnosed with severe mental illness to live, learn, and work in their own communities. Psychiatric rehabilitation uses a person-centered, people-to-people approach that differs from the traditional medical model of care as seen in Table 14-1.

Critical Reasoning Compare the principles of psychiatric rehabilitation with your knowledge of physical rehabilitation. How do the principles affect nursing intervention?

Some mental health care providers have concerns that the focus on recovery is not realistic. However as individuals participate in recovery-oriented programs and mental health professionals observe the progress that they make, these concerns are addressed and corrected (Delaney, 2010).

For example, a recovery-oriented approach to providing nursing care to individuals who are taking psychiatric medication would take into account the fact that reluctance to take medication is often related to the person's illness or refusal to acknowledge a need for medication. The recovery-oriented response is focused on learning about the patient's reasons for not taking medication and then working with the patient to identify ways to make medication more acceptable based on the patient's life goals (Roe and Swarbrick, 2007).

TABLE 14-1 COMPARISON OF PSYCHIATRIC REHABILITATION AND TRADITIONAL MEDICAL MODELS OF CARE

ASPECT OF CARE	PSYCHIATRIC REHABILITATION	TRADITIONAL MEDICAL REHABILITATION
Focus	Focus on wellness and health, not symptoms	Focus on disease, illness, and symptoms
Basis	Based on person's abilities and functional behavior	Based on person's disabilities and intrapsychic functioning
Setting	Caregiving in natural setting	Treatment in institutional settings
Relationship	Adult-to-adult relationship	Expert-to-patient relationship
Medication	Medicate as appropriate and tolerate some illness symptoms	Medicate until symptoms are controlled
Decision making	Case management in partnership with patient	Physician makes decisions and prescribes treatment
Emphasis	Emphasis on strengths, self-help, and interdependence	Emphasis on dependence and compliance

There are a number of evidence-based practices that support and enhance recovery including: assertive community treatment, supported employment, illness management and recovery, integrated treatment for co-occurring mental illness and substance abuse, family psychoeducation, medication management, and permanent supported housing. All these practices except integrated treatment for co-occurring mental illness and substance abuse (see Chapter 23) and medication management (see Chapter 26) are addressed in this chapter.

Recovery support in psychiatric nursing care involves working with a multidisciplinary treatment team that can include psychiatrists, psychologists, social workers, counselors, occupational therapists, consumer and peer specialists, case managers, family advocates, employment specialists, or job coaches. It also requires the nurse to focus on three elements: the individual, the family, and the community. The nursing care of people with serious mental illnesses is related to these three elements and the activities of assessment, planning and implementation, and evaluation.

QUALITY AND SAFETY ALERT

- All nurses must adopt Recovery Support as the model of contemporary psychiatric care.
- The elements of *health, home, purpose,* and *community* are the pillars of person-centered, evidence-based, quality-driven systems and services that support recovery from mental and substance use disorders.

ASSESSMENT

The Individual

The Stuart Stress Adaptation Model can be applied when providing recovery support. Assessment of the person's recovery goals begins with the initial contact between the nurse and the patient. A comprehensive psychiatric nursing assessment provides information that enables the nurse to help the patient achieve maximum possible functioning.

When conducting an initial assessment, the nurse needs to assist the patient to plan for recovery by first identifying the individual's life goals. Nurses then identify and reinforce strengths as one means of helping the patient cope. They assess challenges that may block the person's ability to achieve these goals, as well as services available from the health care system and the person's social support network that will support strengths and assist in goal achievement.

Critical Reasoning What changes does the recovery model require in the traditional attitudes and behaviors of psychiatric nurses?

Characteristics of Serious Mental Illness. People who have serious mental illnesses are likely to have both primary and secondary symptoms. **Primary symptoms** are directly caused by the illness. For example, hallucinations and delusions are primary symptoms of schizophrenia, and elation and hyperactivity are primary symptoms of bipolar disorder. **Secondary symptoms,** such as loneliness and social isolation, are caused by the person's response to the illness or its treatment.

Behaviors related to primary symptoms may violate social norms and be considered deviant. Society then tries to protect itself from the person's norm violation. An example of this is community opposition to the establishment of group homes.

As behavior problems become more serious, people increasingly identify themselves as mentally ill. They begin to relate to society in terms of this identity rather than others, such as wife, mother, husband, father, or worker. This is sometimes referred to as **self-stigmatizing behavior.** The person's acceptance of mentally ill status and adjustment to society in terms of this role are accompanied by the secondary symptoms of serious mental illness.

Behaviors Related to Serious Mental Illness. Roadblocks to the recovery of individuals with severe mental illness include poverty, victimization, and stigma. People with serious mental illnesses are often unemployed, are less likely to be involved in close relationships, and tend to have fewer financial resources than their peers.

BOX 14-2 MYTHS AND FACTS ABOUT MENTAL ILLNESS

Myth: Psychiatric disorders are not true medical illnesses like heart disease and diabetes. People who have a mental illness are just "crazy."

Fact: Brain disorders, like heart disease and diabetes, are true medical illnesses. Research shows genetic and biological causes for psychiatric disorders, and they can be treated effectively.

Myth: People with a severe mental illness, such as schizophrenia, are usually dangerous and violent.

Fact: Statistics show that the incidence of violence in people who have a brain disorder is not much higher than it is in the general population. Those suffering from a psychosis, such as schizophrenia, are more often frightened, confused, and despairing than violent.

Myth: Mental illness is the result of bad parenting.

Fact: A genetic susceptibility, combined with other risk factors and stressors, leads to a psychiatric disorder. In other words, mental illnesses have a physical cause.

Myth: Depression results from a personality weakness or character flaw, and people who are depressed could just snap out of it if they tried hard enough.

Fact: Depression has nothing to do with being lazy or weak. It results from changes in brain chemistry or brain function, and medication and/or psychotherapy often helps people recover.

Myth: Schizophrenia means split personality, and there is no way to control it.

Fact: Schizophrenia is not split personality or multiple personality disorder. Schizophrenia is a brain disorder that robs people of their ability to think clearly and logically. The estimated 2.5 million Americans with schizophrenia have symptoms ranging from social withdrawal to hallucinations and delusions. Treatment has helped many of these individuals lead fulfilling, productive lives.

Myth: Depression is a normal part of the aging process.

Fact: It is not normal for older adults to be depressed. Depression in the elderly is often undiagnosed, and it is important for seniors and their family members to recognize the problem and seek professional help.

Myth: Depression and other illnesses, such as anxiety disorders, do not affect children or adolescents. Any problems they have are just a part of growing up.

Fact: Children and adolescents can develop severe mental illnesses. In the United States, one in five children and adolescents has a mental disorder severe enough to cause impairment. However, only about one third of these children receive needed treatment. Left untreated, these problems get worse and continue into adulthood.

Myth: If you have a mental illness, you can will it away. Being treated for a psychiatric disorder means an individual has in some way "failed" or is weak.

Fact: A serious mental illness cannot be willed away. Ignoring the problem does not make it go away, either. It takes courage to seek professional help.

Myth: Addiction is a lifestyle choice. People with a substance abuse problem are morally wrong or "bad."

Fact: Addiction is a disease that generally results from changes in brain chemistry. It has nothing to do with being a "bad" person.

Myth: Electroconvulsive therapy (ECT), formerly known as "shock treatment," is painful and barbaric.

Fact: ECT has given a new lease on life to many people who suffer from severe and debilitating depression. It is used when other treatments such as psychotherapy or medication fail or cannot be used. Patients who receive ECT are asleep and under anesthesia, so they do not feel anything.

From NARSAD (National Alliance for Research on Schizophrenia and Depression): *Research Newsletter,*13, winter 2001/2002.

The exact causes of these characteristics have not been identified. Some could be related to primary and secondary symptoms or disabilities of the illness and others to society's reaction to the person with mental illness (Pope, 2011).

Attitudes that could contribute to this reaction are illustrated by the list of myths and facts about people with mental illness seen in Box 14-2. None of these myths is true, but they are commonly believed and stigmatize people with mental illness. They also can prevent people with mental illness from gaining access to needed services and opportunities.

Stigma experienced by those who are mentally ill has been linked to self-esteem. **Thus, the effects of stigma, poverty and victimization should be included in patient assessment and treatment planning.**

Critical Reasoning Copy the list of myths about mental illness, and discuss them with a group of people who have little personal experience with mental illness. Then discuss the list with a small group of people who have a serious mental illness. Compare the responses of the two groups.

Activities of daily living. Activities of daily living (ADLs) are the skills that are necessary to live independently, such as housekeeping, shopping, food preparation, money management, and personal hygiene. A major goal of recovery is to help the person develop independent living skills.

Interpersonal relations. People who have serious mental illnesses are often described as withdrawn and socially isolated. These difficulties are often related to the primary symptoms of the illness. For instance, depression causes apathy and withdrawal, and schizophrenia leads to problems in perceiving and processing communications from others. These behaviors create serious problems in establishing close relationships. Nonetheless, formal and informal networks are needed by individuals who have serious mental illnesses.

QUALITY AND SAFETY ALERT

- The seriously mentally ill are at high risk for victimization and social isolation.

Low self-esteem. Self-esteem is the feeling of self-worth or regard for oneself. It is difficult to maintain high self-esteem when a person is aware of low achievement compared with

cultural expectations. Lack of ability to maintain employment, live independently, marry, and have children contributes to low self-esteem. People who have serious mental illnesses often feel cheated of the life experiences they expected to enjoy before they became ill.

One mental health professional who also has a serious mental illness describes her experience of being diagnosed with schizophrenia during adolescence (Deegan, 1993):

> I was told I had a disease that was like diabetes, and if I continued to take neuroleptic medications for the rest of my life and avoided stress, I might be able to cope. I remember that as these words were spoken to me by my psychiatrist it felt as if my whole teenage world—in which I aspired to dreams of being a valued person in valued roles, of playing lacrosse for the U.S. Women's Team or maybe joining the Peace Corps—began to crumble and shatter. It felt as if these parts of my identity were being stripped from me. I was beginning to undergo that radically dehumanizing and devaluing transformation from being a person to being an illness; from being Pat Deegan to being a schizophrenic.

Motivation. Fear of failure often discourages a person from trying new experiences. Others may perceive this as lack of motivation. Apparent lack of motivation also may be caused by low energy. This can be related to the biological effect of the illness or to medication. In this case the person may want to be more active but is physically unable.

Strengths. Rehabilitation and recovery depend on the control of illness, as well as on the development of health potential by mobilizing strengths. A strength is an ability, skill, or interest that a person has used before. An emphasis on strengths provides hope that improved functioning is possible.

Strengths may be related to recreational and leisure activities, work skills, educational accomplishments, self-care skills, special interests, talents and abilities, and positive interpersonal relationships. People with serious mental illness often need help in defining their skills, abilities, and interests as strengths. Low self-esteem may lead them to believe that they have only problems, not strengths.

Nonadherence. Failure to take medication is a common cause of rehospitalization. It is important to assess the reasons for nonadherence. There may be a denial of the illness or a lack of understanding of the reason for the treatment regimen. Sometimes the person wants to comply but needs help, such as transportation to a pharmacy or advice about obtaining a medical assistance card. Some patients do not like the side effects of their medication, but they may not be assertive enough to tell the prescriber about their discomfort.

The nurse can help patients by developing a therapeutic alliance with them, educating them about their illness and the beneficial effects of their treatment including medication, and engaging them in the treatment plan. Teaching patients to write notes about their medicines and to keep lists of questions for the provider also may increase adherence. **Linking the benefits of medication to the achievement of personal goals is especially important.**

Critical Reasoning Think about how medication adherence is influenced by all the behaviors described above that are related to serious mental illness. How will this knowledge impact your work with patients in relation to their medication?

QUALITY AND SAFETY ALERT

- Medication nonadherence is a major cause of hospitalization among the seriously mentally ill.

Living Skills Assessment. The nursing assessment of a patient with a serious mental illness should include an analysis of the physical, emotional, and intellectual components of the skills needed for living, learning, and working in the community. Table 14-2 presents skills required for successful functioning in the community.

The nurse may use these examples in working with the patient to identify strengths, establish goals, and set priorities for skill development. Such a model provides a basis for assessing the patient's readiness to function productively in

TABLE 14-2 POTENTIAL SKILLS NEEDED IN RECOVERY SUPPORT

PHYSICAL	EMOTIONAL	INTELLECTUAL
Living Skills		
Personal hygiene	Human relations	Money management
Physical fitness	Self-control	Use of community resources
Use of public transportation	Selective reward	Goal setting
Cooking	Stigma reduction	Problem development
Shopping	Problem solving	
Cleaning	Conversational skills	
Sports participation		
Using recreational facilities		
Learning Skills		
Being quiet	Speech making	Reading
Paying attention	Question asking	Writing
Staying seated	Volunteering answers	Arithmetic
Observing	Following directions	Study skills
Punctuality	Asking for directions	Hobby activities
	Listening	Typing
Working Skills		
Punctuality	Job interviewing	Job qualifying
Use of job tools	Job decision making	Job seeking
Job strength	Human relations	Specific job tasks
Job transportation	Self-control	
Specific job tasks	Job keeping	
	Specific job tasks	

From Anthony WA: *Principles of psychiatric rehabilitation*, Baltimore, 1999, University Park Press.

the community. It also provides objective information on quality of life that can be shared with other mental health care providers.

The Family

Most people with mental illness are involved with their families and have frequent contact with family members while they are living in the community. Approximately 65% of people who have mental illnesses live with their families. Therefore, family resources must be assessed when a recovery plan is being developed.

Families and other caregivers can be a major source of support for individuals who have serious mental illnesses. They can help by identifying potential problem areas and enhancing the patient's adherence to the treatment plan. Caregivers should be educated about the patient's condition and involved in the treatment process. **Families should be viewed as resources, caregivers, and collaborators by psychiatric nurses** (see Chapter 10).

Unfortunately, families are often overlooked and not provided with education about mental illness. This is frustrating and interferes with their ability to assist in the patient's recovery. Although issues of confidentiality and respect for the patient's wishes regarding disclosure of treatment information must always be primary, nurses should strive as much as possible to include family members as partners in the treatment process.

Components of Family Assessment. The nurse who assesses the family as part of a recovery plan should consider the following aspects of family dynamics:

- Family structure, including developmental stage, roles, responsibilities, norms, and values
- Family attitudes toward the mentally ill member
- The emotional climate of the family (fearful, angry, depressed, anxious, calm)
- The social supports available to the family, including extended family, friends, financial support, religious involvement, and community contacts
- Past family experiences with mental health services
- The family's understanding of the patient's problem and the plan of care

Some of this information may be obtained from other members of the treatment team. However, it is the nurse's responsibility to be available to the family.

QUALITY AND SAFETY ALERT

- With the patient's permission, the nurse should plan on regular contacts with family members and include them as partners with the treatment team.

Family Burden. The mental illness of a family member affects the entire family. This impact is often called family burden. It can be related to worry about the future, poor concentration, upset household routines, feeling guilty about not doing enough, feeling trapped, and being upset by changes in their family member.

Burden may be objective or subjective. **Objective burden** is related to the patient's behavior, role performance, adverse effects on the family, need for support, and financial costs of the illness. **Subjective burden** is the person's own feeling of being burdened; it is individual and not always related to objective burden. For instance, a patient may lack ambition and remain in a dependent role well into adulthood. Family members who value success and upward mobility may feel more subjective burden related to this situation than members who are comfortable with nurturing and supporting someone.

By assessing burden the nurse can work with the family to identify concerns with which they would like help. Several responses are frequently noted in families who have members with serious mental illness. It is helpful to consider these when assessing subjective burden.

Grief is common and is related to the loss of the person they knew before the illness, as well as loss of the future that they expected to share with the ill family member. Because serious mental illness is usually cyclical, grief tends to be recurrent; it subsides during remissions and returns during exacerbations. This is especially difficult for families to handle. In addition, social support systems may not recognize or respond to their need because of discomfort with the situation or the related stigma.

Guilt is another emotion that families may experience in relation to their relative's illness. It is common for those who are close to a person with any serious illness to wonder whether they could have done something to prevent it. For instance, the wife of a heart attack victim may think she could have prevented it if she had not encouraged him to shovel snow. Similarly, parents of a depressed woman may believe that they could have prevented her depression if they had not shared their own worries with her.

In neither of these situations did relatives cause the illnesses, but they feel guilt because of their interpretation of the situation. Another source of guilt for relatives of people with mental illness is the need to set limits on the patient's behavior at times. For instance, the family of a patient who is physically agitated may need to arrange hospitalization to keep the patient safe.

Anger may be directed toward the patient, but it is more often felt toward other family members, mental health care providers, or the entire health care system. Anger within the family relates to differing perceptions of the patient and varied ideas about how to manage the illness. Prolonged stress results in irritability that is often taken out on those to whom one is closest. Anger at the system often is justified because it is related to deficiencies in the accessibility or acceptability of needed mental health services.

Powerlessness and **fear** often result from families' realization that they are dealing with a long-term recurrent illness. Most people believe that the health care system should cure illnesses. When this does not happen, they feel powerless and frustrated. This can result in fear about the future of the ill family member, as well as fear for themselves.

Powerlessness and fear are especially troublesome for parents who are aging and worried about care arrangements for their mentally ill child when they can no longer provide care

themselves. Some families also fear ill members who may become dangerous if they stop adhering to their treatment.

> **Critical Reasoning** Ask if you can speak with a family member of one of your patients about his or her experience with the mentally ill family member. Try not to talk much; listen closely to what the family member has to share with you.

Social Support Needs. Families who are providing care for members who have serious mental illnesses often feel isolated and alone in dealing with the challenges of caregiving. Previous sources of social support may be lost or limited because of the demands of attending to the mentally ill family member.

Caregivers may be embarrassed about the illness or fear that the person with mental illness will behave inappropriately in the presence of others. Sometimes a family member may decide to stop working outside the home to be more available for the ill person. All aspects of the subjective burden of the illness also may limit access to social support systems. These families need assistance in rebuilding their social supports.

Support also may be found within the family. Even though a mental illness can be stressful for all family members, many families meet this challenge with a great deal of resilience. The person who has the mental illness can contribute to the family also, helping to ease the stress on other members. Nurses can play an important role in offering family members opportunities to discuss their concerns and taking action to meet their needs whenever possible.

The Community

The community greatly influences the rehabilitation and recovery of its mentally ill members. Mental health professionals have a unique role in the community because they are community members and also advocates for people with mental illness and their families at the same time. **Care providers, including nurses, should assume a leadership role in assessing the adequacy and effectiveness of community resources and in recommending changes to improve access and quality of mental health care.**

Nurses in all settings must be familiar with the community agencies that provide services to people with mental illnesses. Most communities have a social and medical services directory that can be consulted for basic information, such as location, type, and cost of the services provided. Most agencies serve people who come from a particular geographical area, such as one part of a city or, in a rural area, one of several counties.

People can also access information about available services online. One such Website is **Network of Care**©, which includes listings of services as well as information about mental illness, links to other sites and a password protected feature where patients can develop a recovery plan and allow access to others at their discretion.

As nurses gain experience, they will become familiar with other agencies that provide services for the same people. Nurses should pay attention to patients' evaluations of the agencies from which they receive services. This information helps to identify agencies that are responsive and helpful as opposed to those that are difficult for patients to approach.

Personal contact with community agencies can be a very useful part of a community assessment. This may be done by making an appointment with an agency staff member. However, a more realistic picture of an agency's services can be obtained by going to the agency with someone who is requesting services. The nurse will see how the agency responds to the patient and how well the patient is able to handle personal affairs in the community.

The nurse can provide emotional support if the patient feels insecure in a new situation. Nurses should introduce themselves to the staff of the agency and explain that they, as well as the patient, would like to learn more about the services. Collaborative relationships between mental health care providers and community agencies can assist in recovery support.

A wide range of community services must be available to patients. Those that are directed toward basic needs include provisions for shelter, food, and clothing; household management; income and financial support; meaningful activities; and mobility and transportation. Other services provide for special needs that may differ from one person to the next, such as general medical services, mental health services, addictions services, habilitation and rehabilitation programs, vocational services, and social services. A third group of services is needed to coordinate the system.

> **Critical Reasoning** You are approached by the parent of a hospitalized young adult patient who has a serious mental illness. The family is upset because the discharge plan is to refer the patient to a community program that has not been helpful in the past. What nursing interventions would you suggest in this case?

PLANNING AND IMPLEMENTATION

The Individual

Treatment planning and intervention in recovery-focused psychiatric nursing aim to foster independence by maximizing the person's strengths. Specifically, the nurse helps the individual to do the following:

- **Develop strengths and potential.**
- **Learn living skills.**
- **Manage one's illness.**
- **Access environmental supports.**

The nurse can assume the role of "helping partner" when providing services to people who have serious mental illnesses. The characteristics of the helping partner include caring and respectful communication, resourcefulness, patience and recovery orientation, a knowledgeable teacher, and interdependence (Anthony, 2008).

The nursing treatment plan should be organized around very specific behavioral goals that are based on a comprehensive assessment of the person's living skills. These goals should build on those that were developed during the acute phase of

the illness. This part of the nursing care plan may be called the discharge plan in an inpatient treatment setting. Discharge plans also should be developed in community care settings. **Discharge plans remind the nurse and patient that the expected outcome of nursing care is independent functioning.**

It is important to consider potential barriers to recovery and community integration when formulating the treatment plan. These should be based on the patient's perception of conditions that might interfere with accomplishment of one's personal goals.

For example, the patient may identify that neighbors near the psychiatric rehabilitation program are unfriendly to program participants. The nurse can assist the patient in identifying ways to address this situation, such as finding out if other program participants share that perception, inviting neighbors to visit the program, or participating in a neighborhood activity, such as spring or fall cleanup.

Patients who need long-term medication often can receive maintenance prescriptions from their primary care or family practitioner as part of their general health care program. This helps to put the mental illness into perspective as a chronic health problem that is not so different from other chronic problems the person might have.

The nurse and patient must decide together on the desired level of functioning. If the patient is unwilling to take on activities that the nurse thinks would be helpful, it is important to determine why. Sometimes nurses try to push a patient ahead too rapidly. Behavior that has developed gradually over time cannot be changed quickly. Learning new behavior patterns and giving up old ones are frightening and cause anxiety.

The nurse must be sure that the patient's coping skills are adequate to deal with the stress of growth. Feedback must be requested to be sure that the recovery plan continues to address the patient's needs. It is a problem if the plan assumes greater importance than the patient. The nurse must prevent this from happening.

> **Critical Reasoning** It has been noted that patient nonadherence to treatment is due to a failure of the patient-clinician alliance. In what ways is this true?

Developing Strengths and Potential. The development of the patient's strengths and potential is critically important. Nursing interventions that develop strengths and potentials can help patients develop independent living skills, interpersonal relationships, and coping resources and thus help meet their special needs.

Ultimately, the expected outcome of such interventions is change in the patient's self-concept and an increase in self-esteem (see Chapter 17). The negative self-concept and low self-esteem that characterize people who have serious mental illnesses interfere with their ability to see themselves as individuals with strengths and potentials.

Through experiences of adequacy, self-concept can be altered and self-esteem increased. One intervention that helps patients alter their negative self-perceptions is for nurses to describe their perception of patients' strengths. Nursing interventions in which patients become aware of their strengths fall into two categories: those that occur spontaneously and those that are planned. The following clinical example illustrates a nurse's use of spontaneously occurring situations to increase awareness of strengths.

CLINICAL EXAMPLE

Theresa, a woman in her 50s, had been in and out of psychiatric hospitals for 30 years and had been living in a community residential program for 1 year. Theresa shared the apartment with two roommates. She was a talented musician and had her own baby grand piano. Despite her love for classical music, she played only the "oldies and goodies" her roommates preferred.

She said that she didn't want to upset her roommates by practicing classical music. She was afraid that if she brought the issue out in the open she might get so upset she would hurt someone. She offered as evidence the many times she'd been placed in seclusion rooms for violent behavior. Clearly, keeping peace was her priority.

The nurse and Theresa discussed her strengths as a peacemaker, as well as ways in which she might calmly express her own needs to her roommates. The nurse offered to be with Theresa during the discussion. Declining the nurse's offer, Theresa said that even though she was somewhat anxious, she had a clearer understanding of the abilities she had to use in the situation, and she wanted to try to "pick up" for herself in a situation of interpersonal conflict.

She carried out her plan and expressed surprise that her roommates accepted her need and quickly arranged 2 hours per day for her to practice. As she told of her success, Theresa smiled, saying she wondered what would have happened if she had tried expressing her needs many months earlier.

Cindy, in her early 20s, had recently moved into the apartment with Theresa and one other roommate. Cindy arrived at the day treatment program crying because she had fainted while at her nursing home job the evening before. She felt that in addition to having been embarrassed, she had failed to live up to the trust invested in her by the director of the nursing home. She had decided to quit her job.

The nurse explored with Cindy the meaning of these events in terms of her many strengths in caring for others. Her sensitivity to anticipated criticism and rejection from the director was related to the same sensitivity that allowed her to respond creatively to others' needs. At this point Cindy firmly stated that the job was important to her sense of being needed.

The nurse encouraged her to call the nursing home and express both her embarrassment and sense of failure, yet state that she wanted to continue working there. Cindy made the telephone call with the nurse present for support. Her pleasure at finding out the job was still hers, and that she was not viewed unfavorably by the director of nursing and her sense of personal achievement at having taken a risk and won were so visible and contagious that the other patients staged an impromptu celebration.

Selected Nursing Diagnoses

- Theresa: Impaired social interaction related to fear of aggressive impulses, as evidenced by social inhibition
- Cindy: Chronic low self-esteem related to fear of rejection, as evidenced by feelings of inadequacy

Learning Living Skills. **Social skills training uses cognitive and behavioral techniques to help people gain the knowledge and skills they need to live in the community** (see Chapter 27). Patients are taught structured ways of examining and modifying their own thoughts and behavior that can be continued with decreasing clinician involvement as the patients become more skillful at managing difficult situations. These include holding conversations, establishing and maintaining friendships, dating, managing medications, grooming, and the numerous other activities that are a part of leading a happy, successful life.

Persons participating in social skills training should be assisted to express their problems as positive goals. For example, instead of the negative, "I'm tired of watching television all the time," encourage the positive, "I am going to see at least one friend every week." Social skills training programs typically use videos, role playing, practice, and homework assignments centered on practical problems.

Another important aspect of psychiatric recovery support relates to promoting the physical well-being of those with serious mental illness. Problems such as high tobacco use, obesity, low exercise level, poor oral health, and limited contact with physicians and dentists are common among people who have serious mental illnesses. Thus psychiatric nurses need to intervene in a holistic way in all health care settings with patients who experience serious and long-term psychiatric illness. The need for the integration of mental health care with physical health care is discussed in Chapter 34.

QUALITY AND SAFETY ALERT

- There are higher rates of mortality and medical comorbidity among patients who are mentally ill.
- Psychiatric nurses must include a thorough biological assessment in their evaluation of psychiatric patients, addressing both mental and physical health needs in their assessments, treatment plans, and patient education.

Illness Management and Recovery. **Illness self-management empowers people who have a serious mental illness to understand and manage their illness effectively.** It focuses on assisting the patient to assume control over the illness and function at the highest possible level of independence. It can reduce hospitalizations and emergency department use and help individuals better manage their illness (Fardig et al, 2011; Salyers et al, 2011).

Four interventions that have been identified to support illness self-management in persons recovering from psychiatric illness are as follows:

1. **Psychoeducation:** An approach that supports the recovery process by teaching the patient and family about the mental illness and the coping skills that will help with successful community living. It is defined as the process of imparting illness management information in a way that can be understood and carried out by the individual.
2. **Behavioral tailoring for medication:** Developing strategies with the patient that integrate medication regimens into the person's daily routine and simplifying the medication schedule.
3. **Training in relapse prevention:** Most people who have serious mental illnesses can learn to recognize signs and symptoms of an approaching relapse. This helps them to seek early intervention, thereby increasing the chance that the episode of illness will be less severe and treated in the community.
4. **Coping skills training:** Teaching the person techniques for coping with persistent symptoms of their mental illness. For instance, a person who has auditory hallucinations can be trained to listen to music using headphones, thus alleviating the distraction of the voices.

Adult learners require an individualized approach to education that focuses on their self-identified needs and engages them as active participants in the teaching-learning process. Psychoeducational curricula and materials should be individualized based on the characteristics of the learner. Techniques vary, but the information conveyed to the patient and family usually covers all aspects of the illness and its treatment, as shown in Box 14-3.

Behaviors related to the mental illness may affect the person's ability to learn. It is particularly important to assess memory and attention span when preparing to implement psychoeducation. It is also important to assess the meaning to the consumer of the illness and related behaviors. It is then possible to plan with the patient to replace less desirable behaviors with healthier or more rewarding ones.

Finally, the National Alliance on Mental Illness's Peer-to-Peer program prepares consumer volunteers who train other consumers about relapse prevention and wellness. An evaluation of this program found that a group of program participants benefited in the following areas: knowledge and management of the illness, feelings of being less powerless and more confident, connection with others, and completion of an advance directive (Lucksted et al, 2009).

QUALITY AND SAFETY ALERT

- Illness self-management is an evidence-based practice for psychiatric recovery support.

BOX 14-3 ELEMENTS OF A PSYCHOEDUCATION PLAN

- Signs and symptoms
- Natural course of the illness
- Possible etiologies
- Diagnostic tests and measures
- Indicated lifestyle changes
- Treatment options
- Expected treatment outcomes
- Medication effects and side effects
- Therapeutic strategies
- Adaptive coping responses
- Potential adherence problems
- Early warning signs of relapse
- Balancing needs and taking care of oneself

Accessing Community Supports. Supporting people who have serious mental illnesses in community settings requires the development of a wide array of community support programs (Figure 14-1). When these services are provided, people who otherwise would have spent much of their time in the hospital can live successfully in the community. **Community-based models of care including case management and assertive community treatment (ACT) are discussed in Chapter 34.**

Rehabilitation programs. Psychiatric rehabilitation programs (also called *psychosocial rehabilitation*) were developed in response to the plight of people who had been discharged from state mental hospitals lacking the skills and resources needed to live independently. *Fountain House* in New York City was established in the late 1940s by a group of former state mental hospital patients. It began as a consumer-operated program, but a decade later employed a professional staff. Many of the current psychiatric rehabilitation programs are built on the Fountain House (1999) model.

Fountain House functions as a club in which patients are members. The usual hierarchical distinctions between staff (the healthy) and patients (the ill) do not exist. It is a place where members care about each other and pool their resources and abilities as they work toward increasing independence. Thus Fountain House combats loneliness and isolation while providing a variety of living and work situations that require differing levels of functional ability.

The first month at Fountain House is a residential phase, and members are taught skills necessary for apartment living. Fountain House owns and leases apartments that have staff on call, although not in residence. These supervised apartments allow people to make a gradual transition to independent living in the community.

Fountain House runs several businesses, providing a protected environment in which members can develop self-confidence and job skills. Progressing to a more complex work situation, Fountain House has creatively arranged for transitional employment placements (TEPs).

Recognizing that job interviews are tremendously stressful, staff members, rather than members, seek and contract with businesses for jobs. The jobs are assigned to Fountain House rather than to individuals. Staff members assign a member to a transitional employment position for as long as needed. The employer is promised that if members are unable to manage the job or do not show up, Fountain House staff will work in their place. In the words of a Fountain House member:

> *I think the greatest need is to have a place to go where you are expected each day, a place where you can be with people like yourself and do things that mean something to yourself and others … places to go and be with people who need us to contribute, to take part, to help, and who notice when we're not present and do something about it (Peterson, 1978).*

Consumer-centered services. There is a strong feeling among some consumers that psychosocial programs are not truly responsive to their needs unless they are consumer run. The Empowerment Model of Recovery was developed by the National Empowerment Center, a research and training organization that is administered by ex-consumers of mental health services and explores issues related to recovery-oriented mental health services. These ex-consumers developed a training and education program called PACE (Personal Assistance in Community Existence) that is based on an empowerment model. The principles of PACE are presented in Box 14-4.

In recent years there has been a growth in peer support and consumer-centered programs (Daniels et al, 2010; Simon et al, 2011; Sledge et al, 2011). Some of these include:

- Bridge programs that connect a peer in recovery with another who is in the hospital or just been discharged
- Drop-in centers that provide peer support and a safe place to be
- Peer-based crisis response
- Consumer-run respite services
- Consumer led recovery courses for providers, consumers, families and the community
- Peer-staffed discharge teams

Successful consumer-centered programs include specific elements. They address needs identified by the members, and participation in all or part of the program is voluntary. Help is provided either by members or by others whom the member selects. Consumers are responsible for the administrative direction of the program, and they determine criteria for

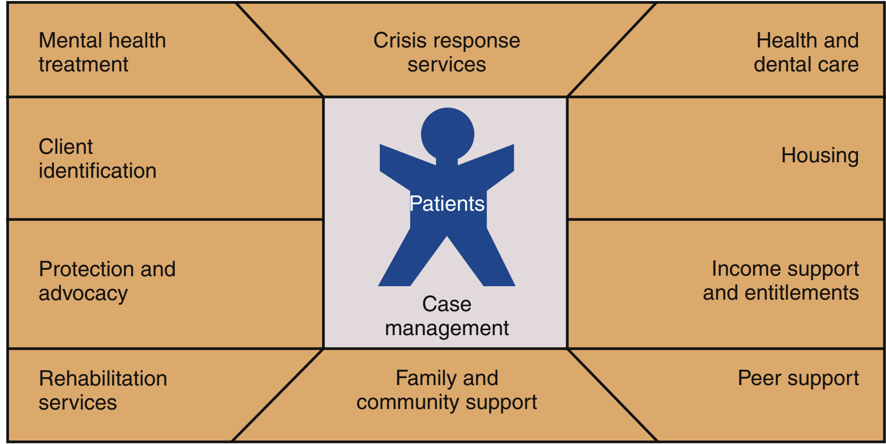

FIG 14-1 Components of a community support system.

membership. Finally, the program is mainly accountable to the members, and strict confidentiality is maintained.

Recovery orientation and peer support have been an important part of substance abuse treatment for many years. Many of the approaches that have been used in that field are also applicable to the broader field of behavioral health. Table 14-3 describes types of social support and the associated peer recovery support services. Although these were developed for use in addictions peer services, they are equally relevant to mental health peer services.

> **Critical Reasoning** What is your response to the idea that consumers should run alternative treatment programs? Discuss potentially positive and negative aspects.

Residential services. Permanent supported housing is a critical element of successful recovery. **Appropriate housing must be safe, affordable, and acceptable to the consumer.** Most recovering patients live at home with their families. For those who do not, group homes and supervised apartments are the predominant types of housing available. Many include some form of rehabilitation program along with housing. Staff supervision ranges from intensive 24-hour awake staffing to telephone consultation, based on the consumer's level of need.

Most housing programs focus on providing a "normal" community living experience, but many fall short of this goal. Supervision needs may lead to organization of housing around levels of care, sometimes requiring consumers to move if their needs become more or less intensive. This can be very disruptive. Consumers rarely have a choice of housemates, and they hardly ever lease or own the house in their own names. This type of housing program structure also leads to clustering of group homes or supervised apartments, reinforcing stigmatization and triggering community apprehension.

Consumers have a preference for independent housing with flexible supports. Some traditional residential programs are evolving into supported-housing programs where housing is thought of as a basic service that should mirror the housing choices of others in the community. As such, it is permanent and under the control of the resident.

Housing program staff members help consumers find affordable housing of their choice. If people decide to live together, it is also their choice. Staff members may introduce consumers to each other, but they decide whether to establish a household. Mental health and rehabilitative services need to be flexible and designed to help the person live successfully in the community.

BOX 14-4 PRINCIPLES OF PERSONAL ASSISTANCE IN COMMUNITY EXISTENCE (PACE)

- People fully recover from even the most severe forms of mental illness.
- Trust is the cornerstone of recovery.
- Control and coercion are emphasized in the absence of trust and interfere with recovery.
- People have to be able to follow their own dreams, not someone else's, to recover.
- Self-determination is vital to recovery.
- Human dignity and respect are vital to recovery.
- Understanding that mental illness is a label for severe emotional distress that interrupts a person's role in society helps in recovery.
- People who believe in people with mental illnesses help them recover.
- People with mental illnesses and those around them have to believe they will recover or they will not recover.
- There is always meaning, even in periods of severe emotional distress, and understanding that meaning helps in recovery.
- People can and do yearn to connect emotionally, especially when they are experiencing severe emotional distress.
- Feeling emotionally safe in relationships is vital to expressing feelings.
- Everything learned about the importance of human connections equally applies to people labeled with mental illnesses.

From Ahern L, Fisher D: *J Psychosoc Nurs Ment Health Serv* 39:22, 2001.

TABLE 14-3 TYPE OF SOCIAL SUPPORT AND ASSOCIATED PEER RECOVERY SUPPORT SERVICES

TYPE OF SUPPORT	DESCRIPTION	PEER SUPPORT SERVICE EXAMPLES
Emotional	Demonstrates empathy, caring, or concern to bolster person's self-esteem and confidence	Peer mentoring Peer-led support groups
Informational	Shares knowledge and information and/or provides life or vocational skills training	Parenting class Job readiness training Wellness seminar
Instrumental	Provides concrete assistance to help others accomplish tasks	Child care Transportation Help accessing community health and social services
Affiliational	Facilitates contacts with other people to promote learning of social and recreational skills, creates community, and acquires a sense of belonging	Recovery centers Sports league participation Alcohol- and drug-free socialization opportunities

From Center for Substance Abuse Treatment: *What are peer recovery support services?* HHS Pub. No. (SMA) 09-4454, Rockville, MD, 2009, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Some supported-housing programs are part of comprehensive psychiatric rehabilitation programs and are an element of a broader supported-living approach. In this case, staff intervention is directed not only at maintaining the person in housing but also at assisting the consumer to become fully involved in community life.

Although the supported-housing approach works well for some consumers, it is still important to provide a choice of living arrangements. Many patients and families prefer a range of choices, from 24-hour supervised group residences to completely independent living.

> **Critical Reasoning** Identify where supported housing for people who have mental illnesses is in your community. Assess the location based on safety, convenience to stores and transportation, and access to recreational areas.

> **QUALITY AND SAFETY ALERT**
> - Permanent supported housing is an evidence-based practice for psychiatric recovery support.

Supported employment. When individuals who have serious mental illnesses are asked about their vision of recovery most identify employment as a major focus. **Working at a competitive job, meaning a job that is available to anyone and not just a person with a mental illness, opens the way to other life goals, such as a decent place to live, education, and access to leisure activities.**

There are a number of barriers to employment for persons with psychiatric disabilities. Recommended actions that would help to overcome the barriers include:

- Health insurance for medical care, mental health care, and medications regardless of employment status
- Integration and coordination of clinical and vocational services
- Access to educational programs
- Benefits planning and assistance with financial management
- Development of assets through special savings programs for low-income individuals
- Safe, affordable, and stable housing that will not be jeopardized by a higher income
- Legal aid to deal with discrimination and assist with access to services, including enforcing the Americans with Disabilities Act
- Peer support and self-help
- Involving employers and the business community in creating and enhancing employment opportunities

Psychiatric rehabilitation programs often provide vocational rehabilitation services. Prevocational training begins within the program itself. Members may be organized into work teams around the activities needed to keep the program running, usually clerical, food service, and maintenance tasks. Aside from the development of marketable work skills, the goal of these programs is to foster good work habits. Some members continue indefinitely in prevocational services. Others may move into temporary employment placements and then into competitive employment. Some consumers use vocational services to achieve this goal.

Supported employment programs assist participants in finding jobs in the community that are consistent with their own interests, pay at least minimum wage, and could be applied for by anyone. Job coaching is provided to assist the service recipient in mastering job skills and learning effective workplace behaviors. The employer is aware that the employee is participating in a vocational rehabilitation program, thereby avoiding the concern that many recovering patients have about disclosing their history of mental illness.

Although mental health service providers support the idea of vocational rehabilitation, they may be reluctant to hiring consumers to work in mental health settings. However, consumers have begun to assert their unique qualifications as counselors and case managers. They have been successfully employed in this role and have achieved good outcomes for themselves and those to whom they provide services.

Georgia was the first state to introduce statewide training and certification of mental health service recipients to be peer support specialists. Graduates of this program have been employed in Georgia public and private mental health services in programs such as Assertive Community Treatment and Community Support Teams. They provide unique insights into consumers' needs and concerns and are also evidence that recovery from mental illness is a realistic expectation. Information about this program, which is now being replicated in other states, may be found at the website www.gacps.org.

Certified peer support specialists have been introduced to the mental health system in several other states. One study found that they tend to work within agencies and perform a variety of roles, including provision of peer support, providing health and wellness information, addressing hopelessness, helping in communication with providers, illness management education, and community stigma reduction (Salzer et al, 2010).

When consumers become employees in mental health programs, it is very important to be aware of issues related to role change as experienced by the consumer-employees as well as by other staff in the program, especially if the consumer-employees have been members of the program. If these issues are not identified and discussed openly, they can interfere with the ability of the consumer-employees to be successful.

> **QUALITY AND SAFETY ALERT**
> - Supported employment is an evidence-based practice for psychiatric recovery support.

Educational services. Many people with serious mental illnesses have not completed formal education through high

school or beyond because of the effects of their illness. Rehabilitation programs often offer remedial education related to vocational services. **Education that is offered in a supportive environment can increase self-esteem, improve job qualifications, and encourage some consumers to pursue higher education.**

> **Critical Reasoning** Review a book intended for mental health consumers. Critique it in terms of accuracy, practical advice, reading level, and emotional tone. Ask a consumer or a family member of a consumer to review the book. Compare your critiques.

The Family

Family support is very important to the successful recovery of a person with mental illness (see Chapter 10). The mental illness of a member is often a shock and a source of great stress to the family. Frequently, families that include members with serious mental illnesses do not receive adequate information about the illness or effective support from mental health professionals. Self-help groups for families of individuals who have mental illnesses are important resources for providing social support as well as education. **Effective programs for families of people with serious mental illnesses include empowerment and education.**

Empowerment. Several common trouble spots in family life can be anticipated. Learning ways to handle these areas empowers the family by giving them a sense of control over their lives. The problem areas include the following:

- Disrupted communications
- Mechanics of everyday life, including the need for privacy and control over personal space, keeping a regular schedule, television use, money management, and grooming
- Responding to hallucinations, delusions, and odd behavior, particularly coping with violent or suicidal threats
- Alcohol and drug use
- Need for relatives to remember to take care of themselves

Family members and professionals alike often ignore this last area of concern. However, it can be accomplished by the following:

- Accepting the fact that a family member has a mental illness
- Planning a self-care program
- Continuing to pursue personal activities and interests
- Getting involved with organizations such as self-help groups or churches
- Avoiding the advice and opinions of those who have not lived with a person with mental illness
- Remembering that happiness is possible
- Avoiding blaming oneself

Identifying feelings related to the illness is the first step toward coping. Sharing feelings with each other can be a great relief to people who feel isolated. When feelings are revealed, family members can be supportive of each other, including the ill person. Coping with feelings also allows the person to be receptive to information about the illness and mental health services. The combination of coping and education empowers the family and facilitates their involvement in the recovery process.

When working with aging families, it is particularly important to address issues related to the care of the mentally ill family member if the primary caregiver becomes disabled or dies. This is an uncomfortable subject that families often worry about but are reluctant to discuss. Because nurses are usually viewed as supportive and helpful, they are in a good position to address the needs of families.

> **Critical Reasoning** Describe the issues facing an aging parent of a person with a serious and persistent mental illness.

Family Psychoeducation. Family education is a primary nursing intervention that is offered to relatives of people with serious mental illness. Education can assist families to identify ways to support the recovery of the patient. Nurses have established workshops for family members that have been well received and have helped families cope with the challenges presented by the mental illness.

Programming for these workshops can include information and skill-building exercises. The experiences of the more seasoned family members can be particularly helpful because they can share their successes and failures in using various coping strategies and provide needed social support.

Two models of family education are particularly effective in assisting families to cope with mental illness. The **Family-to-Family Model** is offered by chapters of the National Alliance on Mental Illness (NAMI) and is taught by family members who have been trained to present a standard curriculum as well as to assist group members to problem solve situations related to the member's mental illness (Dixon et al, 2011).

The **Family Psychoeducation Model** is an evidence-based practice that is designed to be led by mental health professionals and includes educational and group supportive elements. Important areas to include in family education are advocacy in communicating with professionals, hospital treatment and rehabilitation, medication compliance, and side effects of medications.

> **Critical Reasoning** If you were responsible for developing a nursing program to promote recovery, what would it be like? Describe the setting, the program, its goals, and the roles of staff and patients.

> **QUALITY AND SAFETY ALERT**
>
> - Family psychoeducation is an evidence-based practice for psychiatric recovery support.

The Community

Nurses can intervene in the community to encourage the establishment of recovery-oriented mental health programs in several ways. Among these are **health education, membership in advocacy groups, networking,** and **political action.** Increased familiarity with and education about the needs and experiences of people who have a serious mental illness help combat stigma and promote community acceptance.

Mental health education in the community can therefore have a real impact on the experience of patients in the community. Greater understanding of the behaviors and needs of people with mental illness could increase community acceptance, leading to the development of better services. Thus nurses should take advantage of opportunities to speak to community groups about mental health.

Psychiatric nurses also can perform a valuable service by educating their co-workers and professional colleagues about current research related to serious mental illnesses. Although they are seldom discussed, stigmatizing attitudes toward mental illness do exist among health care workers. These attitudes are transmitted to the general public. Professionals have even taken the lead in opposing the establishment of group homes in their neighborhoods. Well-informed nurses can make health care workers aware of their prejudices and assist them in changing their behavior.

Membership by nurses in community advocacy groups also can be helpful. Nurses can join forces with other professional and lay people who share concerns about the care of the mentally ill. Mental Health America, formerly the National Mental Health Association, is the largest advocacy group that addresses mental health issues. Members of this organization have been influential in drawing attention to the needs of people with mental illness and in supporting positive legislation at the federal and state levels.

Nurses can promote working relationships among advocacy groups, professional organizations, self-help groups, and concerned citizens. With limited funding available and health care costs escalating, the formation of coalitions is essential if lobbying efforts focused on allocating needed resources to mental health care are to be successful. Psychiatric nurses have taken a leadership role in coalitions to influence reforms in the health care system.

Nurses need to be aware of and involved in the political process. They should communicate directly with legislators at all levels, sharing their interests and concerns. Politicians are well aware of the need to respond to the priorities of their constituents.

Nurses can become more directly involved in the political system. They can run for office and support other nurses who are legislators. Nurses are often invaluable members of appointed boards and commissions on health care. Their knowledge can be shared with others who are planning community health care systems. These voluntary activities can have great impact on the health care system.

> **Critical Reasoning** Obtain a copy of a bill being considered by your state legislature that is relevant to psychiatric rehabilitation. Explain the effect this legislation would have on the mental health care system, including the potential effect on nursing.

EVALUATION

Evaluation of psychiatric recovery support services examines the impact on the patient and family and the effectiveness of the community service system.

Patient and Family Evaluation

Evaluation of services provided to patients and family members should focus on the achievement of the expected recovery-oriented outcomes of the intervention. Most evaluation programs rely on both objective and subjective measures of outcome. Objective measures are generally related to the following questions:

- Is the person living in housing of personal choice?
- Have days of hospitalization in the last year decreased?
- How many emergency department visits has the person made?
- How many days in the last year have been spent in a transitional employment placement? In competitive employment?
- How often does the person have contact with family members? Who are they?
- Can the person identify people to provide support in a crisis?
- Is the person involved in community activities?
- Is the person enrolled in an adult education course? In an academic education program?

The answers to such questions are compared with the individual recovery plans, thereby providing a picture of the success of the services. They should be discussed with program participants and their families as a basis for further planning.

Subjective measures of effectiveness are critically important and should focus on the patient's perceived quality of life, progress in obtaining life goals, and satisfaction with services received. They take place in periodic discussions with patients and families about the progress of recovery.

Staff members can share their observations about the person's response to the program and invite feedback from the consumers. Many programs also conduct formal consumer satisfaction surveys. More recently, consumers have been employed as advocates to seek information about consumer dissatisfaction and present complaints to program administrators.

Program Evaluation

Program evaluation informs administrators about the relevance and cost-effectiveness of the services they offer. It is often required by funding, regulatory, and licensure agencies to confirm that public mental health dollars are being spent wisely. The federal Substance Abuse and Mental Health Services Administration requires that states receiving Mental

Health Block Grant funding conduct annual assessments of consumer satisfaction with public mental health services.

Outcome measurement is an approach to evaluation that provides information about the effectiveness of services to individuals with mental illnesses and can also be used to analyze the impact of funding initiatives. Some states are beginning to base funding for services on outcomes. Outcome measurement also can lead to policy recommendations.

Program evaluation is evolving as program funders and the public demand greater accountability from service providers. Community advisory boards, legislators, and consumer advocates are all recognizing the importance of reviewing the effectiveness of individual programs and service systems. As comprehensive community-based service systems for people with serious mental illnesses continue to grow, evaluation approaches will provide direction.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Tananarieve Brown, BS, RN

It was a typical workday, and I was waiting outside the psychiatrist's office to consult with him about a patient. His door opened, and the patient meeting with the psychiatrist emerged and headed for the receptionist's desk to check out. I went inside and, after finishing my consultation with him, came out of the office to find the patient who had just left still standing in the outer office. She asked if she could speak with me privately. We went into my office and shut the door. She began by thanking me for saving her life and the lives of her children. I honestly did not remember what I had done, and I told her so. She reminded me that she had suffered from depression for many years beginning with the birth of the first of her three children.

She had come in 6 months ago to see me and at that time was struggling with poor energy as well. She said that we talked about all the stress she was under and how she felt compelled to do for others but could never find time for herself. I remained confused as her complaints struck me as typical of a single mother of three young children. She went on to say that at our visit I asked her about her health and conducted a physical assessment. I found her blood pressure and pulse to be elevated and strongly recommended that she see her medical doctor since she had not had a recent physical examination.

She waited to see me this day to tell me that she did go to see her doctor. She was immediately admitted into the hospital when her doctor discovered she had been bleeding internally from a large uterine fibroid. He told her that any further delay would have cost her her life. Presently, she remains on antidepressants but her doses have been reduced and she is doing well. She is now working with vocational rehabilitation to find employment.

Although I initially did not remember my actions, that patient reminded me that a psychiatric nurse is also a medical nurse who remains sensitive to how the mental and physical aspects of the patient profoundly affect one another. Often psychiatric patients present with complaints such as poor energy, sensory disturbances, and other symptoms that could be easily attributed to their psychiatric illness but may, in fact, have physical causes. This is especially pertinent when monitoring a patient's response to psychiatric medications since they can affect medical disorders such as hypertension and diabetes. All these issues must be considered even if the patient is hostile or psychotic.

Caring for the serious and persistently mentally ill and maintaining them in the community are both challenging and rewarding and often requires creativity. It demands a broad medical knowledge, emotional discipline, and keen psychiatric discretion, encompassed by sharp nursing intuition and skill. This is what I have learned in my practice as a psychiatric nurse.

CHAPTER IN REVIEW

- People who have serious and persistent mental illnesses, with the provision of appropriate and individualized supports, can recover from their illnesses and lead satisfying and productive lives.
- Self-determination is the foundation of person-centered and consumer-driven recovery supports and systems.
- Recovery is the process in which people are able to live, work, learn, and participate fully in a community of the person's choice while striving to achieve full potential. Hope plays an integral role in an individual's recovery.
- Psychiatric rehabilitation is the range of social, educational, occupational, behavioral, and cognitive interventions for increasing the role performance of persons with serious and persistent mental illness and enhancing their recovery.
- Evidence-based practices include assertive community treatment, supported employment, illness management and recovery, integrated treatment for co-occurring mental illness and substance abuse, family psychoeducation, medication management and permanent supported housing.
- A comprehensive psychiatric nursing assessment enables the nurse to help the patient achieve maximum possible functioning. In addition to identifying the patient's goals, nurses should identify and reinforce strengths as one way of helping the patient cope with challenges and move toward recovery.

CHAPTER IN REVIEW—cont'd

- Primary symptoms of serious mental illness are directly caused by the illness, such as hallucinations and delusions. Secondary symptoms such as loneliness and social isolation are caused by the person's response to the illness or its treatment.
- The nursing assessment of a patient who has a serious mental illness should include an analysis of the physical, emotional, and intellectual components of the skills needed for living, learning, and working in the community.
- Families and other caregivers can be a major source of support for individuals who have serious mental illnesses. They can help by identifying potential problem areas and enhancing the patient's adherence to the treatment plan. The nurse should be available to the family through regular planned contacts and inclusion of the family as part of the treatment team.
- Care providers, including nurses, should assume a leadership role in assessing the adequacy and effectiveness of community resources and in recommending changes to improve access and quality of mental health care.
- A wide range of community services must be available to patients, including provisions for shelter, food, and clothing; household management; income and financial support; meaningful activities; and mobility and transportation.
- In promoting recovery, the nurse helps the individual develop strengths and potential; learn living skills; manage one's illness; and access environmental supports.
- Through experiences of adequacy, self-concept can be altered and self-esteem increased. Social skills training uses cognitive and behavioral techniques to help people gain the knowledge and skills they need to live in the community.
- An important aspect of psychiatric recovery promotes the physical well-being of those with serious mental illness.
- Four interventions that have been identified to support illness management include psychoeducation, behavioral tailoring for medication, training in relapse prevention, and coping skills training.
- Supporting people who have serious mental illnesses in community settings requires the development of a wide array of community support programs including case management and assertive community treatment (ACT) (discussed in Chapter 34), rehabilitation centers, consumer-run services, residential services, employment opportunities, and education.
- Permanent supported housing is a critical element of successful psychiatric rehabilitation services. Appropriate housing must be safe, affordable, and acceptable to the consumer.
- Supported employment programs assist participants in finding jobs in the community that are consistent with their own interests, pay at least minimum wage, and could be applied for by anyone.
- Education that is offered in a supportive environment can increase self-esteem, improve job qualifications, and encourage some consumers to pursue higher education.
- Effective programs for families of people with serious mental illnesses include empowerment and psychoeducation.
- Nurses should intervene in the community to encourage the establishment of recovery-oriented programs in several ways. Among these are health education, membership in advocacy groups, networking, and political action.
- Evaluation of the services provided to patients and family members must focus on the achievement of the expected outcomes of the intervention. Program evaluation is conducted to inform administrators about the relevance and cost-effectiveness of the services they offer.

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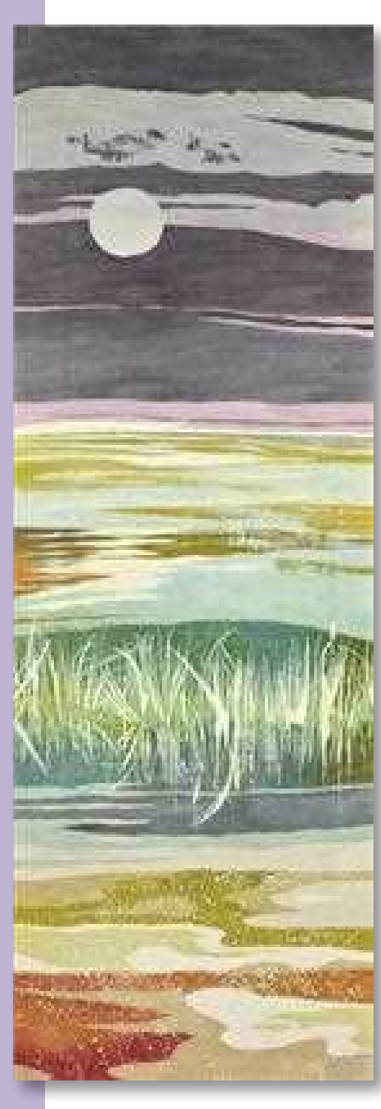
UNIT 3

Applying Principles in Nursing Practice



CHAPTER

15

Anxiety Responses and Anxiety Disorders

Gail W. Stuart

The fears we know are of not knowing.… It is getting late. Shall we ever be asked for? Are we simply not wanted at all?

W. H. Auden, The Age of Anxiety

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive anxiety responses.
2. Identify behaviors associated with anxiety responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to anxiety responses.
4. Describe coping resources and coping mechanisms related to anxiety responses.
5. Formulate nursing diagnoses related to anxiety responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to anxiety responses.
7. Identify expected outcomes and short-term nursing goals related to anxiety responses.
8. Develop a patient education plan to promote the relaxation response.
9. Analyze nursing interventions related to anxiety responses.
10. Evaluate nursing care related to anxiety responses.

Anxiety is a part of everyday life. It has always existed and belongs to no particular era or culture. Anxiety involves one's body, perceptions of self, and relationships with others, making it a basic concept in the study of psychiatric nursing and human behavior.

Anxiety disorders are the most common psychiatric disorders in the United States, affecting between 15% and 25% of the population. Those with an anxiety disorder have significant impairment in quality of life and functioning.

It has been estimated that only about one fourth of those with anxiety disorders receive treatment (Giacobbe et al, 2008). However, these people are high users of health care services because they seek treatment for the various symptoms caused by anxiety, such as chest pain, palpitations, dizziness, and shortness of breath.

CONTINUUM OF ANXIETY RESPONSES

Anxiety **is a vague sense of apprehension that is accompanied by feelings of uncertainty, helplessness, isolation, and insecurity.** The person senses that the core of his personality is being threatened. Experiences provoking anxiety begin in infancy and continue throughout life. They end with the fear of the greatest unknown, death.

Defining Characteristics

Anxiety is an emotion and a subjective individual experience. It is energy and cannot be observed directly. A nurse infers that a patient is anxious based on certain behaviors. The nurse needs to validate this inference with the patient.

Anxiety is an emotion without a specific object. It is provoked by the unknown and accompanies all new experiences,

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

It was all so hard to explain. He said it took months, but yet it had happened so suddenly that it is difficult to say where to start. He had been a very successful contractor, more successful than he had ever expected. Then he underbid a project and lost money; his foreman quit and became a competitor; and slowly he began to doubt himself. Finally it happened. One morning before leaving the house, his heart started pounding; he began to tremble and felt numb. He felt strange, like he was in a movie, so unreal. He started gasping for breath. He thought he was having a heart attack or was about to die. He was terrified. Nothing like this had ever happened to him before.

His wife took him to an urgent care center in town where they did an EKG and told him his heart was fine; he was just stressed. He took the day off. Before he knew it, he couldn't leave his house and he would shake whenever he tried to get in his truck. Quickly his crew went to work for his competitor, and he could no longer bid on jobs. His business started failing. He started drinking and soon was drinking a 12-pack of beer a day just to get by. His wife said if he didn't do something, she was leaving him. Now he was really scared but didn't know what to do.

When he arrived in the primary care office his appearance was flushed; he was sweating; his hands were shaking; he was breathing rapidly; and he was very tense. He said he hated what his life had become.

Case Critical Reasoning Questions

1. What are the stressors that led to his current condition?
2. What medical and nursing diagnoses do his symptoms suggest?
3. What comorbidity has he developed?
4. What neurotransmitters might be involved in his behavioral responses?
5. Which medications do you think would be helpful to him? Which ones should be avoided and why?
6. What types of education do he and his wife need?

such as entering school, starting a new job, or giving birth to a child. This characteristic of anxiety differentiates it from fear.

Fear has a specific source or object that the person can identify and describe. Fear involves the cognitive appraisal of a threatening stimulus; anxiety is the emotional response to that appraisal. Fear is caused by physical or psychological exposure to a threatening situation. **Fear produces anxiety.** Fear and anxiety are different, and this is reflected in our speech: We speak of *having a fear* but of *being anxious*.

Anxiety is communicated interpersonally. If a nurse is talking with a patient who is anxious, within a short time the nurse also will experience feelings of anxiety. Similarly, if a nurse is anxious in a particular situation, this anxiety will be communicated to the patient. The "contagious" nature of anxiety can have positive and negative effects on the therapeutic relationship. The nurse must carefully monitor these effects.

Anxiety is about self-preservation. It occurs as a result of a threat to a person's selfhood, self-esteem, or identity. It results from a threat to something that is central to one's personality and essential to one's existence and security. It may be connected with fear of punishment, disapproval, withdrawal of love, disruption of a relationship, isolation, or loss of body functioning. **Culture is related to anxiety, because culture can influence the values one considers most important** (Gwynn et al, 2008; Westermeyer et al, 2010).

It is important to remember that anxiety is part of everyday life. It is basic to the human condition and provides a valuable warning. In fact, the capacity to be anxious is necessary for survival. In addition, one can grow from it if one successfully confronts, deals with, and learns from anxiety-creating experiences.

Critical Reasoning Name two situations that provoke anxiety in you. Compare these with two situations that you fear.

Levels of Anxiety

Peplau (1963) identified four levels of anxiety and described their effects:

1. **Mild anxiety occurs with the tension of day-to-day living.** During this stage the person is alert and the perceptual field is increased. The person sees, hears, and grasps more than before. This kind of anxiety can motivate learning and produce growth and creativity.
2. **Moderate anxiety, in which the person focuses only on immediate concerns, involves narrowing of the perceptual field.** The person sees, hears, and grasps less. The person blocks selected areas but can attend to more if directed to do so.
3. **Severe anxiety is marked by a significant reduction in the perceptual field.** The person tends to focus on a specific detail and not think about anything else. All behavior is aimed at relieving anxiety, and much direction is needed to focus on another area.
4. **Panic is associated with dread and terror, as the person experiencing panic is unable to do things even with direction.** Increased motor activity, decreased ability to relate to others, distorted perceptions, and loss of rational thought are all symptoms of panic. The panicked person is unable to communicate or function effectively. This level of anxiety cannot persist indefinitely, because it is incompatible with life. A prolonged period of panic would result in exhaustion and death. **But panic can be treated safely and effectively.**

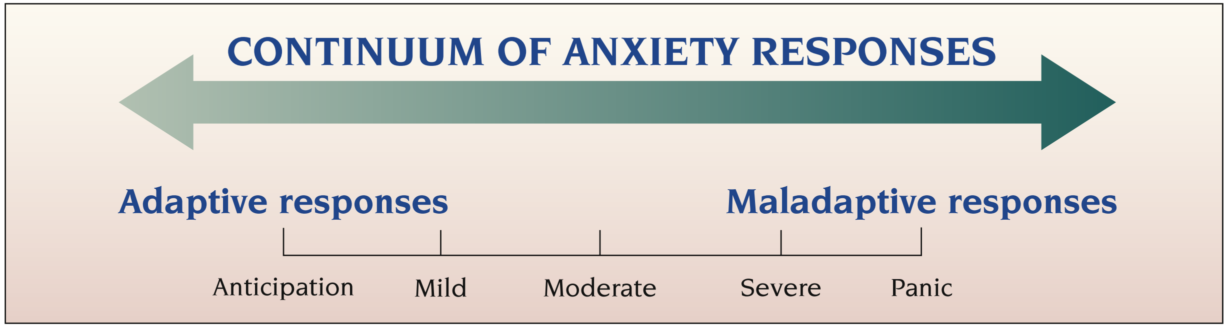


FIG 15-1 Continuum of anxiety responses.

QUALITY AND SAFETY ALERT

- Panic is a frightening and paralyzing experience.
- It involves the disorganization of the personality and can be life threatening.

The nurse needs to be able to identify which level of anxiety a patient is experiencing by the behaviors observed. Figure 15-1 shows the range of anxiety responses from **the most adaptive response of anticipation to the most maladaptive response of panic.** The patient's level of anxiety and its position on the continuum of coping responses are relevant to the nursing diagnosis and influence the type of intervention the nurse implements.

ASSESSMENT

Behaviors

Anxiety can be expressed directly through physiological and behavioral changes or indirectly through cognitive and affective responses, including the formation of symptoms or coping mechanisms developed as a defense against anxiety. The nature of the responses displayed depends on the level of anxiety. The intensity of the response increases with increasing anxiety.

In describing the effects of anxiety on **physiological responses,** mild and moderate anxiety levels heighten a person's capacities. In contrast, severe anxiety and panic paralyze or overwork capacities. The physiological responses associated with anxiety are modulated primarily by the brain through the **autonomic nervous system** (Figure 15-2). The body adjusts internally without a conscious or voluntary effort.

There are two types of autonomic responses:

1. **Parasympathetic—conserve body responses**
2. **Sympathetic—activate body processes**

The **sympathetic reaction** occurs most often in anxiety responses. This reaction prepares the body to deal with an emergency situation by a *fight-or-flight* reaction. It also can trigger the *general adaptation syndrome* (Chapter 16). When the cortex of the brain perceives a threat, it sends a stimulus down the sympathetic branch of the autonomic nervous system to the adrenal glands. Because of a release of epinephrine, respiration deepens, the heart beats more rapidly, and arterial pressure rises. Blood is shifted away from the stomach and intestines to the heart, central nervous system, and muscles. Glycogenolysis is accelerated, and the blood glucose level rises.

For a few people the **parasympathetic reaction** may coexist or dominate and produce opposite effects. Other physiological reactions also may be evident. The variety of physiological responses to anxiety that the nurse may observe in patients is summarized in Box 15-1.

Behavioral responses of the anxious patient have both personal and interpersonal aspects. High levels of anxiety affect coordination, involuntary movements, and responsiveness and also can disrupt human relationships. The anxious patient typically withdraws and decreases interpersonal involvement. The possible behavioral responses the nurse might observe are presented in Box 15-1.

Mental or intellectual functioning also is affected by anxiety, resulting in problems concentrating, confusion, and poor problem solving. **Cognitive responses** the patient might display when experiencing anxiety are described in Box 15-1.

Finally, the nurse can assess a patient's emotional reactions, or **affective responses,** to anxiety by the subjective description of the patient's personal experience. Often, patients describe themselves as tense, jittery, on edge, jumpy, worried, or restless. One patient described feelings in the following way: "I'm expecting something terribly bad to happen, but I don't know what. I'm afraid, but I don't know why. I guess you can call it a generalized bad feeling." All these phrases are expressions of apprehension and overalertness. It seems clear that the person interprets anxiety as a kind of warning sign. Additional affective responses are listed in Box 15-1.

Anxiety is an unpleasant and uncomfortable experience that most people try to avoid. They often try to replace anxiety with a more tolerable feeling. Pure anxiety is rarely seen. **Anxiety is usually observed in combination with other emotions.**

Patients might describe feelings of anger, boredom, contempt, depression, irritation, worthlessness, jealousy, self-depreciation, suspicion, sadness, or helplessness. This combination of emotions makes it difficult for the nurse to discriminate between anxiety and depression, for instance, because the patient's descriptions may be similar.

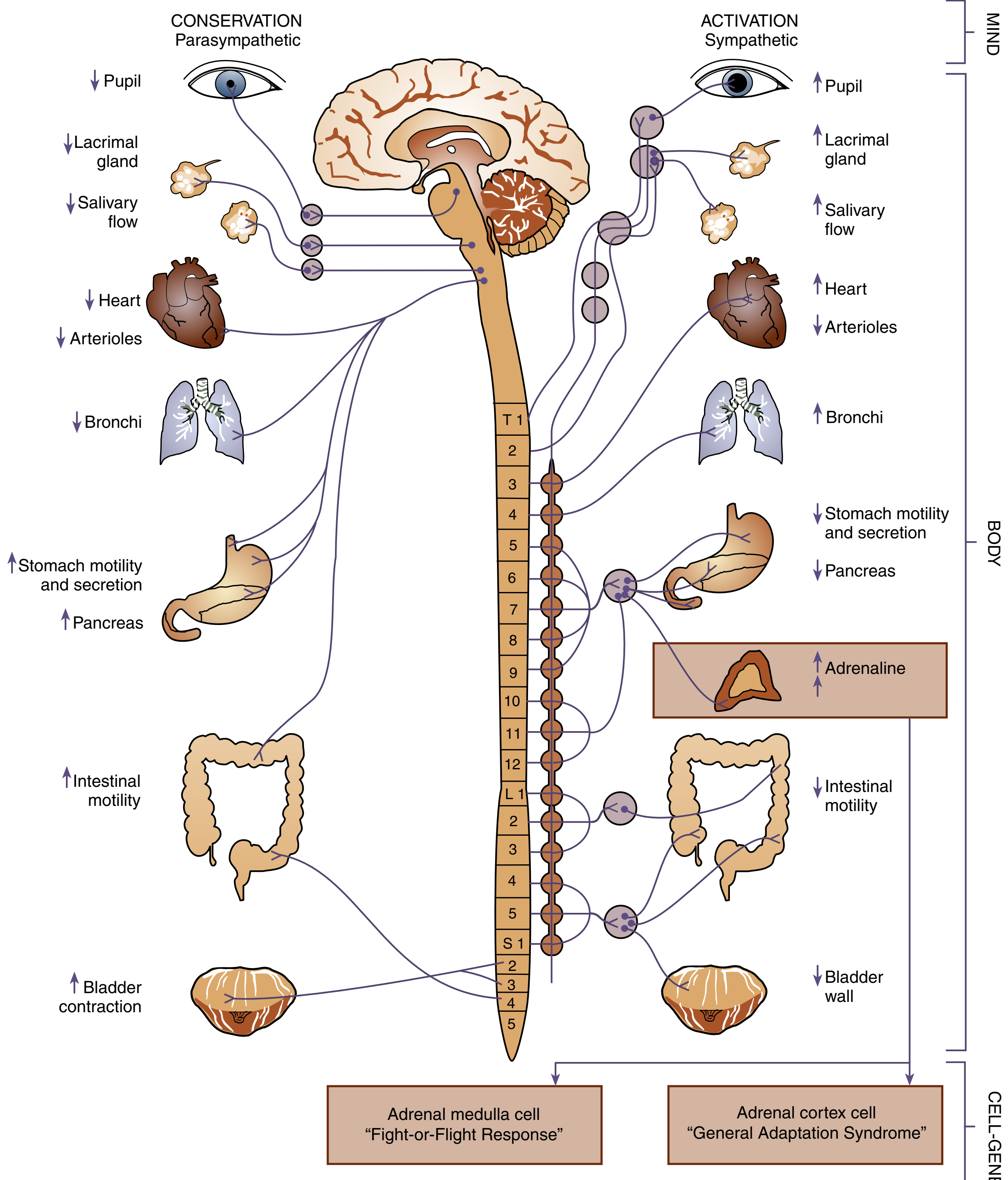


FIG 15-2 Mind modulation of the autonomic nervous system and its two branches, the parasympathetic (conserving) and the sympathetic (activating), down to the cellular level.

Close ties exist among anxiety, depression, guilt, and hostility. One feeling can act to generate and reinforce the others. The relationship between anxiety and hostility is particularly close. The pain experienced with anxiety often causes anger and resentment toward those thought to be responsible. These feelings of hostility in turn increase anxiety.

This cycle was seen in the case of a highly anxious, dependent, and insecure wife who was very attached to her husband. In exploring her feelings she also expressed great hostility toward her husband and their relationship. Verbalizing these angry feelings further increased her anxiety and unresolved conflict. Anxiety is often expressed through

BOX 15-1 PHYSIOLOGICAL, BEHAVIORAL, COGNITIVE, AND AFFECTIVE RESPONSES TO ANXIETY

Physiological

Cardiovascular
Palpitations
Racing heart
Increased blood pressure
Faintness*
Actual fainting*
Decreased blood pressure*
Decreased pulse rate*

Respiratory
Rapid breathing
Shortness of breath
Pressure on chest
Shallow breathing
Lump in throat
Choking sensation
Gasping

Gastrointestinal
Loss of appetite
Revulsion toward food
Abdominal discomfort
Abdominal pain*
Nausea*
Heartburn*
Diarrhea*

Neuromuscular
Increased reflexes
Startle reaction
Eyelid twitching
Insomnia
Tremors
Rigidity
Fidgeting
Pacing
Strained face
Generalized weakness
Wobbly legs
Clumsy movement

Urinary Tract
Pressure to urinate*
Frequent urination*

Skin
Flushed face
Localized sweating (e.g., palms)
Itching
Hot and cold spells
Pale face
Generalized sweating

Behavioral
Restlessness
Physical tension
Tremors
Startle reaction
Hypervigilance
Rapid speech
Lack of coordination
Accident proneness
Interpersonal withdrawal
Inhibition
Flight
Avoidance
Hyperventilation

Cognitive
Impaired attention
Poor concentration
Forgetfulness
Errors in judgment
Preoccupation
Blocking of thoughts
Decreased perceptual field
Reduced creativity
Diminished productivity
Confusion
Self-consciousness
Loss of objectivity
Fear of losing control
Frightening visual images
Fear of injury or death
Flashbacks
Nightmares

Affective
Edginess
Impatience
Uneasiness
Tension
Nervousness
Fear
Fright
Frustration
Helplessness
Alarm
Terror
Jitteriness
Jumpiness
Numbing
Guilt
Shame
Frustration
Helplessness

*Parasympathetic response.

anger, and a tense and anxious person is more likely to become angry.

Critical Reasoning Think of a patient you cared for recently who appeared to be angry or critical. Could this have been the patient's way of dealing with anxiety? If so, how would your nursing interventions have differed?

Predisposing Factors

Biological. The majority of studies point to a dysfunction in multiple systems rather than implicating one particular neurotransmitter in the development of an anxiety disorder. These systems include the following:

- **GABA system.** The regulation of anxiety is related to the activity of the neurotransmitter gamma-aminobutyric acid (GABA), which controls the activity, or firing rates, of neurons in the parts of the brain responsible for producing anxiety. **GABA is the most common inhibitory neurotransmitter in the brain.**
  - When it crosses the synapse and attaches or binds to the GABA receptor on the postsynaptic membrane, the receptor channel opens, allowing for the exchange of ions. This exchange results in an inhibition or reduction of cell excitability and thus a slowing of cell activity. The theory is that people who have an excess of anxiety have a problem with the efficiency of this neurotransmission process.
  - When a person with anxiety takes a **benzodiazepine (BZ)** medication, which is from the antianxiety class of drugs, it binds to a place on the GABA receptor next to GABA. This makes the postsynaptic receptor more sensitive to the effects of GABA, enhancing neurotransmission and causing even more inhibition of cell activity (Figure 15-3).
  - The effect of GABA and BZ at the GABA receptor in various parts of the brain is a reduced firing rate of cells in areas implicated in anxiety disorders. The clinical result is that the person becomes less anxious.
  - The areas of the brain where GABA receptors are coupled to BZ receptors include the **amygdala and hippocampus, both structures of the limbic system,** which functions as the center of emotions (e.g., rage, arousal, fear) and memory. Patients with anxiety disorders may have a decreased antianxiety capacity of the GABA receptors in areas of the limbic system, making them more sensitive to anxiety and panic.
- **Norepinephrine system.** The norepinephrine (NE) system is thought to mediate the fight-or-flight response. The part of the brain that manufactures NE is the **locus ceruleus.** It is connected by neurotransmitter pathways to other structures of the brain associated with anxiety, such as the amygdala, the hippocampus, and the cerebral cortex (the thinking, interpreting, and planning part of the brain).
  - Medications that decrease the activity of the locus ceruleus (antidepressants such as the tricyclics) effectively treat some anxiety disorders. This suggests that anxiety

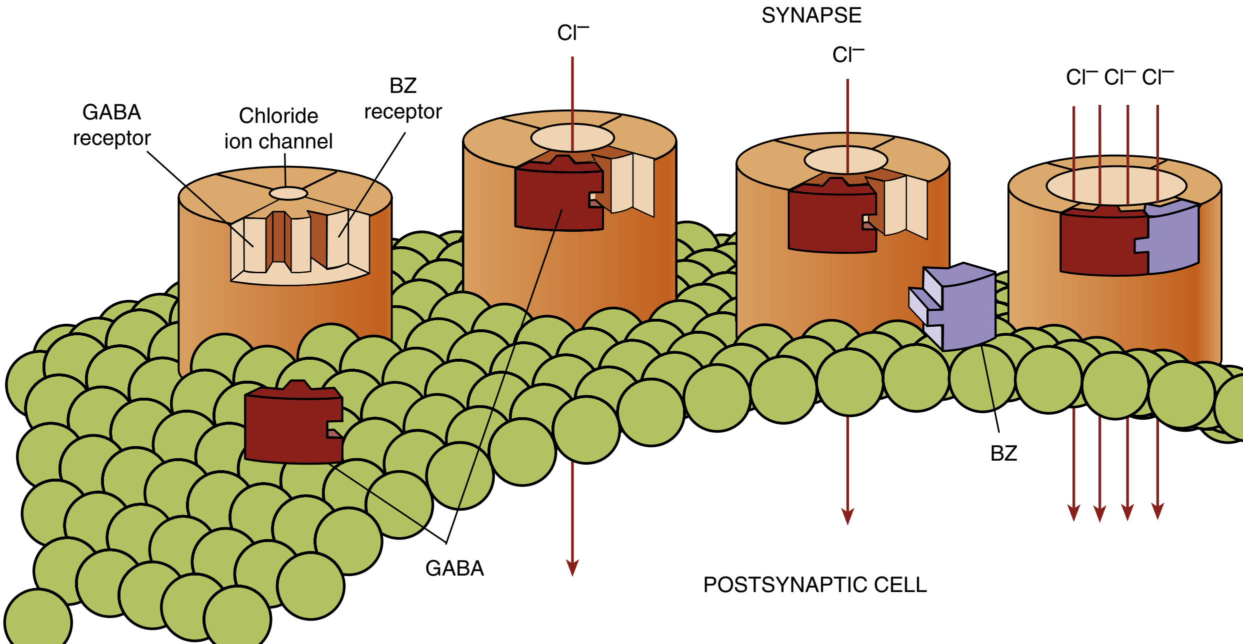


FIG 15-3 Effects of a benzodiazepine *(BZ)* drug at the gamma-aminobutyric acid *(GABA)* receptor. *Cl,* Chloride ion.

may be caused in part by an inappropriate activation of the NE system in the locus ceruleus and an imbalance between NE and other neurotransmitter systems.

- **Serotonin system.** A dysregulation of serotonin (5-HT) neurotransmission may play a role in the etiology of anxiety, because patients experiencing these disorders may have hypersensitive 5-HT receptors.
  - Drugs that regulate serotonin, such as the **selective serotonin reuptake inhibitors (SSRIs)**, have been shown to be particularly effective in treating several of the anxiety disorders, suggesting a major role for 5-HT and its balance with other neurotransmitter systems in the etiology of anxiety disorders.

Traumatic experiences may change the brain and the ways in which it responds to subsequent stressors. The effects of trauma involve alterations in many regions of the brain, particularly the limbic system. The hypothalamic-pituitary-adrenal (HPA) axis, a major response system, appears to be modified by trauma, as do the neurotransmitters discussed earlier.

Studies also suggest an excess of **inflammatory actions of the immune system** in individuals with chronic posttraumatic stress disorder (PTSD). High levels of inflammatory cytokines have been linked to PTSD vulnerability in traumatized individuals. The excessive inflammation may result from insufficient regulation by cortisol (Gill et al, 2009).

A person's general health has a great effect on predisposition to anxiety. Anxiety may accompany some physical disorders, such as those listed in Box 15-2. Coping mechanisms also may be impaired by toxic influences, dietary deficiencies, reduced blood supply, hormonal changes, and other physical causes (Strine et al, 2008). In addition, symptoms from some physical disorders may mimic or exacerbate anxiety.

BOX 15-2 PHYSICAL DISORDERS ASSOCIATED WITH ANXIETY

Cardiovascular/Respiratory Disorders
Asthma
Cardiac arrhythmias
Chronic obstructive pulmonary disease
Congestive heart failure
Coronary insufficiency
Hyperdynamic beta-adrenergic state
Hypertension
Hyperventilation syndrome
Hypoxia, embolus, infections

Endocrinologic Disorders
Carcinoid
Cushing syndrome
Hyperthyroidism
Hypoglycemia
Hypoparathyroidism
Hypothyroidism
Menopause
Pheochromocytoma
Premenstrual syndrome

Neurological Disorders
Collagen vascular disease
Epilepsy
Huntington disease
Multiple sclerosis
Organic brain syndrome
Vestibular dysfunction
Wilson disease

Substance-Related Disorders

Intoxications
Anticholinergic drugs
Aspirin
Caffeine
Cocaine
Hallucinogens, including phencyclidine ("angel dust")
Steroids
Sympathomimetics

Withdrawal Syndromes
Alcohol
Narcotics
Sedative-hypnotics

Similarly, fatigue increases irritability and feelings of anxiety. It appears that fatigue caused by nervous factors predisposes the person to a greater degree of anxiety than does fatigue caused by purely physical causes. Thus fatigue may actually be an early symptom of anxiety. Patients with

nervous fatigue and sleep problems may already be experiencing moderate anxiety and be more susceptible to future stress situations.

Familial. **Anxiety disorders run in families.** The heritability of panic disorder is estimated to be about 40%. Individuals with a family history of psychiatric illness are three times more likely to develop PTSD after a traumatic event.

Despite strong evidence for genetic vulnerability, no single or specific gene has been clearly identified for anxiety disorders. This is due, in part, to the critical role that the environment plays in interacting with genetic vulnerability in mental disorders.

It is also important to understand that anxiety disorders can overlap, as can anxiety disorders and depression. **People with one anxiety disorder are more likely to develop another or to experience a major depression within their lifetime**.

Psychological. Learning theorists believe that people who have been exposed in early life to intense fears are more likely to be anxious in later life, so **parental influences are important.** Children who see their parents respond with anxiety to every minor stress soon develop a similar pattern. In contrast, if parents are completely unmoved by potentially stressful situations, children feel alone and lack emotional support from their families. The appropriate emotional response of parents gives children security and helps them learn constructive coping methods.

A person's level of self-esteem is an important factor related to anxiety. **A person who is easily threatened or has a low level of self-esteem is more susceptible to anxiety**. This is seen in students who have test anxiety. Anxiety is high because they doubt they can succeed. This anxiety may have nothing to do with their actual abilities or how much they studied. The anxiety is caused only by their perception of their ability, which reflects their self-concept. They may be well prepared for the examination, but their severe level of anxiety reduces their perceptual field significantly. They may omit, misinterpret, or distort the meaning of the test items. They may even block out all their previous studying. The result will be a poor grade, which reinforces their poor perception of self.

Perhaps the most important psychological trait is resilience to stress. **Resilience** is the ability to maintain normal functioning despite adversity. **Resilience is associated with a number of protective psychosocial factors, including active coping style, positive outlook, interpersonal relatedness, moral compass, social support, role models, and cognitive flexibility.** Resilience is discussed in Chapter 12.

Having purpose in life and undertaking and mastering difficult tasks are effective ways to increase one's resilience to stress (Alim et al, 2008). For example, men and women who successfully managed stressful situations in childhood, such as death or illness of a parent or sibling, family relocation, or loss of friendship, are more resistant to adult stressors, such as divorce, death, major illness, or job loss. However individuals who experienced extreme childhood stress that they could not control or master, such as physical or sexual abuse, may be more vulnerable to future stressors.

> **Critical Reasoning** How would you rate yourself on the protective psychosocial factors associated with resilience?

Behavioral. **Anxiety can be a product of frustration caused by anything that interferes with attaining a desired goal**. An example of an external frustration might be the loss of a job. Many goals may thus be blocked, such as financial security, pride in work, and perception of self as family provider. An internal frustration is seen when young college graduates set unrealistically high career goals and are frustrated by entry-level job offers. Their view of self is threatened by their unrealistic goals and they are likely to experience feelings of failure, insignificance, and mounting anxiety.

Anxiety also may arise through conflict that occurs when a person experiences two competing drives and must choose between them. A reciprocal relationship exists between conflict and anxiety. **Conflict produces anxiety, and anxiety increases the perception of conflict by producing feelings of helplessness**.

In this view conflict is a result of two desires: approach and avoidance. Approach is the desire to do something or move toward something. Avoidance is the opposite desire: not to do something or not to move toward something. There are four kinds of conflict:

1. **Approach-approach,** in which the person wants to pursue two equally desirable but incompatible goals. An example is having two very attractive job offers. This type of conflict seldom produces anxiety.
2. **Approach-avoidance,** in which the person wishes to both pursue and avoid the same goal. The patient who wants to express anger but feels great anxiety and fear in doing so experiences this type of conflict. Another example is the ambitious business executive who must compromise values of honesty and loyalty to be promoted.
3. **Avoidance-avoidance,** in which the person must choose between two undesirable goals. Because neither alternative seems beneficial, this is a difficult choice that is usually accompanied by much anxiety. An example is when a person observes a friend cheating and feels the need to report the act but worries about the loss of friends that might result from reporting the violation.
4. **Double approach-avoidance,** in which the person can see both desirable and undesirable aspects of both alternatives. An example is the conflict experienced by a person living with the pain of an unsatisfying social and emotional life. The alternative is to seek psychiatric help and expose oneself to the threat and potential pain of the therapy process. Double approach-avoidance conflict feelings often are described as ambivalence.

> **Critical Reasoning** Think of an example of each of the four kinds of conflict that you have experienced in your own life.

Precipitating Stressors

Experiencing or witnessing trauma has been associated with a variety of anxiety disorders, particularly posttraumatic stress disorder (PTSD). Most traumatized individuals experience more than one trauma in their lifetime, and the risk of PTSD increases with each event (Nayback, 2009; Doctor et al, 2011).

The majority of individuals involved in traumatic events will not develop a psychological disorder. Only 5% to 10% of those who experience trauma develop PTSD (Snyder, 2008). The so-called "normal" response is highly variable. Some people develop a marked initial reaction that resolves over a few weeks. Others have little or no initial reaction and do not develop any difficulties. However, a minority develop mental health problems that require intervention.

With the return of soldiers serving in wars and the increasing violence in society, PTSD is becoming a more prevalent and impairing condition (Ray, 2008). Specifically, the negative effects of combat are deep and enduring, and veterans with combat stress reaction may be six times more likely to develop PTSD. PTSD in veterans is discussed in Chapter 39.

An individual at risk for PTSD should be screened using the primary care tool presented in Box 15-3. It focuses on the core PTSD symptom clusters. Anyone answering "yes" to three of the four items should have a more formal assessment.

Maturational and situational crises, as described in Chapter 13, also can precipitate a maladaptive anxiety response (Ameratunga et al, 2009). In total, precipitating stressors can be grouped into two categories: threats to physical integrity and threats to self-system.

Threats to Physical Integrity.

Threats to physical integrity involve potential physical disability or decreased ability to perform activities of daily living. They may come from internal or external sources.

External sources include exposure to viral and bacterial infection, environmental pollutants, and safety hazards; lack of adequate housing, food, or clothing; and traumatic injury. Internal sources include the failure of body systems such as the heart, immune system, or temperature regulation. The normal biological changes that can occur with pregnancy and failure to participate in preventive health practices are other internal sources.

Pain is often the first indication that physical integrity is being threatened. It creates anxiety that often motivates the person to seek health care.

Threats to Self-System.

Threats to one's self-system involve harm to a person's identity, self-esteem, and integrated social functioning. Both external and internal sources can threaten self-esteem.

External sources include the loss of a valued person through death, divorce, or relocation; a change in job status; an ethical dilemma; social or cultural group pressures; and work stress. Internal sources include interpersonal problems at home or at work or when assuming a new role, such as parent, student, or employee. In addition, many threats to physical integrity also threaten self-esteem, because the mind-body relationship is an overlapping one.

BOX 15-3 PRIMARY CARE POSTTRAUMATIC STRESS DISORDER (PTSD) SCREEN*

In your life, have you ever had any experience that was so frightening, horrible, or upsetting, that ***in the past month,*** you…

1. Have had nightmares about it or thought about it when you did not want to?
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
3. Were constantly on guard, watchful, or easily startled?
4. Felt numb or detached from things, activities, or your surroundings?

*Screen is positive if patient answers "yes" to any three items.

It is important to remember, however, that this distinction of categories is only theoretical. The person responds to all stressors, whatever their nature and origin, as an integrated whole. No specific event is equally stressful to all people or even to the same person at different times.

Appraisal of Stressors

A true understanding of anxiety requires integration of knowledge from the various points of view. The Stuart Stress Adaptation Model integrates data from biological, genetic, psychological, and behavioral perspectives.

Coping Resources

A person can cope with stress and anxiety by mobilizing coping resources found internally and in the environment. Resources such as financial assets, problem-solving abilities, social supports, and cultural beliefs can help people integrate stressful experiences into their lives and learn to adopt successful coping strategies. They also can help people find meaning from stressful experiences and consider alternative strategies for dealing with stressful events.

Critical Reasoning How might a person's religious or spiritual belief system serve as a resource in coping with a moderate level of anxiety?

Coping Mechanisms

As anxiety increases to the severe and panic levels, the behaviors displayed by a person become more intense and potentially injurious, and quality of life decreases. People seek to avoid anxiety and the circumstances that produce it. When experiencing anxiety, people use various coping mechanisms to try to relieve it (Box 15-4). The inability to cope with anxiety constructively is a primary cause of psychological problems.

The nurse needs to be familiar with the coping mechanisms people use when experiencing the various levels of anxiety. For mild anxiety, caused by the tensions of day-to-day living, several coping mechanisms commonly used include

BOX 15-4 A PATIENT SPEAKS

It's hard to describe what it feels like. You know something isn't right. Most people don't have to check their doors five or six times before they go to bed. Most people aren't afraid to be near children or feel like they have to count their money over and over again before they can put it back in their wallets. But that's the way my life has been ever since I was a little girl.

Of course I realized I needed help, so I saw a number of different professionals. With one psychologist we discussed every aspect of my childhood and my earliest memories of life. Unfortunately, I finished that therapy still counting everything around me. Next I went to a physician, but he told me that I was just nervous about getting married and things would get better with time. They didn't. Then my mother suggested I go to the university and see someone. That's where I met the psychiatric nurse who did a number of things I'll always remember. First she put me at ease and clearly told me that I wasn't crazy. Then she told me that what I had was called obsessive-compulsive disorder, and she gave me lots of great books and information to read. Finally, she told me that it was a treatable illness, and together we devised a treatment plan. It included both medication and behavioral therapy and, wow, what a difference! I'm sure glad I was persistent, but I'm even more glad that there are caring professionals out there who can really help.

QUALITY AND SAFETY ALERT

- The pattern used to cope with mild anxiety dominates when anxiety becomes more intense.
- Anxiety plays a major role in the expression of emotional illness because many symptoms of illness develop as attempted defenses against anxiety.

crying, sleeping, eating, yawning, laughing, cursing, physical exercise, and daydreaming. Oral behavior, such as smoking and drinking, is another way of coping with mild anxiety.

When dealing with other people, the individual copes with low levels of anxiety through superficiality, lack of eye contact, use of clichés, and limited self-disclosure. People also can protect themselves from anxiety by assuming comfortable roles and limiting close relationships to those with values similar to their own.

Moderate, severe, and panic levels of anxiety pose greater threats to the ego. They require more energy to cope with the threat. These coping mechanisms can be categorized as problem or task focused and as emotion or ego focused.

Problem- or Task-Focused Coping. **Problem- or task-focused coping mechanisms are thoughtful, deliberate attempts to solve problems, resolve conflicts, and gratify needs.** These reactions can include attack, withdrawal, and compromise. They are aimed at realistically meeting the demands of a stress situation that has been objectively appraised. They are consciously directed and action oriented.

In attack behavior a person attempts to remove or overcome obstacles to satisfy a need. There are many possible ways of attacking problems, and this type of reaction can be destructive or constructive. Destructive patterns are usually accompanied by great feelings of anger and hostility. These feelings may be expressed by negative or aggressive behavior that violates the rights, property, and well-being of others. Constructive patterns reflect a problem-solving approach. They are evident in self-assertive behaviors that respect the rights of others.

Withdrawal behavior may be expressed physically or psychologically. Physically, withdrawal involves removing oneself from the source of the threat. This reaction can apply to biological stressors, such as smoke-filled rooms, exposure to radiation, or contact with contagious diseases.

A person also can withdraw in various psychological ways, such as by admitting defeat, becoming apathetic, or lowering aspirations. As with attack, this type of reaction can be constructive or destructive. When it isolates the person from others and interferes with the ability to work, the reaction creates additional problems.

Compromise involves changing one's usual way of thinking about things, substituting goals, or sacrificing aspects of personal needs. It is necessary in situations that cannot be resolved through attack or withdrawal. Compromise reactions are usually constructive and are often used in approach-approach and avoidance-avoidance situations. Occasionally, however, the person realizes over time that the compromise is not acceptable; a solution must then be renegotiated or a different coping mechanism adopted.

The likelihood of effective problem solving is influenced by the person's expectation of at least partial success. This depends on remembering past successes in similar situations, which allows the person to go forward and deal with the current stressful situation.

Critical Reasoning What coping mechanisms do you use when you are mildly, moderately, and severely anxious? How adaptive or maladaptive are they?

Emotion- or Ego-Focused Coping. **Emotion- or ego-focused coping mechanisms, known as defense mechanisms, protect the person from feelings of inadequacy and worthlessness and prevent awareness of anxiety.** Everyone uses them, and they often help people cope successfully with mild and moderate levels of anxiety. However, **they can be used to such an extreme degree that they distort reality, interfere with interpersonal relationships, and limit the ability to work productively.**

As coping mechanisms, they have certain drawbacks. First, ego defense mechanisms operate on unconscious levels. The person has little awareness of what is happening and little control over events. Secondly, they involve a degree of self-deception and reality distortion. Therefore they usually do not help the person cope with the problem realistically. Table 15-1 lists some of the more common ego defense mechanisms and examples of each.

TABLE 15-1 EGO DEFENSE MECHANISMS

DEFENSE MECHANISM	EXAMPLE
Compensation: Process by which people make up for a perceived weakness by strongly emphasizing a feature that they consider more desirable.	A businessman perceives his small physical stature negatively. He tries to overcome this by being aggressive, forceful, and controlling in business dealings.
Denial: Avoidance of disagreeable realities by ignoring or refusing to recognize them; the simplest and most primitive of all defense mechanisms.	Ms. P has just been told that her breast biopsy indicates a malignancy. When her husband visits her that evening, she tells him that no one has discussed the laboratory results with her.
Displacement: Shift of emotion from a person or object to another, usually neutral or less dangerous, person or object.	A 4-year-old boy is angry because he has just been punished by his mother for drawing on his bedroom walls. He begins to play war with his soldier toys and has them fight with each other.
Dissociation: The separation of a group of mental or behavioral processes from the rest of the person's consciousness or identity.	A man is brought to the emergency room by the police and is unable to explain who he is and where he lives or works.
Identification: Process by which people try to become like someone they admire by taking on thoughts, mannerisms, or tastes of that person.	Sally, 15 years old, has her hair styled like that of her young English teacher, whom she admires.
Intellectualization: Excessive reasoning or logic is used to avoid experiencing disturbing feelings.	A woman avoids dealing with her anxiety in shopping malls by explaining that shopping is a frivolous waste of time and money.
Introjection: Intense identification in which people incorporate qualities or values of another person or group into their own ego structure. It is one of the earliest mechanisms of the child, important in formation of conscience.	Eight-year-old Jimmy tells his 3-year-old sister, "Don't scribble in your book of nursery rhymes. Just look at the pretty pictures," thus expressing his parents' values.
Isolation: Splitting off of emotional components of a thought, which may be temporary or long term.	A medical student dissects a cadaver for her anatomy course without being disturbed by thoughts of death.
Projection: Attributing one's thoughts or impulses to another person. Through this process one can attribute intolerable wishes, emotional feelings, or motivation to another person.	A young woman who denies she has sexual feelings about a co-worker accuses him without basis of trying to seduce her.
Rationalization: Offering a socially acceptable or apparently logical explanation to justify or make acceptable otherwise unacceptable impulses, feelings, behaviors, and motives.	John fails an examination and complains that the lectures were not well organized or clearly presented.
Reaction formation: Development of conscious attitudes and behavior patterns that are opposite to what one really feels or would like to do.	A married woman who feels attracted to one of her husband's friends treats him rudely.
Regression: Retreat to behavior characteristic of an earlier level of development.	Four-year-old Nicole, who has been toilet trained for more than 1 year, begins to wet her pants again when her new baby brother is brought home from the hospital.
Repression: Involuntary exclusion of a painful or conflicted thought, impulse, or memory from awareness. It is the primary ego defense, and other mechanisms tend to reinforce it.	Mr. R does not recall hitting his wife when she was pregnant.
Splitting: Viewing people and situations as either all good or all bad; failure to integrate the positive and negative qualities of oneself.	A friend tells you that you are the most wonderful person in the world one day and how much she hates you the next day.
Sublimation: Acceptance of a socially approved substitute goal for a drive whose normal channel of expression is blocked.	Ed has an impulsive and physically aggressive nature. He tries out for the football team and becomes a star tackle.
Suppression: A process often listed as a defense mechanism, but really it is a conscious counterpart of repression. It is intentional exclusion of material from consciousness. At times, it may lead to repression.	A young man at work finds he is thinking so much about his date that evening that it is interfering with his work. He decides to put it out of his mind until he leaves the office for the day.
Undoing: Act or communication that partially negates a previous one; a primitive defense mechanism.	Larry makes a passionate declaration of love to Sue on a date. At their next meeting he treats her formally and distantly.

The evaluation of whether the patient's use of certain defense mechanisms is adaptive or maladaptive involves four issues:

1. The accurate recognition of the patient's use of the defense mechanism by the nurse
2. The degree to which the defense mechanism is used: Is there a high degree of personality disorganization? Is the person open to facts about the life situation?
3. The degree to which use of the defense mechanism interferes with the patient's functioning
4. The reason the patient used the ego defense mechanism

Many coping mechanisms can be used to minimize anxiety. Some of them are essential for emotional stability. The exact nature and number of the defenses used strongly influence the personality pattern. **When these defenses are overused or used unsuccessfully, they cause many physiological**

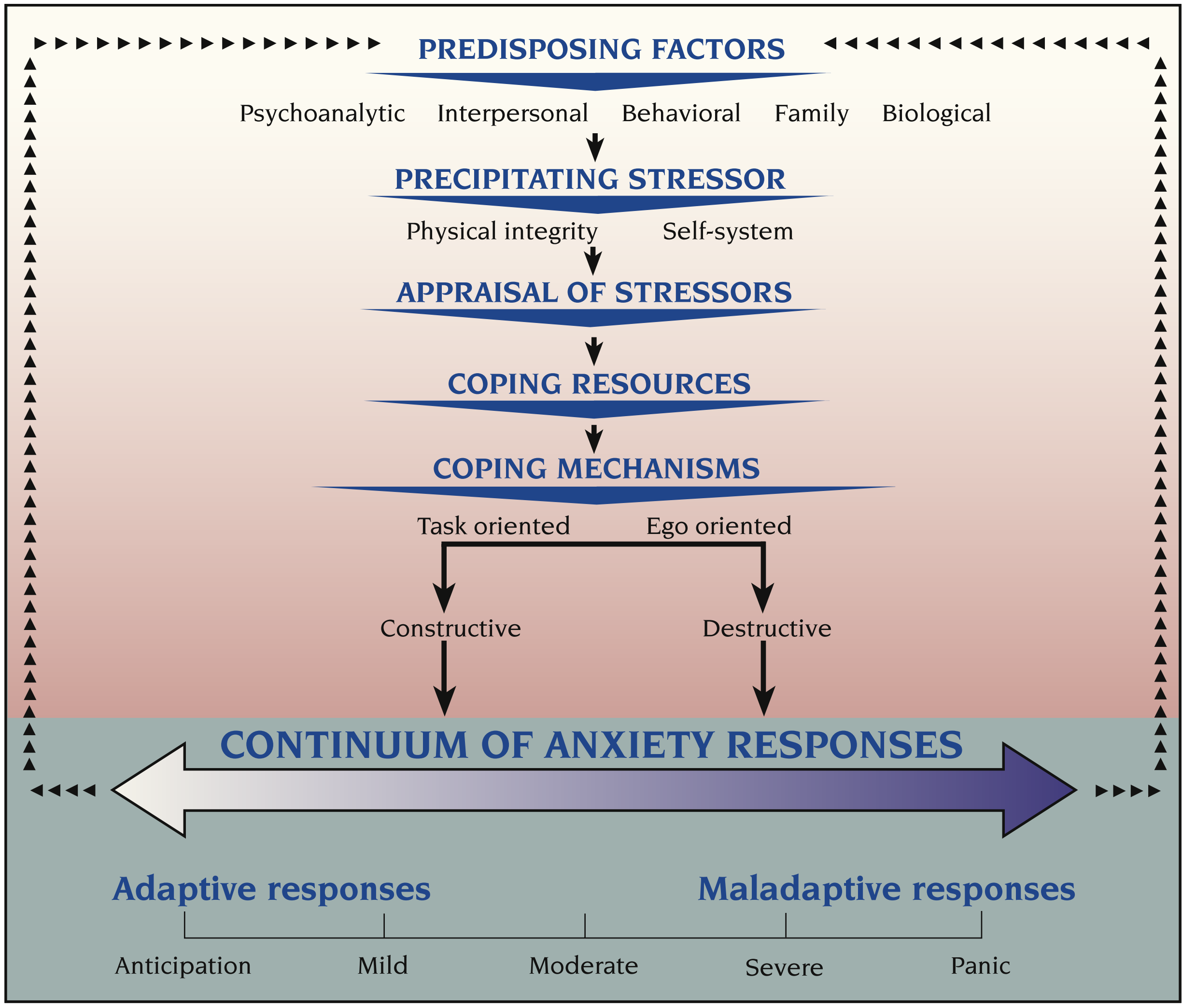


FIG 15-4 The Stuart Stress Adaptation Model as related to anxiety responses.

and psychological symptoms commonly associated with emotional illness.

DIAGNOSIS

Nursing Diagnoses

The nurse who has adequately assessed a patient and uses the Stuart Stress Adaptation Model can formulate a nursing diagnosis based on the patient's position on the continuum of anxiety responses (Figure 15-4).

Initially the nurse needs to determine the quality and quantity of the anxiety experienced by the patient. Is the patient's response to the perceived threat appropriate? Is it adaptive or irrational? A problem may exist if the response is out of proportion to the threat, indicating that the patient's cognitive appraisal of the threat is unrealistic. Maladaptive responses are seen with severe and panic levels of anxiety.

The nurse also needs to explore how the patient is coping with the anxiety. Constructive coping mechanisms are protective responses that consciously confront the threat. Destructive coping mechanisms involve repression into the unconscious. They tend to be ineffective, inadequate, disorganized, inappropriate, and exaggerated. They may be evident in bizarre behavior or symptom formation.

Finally, the nurse needs to determine the overall effect of the anxiety. Is it stimulating growth? Or is it interfering with effective living and life satisfaction? Is it enhancing one's sense of self? Or is it depersonalizing? Whenever possible, the patient should be included in identifying problem areas. Such involvement may not always be feasible, however, particularly if the patient's anxiety is at the severe or panic level.

The four primary NANDA International (NANDA-I) nursing diagnoses concerned with anxiety responses are anxiety, ineffective coping, readiness for enhanced coping, and fear. Many additional nursing problems may be identified from the way the patient's anxiety reciprocally influences interpersonal relationships, self-concept, cognitive functioning, physiological status, and other aspects of life. The primary NANDA-I nursing diagnoses and examples of expanded nursing diagnoses are presented in Table 15-2.

TABLE 15-2 NURSING DIAGNOSES AND MEDICAL TERMS RELATED TO *Anxiety Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Anxiety	Panic level of anxiety related to family rejection, as evidenced by confusion and impaired judgment Severe anxiety related to sexual conflict, as evidenced by repetitive hand washing and recurrent thoughts of dirt and germs Severe anxiety related to marital conflict, as evidenced by inability to leave the house Moderate anxiety related to financial pressures, as evidenced by recurring episodes of abdominal pain and heartburn Moderate anxiety related to assumption of motherhood role, as evidenced by inhibition and avoidance Moderate anxiety related to poor school performance, as evidenced by excessive use of denial and rationalization
Ineffective coping	Ineffective coping related to daughter's death, as evidenced by inability to recall events pertaining to the car accident Ineffective coping related to child's illness, as evidenced by limited ability to concentrate and psychomotor agitation
Readiness for enhanced coping	Readiness for enhanced coping related to adoption of grandchild after death of the child's parents, as evidenced by engagement in family therapy and modification of living environment to promote inclusion of a child in the home
Fear	Fear related to impending surgery, as evidenced by generalized hostility toward staff and restlessness
MEDICAL TERM	**DEFINITION***
Agoraphobia	Abnormal fear of being helpless in a situation from which escape may be difficult or embarrassing. It is often accompanied by panic or anticipatory anxiety and eventually by avoidance of open or public places.
Generalized anxiety disorder	An anxiety disorder marked by chronic excessive anxiety and worry that is difficult to control, causes distress or impairment in daily functioning, and is accompanied by symptoms such as restlessness, irritability, poor concentration, and sleep disturbances.
Obsessive-compulsive disorder	An anxiety disorder in which the patient experiences obsessions or compulsions or both and suffers extreme anxiety or depression if unable to think the obsessive thoughts or perform the compelling acts. Often abbreviated as OCD.
Panic disorder	An anxiety disorder in which the patient frequently experiences inappropriate, intense apprehension and physical symptoms of fear called panic attacks. These produce significant impairment in functioning with worry about their recurrence.
Phobia	A persistent, irrational fear of a specific object, activity, or situation that leads to a compelling desire to avoid it.
Social phobia	An anxiety disorder characterized by shyness and heightened self-consciousness in particular social situations.
Posttraumatic stress disorder	An anxiety disorder that occurs after experiencing a highly stressing event (such as wartime combat, physical violence, or a natural disaster) that is outside the range of normal human experience and that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event. Often abbreviated as PTSD.

Nursing Diagnoses–Definitions and Classification 2012-2014. Copyright © 2012, 1994-2012 by NANDA International. Used by arrangement with Blackwell Publishing Limited, a company of John Wiley & Sons, Inc.
*Sources: http://www.merriam-webster.com/dictionary; http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001923/; http://www.medicinenet.com/agoraphobia/article.htm#what.

Medical Diagnoses

Many patients with mild or moderate anxiety have no medically diagnosed health problem. However, patients with more severe levels of anxiety usually have neurotic disorders that fall under the category of anxiety disorders in the *DSM-IV-TR* (American Psychiatric Association, 2000).

- Neurosis **describes a mental disorder characterized by anxiety that involves no distortion of reality.** Neurotic disorders are maladaptive anxiety responses associated with moderate and severe levels of anxiety.
- Psychosis **is disintegrative and involves a significant distortion of reality.** It can emerge with the panic level of anxiety. Chapter 20 discusses psychotic disorders.

The medical diagnoses related to anxiety include panic disorder with or without agoraphobia, agoraphobia, specific phobia, social phobia, obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, and generalized anxiety disorder. The definitions of some of the medical terms related to anxiety responses are presented in Table 15-2. Panic attacks are described in Box 15-5 and obsessions and compulsions are described in Box 15-6.

BOX 15-5 PANIC ATTACK

A panic attack is a sudden episode of intense fear that develops for no apparent reason and that triggers severe physical reactions. Panic attacks can be very frightening. When panic attacks occur, people think that they are losing control, having a heart attack or even dying. Panic attacks typically include a few or many of these symptoms:

- A sense of impending doom or death
- Rapid heart rate
- Sweating
- Trembling
- Shortness of breath
- Hyperventilation
- Chills
- Hot flashes
- Nausea
- Abdominal cramping
- Chest pain
- Headache
- Dizziness
- Faintness
- Tightness in the throat
- Trouble swallowing

Panic attacks typically begin suddenly, without warning. They can strike at almost any time—while driving, shopping at the mall, sleeping or at work. Symptoms usually peak within 10 minutes and last about half an hour. One of the worst things about panic attacks is the intense fear of having another panic attack.

Source: http://www.mayoclinic.com/health/panic-attacks/DS00338.

BOX 15-6 OBSESSIONS AND COMPULSIONS

Obsessions

Obsessions are repeated, persistent and unwanted ideas, thoughts, images, or impulses that occur involuntarily and that seem to make no sense.

Examples

Fear of dirt and germs
Fear of burglary or robbery
Worries about discarding something important
Concerns about contracting a serious illness
Worries that things must be symmetrical or matching

Compulsions

Compulsions are repetitive behaviors that the person feels driven to perform. These repetitive behaviors are meant to prevent or reduce anxiety related to one's obsessions.

Examples

Excessive hand washing
Repeated checking of door and window locks
Counting and recounting of objects in everyday life
Hoarding of objects
Excessive straightening, ordering, or arranging of things
Repeating words or prayers silently

Source: http://www.mayoclinic.com/health/obsessive-compulsive-disorder/DS00189.

The nurse also must discriminate between anxiety and other disorders such as alcohol use disorders (Strine et al, 2008). Anxiety and depression often overlap, because anxious patients are often depressed and depressed patients are often anxious (Young et al, 2008; Encrenaz et al, 2009).

For example, anxious patients and depressed patients share the following symptoms: sleep disturbances, appetite changes, nonspecific cardiopulmonary and gastrointestinal complaints, difficulty concentrating, irritability, and fatigue or lack of energy. Yet there are often discrete (if subtle) differences between the two groups. These are described in Table 15-3.

About 25%, or one of four people, will experience an anxiety disorder sometime in their life, making anxiety disorders the most common psychiatric disorders in U.S. society. Specifically, obsessive-compulsive disorder (OCD) affects about 3% of the U.S. population; generalized anxiety disorder (GAD), about 5%; social phobia, about 13%; phobias, about 15%; panic disorder, about 3%; and PTSD, about 8%.

PTSD is rarely a patient's only psychiatric diagnosis (Goldstein et al, 2010). The likelihood that a patient with PTSD will meet diagnostic criteria for at least one other psychiatric disorder is 80%. Almost half of all people with PTSD also experience major depression, and more than one third experience phobias and alcoholism.

Anxiety disorders, including PTSD, occur twice as often in women as in men, and OCD is about equally prevalent in women and men. There is no difference in the prevalence of anxiety disorders based on race, income, education, or rural versus urban setting.

QUALITY AND SAFETY ALERT

- Patients with a lifetime history of PTSD are more likely to have made a suicide attempt.
- They also are at higher risk for medical illnesses.

OUTCOMES IDENTIFICATION

Goals such as "decrease anxiety" or "minimize anxiety" lack specific behaviors and evaluation criteria. Therefore these goals are not particularly useful in guiding nursing care and evaluating its effectiveness. The **expected outcome** for patients with maladaptive anxiety responses is as follows: ***The patient will demonstrate adaptive ways of coping with stress.***

Short-term goals can break this expected outcome down into readily attainable steps. This identification of steps allows the patient and nurse to see progress even if the ultimate goal still appears distant.

If the patient's anxiety is at the severe or panic level, the highest-priority short-term goals should address safety and

TABLE 15-3 DIFFERENCES BETWEEN ANXIETY AND DEPRESSION

ANXIETY	DEPRESSION
Predominantly fearful or apprehensive	Predominantly sad or hopeless with feelings of despair
Difficulty falling asleep (initial insomnia)	Early-morning awakening (late insomnia) or hypersomnia
	Diurnal variation (feels worse in the morning)
Phobic avoidance behavior	Slowed speech and thought processes
Rapid pulse and psychomotor hyperactivity	Psychomotor retardation (agitation also may occur)
Breathing disturbances	Delayed response time
Tremors and palpitations	
Sweating and hot or cold spells	
Faintness, lightheadedness, dizziness	
Depersonalization (feeling detached from one's body)	Inability to experience pleasure
Derealization (feeling that one's environment is strange, unreal, or unfamiliar)	Loss of interest in usual activities
Selective and specific negative appraisals that do not include all areas of life	Negative appraisals are pervasive, global, and exclusive
Sees some prospects for the future	Thoughts of death or suicide
	Sees the future as bleak and has given up all hope
Does not regard defects or mistakes as irrevocable	Regards mistakes as beyond redemption
Uncertain in negative evaluations	Absolute in negative evaluations
Predicts that only certain events may go badly	Global view that nothing will turn out right

lowering the anxiety level. Only after decreased anxiety has been achieved can additional progress be made. The reduced level of anxiety should be evident in a reduction of behaviors associated with severe or panic levels.

When these goals are met, the nurse can assume that the patient's level of anxiety has been reduced. The nurse may then develop new short-term goals directed toward insight or relaxation therapy. In addition, because anxiety is a subjective response, a useful measure would be to ask the patient to rate the level of anxiety from 1 to 10. Obtaining a rating of 2 or 3 might be another expected outcome.

Outcome indicators related to anxiety self-control from the Nursing Outcome Classification (NOC) project are presented in Box 15-7 (Moorhead et al, 2008).

BOX 15-7 NOC OUTCOME INDICATORS FOR ANXIETY SELF-CONTROL

- Monitors intensity of anxiety
- Eliminates precursors of anxiety
- Decreases environmental stimuli when anxious
- Seeks information to reduce anxiety
- Plans coping strategies for stressful situations
- Uses effective coping strategies
- Uses relaxation techniques to reduce anxiety
- Monitors duration of episodes
- Monitors length of time between episodes
- Maintains role performance
- Maintains social relationships
- Maintains concentration
- Monitors sensory perceptual distortions
- Maintains adequate sleep
- Monitors physical manifestations of anxiety
- Monitors behavioral manifestations of anxiety
- Controls anxiety response

NOC, Nursing outcomes classification.
From Moorhead S et al, editors: *Nursing outcomes classification (NOC),* ed 4, St Louis, 2008, Mosby.

PLANNING

Patients need to develop the ability to tolerate mild anxiety and use it consciously and constructively. In this way the self will become stronger and more integrated. As patients learn from these experiences, they will move on in their development.

Anxiety can be considered a war between the threat and the values people identify with their existence. Maladaptive behavior means that the struggle has been lost. The constructive approach to anxiety means that the struggle is won by the person's values. Thus a general nursing goal is to help patients develop sound values. This approach does not mean that patients assume the nurse's values. Rather, the nurse helps patients sort out their own values.

Anxiety can be an important factor in the patient's decision to seek treatment. Because anxiety is undesirable, the patient will seek ways to reduce it. If the patient's coping mechanism or symptom does not minimize anxiety, the motivation for treatment increases. In contrast, anxiety about the therapeutic process can delay or prevent the person from seeking treatment.

The patient should actively participate in planning treatment strategies. If the patient is actively involved in identifying relevant stressors and planning possible solutions, the success of the implementation phase will be maximized.

TABLE 15-4 SUMMARIZING EVIDENCE-BASED TREATMENT FOR *Anxiety Disorders*

DISORDER	TREATMENT
Generalized anxiety disorder (GAD)	The most successful psychological treatments for GAD combine relaxation, exercise, and cognitive therapy with the goal of bringing the worry process under the patient's control. The pharmacological treatments of choice are buspirone and antidepressants, including SSRIs and venlafaxine.
Obsessive-compulsive disorder (OCD)	Cognitive behavioral therapy involving exposure and ritual prevention is a well-established treatment for OCD in adults. SSRIs have been shown repeatedly to be efficacious in the treatment of OCD. Behavior therapy and perhaps cognitive therapy may be superior to medication with respect to risks, costs, and enduring benefit.
Panic disorder (PD) with or without agoraphobia	Situational in vivo exposure has been shown to be effective for patients with PD with moderate to severe agoraphobia. Cognitive behavioral treatments are effective for persons with panic disorder with no more than mild agoraphobia. These treatments focus on cognitive therapy, exposure to interoceptive sensations similar to physiological panic sensations, and breathing. SSRIs are now considered to be first-line pharmacological treatment for PD, affecting panic frequency, generalized anxiety, disability, and phobic avoidance.
Posttraumatic stress disorder (PTSD)	SSRIs are efficacious in reducing PTSD-specific symptoms and improving global outcome. Tricyclic antidepressants and MAOIs have also been found to be efficacious. Several past- and present-focused psychosocial treatments are effective. Past-focused treatments emphasize repeated exposure to the memories and emotions of the event in order to diminish their impact. Present-focused treatments teach coping skills to improve functioning.
Social phobia	The most common treatment approaches are social skills training, relaxation techniques, exposure-based methods, and multicomponent cognitive behavioral treatments, with the latter two attaining the highest levels of treatment efficacy. SSRIs are an attractive first-line treatment.
Specific phobias	The treatment of choice for specific phobias is exposure-based procedures, particularly in vivo exposure. In general, pharmacological treatments have not proved effective for specific phobias.

MAOIs, Monoamine oxidase inhibitors; *SSRIs,* selective serotonin reuptake inhibitors.
From Nathan P, Gorman J: *A guide to treatments that work*, ed 3, New York, 2007, Oxford University Press.

A patient in extreme anxiety initially will not be able to participate in the problem-solving process. However, as soon as anxiety is reduced, the nurse should encourage patient involvement. This participation reinforces the idea that patients are responsible for their own growth and personal development.

IMPLEMENTATION

Practice guidelines have been developed to treat a variety of anxiety disorders (American Psychiatric Association, 2007, 2009). **Empirically validated treatments for some of the medical diagnoses related to anxiety disorders are summarized in Table 15-4** (Nathan and Gorman, 2007).

Severe and Panic Levels of Anxiety

Establishing a Trusting Relationship. **To reduce the patient's level of anxiety, most nursing actions are purposely protective and supportive.** Initially nurses need to establish an open, trusting relationship. Nurses should actively listen to patients and encourage them to discuss their feelings of anxiety, hostility, guilt, and frustration. Nurses should answer patients' questions directly and offer unconditional acceptance. Their verbal and nonverbal communications should convey awareness and acceptance of patients' feelings.

Nurses should remain available and respect the patient's personal space. A 6-foot distance in a small room may create the optimum condition for openness and discussion of fears. The more this distance is increased or decreased, the more anxious the patient may become.

Nurses' Self-Awareness. Nurses' feelings are particularly important in working with highly anxious patients. They may find themselves feeling unsympathetic, impatient, and frustrated. These are common feelings of reciprocal anxiety. **If nurses are alert to the development of anxiety in themselves, they can learn from it and use it therapeutically.**

Nurses should be alert to the signs of anxiety in themselves, accept them, and attempt to explore their cause. The nurse may ask the following questions:

- What is threatening me?
- Have I failed to live up to what I imagine to be the patient's ideal?

- Am I comparing myself with a peer or another health professional?
- Is the patient's area of conflict one that I have not resolved in myself?
- Is my anxiety related to something that will or may happen in the future?
- Is my patient's conflict really one of my own that I am projecting?

If nurses deny their own anxiety, it can have detrimental effects on the nurse-patient relationship. Because of their own anxiety, nurses may be unable to differentiate among levels of anxiety in others. They also may transfer their fears and frustrations to patients, thus compounding their problems.

Nurses who are anxious arouse defenses in patients and other staff members that interfere with their therapeutic usefulness. **Nurses should strive to accept their patients' anxiety without becoming anxious themselves.** They can do this by continually clarifying their own feelings and role. This is seen in the following clinical example.

CLINICAL EXAMPLE

Ms. R was a 35-year-old married woman and mother of three children, ages 4, 6, and 9 years. She was a full-time homemaker and mother. Her husband was a salesperson and spent about 2 nights each week out of town. She came to the clinic complaining of severe headaches that "come on me very suddenly and are so terrible that I have to go to bed. The only thing that helps is for me to lie down in a dark and absolutely quiet room." She said that these headaches were becoming a real problem for everyone in the family, and her husband told her that she "just had to get over them and get things back to normal."

Mr. W, a psychiatric nurse, offered to see Ms. R in therapy weekly. After 3 weeks he was asked to present his evaluation, treatment plan, and progress report to the clinic staff at their weekly team conference. Mr. W began his presentation by stating, "This case is really tough. I'll start with the progress report and say that there is none because I can't seem to get past all the complaining this patient does!" He then went on to discuss his evaluation and treatment plan in depth. It became obvious to the other members of the staff that Mr. W saw his patient as a woman who was not living up to her roles and responsibilities. He defended Ms. R's husband even though the husband refused to come to the sessions with his wife. When one of the team members asked about a neurological and medication evaluation for Ms. R, the nurse replied, "Everyone gets headaches. I don't think we should reward or reinforce this woman's complaints."

In reviewing this case, the staff noted that Mr. W appeared to have problems relating empathetically to his patient because of her particular set of problems and some of his own values and perceptions. Mr. W agreed with this and said he had thought of asking someone else to work with Ms. R. Mr. W's supervisor observed that the nurse had had problems with this type of patient in the past and suggested that a more constructive approach would be to increase his supervision on this case, focusing on the dynamics between patient and nurse that were blocking learning and growth for both of them. Mr. W and his supervisor set a time when they could begin to meet for this purpose.

Critical Reasoning What clinical situations or patient problems raise your level of anxiety, and how do you deal with them.

Protecting the Patient. A major area of intervention is protecting patients and assuring patients of their safety. One way to decrease anxiety is by allowing patients to determine the amount of stress they can handle at the time. Nurses should not force severely anxious patients into situations they are not able to handle. Neither should they attack patients' coping mechanisms. Rather, nurses should attempt to protect patients' defenses.

The coping mechanism or symptom is attempting to deal with an unconscious conflict. Usually patients do not understand *why* the symptom has developed or *what* they are gaining from it. They know only that the symptom relieves some of the intolerable anxiety and tension. **Therefore, asking "why" questions of patients related to their behaviors or symptoms is not helpful.**

If patients are unable to release this anxiety, their tension mounts to the panic level, and they could lose control. **It also is important to remember that the severely anxious patient has not worked through the area of conflict and therefore has no alternatives or substitutes for present coping mechanisms.** This principle applies to severe levels of anxiety, such as are seen in obsessive-compulsive reactions, phobias, and panic attacks.

Nurses should not initially interfere with a patient's repetitive act or force patients to confront the avoided situation or phobic object. They should not attack or belittle the nature of the defense. Also, nurses should not attempt to argue with patients about it or reason them out of it. Patients need their coping mechanisms to keep anxiety within tolerable limits.

Neither should nurses reinforce the phobia, ritual, avoidance, or physical complaint by focusing attention on it and talking about it a great deal. With time, however, nurses can place some limits on patients' behavior and attempt to help them find satisfaction with other aspects of life.

Some nursing interventions can increase anxiety in severely anxious patients. These include pressuring the patient to change prematurely, being judgmental, verbally disapproving of the patient's behaviors, and asking the patient a direct question that brings on defensiveness. Focusing in a critical way on the patient's anxious feelings with others present, lacking awareness of one's own behaviors and feelings, and withdrawing from the patient also can be harmful.

Modifying the Environment. The nurse can work with the patient and others to identify anxiety-producing situations and attempt to reduce them. The nurse can set limits by assuming a quiet, calm manner and decreasing environmental

stimulation. Supportive physical measures such as warm baths, massages, or whirlpool baths also may be helpful in decreasing a patient's anxiety.

Encouraging Activity. The nurse needs to encourage the patient's interest in activities. This involvement limits the time available for destructive coping mechanisms and increases participation in and enjoyment of other aspects of life. The nurse might suggest physical activities, such as walking, a sport, or an active hobby. This form of physical exercise helps to relieve anxiety because it provides an emotional release and directs the patient's attention outward. Family members should be involved in the planning because they can be very supportive in setting limits and stimulating outside activity (Box 15-8).

Medication. **Benzodiazepines** and **antidepressants** are effective in the treatment of anxiety disorders (Table 15-5). Benzodiazepines have not been shown to be effective in the treatment of PTSD; SSRIs are the first-line and most frequently used treatment (Roman, 2010a). Detailed information on

BOX 15-8 A FAMILY SPEAKS

My daughter has obsessive-compulsive disorder (OCD). I didn't always know that, and I've spent many years of my life wondering what was wrong with her and if I were to blame. It's not easy living with someone who has an illness like that. At times it is just annoying. At other times it really makes you mad, and still other times you want to burst out laughing, but all that only makes it worse.

I think the one thing family members need from the mental health care system is for health care professionals to talk with them. The nurse who sees my daughter told me that I can call her with questions, and she explained all about OCD to my husband and me in great detail. Families want to help and support their members who are suffering, but how can we help if we don't know what to do? I used to try to physically stop my daughter from checking things. Then I told her how ridiculous it was. I even tried ignoring it for a while. How was I supposed to know what to do? Things are different now. We've all learned about this illness and how we can best help our daughter. After all, that's all we ever really wanted.

TABLE 15-5 ANTIANXIETY DRUGS

GENERIC NAME (TRADE NAME)	USUAL DOSAGE RANGE (mg/day)
Antianxiety Drugs	
Benzodiazepines	
Alprazolam (Xanax)	1-4
Chlordiazepoxide (Librium)	10-40
Clonazepam (Klonopin)	0.5-10
Clorazepate (Tranxene)	10-40
Diazepam (Valium)	2-40
Halazepam (Paxipam)	60-160
Lorazepam (Ativan)	1-6
Meprobamate (Miltown)	1200-1600
Oxazepam (Serax)	15-120
Pregabalin (Lyrica)	50-600
Antihistamines	
Diphenhydramine (Benadryl)	50
Hydroxyzine (Atarax, Vistaril)	100-300
Noradrenergic Agents	
Clonidine (Catapres)	0.2-0.6
Propranolol (Inderal)	6-160
Anxiolytic	
Buspirone (BuSpar)	15-60
Antidepressant/Antianxiety Drugs	
Selective Serotonin Reuptake Inhibitors	
Citalopram (Celexa)	20-60
Escitalopram (Lexapro)	10-20
Fluoxetine (Prozac)	20-60
Fluvoxamine (Luvox)	100-200
Fluvoxamine maleate (Luvox CR)	100-300
Paroxetine (Paxil)	20-50
Sertraline (Zoloft)	50-200
Other Newer Antidepressants	
Bupropion (Wellbutrin)	150-450*
Duloxetine (Cymbalta)	30-120
Maprotiline (Ludiomil)	50-200*
Mirtazapine (Remeron)	15-45
Nefazodone (Serzone)	300-500
Trazodone (Desyrel)	150-300
Venlafaxine (Effexor)	75-375
Vilazodone (Viibryd)	10-40
Tricyclic Antidepressants	
Amitriptyline (Elavil)	50-300
Amoxapine (Asendin)	200-300
Clomipramine (Anafranil)	100-250
Desipramine (Norpramin)	50-300
Doxepin (Sinequan)	25-150
Imipramine (Tofranil)	50-300
Nortriptyline (Pamelor)	50-150
Protriptyline (Vivactil)	15-60
Trimipramine (Surmontil)	150-300
Monoamine Oxidase Inhibitors (MAOIs)	
Isocarboxazid (Marplan)	10-60
Phenelzine (Nardil)	45-90
Selegiline (Eldepryl)	10-50
Selegiline (Emsam)	6-12
Tranylcypromine (Parnate)	20-60

*Antidepressants with a ceiling dose because of dose-related seizures.

antianxiety medications is presented in Chapter 26. The goals of pharmacological treatment are to do the following:

- Reduce core symptoms.
- Improve functioning.
- Strengthen resilience.
- Relieve comorbid symptoms.
- Prevent relapse.

QUALITY AND SAFETY ALERT

- The use of benzodiazepines in combination with alcohol may result in a serious or even fatal sedative reaction.
- Other potential dangers of benzodiazepines include withdrawal syndrome side effects and addiction.

Prescription anxiety medications have great clinical efficacy, but their nonmedical use has increased. Such use can be dangerous and even fatal. Therefore the nonmedical use of these drugs is a growing and important public health problem (Fenton et al, 2010).

Although some patients may need to take antianxiety drugs for extended periods, these drugs should always be used together with psychosocial treatments (Roy-Byrne et al, 2010). Medication is not a substitute for an ongoing therapeutic relationship, but it can enhance the therapeutic alliance. Chemical control of painful symptoms allows the patient to direct attention to the conflicts underlying the anxiety.

The Nursing Treatment Plan Summary (Table 15-6) reviews interventions related to severe and panic levels of anxiety.

Moderate Levels of Anxiety

The nursing interventions previously described are supportive and directed toward the short-term goal of reducing severe- or panic-level anxiety. After the patient's anxiety has been reduced to a moderate level, the nurse can begin helping with problem-solving efforts to cope with the stress.

TABLE 15-6 NURSING TREATMENT PLAN SUMMARY

Severe and Panic Anxiety Responses

Nursing Diagnosis: Severe/panic level anxiety

Expected Outcome: The patient will reduce anxiety to a moderate or mild level.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will be protected from harm.	Initially accept and support, rather than attack, the patient's defenses. Do not ask the patient why the symptoms exist. Acknowledge the reality of the pain associated with the patient's present coping mechanisms. Do not focus on the phobia, ritual, or physical complaint itself. Give feedback to the patient about behavior, stressors, appraisal of stressors, and coping resources. Reinforce the idea that physical health is related to emotional health and that this is an area that will need exploration. In time, begin to place limits on the patient's maladaptive behavior in a supportive way.	Severe and panic levels of anxiety can be reduced by initially allowing the patient to determine the amount of stress that can be handled. If the patient is unable to release anxiety, tension may mount to the panic level and the patient may lose control. At this time the patient has no alternative coping mechanisms.
The patient will experience fewer anxiety-provoking situations.	Assume a calm manner with the patient. Decrease environmental stimulation. Limit the patient's interaction with other patients to minimize the contagious aspects of anxiety. Identify and modify anxiety-provoking situations for the patient. Administer supportive physical measures, such as warm baths and massages.	The patient's behavior may be modified by altering the environment and the patient's interaction with it.
The patient will engage in a daily schedule of activities.	Initially share an activity with the patient to provide support and reinforce socially productive behavior. Provide for physical exercise of some type. Plan a schedule or list of activities that can be carried out daily. Involve family members and other support systems as much as possible.	By encouraging outside activities, the nurse limits the time the patient has available for destructive coping mechanisms while increasing participation in and enjoyment of other aspects of life.
The patient will experience relief from the symptoms of severe anxiety.	Administer medications that help reduce the patient's discomfort. Observe for medication side effects, and initiate relevant health teaching.	The effect of a therapeutic relationship may be enhanced if the chemical control of symptoms allows the patient to direct attention to underlying conflicts.

Goals now focus on helping the patient understand the cause of the anxiety and learn new ways of controlling it. **Goals for a moderate level of anxiety focus on recognizing and gaining insight into the anxiety and learning new, adaptive coping behaviors.** They include the variety of behavior change strategies discussed in Chapter 27. These strategies can be implemented in any setting—psychiatric, community, home, or general hospital.

Psychoeducation. Education is important in promoting the patient's adaptive responses to anxiety. The nurse can identify the health teaching needs of each patient and then formulate a plan to meet those needs.

Plans should be designed to increase patients' knowledge of their own predisposing and precipitating stressors, coping resources, and adaptive and maladaptive responses. Alternative coping strategies can be identified and explored. Health teaching also should address the beneficial aspects of mild levels of anxiety in motivating learning and producing growth and creativity.

Specifically, patients can be told that anxiety disorders are related to the normal fight-or-flight response, which is important to survival. The nurse also can explain that anxiety disorders are a result of genetic vulnerability and a person's reactions to life's stressors. Most importantly, **patients should be told that anxiety disorders can be successfully treated by a variety of evidence-based treatments.** This information can give patients a sense of control over anxiety's seemingly uncontrollable and debilitating effects.

Recognition of Anxiety. After analyzing the patient's behaviors and determining the level of anxiety, the nurse helps the patient recognize anxiety by exploring underlying feelings with questions such as "Are you feeling anxious now?" or "Are you uncomfortable?"

It is helpful for the nurse to identify the patient's behavior and link it to the feeling of anxiety (e.g., "I noticed you have been tapping your foot since we started talking about your sister. Are you feeling anxious?"). In this way the nurse acknowledges the patient's feeling, attempts to label it, encourages the patient to describe it further, and relates it to a specific behavioral pattern. The nurse is also validating inferences and assumptions with the patient.

However, the patient's goal is often to avoid or deny anxiety, and the patient may use any of the resistive approaches described in Box 15-9. All these approaches may create feelings of frustration, irritation, or reciprocal anxiety in the nurse, who must recognize personal feelings and identify the patient's behavior pattern that might be causing them.

At this time a trusting relationship is very important. Nurses who establish themselves as warm, responsive listeners; give the patient adequate time to respond; and support the patient's self-expression will become less threatening.

In helping patients recognize their anxiety, nurses should use open-ended questions that move from nonthreatening topics to central issues of conflict. In time, supportive confrontation may be used to address a particularly resistive pattern. However, if the patient's level of anxiety begins to rise rapidly, the nurse might choose to refocus the discussion to another topic.

Insight into the Anxiety. **Once the patient is able to recognize anxiety, the nurse can help the patient gain insight by asking him to describe the situations, interactions, and thoughts that immediately precede the increase in anxiety.** Together the nurse and patient make inferences about the precipitating causes or biopsychosocial stressors.

The nurse then helps the patient see which values are being threatened by linking the threat with underlying causes, analyzing how the conflict developed, and relating the patient's

BOX 15-9 PATIENT RESISTANCES TO RECOGNIZING ANXIETY

Screen symptoms. The patient focuses attention on minor physical ailments to avoid acknowledging anxiety and conflict areas.

Superior status position. The patient attempts to control the interview by questioning the nurse's abilities or asserting the superiority of the patient's knowledge or experiences. The nurse should not respond emotionally to this approach or accept the patient's challenge and compete, because this would only further avoid the issue of anxiety.

Emotional seduction. The patient attempts to manipulate the nurse and elicit pity or sympathy.

Superficiality. The patient relates on a surface level and resists the nurse's attempts to explore underlying feelings or analyze issues.

Circumlocution. The patient gives the pretense of answering questions but actually talks around the topic to avoid it.

Amnesia. This is a type of purposeful forgetting of an incident to avoid confronting and exploring it with the nurse.

Denial. The patient may use this approach only when discussing significant issues with the nurse or may generalize denial to all others, including self. The purpose is often to avoid humiliation.

Intellectualization. Patients who use this technique usually have some knowledge of psychology or medicine. They are able to express appropriate insights and analysis yet lack personal involvement in the problem they describe. They are not actually participating in the problem-solving process.

Hostility. The patient believes that offense is the best defense and therefore relates to others in an aggressive, defiant manner. The greatest danger in this situation is that the nurse will take this behavior personally and respond with anger. This reinforces the patient's avoidance of anxiety.

Withdrawal. The patient may resist the nurse by replying in vague, diffuse, indefinite, and remote ways.

present experiences to past ones. It is also important to explore how the patient reduced anxiety in the past and what kinds of actions produced relief.

Coping with the Threat. If previous coping responses have been adaptive and constructive, the patient should be encouraged to use them. If not, the nurse can point out ways in which they have not been helpful and have instead contributed to the unsatisfactory and distressing aspects of the patient's life. **Most of all, the patient needs to assume responsibility for his own decisions and actions.** Other people must not be blamed.

In this phase of intervention the nurse assumes an active role by interpreting, analyzing, confronting, and identifying cause-and-effect relationships. The nurse should proceed clearly so that the patient can follow while keeping anxiety within appropriate limits.

The nurse can help the patient in problem-solving efforts using a variety of cognitive and behavioral strategies. Cognitive behavioral therapy (CBT) has been shown to be most effective in treating anxiety disorders, including PTSD (Yadin and Foa, 2009; Cloitre et al, 2010; Roman, 2010b). These treatments include a number of therapeutic strategies, which can be divided into two groups:

- **Cognitive restructuring**
- **Learning new behavior**

Trauma-focused CBT within 3 months of a traumatic event can be effective for individuals with traumatic stress symptoms (Roberts et al, 2009). The specific strategies for each group are listed in Box 15-10. They are explained in detail in Chapter 27.

One way of helping the patient cope is to reevaluate the nature of the threat or stressor. Is it as bad as the patient perceives it? Is the cognitive appraisal realistic? Together the nurse and patient might discuss fears and feelings of inadequacy. Does the patient fear that others are as critical, perfectionistic, and rejecting as the patient is of others? Is the conflict based in reality, or is it the result of unvalidated, isolated, and distorted thinking? By sharing fears with family members, peers, and staff, the patient often gains insight into such misperceptions.

Another approach is to help the patient modify behavior and learn new ways of coping with stress. The nurse may act as a role model or engage the patient in role playing. This activity can decrease anxiety about new responses to problem situations.

Yet another nursing intervention is to teach the patient how aspects of mild anxiety can be constructive and produce growth. Physical activity should be encouraged as a way to discharge anxiety. Interpersonal resources such as family members or close friends should be incorporated into the nursing plan of care to provide the patient with support.

Often the cause for anxiety arises from a relationship problem. In such cases it is helpful to include the people involved when analyzing the situation with the patient. In this way, cause-and-effect relationships are more open to examination.

BOX 15-10 COGNITIVE BEHAVIORAL TREATMENT STRATEGIES FOR ANXIETY DISORDERS

Cognitive Restructuring

Monitoring thoughts and feelings
Questioning the evidence
Examining alternatives
"Decatastrophizing"
Reframing
Thought stopping

Learning New Behavior

Behavioral activation
Modeling
Shaping
Token economy
Role playing
Social skills training
Aversion therapy
Contingency contracting

Coping patterns can be examined in light of their effect on others as well as on the patient.

Working through this problem-solving or reeducative process with the patient takes time. It has to be accepted both intellectually and emotionally. Breaking previous behavioral patterns can be difficult. Nurses must be patient and consistent and continually reappraise their own anxiety.

Relaxation Training. In addition to problem solving, one also can cope with stress by regulating the emotional distress associated with it. **Long-term goals directed toward helping the patient regulate emotional distress include promoting the relaxation response.**

As a therapeutic tool, **relaxation training** effectively decreases tension and anxiety. It can be used alone, in combination with other cognitive behavioral techniques, or in addition to supportive or insight therapy. **The basic premise is that muscle tension is related to anxiety. If tense muscles can be made to relax, anxiety will be reduced.**

All relaxation procedures involve rhythmic breathing, reduced muscle tension, and an altered state of consciousness. Individual differences exist in the experience of relaxation. Not everyone demonstrates all the characteristics of a relaxed physiological state. The physiological, cognitive, and behavioral signs of relaxation are listed in Box 15-11.

Systematic relaxation training involves tensing and relaxing voluntary muscles in an orderly sequence until the body, as a whole, is relaxed. For this technique the patient should be seated in a comfortable chair. Soft music or pleasant visual cues may be present. Before the exercises are begun, a brief explanation should be given about how anxiety is related to muscle tension. The relaxation procedure also should be described.

The patient begins by taking a deep breath and exhaling slowly. This is followed by a sequence of tension-relaxation

BOX 15-11 INDICATORS OF RELAXATION

Physiological
Decreased pulse
Decreased blood pressure
Decreased respirations
Decreased oxygen consumption
Decreased metabolic rate
Pupil constriction
Peripheral vasodilation
Increased peripheral temperature

Cognitive
Altered state of consciousness
Heightened concentration on single mental image
Receptivity to positive suggestion

Behavioral
Lack of attention to and concern for environmental stimuli
No verbal interaction
No voluntary change of position
Passive movement easy

exercises beginning with the hands and ending with the feet. The patient is instructed to tense each muscle group for approximately 10 seconds while the nurse describes how tense and uncomfortable this body part feels. The nurse then asks the patient to relax this muscle group as the nurse comments, "Notice how all the hardness and tension are draining from your hands. Now notice how they feel—warm, soft, and calm. Compare this feeling with when they were tense and see how much better they feel now." The patient should be reminded to tense only the muscle group named. The patient then proceeds to the next muscle group in the sequence listed in Box 15-12.

The final exercise asks the patient to become completely relaxed, beginning with the toes and moving up through the body to the eyes and forehead. Once the patient has learned the procedure, these exercises can be performed only for the muscles that usually become tense. This is different for each person and may include the shoulders, forehead, back, or neck. Patients may also eliminate the tensing exercises and perform only the relaxation ones.

Meditation also may be used to evoke the relaxation response. It may follow or replace systematic relaxation. The basic components for meditation include the following:

- A quiet environment
- A passive attitude
- A comfortable position
- A word or scene to focus on

The first three components are necessary for any relaxation procedure. The fourth component refers to **visualization**—the process in which the patient selects a cue word or scene with pleasant connotations. The nurse then instructs the patient to close both eyes, relax each of the major muscle groups, and begin repeating the word silently at each exhalation.

BOX 15-12 SEQUENCE OF PROGRESSIVE MUSCLE RELAXATION

Hands. First the fists are tensed and relaxed, and then the fingers are extended and relaxed.
Biceps and triceps. These are tensed and relaxed.
Shoulders. They are pulled back and relaxed and then pushed forward and relaxed.
Neck. The head is turned slowly as far to the right as possible and relaxed; then it is turned to the left and relaxed. It is then brought forward until the chin touches the chest and relaxed.
Mouth. The mouth is opened as wide as possible and then relaxed. The lips form a pout and then relax. The tongue is extended out as far as possible and then relaxed; then it is retracted into the throat and then relaxed. It is pressed hard into the roof of the mouth and relaxed; then it is pressed hard into the floor of the mouth and relaxed.
Eyes. They are opened as wide as possible and relaxed and then closed as hard as possible and relaxed.
Breathing. The patient inhales as deeply as possible and relaxes and then exhales as much as possible and relaxes.
Back. The trunk of the body is pushed forward so that the entire back is arched and then relaxed.
Midsection. The buttock muscles are tensed and then relaxed.
Thighs. The legs are extended and raised approximately 6 inches off the floor and then relaxed. The backs of the feet are pressed into the floor and relaxed.
Stomach. It is pulled in as much as possible and relaxed; then it is extended and relaxed.
Calves and feet. With legs supported, the feet are bent with the toes pointing toward the head and then relaxed. Feet are then bent in the opposite direction and relaxed.
Toes. The toes are pressed into the bottom of the shoes and relaxed. They are then bent to touch the top inside of the shoes and relaxed.

Other relaxation techniques include guided imagery, centering, mindful meditation, and focusing. Although each of these approaches varies slightly, the intent of all of them is to use the mind to get in touch with the inner self. As such, they have been found to promote relaxation, enhance sleep, reduce pain, and increase creativity.

Relaxation can be taught individually, in small groups, or in large-group settings. A Patient Education Plan for teaching the relaxation response is presented in Table 15-7. It is within the scope of nursing practice, requires no special equipment, and does not need a physician's supervision.

As a group of interventions, relaxation can be implemented in various settings. A major benefit for patients is that after several training sessions, they can practice the techniques on their own. This puts the control in their hands and increases their self-reliance.

Biofeedback. Biofeedback uses a machine to reduce anxiety and modify behavioral responses. Small electrodes connected to the biofeedback equipment are attached to the patient's

TABLE 15-7 PATIENT EDUCATION PLAN

The Relaxation Response

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Describe the characteristics and benefits of relaxation.	Discuss physiological changes associated with relaxation, and contrast these with the behaviors of anxiety.	Patient identifies own responses to anxiety. Patient describes elements of a relaxed state.
Teach deep muscle relaxation through a sequence of tension-relaxation exercises.	Engage the patient in the progressive procedure of tensing and relaxing voluntary muscles until the body as a whole is relaxed.	Patient is able to tense and relax all muscle groups. Patient identifies muscles that become particularly tense.
Discuss the relaxation procedure of meditation and its components.	Describe the elements of meditation, and help the patient use this technique.	Patient selects a word or scene with pleasant connotations and engages in relaxed meditation. Patient identifies and ranks anxiety-provoking situations.
Help patient overcome anxiety-provoking situations through systematic desensitization.	With patient, construct a hierarchy of anxiety-provoking situations or scenes. Through imagination or reality, work through these scenes using relaxation techniques.	Patient exposes self to these situations while remaining in a relaxed state.
Allow the rehearsing and practical use of relaxation in a safe environment.	Role play stressful situations with the nurse or other patients.	Patient becomes more comfortable with new behavior in a safe, supportive setting.
Encourage patient to use relaxation techniques in life.	Assign homework of using the relaxation response in everyday experiences.	Support success of patient. Patient uses relaxation response in life situations. Patient is able to regulate anxiety response through use of relaxation techniques.

forehead. Brain waves, muscle tension, body temperature, heart rate, and blood pressure can then be monitored for small changes. These changes are communicated to the patient by auditory and visual means.

The more relaxed the patient becomes, the more pleasant are the sounds or sights presented. These pleasant sights and sounds stop when the patient stops relaxing, and they resume when the patient again achieves the relaxed state. After developing the ability to relax, the patient is encouraged to apply the technique during stressful situations.

Systematic Desensitization. **Systematic desensitization** was designed to decrease the avoidance behavior linked to a specific stimulus (e.g., heights, airplane travel). The goal of systematic desensitization is to help the patient change the response to a threatening stimulus. It involves combining deep muscle relaxation with imagined scenes of situations that cause anxiety.

The assumption is that relaxation is incompatible with anxiety. Therefore if the person is taught to relax while imagining such scenes, the real-life situation depicted by the scene will cause much less anxiety.

With systematic desensitization the patient must first be able to relax the muscles. Next, a hierarchy of the anxiety-provoking or feared situations is constructed. These situations are ranked from 1 to 10 in order of difficulty, with 1 evoking little or no anxiety and 10 evoking intense or severe anxiety. Box 15-13 presents a sample hierarchy for a patient with agoraphobia.

With ***in vitro***, or **imagined desensitization,** the patient proceeds with the imagined pairing of the hierarchy items with the relaxed state, progressing from the least anxiety-provoking item to the most anxiety-provoking item. ***In vivo* desensitization exposes the patient to real-life situations** rather than imagined ones. ***In vivo* exposure is widely considered to be the treatment of choice for simple and social phobias and for obsessive-compulsive disorders.**

This technique works through a combination of positive reinforcement for confronting anxiety-provoking stimuli and the extinction of maladaptive behavior that occurs when it is realized that the feared negative consequences never happened. It is helpful for the nurse to share the following thoughts with the patient during exposure therapy:

- Anxiety is unpleasant but is not dangerous; that is, the patient will not die or lose control.
- Anxiety does eventually decrease and does not continue indefinitely.
- Practice makes perfect; the more the patient repeats a particular exposure exercise, the easier it becomes.

For example, a boy may have a fear of spiders. His daily schedule may include a series of planned activities involving reading about spiders. He may then begin gradual exposure to pictures and photographs of spiders, followed by

BOX 15-13 SAMPLE PATIENT HIERARCHY FOR PHOBIAS

A hierarchy of phobias is a list of your fears and avoidances in order of severity. Your greatest phobia should be at the top of the list and your smallest fear at the bottom. In between, rank your other fears and phobias in order of severity. Try to list 10, but not more than 20, phobias. These activities should be convenient to do, because you will be doing them from several times per day to at least several times per week.

For example, think of yourself standing at the end of a football field marked off in 10-yard lines. Closest to you, at the 0-yard line, is something you are mildly fearful of or avoid doing sometimes but not always; the farthest end of the field is your biggest fear; at the 50-yard line is a medium fear; and on the 10-yard line is a minor fear but one that is stronger than at the 0-yard line.

Remember that everyone's hierarchy will be different. There are no "right" or "wrong" hierarchies. Your hierarchy is a tool to help you approach feared situations in a systematic and controlled way.

Sample Hierarchy

100 Driving alone across a high bridge in the rain
90 Driving alone on the interstate far from home
80 Driving alone on side streets that are unfamiliar
70 Speaking in front of groups of people
60 Using elevators alone
50 Eating in restaurants alone
40 Going to large public gatherings with safe people
30 Eating with friends or family in familiar restaurants
20 Driving more than several miles from home with a passenger in the car
10 Going shopping with a safe person in big stores and malls
0 Going shopping with a safe person in small stores near home

looking at real spiders in his yard. The progressive exposure gradually leads to anxiety reduction and more adaptive behaviors.

Critical Reasoning Do you think a highly anxious nurse can effectively implement anxiety-reduction strategies with patients? Why or why not?

A Nursing Treatment Plan Summary for patients with moderate anxiety is presented in Table 15-8.

EVALUATION

Even before beginning to formulate the nursing diagnosis, the nurse should ask, "Did I accurately observe my patient's behaviors? Did I listen to my patient's subjective description of anxiety? Did I fail to see the relationships between my patient's expressed hostility or guilt and underlying anxiety? Did I assess intellectual and social functioning?"

After collecting the data, the nurse should analyze them: "Was I able to identify the precipitating stressor for the patient? What was the patient's perception of the threat? How was this influenced by physical health, past experiences, and present feelings and needs? Did I correctly identify the patient's level of anxiety and validate it?"

Other questions also can be raised:

- Were the planning, implementation, and evaluation mutual?
- Were goals and actions adequate in number and specific enough to minimize the patient's level of anxiety?
- Were maladaptive responses reduced?
- Were new adaptive coping responses learned?
- Was the nurse accepting of the patient and able to monitor personal anxiety throughout the relationship?

The nurse should identify personal strengths and limitations in working with the anxious patient. Plans may then be made for overcoming the areas of limitation and further improving nursing care.

TABLE 15-8 NURSING TREATMENT PLAN SUMMARY

Moderate Anxiety Responses

Nursing Diagnosis: Moderate level of anxiety

Expected Outcome: The patient will demonstrate adaptive ways of coping with stress.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will identify and describe feelings of anxiety.	Help the patient identify and describe underlying feelings. Link the patient's behavior with such feelings. Validate all inferences and assumptions with the patient. Use open questions to move from nonthreatening topics to issues of conflict. In time, supportive confrontation may be used judiciously.	To adopt new coping responses, the patient first needs to be aware of feelings and to overcome conscious or unconscious denial and resistance.
The patient will identify antecedents of anxiety.	Help the patient describe the situations and interactions that immediately precede anxiety. Review the patient's appraisal of the stressor, values being threatened, and the way in which the conflict developed. Relate the patient's present experiences with relevant ones from the past.	Once feelings of anxiety are recognized, the patient needs to understand their development, including precipitating stressors, appraisal of the stressors, and available resources.
The patient will describe adaptive and maladaptive coping responses.	Explore how the patient reduced anxiety in the past and what kinds of actions produced relief. Point out the maladaptive and destructive effects of present coping responses. Encourage the patient to use adaptive coping responses that were effective in the past. Focus responsibility for change on the patient. Actively help the patient correlate cause-and-effect relationships while maintaining anxiety within appropriate limits. Help the patient reappraise the value, nature, and meaning of the stressor when appropriate.	New adaptive coping responses can be learned through analyzing coping mechanisms used in the past, reappraising the stressor, using available resources, and accepting responsibility for change.
The patient will implement two adaptive responses for coping with anxiety.	Help the patient identify ways to restructure thoughts, modify behavior, use resources, and test new coping responses. Encourage physical activity to discharge energy. Include significant others as resources and social supports in helping the patient learn new coping responses. Teach the patient relaxation exercises to increase control and self-reliance and reduce stress.	One also can cope with stress by regulating the emotional distress that accompanies it through the use of stress management techniques.

LEARNING FROM A CLINICAL CASE OUTCOME

1. What are the stressors that led to his current condition?

This man made a business error and lost money on a contracting job. This started a spiral of negative events that saw the loss of his employees, the creation of a competing business, and a threat to his financial livelihood.

2. What medical and nursing diagnoses do his symptoms suggest?

His primary medical diagnosis would be panic disorder with agoraphobia. The nursing diagnoses would include Coping, ineffective; Role performance, ineffective; and Self-esteem, situational low.

3. What comorbidity has he developed?

He has a comorbid substance use problem. His drinking likely started in an attempt to deal with his overwhelming anxiety.

4. What neurotransmitters might be involved in his behavioral responses?

The three neurotransmitters that may be involved are gamma-aminobutyric acid (GABA), norepinephrine (NE), and serotonin (5-HT).

5. Which medications do you think would be helpful to him? Which ones should be avoided and why?

SSRIs are typically the first line of treatment for panic disorder. Paxil, Lexapro, Zoloft, and Celexa are several that are effective. Because he is abusing alcohol, the use of benzodiazepines should be avoided; they are addictive and could further complicate his health status.

6. What types of education do he and his wife need?

He and his wife need to be educated about how stress and coping mechanisms impact their health. He needs to learn the

LEARNING FROM A CLINICAL CASE OUTCOME—cont'd

relaxation response, engage in regular exercise, review his cognitive distortions, and consider alternatives. Together they need to agree on their marital goals and expectations and proactively address issues related to his business.

Case Outcome

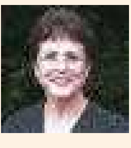
When he was diagnosed with panic disorder with agoraphobia he was started on Paxil. However he developed sexual dysfunction and was changed to Zoloft. His sexual functioning returned. He started walking every day, stopped drinking during the week as his wife requested, and drank only 2 beers a night on the weekends. He was not given benzodiazepines because of his alcohol misuse.

During therapy he realized that the responsibility for his crew's financial well-being was too stressful for him, and his wife supported his need for a change. He became trained as a locksmith and started his own locksmith business. On his last visit he reported that he had gotten a contract with the local college for being their locksmith and now felt more financially secure. He continues on his SSRI, and his panic attacks have not returned.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Madelyn Myers, MSN, RN, PMH-NP



As the night shift charge nurse on an adult psychiatric unit, I learned that the graveyard shift was anything but routine. On return to the unit after my days off, I was told that Mr. B's behavior had deteriorated in the last few days. Mr. B was a 68-year-old man admitted for cognitive deficits secondary to alcohol abuse. He was unable to stay in bed for more than a few minutes at a time, and he was at risk for falls because of his confusion and as a side effect of his tranquilizing medication. On the previous nights the staff had found it necessary to contain Mr. B with soft restraints to keep him in bed and reduce his risk of falling.

After shift report I made my nursing rounds, accounting for all patients and assessing the situation of the unit. Mr. B was obviously distraught and anxious. His first question to me was, "You're not going to rope me, are you?" I sat down to talk with Mr. B to reassure him and explain that it was time for him to get ready for bed. He refused to change his clothing, stating that he just needed to walk around a little longer. I asked the therapeutic assistants if they would walk him around a while longer to try calming him down. I went to the office to start verifying the day's orders, but I found it impossible to get much done because Mr. B was calling me and coming to the nursing office to ask questions very frequently. The staff members were also getting frustrated because he seemed very tired but would sit down for only a few minutes before jumping up again.

After I did a few more tasks, I relieved the staff member. I was able to get Mr. B to lie down on his bed only after he saw me take the posey off the bed and out of the room. I watched him as he lay down and he seemed to doze off to sleep almost immediately. Then again just as quickly he awoke and started out of bed. He said, "Something is very wrong with me—I'm afraid I might die." We discussed his anxiety, and I reassured him that one of the staff would sit with him if that would make him feel more secure. He nodded in agreement. I sat by his bedside. He fell asleep immediately and again repeated his previous pattern of awakening with a start, but this time he just looked over, saw me, and returned to sleep.

A short while later, one of the other staff members came to relieve me. I shared with her my concern that Mr. B had been quite anxious and that my plan was to sit at his bedside and gradually move the chair back until we were sitting just outside his room but still in his line of sight. This way, he would be reassured that staff were still close by, and we could observe him if he tried to get out of bed. That night he actually slept 4 hours with only two brief awakenings. The previous nights he had only dozed for minutes at a time.

The next morning I spoke with the nurse on his team about his fear of dying and of being "roped" with the posey. I shared with her the strategy we used of sitting with him and how he was able to sleep when we stayed nearby. The new plan of care was placed in his chart for all to follow. The next few nights we continued with our plan, and each night Mr. B slept a little longer. He would even change into his pajamas before bed. He no longer started to "escalate" at bedtime. As he was sleeping better, Mr. B was also feeling better physically, and his anxiety level decreased dramatically. He required less medication for his anxiety; thus he was much more stable on his feet and no longer at risk for falls. Mr. B's ability to perform his activities of daily living increased over the next week, and he was able to return to his previous living situation.

Many of his symptoms seemed to have been from sleep deprivation, high levels of anxiety, and the untoward effects of tranquilizers. This rewarding experience was not an isolated event on the night shift. It seems that many people sleep through the night and see only the shadows of the staff making rounds, but there are others for whom the care they receive during these darkened hours makes a critical difference.

CHAPTER IN REVIEW

- Anxiety disorders are the most common psychiatric disorders in the United States, affecting between 15% and 25% of the population. Anxiety is a vague sense of apprehension accompanied by feelings of uncertainty, helplessness, isolation, and insecurity. It is an emotion without a specific object, a subjective individual experience, and an energy that cannot be observed directly. Anxiety is communicated interpersonally.
- Anxiety is about self-preservation. Anxiety occurs as a result of a threat to a person's selfhood, self-esteem, or identity.
- Mild and moderate levels of anxiety heighten the person's capacities, whereas severe and panic levels paralyze or overwork capacities. A panic level of anxiety can be life threatening.
- Anxiety can be expressed directly through physiological and behavioral changes or indirectly through cognitive and affective responses, including the formation of symptoms or coping mechanisms developed as a defense against anxiety.
- Behavioral changes with anxiety are most often the result of a sympathetic (flight-or-fight) reaction of the autonomic nervous system.
- Anxiety is a prime factor in the development of the personality and formation of individual character traits. Predisposing factors for anxiety responses can be explained by biological, familial, psychological, and behavioral perspectives.
- The regulation of anxiety is related to the activity of the neurotransmitter gamma-aminobutyric acid (GABA), which controls the activity, or firing rates, of neurons in the parts of the brain responsible for producing anxiety. These are the limbic system, which is an area thought to be of central importance for emotional behavior, and the locus ceruleus, which is the primary manufacturing center of norepinephrine, an excitatory neurotransmitter.
- Both benzodiazepines and antidepressant drugs are effective, indicating that these disorders may involve additional alterations in synaptic functioning in the norepinephrine and serotonin pathways in the brain. Inflammatory actions of the immune system may also be involved.
- Anxiety disorders run in families, but no single gene has been identified due to the critical role that environment plays in interacting with genetic vulnerability.
- The most important psychological trait is resilience to stress. Resilience is associated with a number of protective psychosocial factors including active coping style, positive outlook, interpersonal relatedness, moral compass, social support, role models, and cognitive flexibility.
- Experiencing or witnessing trauma has been associated with a variety of anxiety disorders, particularly posttraumatic stress disorder (PTSD).
- Precipitating stressors include threats to physical integrity and threats to one's self-system that imply harm to one's identity, self-esteem, and integrated social functioning.
- Coping mechanisms can be problem- or task-focused, or they can be emotion- or ego-focused. Problem-focused reactions are thoughtful, deliberate attempts to solve problems, resolve conflicts, and gratify needs; they include attack, withdrawal, and compromise. Emotion- or ego-focused reactions are defense mechanisms used to protect the self. They can be constructive or destructive in nature.
- Initially the nurse needs to determine the quality and quantity of the anxiety experienced by the patient. The nurse also needs to explore how the patient is coping with the anxiety and then the overall effect of the anxiety.
- Primary NANDA-I diagnoses related to anxiety responses are Anxiety, Ineffective coping, Readiness for enhanced coping, and Fear.
- Medical diagnoses are categorized as anxiety disorders. These psychiatric disorders include panic disorder with or without agoraphobia, agoraphobia, specific phobia, social phobia, obsessive-compulsive disorder, PTSD, acute stress disorder, and generalized anxiety disorder.
- *Neurosis* describes a mental disorder characterized by anxiety that involves no distortion of reality. Neurotic disorders are maladaptive anxiety responses associated with moderate and severe levels of anxiety. Psychosis is disintegrative and involves a significant distortion of reality. It can emerge with the panic level of anxiety.
- The expected outcome of nursing care for patients with maladaptive anxiety responses is that the patient will demonstrate adaptive ways of coping with stress.
- Patients need to develop the capacity to tolerate mild anxiety and to use it consciously and constructively. Anxiety can be an important factor in the patient's decision to seek treatment.
- Nursing interventions in severe and panic levels of anxiety include establishing a trusting relationship, self-awareness, protecting the patient, modifying the environment, encouraging activity, and medication.
- Benzodiazepines and antidepressants are effective in the treatment of anxiety disorders. Benzodiazepines have not been shown to be effective in the treatment of PTSD.
- Nursing interventions in a moderate level of anxiety include education, recognizing anxiety, developing insight into the anxiety, learning new ways to cope, relaxation training, biofeedback, and systematic desensitization.
- The nurse should use the criteria of adequacy, effectiveness, appropriateness, efficiency, and flexibility in evaluating nursing care.

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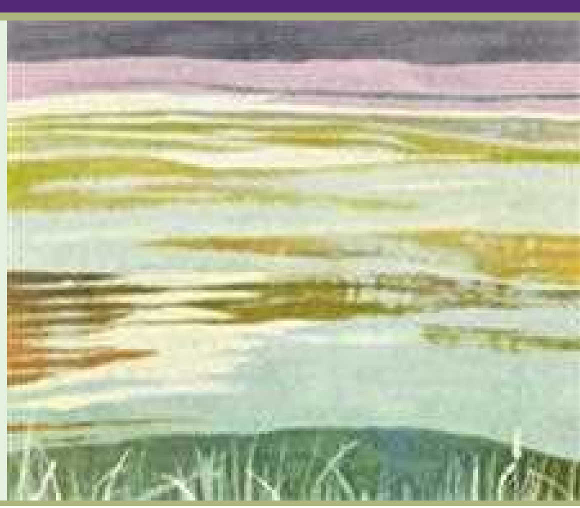
CHAPTER

16



Psychophysiological Responses and Somatoform and Sleep Disorders

Gail W. Stuart

The cure of many diseases is unknown to the physicians of Hellas, because they disregard the whole, which ought to be studied also, for the part can never be well unless the whole is well.

Plato

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive psychophysiological responses.
2. Identify behaviors associated with psychophysiological responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to psychophysiological responses.
4. Describe coping resources and coping mechanisms related to psychophysiological responses.
5. Formulate nursing diagnoses related to psychophysiological responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to psychophysiological responses.
7. Identify expected outcomes and short-term nursing goals related to psychophysiological responses.
8. Develop a patient education plan to teach adaptive strategies to cope with stress.
9. Analyze nursing interventions related to psychophysiological responses.
10. Evaluate nursing care related to psychophysiological responses.

Throughout history, philosophers and scientists have debated the nature of the relationship between the mind ***(psyche)*** and the body ***(soma)***. There is now great interest in holistic health practices, and research is identifying the links among thoughts, feelings, and body functioning. **It is now recognized that physical disorders have a psychological component and psychological disorders have a physical one.**

CONTINUUM OF PSYCHOPHYSIOLOGICAL RESPONSES

Current thinking about psychophysiological responses is related to an increased understanding of the role of stress in human life. In 1956 stress theory was advanced when Hans Selye published *The Stress of Life,* in which he described the stress response and the effect of stressful experiences on physical functioning. He identified a three-stage process of response to stress called the **general adaptation syndrome (GAS):**

1. **The alarm reaction.** This reaction is the immediate response to a stressor in a localized area. Adrenocortical mechanisms respond, resulting in behaviors associated with the fight-or-flight response.
2. **Stage of resistance.** The body makes some effort to resist the stressor. The body adapts and functions at a less than optimal level. This requires a greater than usual expenditure of energy for survival.
3. **Stage of exhaustion.** The adaptive mechanisms become worn out and then fail. The negative effect of the stressor

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

As the patient walks through the door you note that she is young and looks almost "doll like," dressed in a frilly print dress with long curly hair. Quickly she becomes tearful. She says she should be happy but she feels so sad. She has been going through this cycle so many times, over and over again. For as long as she can remember, she has been convinced that she had some dreaded severe illness but no one has been able to diagnose it. She can't stop thinking about it. It causes so much stress; she hates herself and her life. She feels like she has been cursed and doesn't know why. When she takes an antidepressant, things get better. She relaxes, feels good, and those thoughts go away.

Just when she thinks she has it figured out and men start to notice her, she gains 30 pounds, doesn't recognize herself in the mirror, and hates how she looks yet again. It seems like she can't get it right. She goes off of the medication and all the thoughts and fears start again. She makes trips to any doctor she can find, pleading with them to find out what is wrong with her. She becomes convinced that she has a fatal illness once more.

By the time you are seeing her, she has had at least 20 MRIs and knows this has to stop. She is too ashamed to tell her boyfriend, but she can see the pounds coming back and she is disgusted with herself. Her parents are both deceased, and she has always been dependent on her grandmother for support.

Case Critical Reasoning Questions

1. Can you identify the stressors that led up to her presenting for care at this time?
2. What medical and nursing diagnoses do her symptoms suggest?
3. Do you think dependency is part of her cycle? If so, how might this impact her?
4. Which medications do you think would be helpful to her?
5. What education does this patient need?

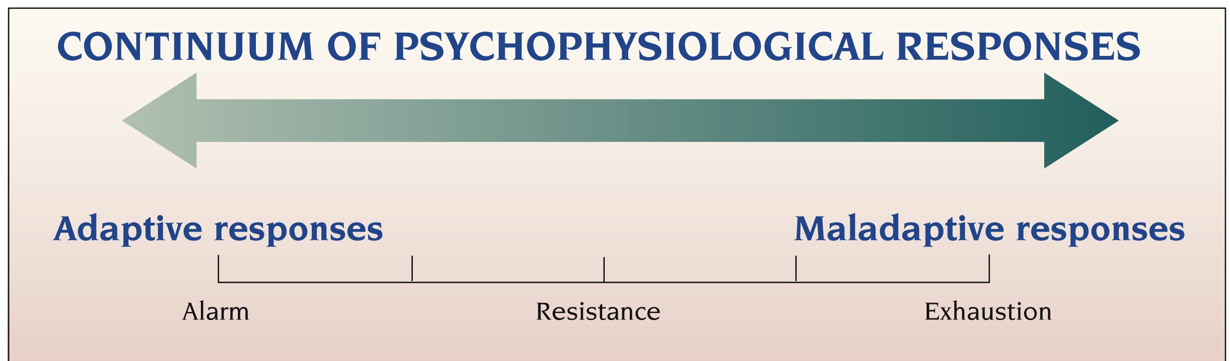


FIG 16-1 Continuum of psychophysiological responses.

spreads to the entire organism. If the stressor is not removed or counteracted, death will result.

Any experience that is perceived by the individual to be stressful may stimulate a psychophysiological response. The stress does not have to be recognized consciously, and often it is not. People who recognize that they are under stress are often unable to connect their cognitive understanding of stress with their physical symptoms of the psychophysiological disorder. Figure 16-1 illustrates the range of possible psychophysiological responses to stress, based on Selye's theory.

ASSESSMENT

Behaviors

Many behaviors are associated with stress and psychophysiological disorders. Careful assessment is needed so that organic problems can be defined and treated. Such illnesses should never be dismissed as being "only psychosomatic" or "all in one's head." They represent real illnesses, many with real physiological changes.

> **QUALITY AND SAFETY ALERT**
> - Serious psychophysiological disorders can be fatal if not treated properly.

Physiological. The primary behaviors observed with psychophysiological responses are the physical symptoms. These symptoms lead the person to seek health care. Psychological factors affecting the physical condition may involve any body part. The organ systems most commonly involved and the associated physical conditions are listed in Box 16-1.

Longer general hospital stays have been reported to be associated with greater psychological comorbidity, particularly

BOX 16-1 PHYSICAL CONDITIONS AFFECTED BY PSYCHOLOGICAL FACTORS

Cardiovascular
Migraine
Essential hypertension
Angina
Tension headaches

Musculoskeletal
Rheumatoid arthritis
Low back pain (idiopathic)

Respiratory
Hyperventilation
Asthma

Gastrointestinal
Anorexia nervosa
Peptic ulcer
Irritable bowel syndrome
Colitis
Obesity

Skin
Neurodermatitis
Eczema
Psoriasis
Pruritus

Genitourinary
Impotence
Frigidity
Premenstrual syndrome

Endocrinologic
Hyperthyroidism
Diabetes

depression, anxiety, and organicity. Such research underscores the importance of linking physiological and psychological assessments.

People are often reluctant to believe that a physical problem may be related to psychological factors. In part, this is because being physically ill is more socially acceptable and less stigmatizing than having psychological problems. The situation is compounded because the patient does have real physical symptoms.

Denial of the psychological component of the illness may lead to "doctor shopping" as the patient searches for someone who will find an organic cause for the illness. This tendency to experience and communicate psychological distress in the form of physical symptoms and to seek help for them in general medical settings is common as seen in the following clinical example.

CLINICAL EXAMPLE

Mr. R was a successful 42-year-old executive who had risen quickly to the top of his company. He worked long hours and had difficulty delegating any responsibilities. He set high standards for his employees and was believed to be insensitive to human concerns. He viewed himself as tough but fair. However, he had little sympathy for a worker who requested extra time off for personal business.

Mr. R was married but saw little of his family. He expected his wife and children to do their part to maintain his standing in the community by associating with "the right people." He seldom interacted with his children except to reprimand them if they disturbed him while he was working. His wife reported that their sexual relationship was unsatisfying to her. Mr. R used it for physical release for himself but was not concerned about meeting her needs. She suspected that he was involved in an extramarital affair but did not want to endanger the marriage by confronting him.

Mr. R was expecting to be named to the board of directors of a prestigious philanthropic foundation. He expected that this would add to his social prominence in the community. Shortly before the announcement was to be made, his 14-year-old son was arrested in a drug raid in an undesirable part of town. Mr. R did not get the appointment to the board. He was furious with his son but dealt with his anger by withdrawing still more.

One day at work, he experienced an episode of dizziness followed by a severe headache. He attributed it to tension, took some aspirin, and continued to work. However, after several similar episodes, he decided to consult his family doctor. The physician arrived at a diagnosis of essential hypertension. He tried to discuss work, family, and social behavior with Mr. R but received only superficial responses. Although he was concerned about Mr. R's condition and stress level, the doctor gave in to Mr. R's demand for medication to lower his blood pressure. He also advised Mr. R to exercise and to find a relaxing activity to help him relieve his stress.

Selected Nursing Diagnoses

- Stress overload related to family and work, as evidenced by denial and development of physical symptoms
- Interrupted family processes related to rigid role expectations, as evidenced by withdrawal and lack of communication

Mr. R is typical of many people with stress-related psychophysiological disorders. He is reluctant to admit to a lack of control over his mind and body. He expects a magical cure that will let him follow his usual lifestyle without interruption. He will probably stop taking his medication as soon as he feels better. Distance from the stressor may allow him to function for a while without noticeable symptoms of his hypertension. Sooner or later, however, new stressors will lead to another dizzy spell, headaches, or possibly myocardial infarction or cerebrovascular accident.

Psychological. Some people have physical symptoms without any organic impairment, and these are called **somatoform disorders.** They include the following:

- **Somatization disorder,** in which the person has many physical complaints
- **Conversion disorder,** in which a loss or alteration of physical functioning occurs
- **Hypochondriasis,** the fear of illness or belief that one has an illness
- **Body dysmorphic disorder,** in which a person with a normal appearance is concerned about having a physical defect
- **Pain disorder,** in which psychological factors play an important role in the onset, severity, or maintenance of the pain

The next clinical example is a case history of a person with a medical diagnosis of somatization disorder.

CLINICAL EXAMPLE

Ms. P, a 28-year-old single woman, was admitted to the medical unit of a general hospital for a complete medical work-up. When asked about her main problem during the nursing assessment, she replied, "I've never been very

well. Even when I was a child I was sick a lot." Ms. P listed multiple complaints during the physical assessment. These included palpitations, dizzy spells, menstrual irregularity, painful menses, blurred vision, dysphagia, backache, pain in her knees and feet, and a variety of gastrointestinal symptoms including stomach pain, nausea, vomiting, diarrhea, flatulence, and intolerance to seafood, vegetables of the cabbage family, carbonated beverages, and eggs. Except for the food intolerances, none of the symptoms were constant. They occurred at random, making her fearful of leaving home.

The psychosocial assessment revealed that Ms. P lived with her parents. She was the youngest of three children. Her siblings were living away from the parental home. She had graduated from high school but had poor grades because of her frequent absences. She had tried to work as a clerk in a retail store but was fired because of absenteeism. She did not seem particularly bothered by the loss of her job. She had never tried to find other work, although she had been unemployed for 8 years. When asked how she spent her time, she said that she did some gardening and some housework when she felt well enough. However, she spent most of her time watching television.

Ms. P's parents visited her every day. Her mother asked whether she could spend the night in her daughter's room and was displeased when told no. The family had many complaints about the quality of the nursing care, mostly about failures to anticipate the patient's needs. Extensive diagnostic studies failed to reveal any organic basis for Ms. P's physical complaints. When informed that the problem was most likely psychological and advised to obtain psychotherapy, the family protested angrily and refused a referral to a psychiatric clinic. Ms. P was discharged and returned to her parents' home.

Selected Nursing Diagnoses

- Ineffective denial related to compromised physical and emotional health status, as evidenced by repeated medical care visits and refusal to obtain psychiatric treatment
- Interrupted family processes related to mother-daughter dependency issues, as evidenced by excessive caretaking by mother and passivity of daughter

Ms. P shows the dependent behavior that is typical of people with **somatization disorder.** Her many symptoms allow her to be taken care of and to avoid the demands of adult responsibility. Her need to be cared for fits with her mother's need to nurture. Therefore she has little incentive to give up her symptoms. A periodic hospital stay reinforces the seriousness of her problem. **Secondary gain related to the gratification of dependency needs is a powerful deterrent to change in many patients.** **Secondary gain** is an indirect benefit, usually obtained through an illness or disability. Such benefits may include personal attention, release from unpleasant situations and responsibilities, or monetary and disability benefits.

Another type of somatoform disorder is **conversion disorder,** in which symptoms of some physical illnesses appear without any underlying organic cause (Tocchio, 2009). The organic symptom reduces the patient's anxiety and usually gives a clue to the conflict.

For example, a patient who has an impulse to harm his domineering father may develop paralysis of his arms and hands. The **primary gain,** or direct benefit from the illness, is that the patient is unable to carry out his impulses. He also may experience secondary gain in the form of attention, manipulation of others, freedom from responsibilities, and economic benefits.

Conversion symptoms may include the following:

- Sensory symptoms, such as numbness, blindness, or deafness
- Motor symptoms, such as paralysis, tremors, or mutism
- Visceral symptoms, such as urinary retention, headaches, or difficulty breathing

It is often difficult to diagnose this reaction. Other patient behaviors may be helpful in making the diagnosis. Patients often display little anxiety or concern about the conversion symptom and its resulting disability. The classic term for this lack of concern is ***la belle indifference*** (Stone et al, 2006). The patient also tends to seek attention in ways not limited to the actual symptom.

Hypochondriasis is another type of somatoform disorder. People with this disorder have an exaggerated concern with physical health that is not based on any real organic disorders. They fear presumed diseases and are not helped by reassurance. They also tend to seek out and use information about diseases to convince themselves that they are ill or about to become ill.

In contrast to conversion reaction, there is no actual loss or distortion of function. Patients appear worried and anxious about their symptoms. This concern may be based on physical sensations overlooked by most people or on symptoms of a minor physical illness that the patient magnifies. This is often a chronic behavior pattern accompanied by a history of visits to numerous practitioners.

Hypochondriacal behavior is not related to a conscious decision. If a person decides to fake an illness, the behavior is called **malingering.** This behavior is usually done to avoid responsibilities the person views as burdensome and to receive financial gain of some type.

Many otherwise healthy people malinger at one time or another. For instance, a person involved in an automobile accident may feign neck pain to receive insurance money. Often, the person exaggerates symptoms, is evasive, and tells contradictory stories about the illness.

Faking Illness. People who fake illness are said to have **factitious disorder.** They may aggravate existing medical conditions or inflict actual injury on themselves or on individuals in their care. Unlike those who malinger, patients with factitious disorder are motivated by the need for the emotional attention that comes with playing the role of a patient. Onset of illness usually occurs between 20 to 40 years of age.

These patients tend to visit the same health care provider repeatedly and are usually well known by the health care team. Many patients with this disorder have other comorbid psychiatric diagnoses including mood disorders, personality disorder, and substance related disorders. Perhaps the

best known factitious disorder is **Munchausen syndrome,** in which patients make up symptoms to gain hospital admission and emotional attention over and over again.

Pain. Pain is increasingly recognized as more than simply a sensory phenomenon. **It is a complex sensory and emotional experience underlying potential disease.** Pain is influenced by behavioral, cognitive, psychological, and motivational processes that require sophisticated assessments and multifaceted treatments for its control (American Nurse Today, 2011).

Long-lasting pain has many effects and can produce changes in one's mood, thought patterns, perceptions, coping abilities, and personality. Chronic pain combined with major depressive disorder results in higher medical service costs (Arnow et al, 2009).

- **Acute pain** is a reflex biological response to injury.
- C**hronic pain** is pain of at least 6 months' duration.
- **Somatoform pain disorder** is a preoccupation with pain in the absence of physical disease to account for its intensity. It does not follow a neuroanatomical distribution. A close correlation between stress or conflict and the initiation or exacerbation of the pain also may be a component of the disorder.

The experience, expression, and treatment of pain are subject to cultural norms and biases. For example, in Western cultures, health care practitioners often take expressions of pain more seriously in males than in females. Members of minority groups who seek health care in culturally insensitive settings may have their requests for support in coping with pain misunderstood, because support is culturally defined and varies across ethnic and racial groups.

All patients with chronic pain should be carefully evaluated for risk of suicide. Risk factors for understanding suicide in chronic pain patients include the following: the type, intensity, and duration of pain; sleep-onset insomnia co-occurring with pain; helplessness and hopelessness about pain; the desire to escape from pain; pain "catastrophizing" and avoidance; and problem-solving deficits (Tang and Crane, 2006).

QUALITY AND SAFETY ALERT

- The risk of suicide appears to be at least doubled in chronic pain patients.

Sleep. Normal sleep is defined as 6 to 9 hours of restorative sleep with characteristic sleep architecture and physiology and no complaints about quality of sleep, daytime sleepiness, or difficulties with mood, motivation, or performance during waking hours (Zunkel, 2005). Sleep disorders are common in the general population as well as among people with psychiatric disorders.

About 80% of people with depression and 90% of patients with anxiety report experiencing problems sleeping (Kierlin, 2008). Sleep disturbance is common after traumatic events such as combat, trauma, or abuse.

Sleep disruption also is reported by many patients in intensive care units. Nurses should remember that hospitals and other clinical settings are not conducive to restful sleep. Staff conversations, doors, pumps, pagers, monitors, and cleaning all can escalate noise levels. Sensitivity to noise and creating a quiet patient environment will directly help patients to sleep (King et al, 2007).

Sleep disturbances can influence the development and course of physical and mental illnesses and addictive disorders and also can affect treatment and recovery. Sleep disturbances caused by worry may increase risk for alcohol-related problems, particularly among those with anxiety and mood disorders.

Insomnia is the most prevalent sleep disorder. Up to 30% of the population have and seek help for insomnia. Other sleep disturbances include excessive daytime drowsiness, difficulty sleeping during desired sleep time, sleep apnea, and unusual nocturnal events such as nightmares or sleepwalking. It is estimated that 80% to 90% of the 9 million people with sleep apnea remain undiagnosed. Sleep disorders are more common in the elderly age group.

The *International Classification of Sleep Disorders* identifies three major groupings (American Academy of Sleep Medicine, 2001):

1. The **dyssomnias** are the disorders that produce either difficulty initiating or maintaining sleep or excessive sleepiness. They are divided into three groups of disorders: intrinsic sleep disorders, extrinsic sleep disorders, and circadian rhythm sleep disorders. **Examples of dyssomnias include insomnia, narcolepsy, obstructive sleep apnea, restless legs syndrome, inadequate sleep hygiene, and alcohol/stimulant–dependent sleep disorder.**
2. The **parasomnias** (i.e., the disorders of arousal, partial arousal, and sleep-stage transition) are disorders that intrude into the sleep process and are not primarily disorders of sleep and wake states per se. These disorders are signs of central nervous system activation, usually transmitted through skeletal muscle or autonomic nervous system channels. **Examples of parasomnias include sleepwalking, sleep terrors, nightmares, sleep paralysis, sleep enuresis, primary snoring, and sudden infant death syndrome.**
3. Sleep disorders associated with medical/psychiatric disorders include those conditions that are not primarily sleep disorders but are **mental, neurological, or other medical disorders that have either sleep disturbance or excessive sleepiness as a major feature of the disorder.**

Approximately 35% to 58% of people in the United States report that they have difficulty initiating or maintaining sleep or experience nonrestorative sleep (National Sleep Foundation, 2011). The majority of those affected are undiagnosed and untreated. In addition, millions of other people get inadequate sleep because of demanding work schedules, school, and other lifestyle issues. This group includes night-shift nurses, who report higher levels of fatigue and poorer sleep quality than day-shift nurses do.

The consequences of sleep disorders, sleep deprivation, and sleepiness are significant. They can result in higher morbidity and mortality risks, and their effects span all aspects of modern society, including health care, education, and family and social life.

QUALITY AND SAFETY ALERT

Sleep problems can have serious life consequences:
- Reduced productivity
- Lowered cognitive performance
- Increased accidents
- Decreased quality of life

The assessment of patients with sleep problems is multifaceted, involving a detailed history and medical and psychiatric examinations, extensive questionnaires, the use of sleep diaries or logs, and often psychological testing (Buysse, 2005; Lee and Ward, 2005; Becker, 2008). Many patients are referred for formal sleep studies, which include all-night polysomnography and physiological measures of daytime sleepiness. Many members of the health care team collaborate within sleep centers to deliver multidisciplinary care.

Critical Reasoning Have you ever had a problem sleeping? Which group would your problem have fit into, and what did you do to relieve it?

Predisposing Factors

A number of biopsychosocial factors influence psychophysiological responses to stress. Most relationships between physical and psychological processes are not well described. Therefore it is important for the nurse to consider all possibilities when assessing factors that might predispose the patient to a particular disorder.

Biological. Research has linked emotions to arousal of the neuroendocrine system through release of corticosteroids by the hypothalamic-pituitary-adrenal (HPA) axis and to the actions of neurotransmitter systems, particularly norepinephrine and serotonin. Neuroendocrine data provide evidence of insufficient glucocorticoid signaling in stress-related neuropsychiatric disorders. Impaired feedback regulation of relevant stress responses, especially immune activation and inflammation, may in turn contribute to stress-related pathology, including alterations in behavior, insulin sensitivity, bone metabolism, and acquired immune responses.

Perceived stress is in part heritable (Federenko et al, 2006). **A biological tendency for particular psychophysiological responses may be inherited, underscoring the importance of genetic factors.** For instance, epidemiological studies have shown that the lifetime prevalence for somatization disorder in the general population is 0.1% to 0.5% and is higher in women. However, among mothers and sisters of affected patients, the prevalence increases to 10% to 20%. The rate in monozygotic (identical) twins is 29%, and in dizygotic (fraternal) twins it is 10%. Therefore an inherited tendency for this disorder clearly exists.

The genetic theory suggests that any prolonged stress can cause physiological changes that result in a physical disorder. Each person has a "shock organ" that is genetically vulnerable to stress. Some patients may be prone to cardiac illness, whereas others may react with gastrointestinal distress or skin rashes. People who are chronically anxious or depressed are believed to have a greater vulnerability to psychophysiological illness.

Psychoneuroimmunology. **Psychoneuroimmunology** is the scientific field that explores the relationships among psychological states, the immune system, and health (see Chapter 5). This field is based on the mind-body connection, which extends to the cellular level (Figure 16-2).

For example, glial cells are found throughout the central nervous system. They are as numerous as neurons, and they form an extensive defensive network in the brain, monitoring and even enhancing normal brain function and migrating to trouble spots to ingest microbes, dying cells, and other debris.

Research also has shown that these cells can begin to function abnormally and then, in some people, exacerbate or even cause several disabling conditions such as stroke, Alzheimer disease, multiple sclerosis, Parkinson disease, dementia associated with human immunodeficiency virus (HIV) infection, and other neurodegenerative disorders.

The immune response can be changed by behavior modification techniques. Researchers are investigating the possibility of modifying the immune response in the treatment of autoimmune illnesses, such as rheumatoid arthritis, systemic lupus erythematosus, myasthenia gravis, and pernicious anemia.

Other research is exploring the relationships among the immune system, stress, and cancer. It is suspected that high stress, especially if prolonged, can decrease the immune system's ability to destroy neoplastic growths.

Sleep. The neurotransmitter that is most involved in sleep regulation is **gamma-aminobutyric acid (GABA),** which is produced by neurons in the hypothalamus. GABA acts to induce sleep by inhibiting the arousal functions of cholinergic neurons.

The peptide **hypocretin** also may regulate sleep and wakefulness. Studies show a dramatic reduction (up to 95%) in the number of neurons containing hypocretin in the brains of people with narcolepsy compared with normal controls. The pronounced loss of these neurons could be caused by either a neurodegenerative process or an autoimmune response.

The brains of those with narcolepsy also revealed signs of an inflammatory process called gliosis, which is linked to neuronal degeneration and may explain the loss of the hypocretin cells. These findings suggest that it may be possible to administer hypocretins to patients with narcolepsy as a potential treatment strategy.

Psychological. The roles of personality and stress in the development of illness are emerging. Research suggests that a negative affective style marked by depression, anxiety, and hostility may be associated with the development of or

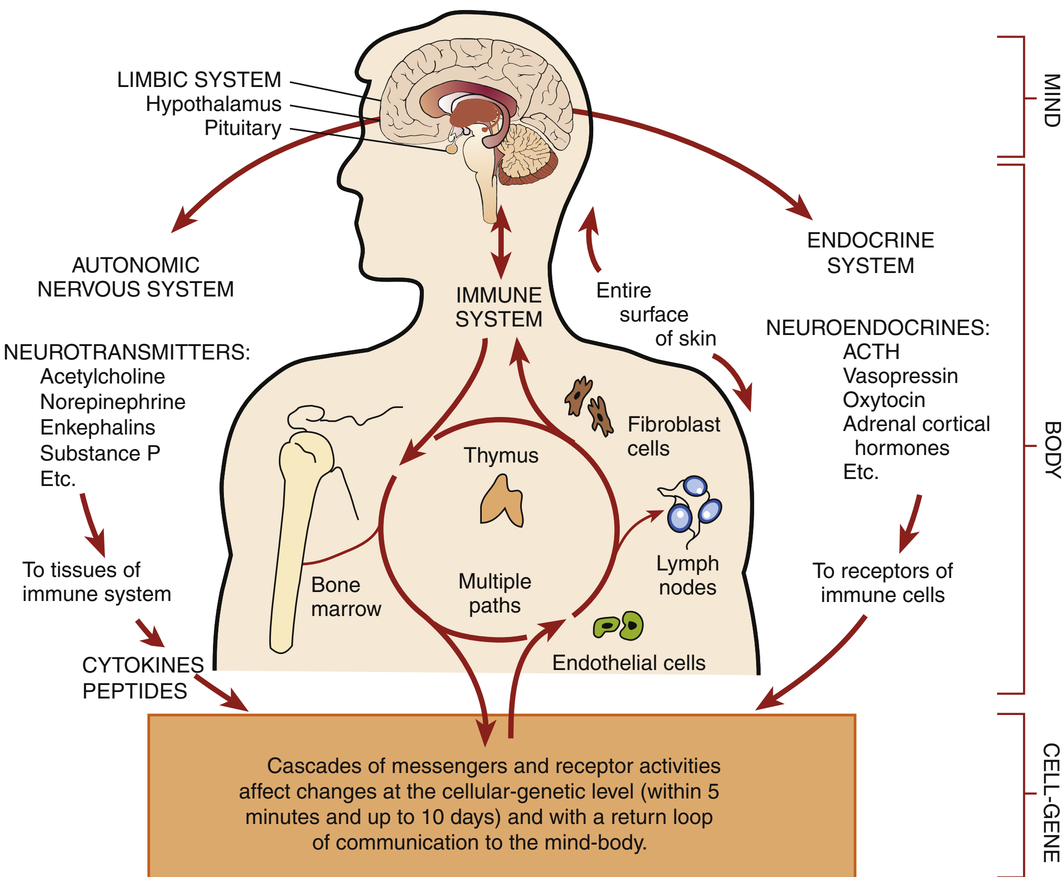


FIG 16-2 Updated view of Selye's general adaptation syndrome emphasizing the mind-body-cell/gene communication loop of the immune system. *ACTH*, Adrenocorticotropic hormone.

recovery from diseases such as asthma, headaches, ulcers, arthritis, and cancer. Evidence also suggests the negative effects of depression on cardiovascular disease for men and women and on osteoporosis in women.

Type A behavior, which has been characterized by competitive drive, impatience, hostility, irritability, and aggressiveness, has been shown to predict the development of coronary artery disease and the physiological changes associated with it. Type A people are more likely to have accidents, to die as a result of accidents or violence, and to have migraine headaches. They also smoke more and have higher levels of serum cholesterol than other people. Therefore type A behavior appears to be a risk factor for both cardiovascular disease and an array of other disorders.

Although such research suggests the possibility of a disease-prone personality, the exact nature of the relationship between personality and susceptibility is unknown. For example, a negative emotional state may do the following:

- Produce pathological physiological changes.
- Lead people to practice high-risk behaviors for illness.
- Produce illness behavior but no underlying pathology.
- Be associated with illness through other unknown factors.

Complementing the research on negative emotional states as a risk factor for disease is the increasing focus on the protective role of positive emotional states. For example, the self-healing personality describes someone who is enthusiastic, emotionally balanced, alert, responsive, and energetic. This person is curious, secure, and constructive. Self-healing personalities also have a sense of continuous growth and **resilience** and an extra margin of emotional stability that they can call on when their capacities are challenged (Kobau et al, 2011).

Two other positive traits are optimism and perceived control. **Optimists** appear to have fewer physical symptoms and may show faster recovery from illness (Bandura, 1997; Seligman, 2000). **Belief in personal control, or self-efficacy, affects the likelihood of developing illness by influencing the practice of positive health behaviors and by buffering people against the adverse effects of stress.**

> **Critical Reasoning** Think of people you know who always seem to be ill. What personality characteristics do they share? How do they compare with people you know who are hardly ever ill?

Sociocultural. Psychophysiological illness is derived from the relationships among body, psyche, and society. Illness is not simply the natural unfolding of an exclusively biological process. Rather, its course is influenced by sociocultural factors. Health, illness, and suffering are influenced by culture and interpreted in personal worlds of experience. Box 16-2 presents some unique somatoform syndromes of various cultures.

BOX 16-2 SOCIOCULTURAL CONTEXT OF CARE

Somatoform Syndromes of Various Cultures

Ataque de nervios: Distress recognized by many Latin-American groups, with common symptoms of uncontrollable crying, trembling, heat in the chest rising to the head, fainting, and a sense of having lost control. These symptoms often occur after a stressful event affecting the individual or one's family.

Brain fag: A West-African term used to describe symptoms experienced by young people that are related to the stress of study, including difficulties in concentration, memory, and thinking.

Dhat: A folk term used by men in India relating to sexual dysfunction and signs of weakness and exhaustion.

Hwa-byung: A Korean folk syndrome attributed to the suppression of anger, with symptoms of insomnia, fatigue, indigestion, anorexia, and generalized aches and pains.

Open mole: In Liberia, it is believed to be an acquired disease state in adults who experience a sudden fright or shock or who endure chronic adversity or stress. Its symptom is a soft spot on the top of the head accompanied by headaches, back pain, fatigue, loss of appetite, and social withdrawal.

Shenjing shuairuo (neurasthenia): In China, a condition characterized by physical and mental fatigue, dizziness, headaches, and concentration and sleep difficulties.

Susto ("fright" or "soul loss"): A Latin-American folk illness that follows a frightening experience. Symptoms include appetite and sleep disturbance, lack of motivation, muscle pains, headaches, and abdominal pain and diarrhea.

The social course of illness has at least two meanings:

1. **Aspects of the social environment influence the severity of the person's symptoms.** This means that subjectively experienced distress can be increased or decreased by the nature and number of problems in one's world and by changes in one's emotions and social life.
2. **The symptoms shape and structure the person's social world, because the illness causes a series of changes in the person's environment.** The resulting chain of illness-related interpersonal events thus becomes a part of the social course of the person's illness.

Critical Reasoning Compare our society's beliefs and expectations about being sick for people with multiple sclerosis, alcoholism, lung cancer, and depression. Do they differ based on each diagnosis, and if so, how and why?

Precipitating Stressors

Any experience that the person interprets as stressful may lead to a psychophysiological response. Some of these responses are mild and short-lived. Examples include diarrhea before an examination or a dry mouth when speaking before a large group of people. Sometimes the response is more serious and indicates a higher level of anxiety. For instance, a person might feel panicky and experience tachycardia when boarding an airplane.

Most psychophysiological disorders come and go related to changes in the person's stress level. When the cumulative stress gets too high, the body "calls time-out" by developing physical symptoms. Because the psychophysiological disorder is an attempt to deal with anxiety, information on stressors related to anxiety should be reviewed (see Chapter 15).

One type of stressor that can cause physical illness and even death is the loss of a significant interpersonal relationship. An increased mortality rate has been found among recently widowed people. Similar observations have been made about people admitted to institutions such as nursing homes, who are separated from significant others. Children who have been separated from their mothers, especially if placed in an impersonal environment, also show a decline in physical health. Illnesses and deaths related to loss of a loved one seem to represent the exhaustion phase of the general adaptation syndrome.

Sometimes a psychophysiological problem is a response to an accumulation of small stressors, such as chronic work stress. A patient may find it difficult to identify one specific stressor that preceded a particular problem. Careful assessment may reveal a pattern of overwork and overcommitment or a series of seemingly minor events that all required extra effort.

Appraisal of Stressors

The complex interaction between mind and body is seen in psychophysiological responses to stress. These responses reinforce the need for an integrated approach to etiology and great sensitivity by the nurse to a person's appraisal of stress and its effects.

Social and cultural factors play a particularly important role in the expression of adaptive and maladaptive behaviors. They are essential in planning effective, individualized treatment strategies.

Coping Resources

One of the most important parts of promoting adaptive psychophysiological responses involves adopting positive health practices, because good health measures can prevent many illnesses. Patient education plans that include coping skills training, such as the one presented in Table 16-1, can increase a person's knowledge about the effects of stress, reduce anxiety, increase a feelings of purpose and meaning in life, reduce pain and suffering, and improve coping abilities.

Social support from family, friends, and caregivers also is an important resource for adaptive psychophysiological responses. It may lower the likelihood of developing maladaptive responses, speed the recovery from illness, and reduce the distress and suffering that accompany illness. Social support groups are another coping resource that can satisfy needs that are unmet by family members and caregivers.

TABLE 16-1 PATIENT EDUCATION PLAN

Coping with Stress

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Define and describe stress.	List feelings that indicate stress. Discuss behaviors associated with elevated stress.	Patient identifies general behaviors associated with stressful situations.
Recognize stressful situations.	Ask patient to describe situations personally experienced as stressful. Role play the situation (with videotape if possible). Discuss stress-related behaviors observed and feelings experienced.	Patient identifies stressful experiences. Patient describes own behaviors when stressed.
Review common life stressors.	Discuss common elements of stressful experiences.	Patient identifies stressful aspects of life.
Identify adaptive and maladaptive coping mechanisms.	Review the role-played stressful situations. Discuss alternative ways to cope with the stressors. Role play at least one adaptive coping mechanism.	Patient identifies and practices adaptive coping mechanisms.
Assign use of adaptive strategy to cope with stress.	Provide feedback about the effectiveness of the selected coping mechanism.	Patient selects an adaptive coping strategy when experiencing stress.

Coping Mechanisms

Psychophysiological disorders may be attempts to cope with the anxiety associated with overwhelming stress. Unconsciously the person links the anxiety to the physical illness. Secondary gain then adds to the psychological relief experienced.

Several defense mechanisms described in Chapter 15 may be seen in psychophysiological disorders. **Repression** of feelings, conflicts, and unacceptable impulses often leads to physical symptoms. The maintenance of repression over long periods requires a great deal of psychic energy. As the system approaches a state of exhaustion, physical symptoms occur. When a psychological basis for illness is suggested, the patient denies it. This denial indicates inability to handle the anxiety that would otherwise be released if the person admitted the psychic conflicts being repressed. The need for this defense should be respected.

Some people respond to psychophysiological illness with **compensation.** They attempt to prove that they are actually healthy by being more active and exerting themselves physically even if told to rest. This coping style is typical of type A people, who need to prove that they are in control of their bodies, not controlled by them (Box 16-3).

The opposite of this reaction is the person who uses **regression** as a coping mechanism. This person becomes dependent and embraces the sick role to avoid responsibility and conflict.

It is important not to confront the basic conflict that is leading to stress and anxiety without sufficient supports and coping alternatives. Premature attempts to convince the person of psychological conflicts may result in the use of a less adaptive coping mechanism. In extreme cases, if the person is stripped of all efforts to cope and not provided with a substitute, death can result, either from worsening of the organic disorder or from suicide (Phillips and Menard, 2006).

BOX 16-3 A FAMILY SPEAKS

I worry about my husband. He drives himself so hard. I also feel guilty at times because I know he's doing it for me and the children. But I sure would like for him to slow down. Here's a good example of how things go in our house. Every year in the weeks before Christmas he works overtime to give us a little extra money. But then on Christmas Eve, without fail, his ulcer kicks up, and we wind up spending part of each holiday in the hospital visiting him.

I know every family has problems, and maybe ours aren't so bad. But then again, maybe they are. This last Christmas our doctor recommended that we see a family therapist to discuss the situation. I want to go, but my husband says it's silly. Maybe this year for Christmas I'll ask him to give me that as my present, and we'll finally have a really happy New Year.

DIAGNOSIS

Nursing Diagnoses

The nursing diagnosis must reflect the complex biopsychosocial interaction that is the hallmark of psychophysiological disorders. The patient's effort to cope with stress-related anxiety may result in many somatic and emotional disorders. All possible disruptions must be considered when formulating a nursing diagnosis.

The Stuart Stress Adaptation Model (Figure 16-3) may help in the diagnostic process. A thorough interview will reveal many of the predisposing factors and precipitating stressors present.

The nurse must use good communication skills during the interview to enable patients to share their experience as completely as possible. Areas of resistance and gaps in information should be noted as possible indicators of a conflict. These may be explored more completely as trust is established in the nurse-patient relationship.

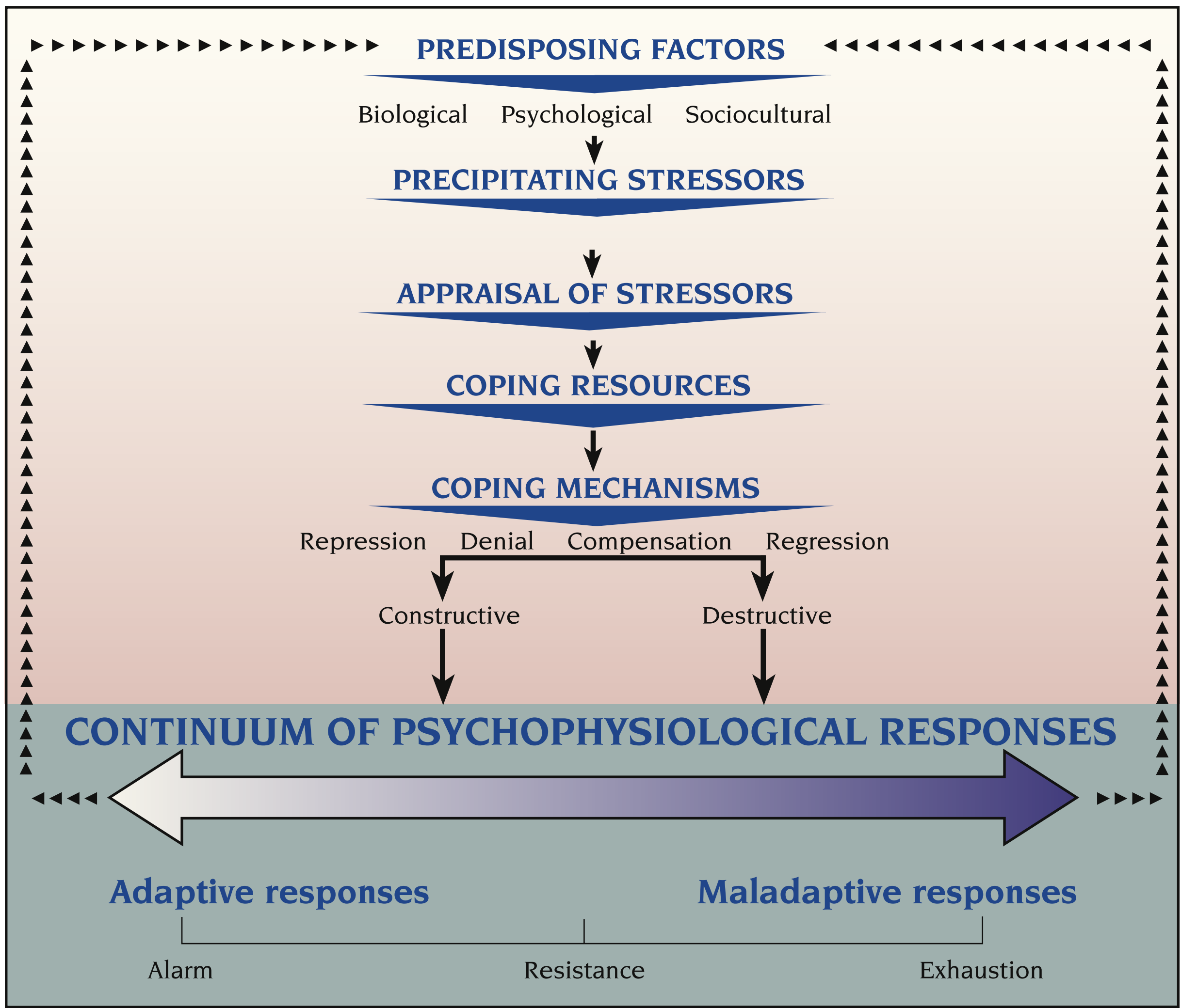


FIG 16-3 The Stuart Stress Adaptation Model as related to psychophysiological responses.

Questions related to lifestyle and activities may help identify precipitating stressors and coping behaviors. It is particularly important to elicit the patient's view of what is happening. This response will provide valuable information about the patient's awareness of the relationship between mind and body. Nonverbal behaviors also give clues about the patient's concerns. Apparent lack of concern may reveal the use of denial suggestive of a conversion disorder.

As the diagnosis is formulated, the nurse must consider the patient's coping in the context of the stress response. Is the patient in the stage of alarm with many coping resources at hand? Or is the patient in the stage of resistance, using coping mechanisms but depleting personal energy resources? Has the patient reached the stage of exhaustion, needing intensive intervention? The interventions selected should be based on the individual's level of stress and coping responses.

The six primary nursing diagnoses for maladaptive psychophysiological responses are as follows:

1. **Risk-prone health behavior**—a state in which the patient is unable to modify lifestyle in order to improve health status
2. **Ineffective denial**—a state in which disavowal is used to reduce anxiety but leads to the detriment of health
3. **Chronic pain**—a state that continues for longer than 6 months
4. **Insomnia**—a disruption in the amount and quality of sleep that impairs functions
5. **Sleep deprivation**—prolonged periods of time without sleep
6. **Stress overload**—excessive amounts and types of demands that require action

Nursing diagnoses related to the range of possible maladaptive responses are presented in Table 16-2.

Medical Diagnoses

Medical diagnoses related to maladaptive psychophysiological responses are classified under the general categories of somatoform disorders, factitious disorders, sleep disorders, and psychological factors affecting medical condition (APA, 2000). Some of the medical terms and their definitions related to these responses are described in Table 16-2.

TABLE 16-2 NURSING DIAGNOSES AND MEDICAL TERMS RELATED TO *Psychophysiological Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSES
Ineffective denial	Ineffective denial related to doubts about self-worth, as evidenced by chronic, unresponsive respiratory symptoms limiting one's work
Chronic pain	Chronic pain related to marital conflict, as evidenced by back problems and protected gait Chronic pain related to work pressures, as evidenced by reports of headaches and facial mask
Risk-prone health behavior	Risk-prone health behavior related to work stress, as evidenced by hypertension and headaches
Sleep deprivation	Sleep deprivation related to sleep apnea, as evidenced by frequently interrupted sleep intervals
Stress overload	Stress overload related to family caretaking, as evidenced by irritable bowel syndrome
MEDICAL TERM	**DEFINITION***
Somatization disorder	A disorder in which the person has many physical complaints. It is often a chronic condition in which a person has physical symptoms that involve more than one part of the body, but no physical cause can be found. The pain and other symptoms people with this disorder feel are real, and are not created or faked on purpose (malingering).
Conversion disorder	A disorder in which there is a loss or alteration of physical functioning that cannot be explained by medical evaluation
Hypochondriasis	The fear of illness or belief that one has an undiagnosed medical illness. It can cause much anxiety and repeated seeking of medical help.
Body dysmorphic disorder	A disorder in which a person with a normal appearance is concerned about having a physical defect. This causes people with this disorder either significant distress or disrupts their daily functioning (or both).
Factitious disorder	A disorder in which a person deliberately produces or falsifies symptoms of illness for the sole purpose of assuming the sick role
Pain disorder	A disorder in which a person experiences pain that is severe enough to disrupt one's everyday life. The pain is like that of a physical disorder, but no physical cause is found. Psychological factors play an important role in the onset, severity, or maintenance of the pain. The pain is thought to be due to psychological problems.
Insomnia	Trouble falling asleep or staying asleep through the night. Episodes may come and go, last up to 3 weeks, or be long-lasting and chronic.
Hypersomnia	Excessive daytime sleepiness that causes significant distress or disrupts daily functioning
Narcolepsy	A sleep disorder that causes excessive sleepiness and frequent daytime sleep attacks. Narcolepsy is a nervous system disorder with no known cause.

Nursing Diagnoses–Definitions and Classification 2012-2014. Copyright © 2012, 1994-2012 by NANDA International. Used by arrangement with Blackwell Publishing Limited, a company of John Wiley & Sons, Inc.
*Sources: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001951; http://www.nlm.nih.gov/medlineplus/ency/article/000922.htm; http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001808; http://www.hypersomnolence.org; http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001805/.

OUTCOMES IDENTIFICATION

The **expected outcome** when working with a patient with maladaptive psychophysiological responses is as follows: ***The patient will express feelings verbally rather than through the development of physical symptoms.*** This is a long-term goal, and some may never reach it. However, an increased level of self-awareness is beneficial and should be achievable by all patients.

An improved ability to deal with conflict will reduce the patient's need to use repression and denial. This in turn will decrease stress and allow the patient to function with fewer episodes of physical illness. In addition, specific goals can be set to address problems related to pain and sleep.

Setting goals with these patients may be a problem. The patient's primary goal is to ease the physical symptoms of the illness, often through medical or surgical treatment. Exploration of psychological conflicts is likely to be seen as unnecessary. This resistance is related to the need to maintain defenses against the extreme anxiety that has led to the illness.

The nurse must work with the patient in partnership to identify common treatment goals. The nurse also should help patients obtain relief from physical symptoms. Many patients undergo medical or surgical treatment and related nursing care. At the same time the nurse should try to build a trusting relationship so that the patient can feel safe in exploring interpersonal conflicts and feelings.

Family members and significant others must be considered in developing the plan of care. It is important to explore their understanding of the patient's problem. They can be valuable allies in encouraging the patient to make a lifestyle change if this is necessary.

At the same time the nurse must recognize that a change in one family member requires a change in all others. The

family may be active participants in the patient's maladaptive behavioral style. In this case, goals should include addressing the family relationships with the patient.

PLANNING

Treatment plans for these patients can be lengthy. The nurse must attend to all the patient's biopsychosocial needs. Most patients, while having needs in all areas, have their most urgent needs in a limited area of functioning. Physical disorders are usually disabling and can be life threatening. Psychosocial problems will hinder recovery from the physical illness and must also be given immediate attention.

Critical Reasoning How would you plan care with a patient who denies that problems with his ulcerative colitis are related to work stress and marital conflict, as reported by his wife?

IMPLEMENTATION

Patients with psychophysiological illnesses are most often seen in general hospital and outpatient settings. They usually seek health care because of symptoms related to physiological functioning. Only after a thorough medical examination can the role of psychosocial stressors in the disorder be evaluated.

In some cases a pathophysiological disruption requires physical nursing intervention. **If the physical condition is life threatening, this intervention is given highest priority.** For instance, a person with a bleeding ulcer needs intensive care to maintain life. However, once the physical crisis is past, the nurse can help the patient avoid similar problems in the future.

Physical illnesses with psychosocial causes require psychiatric nursing care. Skilled and compassionate nursing care directed to the patient's physical needs is the first step in establishing the trusting relationship. A person who is in pain, bleeding, or covered with a rash is unable to discuss emotions or interpersonal relationships.

TABLE 16-3 SUMMARIZING EVIDENCE-BASED TREATMENT FOR *Psychophysiological Responses*

DISORDER	TREATMENT
Insomnia	The efficacy of cognitive behavioral approaches to insomnia, such as stimulus control, sleep/bed restriction, sleep hygiene education, and relaxation therapies, has been established. Benzodiazepine receptor agonists are considered a first-line pharmacotherapy for primary insomnia.
Restless legs syndrome	The use of low-dose dopamine agonists is supported.

From Nathan P, Gorman J: *A guide to treatments that work,* ed 3, New York, 2007, Oxford University Press.

The most important principle for patients with psychophysical disorders is to assess the patient's stress level and, whenever possible, act to reduce it. Stress and anxiety are at the root of the patient's problem. The nurse must care for immediate needs before addressing less obvious ones.

Very few studies assess the treatment of most medical diagnoses associated with psychophysiological responses. Clinical findings are inconsistent and do not meet standards that would establish them as empirically supported. **Empirically validated treatments for insomnia and restless legs syndrome are summarized in** Table 16-3 (Nathan and Gorman, 2007).

QUALITY AND SAFETY ALERT

- A thorough medical examination should be conducted before the role of psychosocial stressors in the disorder is evaluated.
- If the physical condition is life threatening, this intervention is given highest priority.
- When working with patients with psychophysical disorders, it is essential to assess the patient's stress level and, whenever possible, reduce it.

Psychological Approaches

The psychophysiological symptom defends the person from overwhelming anxiety. It provides a way to receive help and nurturance without admitting the need for it. Recognizing the defensive nature of the symptom, the nurse should never try to convince the patient that the problem is entirely psychological.

Likewise, the attitude that the patient needs only to get his life under control to get better is not therapeutic. The patient has not made a conscious choice to be hypertensive or to develop a conversion disorder.

The dilemma of these disorders is that the patient consciously would like nothing more than to be cured but is unconsciously unable to give up the symptom. Conscious recognition of the psychological role of the symptom defeats its purpose and is therefore vigorously resisted. An example of this resistance is illustrated in the accompanying clinical example.

CLINICAL EXAMPLE

Ms. W was a 20-year-old woman admitted to the general hospital after the sudden onset of blindness. There was no evidence of any pathophysiological process affecting her eyes. Assessment revealed that she had witnessed her father's suicide by gunshot at the age of 5 years, although she claimed to have no memory of this. Her boyfriend had recently been expressing suicidal thoughts to her.

It appeared that the blindness was a conversion reaction. To confirm the diagnosis, the physician decided to interview Ms. W while she was sedated with amobarbital sodium. The interview was videotaped. During the interview, Ms. W was able to see. She read the day's menu and told the time by looking at a clock across the room. She also described her father's suicide. However, when the sedation wore off, Ms. W was again blind. The decision was made to play the videotape for her so that she would recognize the psychogenic nature of her blindness.

As the tape was played, she regained the ability to see. However, when it reached the part in which she described her father's suicide, she became deaf.

Selected Nursing Diagnoses

- Ineffective denial related to early life events, as evidenced by symptoms affecting sight and hearing
- Impaired social interaction related to boyfriend's depressive thoughts, as evidenced by development of physical symptom

It is not unusual for a person with a conversion disorder to substitute another symptom if the original one is taken away. This substitution happens because the basic conflict remains. The ego still needs to be defended from experiencing repressed anxiety.

The patient really needs assistance in dealing with the conflict. When this is resolved, the symptom will disappear because it is no longer needed. Great skill is needed to intervene therapeutically with patients who have maladaptive psychophysiological responses.

Psychological approaches include cognitive behavioral strategies, supportive therapy, group therapy, stress reduction, relaxation training, and complementary and alternative therapies such as meditation, biofeedback, massage therapy, and physical activity (see Chapters 15, 27 and 30). The nurse should be supportive and available to talk with the patient and provide physical care (Box 16-4).

BOX 16-4 A PATIENT SPEAKS

All I want to do is to feel better. My husband tells me that I make up all these complaints, but who would want to be sick? It isn't any fun missing out on family and church events because you don't feel good. It isn't fun going to bed with a headache and waking up with back pain day after day after day. On the other hand, my doctors tell me that they can't find anything wrong. Where does that leave me?

Right now I'm working with a nurse who is helping me to learn new habits that may help my physical condition. She has taught me how I can relax myself when I am tense and in pain. She has suggested some activities that I can start doing right now and is also reviewing with me situations and events that seem to trigger my physical problems. Will it help? I don't know, because we're just starting out, but I do know that she is at least one person I can talk to who supports me in my fight to feel like my old self again.

Behavioral change and cognitive interventions for patients with psychophysiological disorders require that the patient's underlying thoughts and feelings be recognized and examined (see Chapter 27). For example, it has been found that more frequent "catastrophizing" responses, such as "I will never get over this pain and my life as I know it is ruined," predict higher levels of distress and disability. More positive responses, such as "I'm a fighter, and this is not going to get me down," tend to be associated with better functioning.

The next step is to identify and explore the patient's defenses, proceeding carefully to help the patient discover and test new, more adaptive coping mechanisms as the dysfunctional ones are given up. The nurse should support the patient in using new behaviors. Spending time with the patient and appreciating the patient's positive qualities will help the patient build self-esteem and confidence.

The nurse also should be alert to signs of increased anxiety. The physical disorder may worsen if the therapy moves too rapidly. The nurse may recommend changes in the environment to help the patient function more comfortably. If the patient must consider a job change or another lifestyle change, the nurse can offer time to talk about alternatives.

Patients also may need help in explaining lifestyle change or changes in themselves to significant others. The family is a system, and a change in one part of the system requires adjustment in the other parts. For instance, a man who was very involved in his job and out several nights each week agreed to limit himself to 8-hour workdays. This change affected the rest of the family.

Although his wife had protested for years that he spent too much time away from home, she had built her life around his schedule. She spent several evenings each week doing outside activities. If he were now to be at home every evening, she would have to reevaluate her activities and decide whether she should go out or be with him. These are not easy decisions for family members to make.

It is important that any underlying feelings of resentment be revealed and discussed to prevent indirect expression of them, which would create a new stressor for the patient. **Family therapy may be necessary if family members have been supporting the patient's disorder**. For instance, families sometimes become adjusted to having a dependent member and unwittingly sabotage efforts to foster independence.

Social support systems may help patients cope with their illnesses. Self-help groups often provide needed support, and group interventions can help in decreasing overuse of health care services by patients with somatoform disorders.

Nurses must be aware that **countertransference** often occurs with these patients (see Chapter 2). It is easy to become impatient with a demanding patient who is not acutely ill when sicker patients also need nursing care. Reacting to this behavior with avoidance or anger only adds to the patient's anxiety.

Clinical supervision by an experienced psychiatric nurse is highly recommended for nurses who work with these difficult patients. Frequent treatment team conferences also are helpful. If possible, a limited number of staff members should be assigned to the care of these patients. This consistent care fosters the development of a trusting relationship.

Patient Education

Health education is important in caring for the patient with a psychophysiological disorder. These patients usually need instruction about medications, treatments, and lifestyle changes. The patient and family will need information about mental health promotion (see Chapter 12), follow-up care, and crisis management and education about ways to cope with anxiety and stress (see Chapter 15).

Group classes on stress management may be productive. They allow patients to share experiences and make suggestions to each other about coping behaviors. Former patients who have made successful life adjustments also can be effective teachers of coping strategies.

The effective treatment of sleep disorders requires that the underlying cause of the sleep problem be identified. Drugs and alcohol often produce fragmented sleep, as does caffeine. Poor sleep hygiene habits also may be a problem. **All patients with sleep problems should be educated on sleep hygiene strategies.** Good sleep hygiene habits are presented in Box 16-5.

Critical Reasoning Do you think that patients with maladaptive psychophysiological responses would be more or less likely to comply with their treatment plans? How might you enhance their adherence?

Physiological Support

A patient who has been relying on alcohol or drugs to cope with stress should identify and use more adaptive coping mechanisms. A variety of physiological treatments can be implemented by the nurse, including the following:

- **Relaxation training** (see Chapter 27) can be very helpful in promoting adaptive psychophysiological responses, particularly pain management and sleep.
- **Encouraging physical activity** is a positive way of promoting stress reduction. Ideally, it should be an activity that the patient enjoys and can share with others.
- **Nutritional counseling** about healthy eating patterns may be helpful in building the person's resistance to stress and illness (Crocker, 2010). Patients who are under stress should not overuse dietary stimulants such as caffeine. They may need education about the elements of a healthful diet and help in planning balanced meals.
- **Medications** can be helpful.
- **Insomnia** can be treated with the medications listed in Table 16-4. These drugs should be used only for a limited time for short-term sleep management. Onset of action and elimination half-life are important pharmacological properties that differentiate these medications. Benzodiazepines are not recommended for patients with a history of drug use or dependence.
- **Narcolepsy** can be treated with dextroamphetamine (Dexedrine), mixed amphetamine salts (Adderall), methylphenidate (Ritalin), modafinil (Provigil), and sodium oxybate (Xyrem).
- **Restless legs syndrome** can be treated with ropinirole (Requip) and pramipexole dihydrochloride (Mirapex).
- **Chronic pain** can be treated with medications from the following medication categories: antidepressants, anticonvulsants, benzodiazepines, opioids, lithium, stimulants, and antipsychotics.
- **Herbal therapies** include chamomile, a calming herbal tea that may be taken before bedtime, and valerian, a central nervous system depressant. Melatonin may be helpful if insomnia is related to shift work or jet lag.

BOX 16-5 SLEEP HYGIENE BEHAVIOR STRATEGIES

- Maintain a regular bedtime and wake-up time 7 days each week.
- Exercise daily to aid sleep initiation and maintenance; however, vigorous exercise too close to bedtime may make falling asleep difficult.
- Schedule time to wind down and relax before bed.
- Try relaxation exercises before bedtime.
- Avoid worrying when trying to fall asleep.
- Guard against nighttime interruptions.
- Earplugs may help with a noisy partner.
- The bedroom should be dark, quiet, cool, and comfortable. Heavy window shades help to screen out light.
- Create a comfortable bed.
- A warm bath or warm drink before bedtime helps some people fall asleep.
- Excessive hunger or fullness may interfere with sleep. Avoid large meals before bedtime. If a person is hungry, a light carbohydrate snack may be helpful.
- Avoid caffeine, excessive fluid intake, stimulating drugs, and excessive alcohol in the evening and before bedtime.
- Excessive napping may make it difficult for some people to fall asleep at night.
- Do not eat, read, work, or watch television in bed. The bed and bedroom should be used only for sleep and sex.
- Maintain a reasonable weight. Excessive weight may result in daytime fatigue and sleep apnea.
- Get out of bed and engage in other activities if not able to fall asleep.

QUALITY AND SAFETY ALERT

- Although prescription medications and sleep hygiene behavior therapy have similar short-term efficacy, behavioral interventions are recommended as the first-line treatment for sleep disorders because of their greater safety and long-term efficacy.
- Benzodiazepines are not recommended for patients with a history of drug use or dependence.

The Nursing Treatment Plan Summary for patients with maladaptive psychophysiological responses is presented in Table 16-5.

EVALUATION

The evaluation of the nursing care of the patient with psychophysiological illness is based on the identified patient care goals. If goal achievement is not attained, the nurse must ask the following questions:

- Was the assessment complete enough to correctly identify the problem?
- Did the patient agree with the goal?
- Was enough time allowed for goal achievement?
- Was I skilled enough to carry out the desired intervention?

TABLE 16-4 MEDICATIONS FOR THE TREATMENT OF INSOMNIA

CLASS	GENERIC NAME (TRADE NAME)	USUAL DOSE (mg)*	ONSET (min)	HALF-LIFE (hr)†
Benzodiazepine, short-acting	Triazolam (Halcion)	0.125-0.25	2-30	2-6
Benzodiazepine, intermediate-acting	Lorazepam (Ativan)	0.5-2	30	10-20
	Temazepam (Restoril)	7.5-30	60-90	8-20
	Quazepam (Doral)	7.5-15	10-60	39
	Estazolam (Prosom)	1-2	8-24	8-24
	Clonazepam (Klonopin)	0.5-2	60-90	30-40
Benzodiazepine, long-acting	Flurazepam (Dalmane)	15-30	15-30	48-120‡
Nonbenzodiazepine	Zaleplon (Sonata)	5-20	10-30	1
	Zolpidem (Ambien, Ambien CR)	5-20	10-30	1.5-4.5
	Eszopiclone (Lunesta)	1-3	10-30	6
Antidepressant	Trazodone (Desyrel)	25-100	60-120	3-14
	Mirtazapine (Remeron)	15	30-120	13-40
	Doxepin (Silenor)	3-6	150	15
Antihistamine	Diphenhydramine (Benadryl)	25-50	30-60	4-8
Melatoninergic	Melatonin	0.5-3	30-60	1
	Ramelteon (Rozerem)	8	30-69	1-2

*Dose range for adults.
†Elimination half-life is not synonymous with duration of effect, which varies significantly from patient to patient; this is another reason for individualizing treatment.
‡Active metabolite.

TABLE 16-5 NURSING TREATMENT PLAN SUMMARY

Maladaptive Psychophysiological Responses

Nursing Diagnosis: Impaired adjustment
Expected Outcome: The patient will express feelings verbally rather than through the development of physical symptoms.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will identify areas of stress and conflict and relate feelings, thoughts, and behaviors to them.	Assist patient in identifying stressful situations by reviewing events surrounding the development of physical symptoms. Facilitate the association among cognitions, feelings, and behaviors.	Inability to deal with intrapsychic conflict leads to anxiety and stress, resulting in physiological dysfunction.
The patient will describe present defenses and evaluate whether they are adaptive or maladaptive.	Proceed slowly in analyzing defenses. Explore alternative coping behaviors with the patient. Teach patient stress management techniques, such as relaxation and imagery.	Defenses should not be attacked; rather, the nurse should support positive exploration by the patient and suggest alternative responses.
The patient will adopt two new coping mechanisms to deal with stress.	Give patient positive feedback for new adaptive behaviors. Actively support patient in testing new coping mechanisms. Enlist support of family and significant others to reinforce change.	Change requires time and positive reinforcement from others. Family members can be important in promoting adaptive responses.
The patient will display a decrease in physical symptoms and greater biological integrity.	Encourage physical activity to reduce stress. Counsel patient on diet and nutrition needs. Review patient's sleep habits, and promote good sleep hygiene practices.	Wellness requires a balance between biological and psychosocial needs. Interventions focused on patient's physiological needs can help patient restore biological integrity.

- Were there environmental constraints that affected goal accomplishment?
- Did additional stressors change the patient's ability to cope?
- Was the goal achievable for this patient?
- What alternative approaches should be tried?

It is very important that neither the patient nor the nurse interpret the lack of goal achievement as a failure. The nurse should look at it as a challenge and convey that attitude to the patient. It is not helpful to add failure to achieve a goal to the patient's collection of stressors.

The care of these patients is very complex. The nurse may need to modify the treatment plan several times before finding a successful approach. The most important thing is to keep trying, encouraging the patient to persist in the effort to find health and conveying hope for the future.

LEARNING FROM A CLINICAL CASE OUTCOME

1. Can you identify the stressors that led up to her presenting for care at this time?

This patient has a cyclical pattern of becoming convinced she has a severe illness, seeking medical care, recognizing that this pattern produces great anxiety, being prescribed an SSRI, and experiencing weight gain. Once the fears have subsided, she stops the medication, loses weight, feels more attractive, and begins dating. Several years have passed; she now is in a relationship that she would like to continue, but she sees the pattern repeating. She feels the pressure to find a coping strategy that will work for her.

2. What medical and nursing diagnoses do her symptoms suggest?

The medical diagnosis that is appropriate for her is the somatoform disorder of hypochondriasis. The powerlessness, self-esteem (situational low).

3. Do you think dependency is part of her cycle? if so, how could this impact her?

Her manner of dress and hairstyling making her appear much younger could suggest an unconscious desire for continued dependency on her grandmother. Her mother's death at a young age had a profound effect on them both.

4. Which medications do you think would be helpful to her?

The patient was prescribed the SSRI Paxil because that had been effective previously. Wellbutrin was added to augment the SSRI and offset the increased appetite and associated weight gain. In completing the family genogram it was learned that her grandmother was also taking Paxil and that she had experienced the same symptoms of hypochondriasis but had never been diagnosed. This was the first time they had received the appropriate diagnosis and recognized its profound effects on both of their lives.

5. What education does this patient need?

This patient needed to be educated about her diagnosis, and how to maintain her weight while taking the appropriate medication. She developed an exercise routine and began to count calories daily. This process was very empowering, making her feel better about her prognosis and more in control or her life.

Case Outcome

The patient was able to maintain a lower level of anxiety with medication and exercise regimen. She began to recognize that her behavior and her dress made her seem younger than her age. She also had developed the habit of staying with her grandmother when she felt concerned about her health. She began to see that this kept her close to but dependent on her grandmother.

She began to talk about her parent's early deaths, her mother from breast cancer and her father from drug addiction. She educated herself about her risk factors and what were reasonable and unreasonable concerns. Through support and counseling she was able to talk to her boyfriend about her illness and educate him.

When she ended therapy, she was about 6 pounds overweight but was accepting. She felt much better about her health and began to dress in a more age appropriate style. Her relationship with her boyfriend was thriving and she felt finally that she could have better control of her life.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Audrey Joseph, MSN, RN

Often it is difficult for health care professionals to communicate with their patients about psychosomatic illness. Also, the patient's denial or rejection of this diagnosis does not make the communication process any easier. Psychiatric staff and family members can get caught in the middle when primary care physicians fail to tell their patients that they need a psychiatric evaluation to rule out a psychosomatic illness. I know this from an experience I had that taught me a lot about psychiatric care.

I was working the evening shift as a staff nurse on an inpatient unit when Ms. O, an elderly woman, was voluntarily admitted. She was well dressed and quite cheerful. Her medical history revealed that she had visited her family doctor and the emergency room weekly for the last 2 months. She had had many diagnostic studies, the results of which were all negative. Ms. O reported that she was referred by her family doctor for a diagnostic work-up. A psychosocial assessment revealed that her husband had recently died and that she lived alone. As the staff explained to her their understanding of why she was admitted, she became angry and left against medical advice.

About 3 weeks later, Ms. O's son arranged for her to be readmitted because she was still constantly going to the emergency room and to her family doctor. She was angry with her son for having her admitted. On this admission, Ms. O was neatly dressed but looked tired. Her chief complaint was choking and a general infection throughout her body that was causing

COMPETENT CARING—cont'd

a vaginal discharge. Her family doctor again had not told her that he could find nothing physically wrong with her. She was started on a regimen of antidepressant medication. During the 2 weeks she was in the hospital, she spent most of her time socializing with other patients. She was not interested in psychotherapy and did not develop a therapeutic alliance with the staff.

On her third admission, approximately 2 months later, Ms. O's family doctor still had not told her that he thought she had a psychosomatic illness. At this time she was disheveled and looked physically ill. Ms. O spent most of the day in bed. She constantly complained of choking and a vaginal discharge. She admitted that she had stopped taking the antidepressant medication right after discharge from the hospital.

At this point she was angry with all her children and thought they were all against her. She could not understand why they would not accept the fact that she was physically ill. After 2 weeks of treatment, Ms. O was discharged home. Two years later, I met Ms. O in another psychiatric hospital, where she had again been admitted for treatment.

Clearly this is not a success story. In fact, it taught me much about the problems of nonintegrated physical and psychiatric systems of care in which patients are treated as parts rather than wholes. I also realized that I shared responsibility for not providing better care for Ms. O. To this day, she is often in my thoughts, and I now advocate for treating patients broadly within the context of their world view rather than within the narrow realm our society defines as medical care.

CHAPTER IN REVIEW

- Many believe that physical disorders have a psychological component and psychological disorders a physical one.
- The continuum of possible psychophysiological responses to stress based on Selye's theory includes the stages of alarm, resistance, and exhaustion. Any experience that is believed by the individual to be stressful may stimulate a psychophysiological response.
- The primary behaviors observed with psychophysiological responses are the physical symptoms that lead the person to seek health care. People are often reluctant to believe that a physical problem may be related to psychological factors.
- Some people have physical symptoms without any organic impairment, and these are called somatoform disorders. Secondary gain, an indirect benefit usually obtained through an illness or disability and related to the gratification of dependency needs, is a powerful deterrent to change in many patients.
- Pain is increasingly recognized as more than simply a sensory phenomenon; rather, it is a complex sensory and emotional experience underlying potential disease. The experience, expression, and treatment of pain are subject to cultural norms and biases.
- Sleep disturbances can influence the development and course of mental illnesses and addictive disorders and also can affect treatment and recovery. The consequences of sleep disorders, sleep deprivation, and sleepiness are significant and include reduced productivity, lowered cognitive performance, increased likelihood of accidents, higher morbidity and mortality risk, depression, and decreased quality of life.
- Research has linked emotions to arousal of the neuroendocrine system through release of corticosteroids by the hypothalamic-pituitary-adrenal (HPA) axis and to the actions of neurotransmitter systems, particularly norepinephrine and serotonin.
- A biological tendency for particular psychophysiological responses may be inherited, underscoring the importance of genetic factors. Psychoneuroimmunology is the scientific field that explores the relationship among psychological states, the immune system, and health.
- Research suggests that a negative affective style marked by depression, anxiety, and hostility may be associated with the development or recovery from diseases such as asthma, headaches, ulcers, arthritis, and cancer. Complementing the research on negative emotional states and disease is the increasing focus on the protective role of positive emotional states and resilience.
- Health, illness, and suffering are influenced by culture and interpreted in personal worlds of experience. The social course of illness has at least two meanings. First, the severity of the person's symptoms is influenced by aspects of the social environment. Second, the symptoms shape and structure the person's social world, because the illness causes a series of changes in the person's environment.
- Any experience that the person interprets as stressful may lead to a psychophysiological response. One type of stressor that has been shown to cause physical illness and even death is the loss of a significant interpersonal relationship. In contrast, a psychophysiological problem also can be a response to an accumulation of rather small stressors.
- One of the most important parts of promoting adaptive psychophysiological responses involves adopting positive health practices, because good health measures can prevent many illnesses. Social support from family, friends, and caregivers also is an important resource for adaptive psychophysiological responses.
- Psychophysiological disorders may be attempts to cope with the anxiety associated with overwhelming stress. A variety of coping mechanisms are used in psychophysiological response, such as repression, denial, compensation, and regression. Common to each of these coping mechanisms is the need not to confront the basic conflict that is leading to stress and anxiety.
- Primary NANDA-I nursing diagnoses for psychophysiological responses are risk-prone health behavior, ineffective denial, chronic pain, sleep pattern disturbance, and stress overload.

CHAPTER IN REVIEW—cont'd

- Medical diagnoses are categorized as somatoform disorders, factitious disorders, sleep disorders, and psychological factors affecting medical condition.
- The expected outcome of nursing care is that the patient will express feelings verbally rather than through the development of physical symptoms.
- Only after a thorough medical examination can the role of psychosocial stressors in the disorder be evaluated. If the physical condition is life threatening, this intervention is given highest priority. The most important principle for patients with psychophysiological disorders is to assess the patient's stress level and, whenever possible, act to reduce it.
- The dilemma of these disorders is that the patient consciously would like nothing more than to be cured but is unconsciously unable to give up the symptom. The process of insight-oriented therapy for patients with psychophysiological disorders requires that the patient's underlying feelings be recognized and confronted in a supportive manner.
- The next step in therapy is to identify and explore the patient's defenses, proceeding very carefully to help the patient discover and test new, more adaptive coping mechanisms as the dysfunctional ones are given up. Patients also may need help in explaining lifestyle change or changes in themselves to significant others. Nurses must be aware that countertransference often occurs with these patients.
- Psychological approaches include cognitive behavioral strategies, supportive therapy, group therapy, stress reduction, relaxation training, and complementary and alternative therapies such as meditation, biofeedback, massage therapy, and physical activity.
- These patients usually need instruction about medications, treatments, lifestyle changes, and mental health promotion.
- A variety of physiological treatments can be implemented by the nurse, including relaxation training, encouraging physical activity, nutritional counseling, medication, and herbal therapies. Patients should be advised not to use alcohol or drugs to cope with stress.
- The effective treatment of sleep disorders requires that the underlying cause of the sleep problem be identified. The patient should be encouraged to develop good sleep hygiene habits. Although prescription medications and sleep hygiene behavior therapy have similar short-term efficacy, behavioral interventions are recommended as the first-line treatment because of their greater safety and long-term efficacy.

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CHAPTER

17

Self-Concept Responses and Dissociative Disorders

Gail W. Stuart

To venture causes anxiety, but not to venture is to lose one's self. And to venture in the highest sense is precisely to be conscious of one's self.

Søren Kierkegaard

http://evolve.elsevier.com/Stuart/

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive self-concept responses.
2. Identify behaviors associated with self-concept responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to self-concept responses.
4. Describe coping resources and coping mechanisms related to self-concept responses.
5. Formulate nursing diagnoses related to self-concept responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to self-concept responses.
7. Identify expected outcomes and short-term nursing goals for patients related to self-concept responses.
8. Develop a patient education plan to improve family relationships.
9. Analyze nursing interventions related to self-concept responses.
10. Evaluate nursing care related to self-concept responses.

Of all human qualities, the *self* is the most complex. It is the frame of reference through which one perceives and evaluates the world. Self-concept consists of all the values, beliefs, and ideas that contribute to a person's self-knowledge and influence relationships with others, including one's perceptions of personal characteristics and abilities and one's goals and ideals.

The self-concept is critical to understanding people and their behavior. It is formed from a person's internal experiences, relationships with others, and interactions with the outer world. It has a powerful influence on human behavior. **Therefore, understanding a patient's self-concept is an essential part of all nursing care.**

CONTINUUM OF SELF-CONCEPT RESPONSES

Self-Concept

Developmental Influences. From birth the self develops as the infant recognizes and begins to differentiate from others. The boundaries of the self are defined as the result of exploration and experience with one's own body. At first self-differentiation is slow, but with the development of language it accelerates. Use of the child's own name helps with the identification and perception of individuality—of being someone special, separate, and unique.

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

This woman appears to have it all together. Her purse and shoes match; her jewelry is perfect; her hair and makeup are applied perfectly. She is a very successful mortgage broker with many brokers working under her. The company has depended on her for years. She definitely knows how to get things done, but she admits that she is very frightened.

Recently she has been getting lost. She doesn't understand how it happens. She suddenly becomes aware that she doesn't know where she is and doesn't know how she got there. She gets so agitated when it happens that she has to call her daughter, who talks her through figuring out where she is and how to get home. She sees packages in the back seat and assumes she has made purchases but has no memory of doing it. She feels like she is watching her life, not living it, and someone has ripped out some of the pages. It is terrifying to her.

She tells you that her father, an alcoholic, abused her until she was about 12. He would stumble into her room at night and fondle her in the dark. She told her mother about it, but her mother never believed her and did nothing about it. She said when her father finally died, she felt relief but also much guilt. Currently, her daughter, who had been trying to get pregnant for some time, was finally successful and is now pregnant with twins. However, it is a tenuous pregnancy, and she expects to be on bed rest soon. Her husband's daughter (from a previous marriage) started using heroin and also is pregnant. Her son has recently come out to the family as being gay. She loves them all but feels completely overwhelmed and stressed beyond her capacity to cope.

Case Critical Reasoning Questions

1. How has her childhood experience shaped her self-concept, body image, self-ideal, self-esteem, and personal identity?
2. How do the concepts of identity diffusion, dissociation, and depersonalization manifest in her behavior?
3. What precipitating stressors does she describe, and how do they threaten her "idealized self"?
4. What medical and nursing diagnoses would be appropriate for helping her?

Significant Others. The self-concept is learned in part through social contacts and experiences with other people over time. This has been called "learning about self from the mirror of other people" (Sullivan, 1963). A person's concept of self therefore rests partly on what he thinks others think of him. For a young child the most significant others are the parents, who help the child grow and react to experiences.

Parents provide the child with the earliest experiences of the following:

- **Feelings of adequacy or inadequacy**
- **Feelings of acceptance or rejection**
- **Opportunities for identification**
- **Expectations concerning acceptable goals, values, and behaviors**

Parental influence is strongest during early childhood and continues to have a significant impact through adolescence and young adulthood. Over time, however, the power and influence of friends and other adults increase, and they become significant others to the person. **Culture and socialization practices also strongly affect self-concept and personality development.**

> **Critical Reasoning** What sociocultural factors had an impact on your self-concept as you were growing up? Which ones currently influence your self-concept?

Self-Perceptions. One's perception of reality is selective and is based on whether the experience is consistent with one's current view of self. The way a person behaves is a result of how the person perceives the situation. It is not the event itself that elicits a specific response but rather the individual's subjective experience of the event.

One's needs, values, and beliefs strongly influence perceptions. **People are more likely to perceive what is meaningful and consistent with present needs and personal values.** Similarly, people behave in a manner consistent with what they believe to be true. In this case a fact is not what is true but what one believes to be true.

Self-perceptions can be difficult to change. However, there are ways to change perceptions, including modifying cognitive processes, taking drugs, undergoing sensory deprivation, and creating biochemical changes within the body. A person with a weak or negative self-concept who is unsure of self is likely to have narrowed or distorted perceptions. Because he feels easily threatened, his anxiety level will rise quickly and he will become preoccupied with defending himself. In contrast, a person with a strong or positive self-concept can explore the world openly and honestly because he has a supporting background of acceptance and success.

Positive self-concepts result from positive experiences leading to perceived competence and acceptance of others different from oneself. Negative self-concepts are correlated with poor personal and social adjustment.

Figure 17-1 describes the continuum of self-concept responses from the **most adaptive state of self-actualization** to the **most maladaptive response of depersonalization.** To provide the best care the nurse needs an understanding of body image, self-ideal, self-esteem, role, and identity.

Body Image

The concept of one's body is central to the concept of self. The body is the most visible part of the self, and it is an anchor for self-awareness. A person's attitude toward the body may mirror important aspects of identity. For example, feelings that

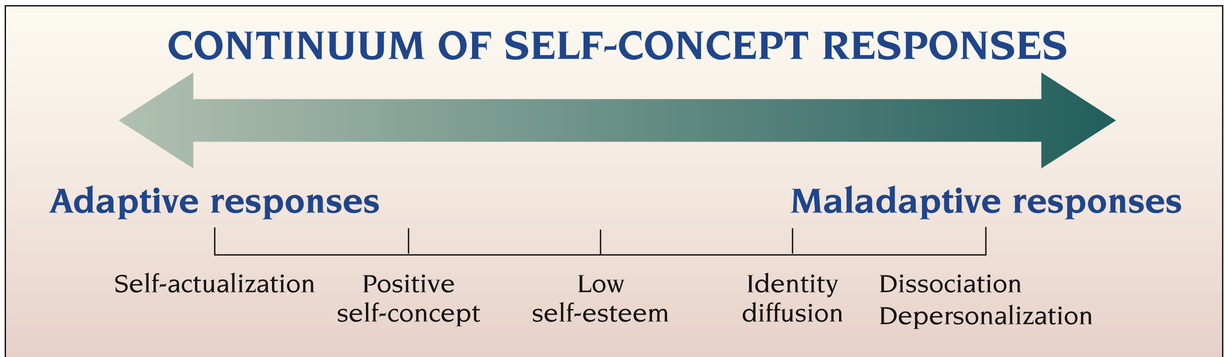

FIG 17-1 Continuum of self-concept responses.

one's body is big or small, attractive or unattractive, weak or strong also reveal something about one's self-concept. A positive relationship between self-concept and body image exists in all cultures.

Body image is the sum of the conscious and unconscious attitudes one has toward one's own body. It includes present and past perceptions as well as feelings about size, function, appearance, and potential. Body image is constantly changing as new perceptions and experiences are encountered in life. As one's body image develops, extensions of the body become important. Clothes become identified with the body, as do one's possessions.

Body image, appearance, and positive self-concept are all related. The more one accepts and likes one's own body, the more secure and free from anxiety one feels. **People who accept their bodies are more likely to have high self-esteem than people who dislike their bodies.**

> **Critical Reasoning** What does it mean when one says that "a child lives in his body but an adult lives in his mind"?

Self-Ideal

The **self-ideal** is the person's perception of how to behave based on certain personal standards. The standard may be an image of the type of person one would like to be or the aspirations, goals, or values that one would like to achieve. **The self-ideal creates self-expectations based in part on society's norms, to which the person tries to conform.**

Formation of the self-ideal begins in childhood and is influenced by significant others, who place demands or expectations on the child. With time the child internalizes these expectations, and they form the basis of the child's own self-ideal. New self-ideals are taken on during adolescence, formed from identification with parents, teachers, and peers. In old age, additional adjustments must be made that reflect diminishing physical strength and changing roles and responsibilities.

Various factors influence self-ideals. First, a person tends to set goals within a range determined by personal abilities. One does not usually set a goal that is accomplished without any effort or that is entirely beyond one's abilities.

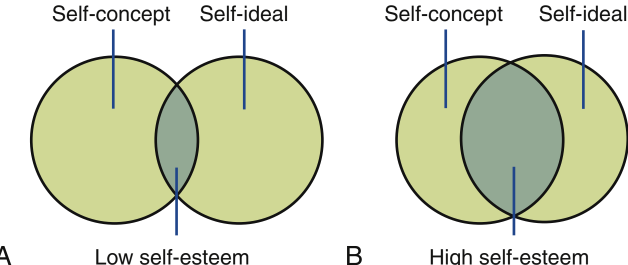

FIG 17-2 A, Person with a low level of self-esteem caused by a large discrepancy between self-concept and self-ideal. **B,** Person with a greater conformity of self-concept and self-ideal and therefore a high level of self-esteem.

Self-ideals also are influenced by cultural factors as the person compares self-standards with those of peers. Other influencing factors include ambitions and the desire to excel and succeed, the need to be realistic, the desire to avoid failure, and feelings of anxiety and inferiority.

Based on these factors, one's self-ideal may be clear and realistic and thus promote personal growth and relations with others, or it may be vague, unrealistic, and demanding. **The well-functioning person has congruence between perception of self and self-ideal; that is, he sees himself as being very similar to the person he wants to be.**

In summary, self-ideals are important in maintaining mental health and balance. The self-ideal must be neither too high and demanding nor too vague and shadowy, yet it must be high enough and defined enough to provide continuous support to one's self-respect.

> **Critical Reasoning** What are your self-ideals in relation to your career as a nurse?

Self-Esteem

Self-esteem is a person's personal judgment of self-worth, based on how well behavior matches up with self-ideal. How frequently a person attains goals directly influences feelings of competency (high self-esteem) or inferiority (low self-esteem) (Figure 17-2).

High self-esteem is a feeling based on unconditional acceptance of self, despite mistakes, defeats, and failures, as

an innately worthy and important being. It involves accepting complete responsibility for one's own life.

Self-esteem comes from two sources: the self and others. It is first a function of being loved and gaining the respect of others. Self-esteem is lowered when love is lost and when one fails to receive approval from others; it is raised when love is regained and when one is applauded and praised.

The origins of self-esteem begin in childhood and are based on acceptance, warmth, involvement, consistency, praise, and respect (Coopersmith, 1967; Mruk, 2006). **The four best ways to promote a child's self-esteem are as follows:**

1. **Providing opportunities for success**
2. **Instilling ideals**
3. **Encouraging aspirations**
4. **Helping the child build defenses against attacks to self-perceptions**

These approaches should provide the child with a feeling of significance or success in being accepted and approved of by others; a feeling of competence, or an ability to cope effectively with life; and a feeling of power, or control over one's own destiny.

Self-esteem increases with age and is most threatened during adolescence, when concepts of self are being changed and many self-decisions are made. Adolescents must choose career paths and decide whether they are good enough to succeed at them. Adolescents also must decide whether they are able to participate or are accepted in various social activities.

With adulthood the self-concept stabilizes, and maturity provides a clearer picture of self. The adult tends to be more self-accepting and less idealistic than the adolescent. Adults have learned to cope with many self-deficiencies and to maximize self-strengths.

In later life, self-esteem problems again arise because of the new challenges posed by retirement, loss of loved ones, and physical disability. The impact of aging on self-esteem also is affected by the status of older people in U.S. society. Being old in a society that values youth often leads to low status and prejudicial attitudes toward the aged. Negative stereotypes of the elderly and the stigmatization that results can decrease self-esteem. Two other potential negative factors are the decreased social interaction of the elderly and their loss of control over their environment, both of which can result in fewer opportunities to validate and confirm the self-concept.

Finally, there is a clear relationship between self-reported physical health and self-esteem. The report of a health problem, regardless of its type or severity, is associated with significantly lower self-esteem than is the report of no health problem.

High self-esteem has been correlated with low anxiety, effective group functioning, and acceptance and tolerance of others. Once self-esteem is achieved, the person is free to concentrate on achieving potential.

> **Critical Reasoning** Why do you think low self-esteem is associated with poor interpersonal relations, intolerance of others, and depressive states?

Role Performance

Roles are sets of socially expected behavior patterns associated with a person's functioning in different social groups. People assume various roles, which they try to integrate into one functional pattern. Role behavior is closely related to self-concept and identity, and role disturbances often involve conflicts between independent and dependent functioning. **High self-esteem results from roles that meet needs and are congruent with one's self-ideal.**

Factors that influence a person's adjustment to a role include the following:

- Knowledge of specific role expectations
- Consistent responses from significant others to one's role
- Compatibility and complementarity of various roles
- Congruency of cultural norms and one's own expectations for role behavior
- Separation of situations that would create incompatible role behaviors

Gender roles affect performance in other roles. They are particularly significant to family roles and are often the cause of role conflict. Another difficult problem faced in growing up is emancipation from one's parents and establishment of an independent life. This primarily occurs during adolescence and early adulthood. A final crisis is faced during old age, when aging parents must again change role behavior. They rely on their children yet strive to balance their lives with a sense of independence and a high level of self-esteem.

Personal Identity

Identity is the awareness of being oneself based on self-observation and judgment. It is not associated with any single accomplishment, activity, characteristic, or role. **Identity differs from self-concept in that it is a feeling of distinctness from others.**

The person with a firm sense of identity feels integrated, not diffuse. When a person acts in accordance with self-concept, the sense of identity is reinforced. When a person acts in ways contrary to the self-concept, anxiety and apprehension result. **The person with a positive sense of identity sees himself as a unique and valuable individual.**

Developmental Influences. The concept of ego identity was developed by Erikson (1963), who identified eight stages of human development. For each stage, Erikson described a psychosocial crisis that must be resolved for further growth and personality development to occur.

In adolescence the crisis of *identity versus identity diffusion* occurs. At no other phase of life are the promise of finding oneself and the threat of losing oneself so closely aligned. The adolescent's task is one of self-definition as the person strives to integrate previous roles into a unique and reasonably consistent sense of self.

Important in achieving identity is the issue of sexuality, the image of oneself as a male or a female and what that implies. Society's ideals of masculinity and femininity are

TABLE 17-1 QUALITIES OF THE HEALTHY PERSONALITY

CHARACTERISTIC	DEFINITION	DESCRIPTION
Positive and accurate body image	Body image is the sum of the conscious and unconscious attitudes one has toward one's body function, appearance, and potential.	A healthy body awareness is based on self-observation and appropriate concern for one's physical well-being.
Realistic self-ideal	Self-ideal is one's perception of how one should behave or the standard by which behavior is appraised.	A person with a realistic self-ideal has attainable life goals that are valuable and worth striving for.
Positive self-concept	Self-concept consists of all the aspects of the self of which one is aware. It includes all self-perceptions that direct and influence behavior.	A positive self-concept implies that the person expects to be successful in life. It includes acceptance of the negative aspects of the self as part of one's personality. Such a person faces life openly and realistically.
High self-esteem	Self-esteem is one's personal judgment of one's own worth, which is obtained by analyzing how well one matches up to one's own standards and how well one's performance compares with that of others. It evolves through a comparison of the self-ideal and self-concept.	Persons with high self-esteem feel worthy of respect and dignity, believe in their own self-worth, and approach life with assertiveness and zest. People with a healthy personality feel very similar to the person they want to be.
Satisfying role performance	Roles are sets of socially expected behavior patterns associated with functioning in various social groups.	The healthy person can relate to others intimately, receive gratification from social and personal roles, trust others, and enter into mutual and interdependent relationships.
Clear sense of identity	Identity is the integration of inner and outer demands in one's discovery of who one is and what one can become. It is the realization of personal consistency.	People with a clear sense of identity experience a unity of personality and perceive themselves to be unique persons. This sense of self gives life direction and purpose.

standards for judging oneself as good or bad, superior or inferior, desirable or undesirable. These ideals are passed down from generation to generation and become a part of the culture. If males are defined as superior, this idea becomes part of the self-image of both males and females. If passivity and obedience are considered to be feminine ideals in a society, most girls will be taught to be unassertive and obedient.

Much of one's identity is expressed in relationships with others. How a person relates to other people is a central personality characteristic. This presents a paradox in that everyone is a part of humanity yet each person is also separate from all others.

Achieving personal identity is a prerequisite for establishing an intimate relationship with another person. Only after a stable sense of identity has been established can one engage in a genuinely mature and successful relationship with a significant other.

Healthy Personality

A person with a healthy personality has the characteristics listed in Table 17-1 and is able to perceive both self and the world accurately. This insight creates a feeling of harmony and inner peace.

> **Critical Reasoning** How do you compare with the qualities of a healthy personality listed in Table 17-1?

ASSESSMENT

Behaviors

Assessing a patient's self-concept is a challenge to the nurse. Because self-concept is the cornerstone of the personality, it is closely related to anxiety and depression, problems in relationships, acting out, and self-destructive behavior.

All behavior is motivated by a desire to enhance, maintain, or defend the self, so the nurse has much information to evaluate. The nurse also must go beyond objective and observable behaviors to the patient's subjective and internal world. Only by exploring this area can the nurse understand the patient's actions.

The nurse begins the assessment by observing the patient's appearance. Posture, cleanliness, makeup, and clothing provide data. The nurse might discuss the patient's appearance with the patient to determine what values are held related to body image. Observing or inquiring about eating, sleeping, and hygiene patterns gives clues to biological habits and self-care.

These initial observations should lead the nurse to ask: What does my patient think about himself as a person? How would he describe himself? What strengths does my patient think he has? What are areas of weakness? What is my patient's self-ideal? Does my patient value his strengths? Does my patient view his weaknesses as important personality deficits, or are they unimportant to self-concept? What are my patient's priorities? Does my patient feel unified and self-directed or diffuse and other-directed?

The nurse then compares the patient's responses with behavior, looking for consistencies and contradictions. How does the patient relate to other people? How does the patient respond to compliments and criticisms? The nurse also can examine her own affective response to the patient. Is it one of hopelessness, despair, anger, or anxiety? **The nurse's own response to the patient is often a good indication of the quality and depth of the patient's emotional state.**

Behaviors Associated With Low Self-Esteem. Low self-esteem is a problem for many people and can be expressed in moderate and severe levels of anxiety. It involves negative self-evaluations and is associated with feelings of being weak, helpless, hopeless, frightened, vulnerable, fragile, incomplete, worthless, and inadequate. Low self-esteem also plays a large role in depression. It may indicate self-rejection and self-hate, expressed in direct or indirect ways.

Direct behaviors. Direct expressions of low self-esteem may include any of the following areas.

Self-criticism. Patients have negative thinking and believe they are doomed to failure. Although the expressed purpose of the criticism may be self-improvement, there is no constructive value in it, and the underlying goal is self-demoralization. Patients might describe themselves as "stupid," "no good," or a "born loser." They view the normal stressors of life as impossible barriers and become preoccupied with self-pity.

Self-diminution. Self-diminution involves minimizing one's ability by avoiding, neglecting, or refusing to recognize one's real assets and strengths.

Guilt and worry. Guilt and worry are destructive activities by which people punish themselves. They may be expressed through nightmares, phobias, obsessions, or the reliving of painful memories and indiscretions. They indicate self-rejection.

Physical manifestations. Physical manifestations may include hypertension, psychosomatic illnesses, and the abuse of various substances, such as alcohol, drugs, tobacco, or food.

Postponing decisions. A high level of ambivalence or procrastination produces an increased sense of insecurity.

Denying oneself pleasure. Self-rejecting people feel the need to punish themselves and express this by denying themselves the things they find desirable or pleasurable. This might be a career opportunity, a material object, or a desired relationship.

Disturbed relationships. The person may be cruel, demeaning, or exploitive with other people. This may be an overt pattern or a passive-dependent pattern of relating that indirectly exploits others. Another behavior is social isolation that comes from feelings of worthlessness.

Withdrawal from reality. When anxiety resulting from self-rejection reaches severe or panic levels, the person may dissociate and experience hallucinations, delusions, and feelings of suspicion, jealousy, or paranoia. Such withdrawal from reality may be a temporary coping mechanism or a long-term pattern indicating a profound problem of identity confusion.

Self-destructiveness. Self-hatred can be expressed through accident proneness or attempting dangerous feats. Extremely low levels of self-esteem can lead to suicide.

Other destructiveness. People who have overwhelming low self-esteem may choose to act out against society. This activity serves to paralyze their own self-hate and displaces or projects it onto victims.

Indirect behaviors. Indirect forms of self-hate complement and supplement the direct forms. The patterns may be chronic and difficult to change.

Illusions and unrealistic goals. Self-deception is the core element; the person refuses to accept a limited here and now. Illusions increase the possibility of disappointment and further self-hate. Examples of illusions are "If I were married, I would be happy" and "Money brings success." This indirect form of low self-esteem may make the person sensitive to criticism or overresponsive to flattery. It also may be evident in the defense mechanisms of blaming others for one's failures and becoming hypercritical to create the illusion of superiority.

Exaggerated sense of self. People may attempt to compensate by expressing an exaggerated opinion of their ability. They may continually boast, brag of their exploits, or claim extraordinary talents. An extreme compensatory behavior for low self-esteem is grandiose thinking and related delusions. Another example is evident in perfectionists. Such people strain toward impossible goals and measure their own worth in terms of productivity and accomplishment.

Boredom. Boredom involves the rejection of one's possibilities and capabilities. The person may neglect or reject aspects that have great potential for future growth.

Polarizing view of life. In this case the person has a simplistic view of life in which everything is worst or best, wrong or right. This person tends to have a closed belief system that acts as a defense against a threatening world. Ultimately this view of life leads to confusion, disappointment, and alienation from others.

The behaviors associated with low self-esteem are described in the clinical example that follows and are summarized in Box 17-1.

CLINICAL EXAMPLE

Ms. G was a 66-year-old woman admitted to the psychiatric hospital because of a major depressive episode. She told the admitting nurse that "things have been building up for some time now" and that the private psychiatrist she had been seeing for the past 6 months suggested that she enter the hospital. She had been employed in a community college as a librarian until 18 months earlier, when she was forced to retire.

Ms. G said she had been married for 39 years and had two grown children, who were married and lived out of state. Her husband had worked as an accountant but had retired 1 month earlier. She said that since her retirement she had felt "useless and lost" and "closed in by their apartment." She seldom left the apartment and had lost contact with many of her friends. She said she worried a great deal about their financial situation, especially now

that her husband was also retired. He repeatedly reassured her that they had enough money, but she could not stop worrying about it.

Ms. G said that she liked her old job very much and thought she was good at it. A younger woman took her place at the library, and Ms. G was very bitter when talking about her. She said that, little by little, this woman took over duties Ms. G was responsible for and one day even cleaned out Ms. G's desk and took it as her own.

Since her retirement, she said, things had been "going downhill steadily." She said she was not a good housewife and disliked cooking. These tasks had become even more difficult since her husband retired, because he was "always underfoot and criticizing" what she did. In the past couple of weeks, she had had great difficulty sleeping, a decreased appetite, fatigue, and little interest in her appearance. She said it seemed that all she had to do was "wait around to die."

Selected Nursing Diagnoses

- Situational low self-esteem related to developmental transition, as evidenced by self-criticism and lack of pleasure in life
- Ineffective role performance related to retirement, as evidenced by feeling useless and failing to complete routine activities
- Social isolation related to low self-worth, as evidenced by lack of contact with friends

In this clinical example, Ms. G's perception of self was closely related to her ability to work. Her retirement created role changes she found difficult to adapt to. This example points out the close relationship between low self-esteem and role strain. The situation was further compounded by her husband's retirement. Ms. G's feelings of low self-esteem were evident in her self-criticism, refusal to recognize her own strengths, worrying, physical complaints, and reduced social contacts. The diagnosis of major depressive episode was based on the severity of her feelings of self-deprecation, somatic problems, saddened emotional tone, history of losses, and absence of a manic episode.

Low self-esteem is also a major element of disturbed body image. The next clinical example illustrates the effect of the loss of a body part on a person's self-concept.

BOX 17-1 BEHAVIORS ASSOCIATED WITH LOW SELF-ESTEEM

Criticism of self or others
Decreased productivity
Destructiveness
Disruptions in relatedness
Exaggerated sense of self-importance
Feelings of inadequacy
Guilt
Irritability or excessive anger
Negative feelings about one's body
Perceived role strain
Pessimistic view of life
Physical complaints
Polarizing view of life
Rejection of personal capabilities
Self-destructiveness
Self-diminution
Social withdrawal
Substance abuse
Withdrawal from reality
Worrying

CLINICAL EXAMPLE

Ms. M was an attractive, 32-year-old married woman who had been admitted to the general hospital for a total hysterectomy. Her history was presented in a nursing care conference because she was making many demands and the nurse manager noted that many of the staff members were avoiding caring for her. Ms. M had been married for 2 years and did not have any children. It was observed that Mr. M had not visited his wife, although he did speak to her over the phone. Ms. M complained that she was unable to sleep at night and often rang for the nurses with apparently minor requests. She appeared to have established a relationship with one of the nurses, who was able to describe some of Ms. M's concerns.

Ms. M appeared to have a severe level of anxiety about her hysterectomy. She feared the effect of the surgery on her sexual desires, attractiveness, and ability to have intercourse and respond to her husband. Without her reproductive organs, she said, she would feel "inadequate and no longer like a woman." She said that she and her husband always planned on having children, and she wondered whether her husband might leave her in the future. She also feared that having the hysterectomy would cause her to lose her beauty and youth.

When the nursing staff became aware of Ms. M's many fears and concerns, they were better able to understand her behavior and plan nursing care accordingly. They discussed with her the physiological implications of a hysterectomy and encouraged her to verbalize her feelings.

Mr. M was not aware of his wife's concerns, and the nursing staff supported open discussions between them. As the staff members were able to identify Ms. M's concerns, they realized that some of their previous avoidance behavior had resulted from their own fears and discomfort. The female nurses had identified with her, and the hysterectomy threatened their own concepts of self, body integrity, and sexual identity.

Selected Nursing Diagnoses

- Disturbed body image related to hysterectomy, as evidenced by expressed fears about attractiveness and functioning as a woman
- Interrupted family processes related to lack of ability to bear children, as evidenced by limited communication with husband

Behaviors Associated With Identity Diffusion. Identity diffusion is the failure to integrate various childhood identifications into a unified adult identity. **Important behaviors that relate to identity diffusion include disruptions in relationships and problems of intimacy.**

The initial behavior may be withdrawal or distancing. A person who is experiencing an undefined identity may wish

to ignore or destroy threatening people. The problem is one of gaining intimacy, but it is reflected in isolation, denial, and withdrawal from others. These patients lack empathy.

A contrasting behavior is seen in personality fusing. **Personality fusion** is a person's attempt to establish a sense of self by fusing with, attaching to, or belonging to someone else. Erikson pointed out that true intimacy involves a sense of mutuality, which implies a firm self-delineation of the partners, not a diffused merger of two people.

A person who is struggling to cope with a weak or undefined identity may try to establish a sense of self by fusing with or belonging to someone else. This may occur in formal relationships, intense friendships, or brief affairs, each of which can be seen as a desperate attempt to outline one's own identity. However, personality fusion leads to a further loss of identity. Some of these behaviors are evident in the clinical example.

CLINICAL EXAMPLE

Ms. P was seen by a psychiatric nurse in the psychiatric outpatient department of a general hospital. She was a well-dressed, 24-year-old woman who had numerous somatic complaints, including decreased appetite, frequent headaches, fatigue, and difficulty falling asleep. She reported that she had no energy or interest in doing anything or being with people. She said she dreaded each day and felt abandoned and alone.

She was married at age 17 years to the only boy she ever dated in high school. He was 19 years old at the time, and she "looked up to him tremendously." He established a successful career in the insurance business, and she stayed at home to care for the house. She described herself as centering her whole world around him. Three months earlier, he had told her that he wanted a separation and suggested she begin making a new life for herself. He said he intended to move out of the house at the end of the month, but Ms. P said she hoped he would not do that when he saw how much she loved and needed him.

Ms. P also described feelings of being unloved and unlovable. She said she felt empty inside and didn't really know who she was. She complained about her appearance and expressed much fear about living alone, finding a job, and getting along with people, especially men.

Selected Nursing Diagnoses

- Disturbed personal identity related to impending separation, as evidenced by feelings of loneliness and abandonment
- Situational low self-esteem related to doubts about self and abilities, as evidenced by expressed fears of living alone, finding a job, and getting along with people

Many of Ms. P's behaviors reflect the problem of identity diffusion. She married at an early age, before defining her own sense of self as an autonomous individual. Her only experience in a close relationship was with her husband, and she attempted to establish her own identity by living through his. Within the security of the marriage, she managed to avoid any self-analysis, but the impending separation brought forth her fears and self-doubts. She displayed a low level of self-esteem and an unresolved conflict between dependence and independence.

Personality fusion and problems with identity have serious implications for the larger family system. Dysfunctional families are often characterized by a fusion of ego mass that may be evident in symptomatology by one or more family members. This may be expressed in some form of family violence or abuse (see Chapter 38) or in the scapegoating of a family member.

Finally, people with identity diffusion also may lack a coherent sense of history, cultural norms, group affiliation, lifestyle, or sound child-rearing practices. A related behavior may be the absence of a moral code or of any genuine inner value. The behaviors characteristic of identity diffusion are summarized in Box 17-2.

Behaviors Associated With Dissociation and Depersonalization. A more maladaptive response to problems in identity is the withdrawal from reality that occurs when a person experiences panic levels of anxiety. This panic state produces a blocking off of awareness, a collapse in reality testing, and feelings of dissociation and depersonalization.

Dissociation is a state of acute mental decompensation in which certain thoughts, emotions, sensations, or memories are compartmentalized because they are too overwhelming for the conscious mind to integrate (MacDonald, 2008; Weber, 2007). **In severe forms of dissociation, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception.**

Depersonalization is the subjective experience of the partial or total disruption of one's ego and the disintegration and disorganization of one's self-concept. It is a feeling of unreality in which one is unable to distinguish between inner and outer stimuli. The person has great difficulty distinguishing self from others, and the body has an unreal or strange quality. It is the most frightening of human experiences.

Dissociation and depersonalization serve as defenses, but they are destructive because they mask and immobilize anxiety without reducing its intensity. They can occur in a variety of clinical illnesses, including depression, schizophrenia, manic states, and organic brain syndromes.

Many behaviors are associated with dissociation and depersonalization. Primarily, patients feel estranged, as though they were hiding something from themselves. They experience a lack of inner continuity and sameness and feel as if life is happening to them rather than living by their own

BOX 17-2 BEHAVIORS ASSOCIATED WITH IDENTITY DIFFUSION

Absence of moral code
Contradictory personality traits
Exploitive interpersonal relationships
Feelings of emptiness
Fluctuating feelings about self
Gender confusion
High degree of anxiety
Inability to empathize with others
Lack of authenticity
Problems of intimacy

QUALITY AND SAFETY ALERT

- Dissociation and depersonalization represent an advanced state of ego breakdown associated with multiple personality disorder and psychotic states.

initiative. This is sometimes described as the experience of being a "passenger" in one's own body rather than the driver.

Patients may say that the world appears strange, dreamlike, or frightening. They may experience a loss of identity and self-respect and feelings of insecurity, inferiority, frustration, fear, hate, and shame. They may be unable to feel a sense of accomplishment from any activity. In depersonalization, a loss of impulse control and an absence of feeling and emotion may be present, which is shown in impersonality and stiffness in social situations.

People may become lifeless and lack spontaneity and animation. They may plod through each day in a state of numbness and may respond to situations without expressions of love, hate, anxiety, or guilt. They may become increasingly passive, withdrawing from social contacts, failing to assert themselves, losing interest in surroundings, and allowing others to make decisions for them.

Another sign of depersonalization is a disturbance in perception of time, space, and memory. The person may become disoriented, unable to recognize past or current events, and unable to plan future activities. A disturbance of memory may be characterized by aphasia, amnesia, or memory distortion. Thinking and judgment may be impaired, with great confusion and distortion or a focus on trivial details. In severe forms, problems in information processing may be seen in visual hallucinations, delusions, auditory hallucinations, and distortions in communication.

Another behavior associated with depersonalization is a confused or disturbed body image. The person may have a feeling of unreality about parts of the body. Patients may feel that their limbs are detached or that the size of their body parts has changed, or they may be unable to tell where the body leaves off and the rest of the world begins. Some patients describe a feeling that they have stepped outside their bodies and are observing themselves as detached and foreign objects.

Finally, the person may exhibit behaviors related to dissociative identity disorder, known as **multiple personality disorder.** In this case, distinct and separate personalities exist within the same person, each of whom recurrently dominates the person's attitudes, behaviors, and self-view as though no other personality existed (Box 17-3).

Because most patients with dissociative identity (multiple personality) disorder hide their condition, the periods in their lives when they show overt symptoms are quite limited, so diagnosing them is not easy. During these times the patients often show subtle dissociative signs in their affects, thoughts, memories, and behaviors.

The many behaviors associated with dissociation and depersonalization are summarized in Box 17-4. The following clinical example may further clarify these behaviors.

BOX 17-3 A FAMILY SPEAKS

My wife has multiple personality disorder, and it feels like I'm living with several different people. One moment everything is great, and the next thing I know, she is in a frenzy or a state of rage. There are other problems, too. For example, things keep appearing in our household, and no one knows where they came from, or I get calls at work from my wife telling me she is lost and doesn't know how she ended up there. At other times she tells me things and later denies she said them. Sometimes people come up to my wife and talk like they know her, but she says she's never seen them before. And then there are days when she dresses up and acts just like our teenage daughter.

What is it like to live with someone with this illness? Well, it's unreal and very upsetting. Most of all, it's like living in a world of doubt and uncertainty. Who is this woman I married 20 years ago? What is she all about? What is she capable of doing? These are the questions I ask myself each night as I fall asleep. They are the same ones that go unanswered in the early morning hours.

QUALITY AND SAFETY ALERT

- Multiple personality disorder should not be confused with schizophrenia or other psychotic disorders. Rather, it is a type of dissociative disorder.

BOX 17-4 BEHAVIORS ASSOCIATED WITH DISSOCIATION AND DEPERSONALIZATION

Affective

Feelings of loss of identity
Feelings of alienation from self
Feelings of insecurity, inferiority, fear, shame
Feelings of unreality
Heightened sense of isolation
Inability to derive pleasure or a sense of accomplishment
Lack of sense of inner continuity

Perceptual

Auditory and visual hallucinations
Confusion regarding one's sexuality
Difficulty distinguishing self from others
Disturbed body image
Dreamlike view of the world

Cognitive

Confusion
Distorted thinking
Disturbance of memory
Impaired judgment
Presence of separate personalities within the same person
Time disorientation

Behavioral

Blunted affect
Emotional passivity and nonresponsiveness
Incongruent or idiosyncratic communication
Lack of spontaneity and animation
Loss of impulse control
Loss of initiative and decision-making ability
Social withdrawal

CLINICAL EXAMPLE

Mr. S was a 40-year-old man with no history of psychiatric hospitalization. Two months before his present admission, he was severely burned while on the job in a steel-making plant. He sustained second- and third-degree burns over his face, hands, chest, and back and was treated in the burn center of a large university hospital.

Three days before he was to be discharged from the burn unit, he experienced a psychotic episode. He reported hearing voices telling him to kill himself, and he was unable to recall any events surrounding the accident that produced his burns. He said he felt his arms were withering away and his eyes were falling into his skull. He was unable to change the dressing on his burns even though he had done this before. When he looked at his arms or chest, his face remained impassive and he showed no emotion. He began to talk continuously about returning to work but was unable to identify how long he had been out on sick leave or the amount of time recommended by his physician for recovery.

With the onset of these symptoms, Mr. S was transferred from the burn unit to the psychiatric unit of the hospital. He remained socially isolated on the unit and refused to participate in ward meetings and group activities. At times he wandered into other patients' rooms and took pieces of their clothing. He was later seen wearing this clothing, and the staff intervened to return it to its owners.

Selected Nursing Diagnoses

- Panic level of anxiety related to severe burn injuries, as evidenced by confusion regarding identity, hearing voices, and reported body distortions
- Disturbed thought processes related to psychotic state, as evidenced by confusion and disorientation

The various feelings and perceptions associated with dissociation and depersonalization are extreme defenses against threats to self that do not relieve the anxiety and may add to it. The patient views his own behavior as foreign and sees himself as a strong, unknown, and unpredictable being that he does not recognize. As both a participant and a spectator, he observes himself with great fear because he is unable to control his own impulses. He cannot completely escape the pain of self-awareness. He therefore disowns his behavior, feelings, thoughts, and body and becomes alienated from his true self.

Predisposing Factors

Factors Affecting Self-Esteem. Predisposing factors that begin in early childhood can contribute to problems with self-concept. Because infants initially view themselves as extensions of their parents, they are very responsive to both their parents' emotional state and any negative feelings toward themselves. Parental rejection causes children to be uncertain of themselves and other human relationships. Because of their failure to be loved, children fail to love themselves and are unable to reach out with love to others.

As children grow older, they may learn to feel inadequate because they are not encouraged to be independent, to think for themselves, and to take responsibility for their own needs and actions. Overpossessiveness, overpermissiveness, or overcontrol by one or both parents can create a feeling of unimportance and lack of self-esteem in the child. Harsh, demanding parents can set unreasonable standards, often raising them before the child can meet them.

Parents also may subject their children to unreasonable, harsh criticism and inconsistent punishment. These actions can cause early frustration and a sense of inadequacy and inferiority. Another factor may be the rivalry or unsuccessful imitation of an extremely bright sibling or a prominent parent, which often creates a sense of hopelessness and inferiority.

In addition, repeated defeats and failures can destroy self-worth. In this instance the failure in itself does not produce a sense of helplessness, but internalization of the failure as proof of personal incompetence does.

Unrealistic Self-Ideals. With age, other factors emerge that can cause feelings of low self-esteem. The person who lacks a sense of meaning and purpose in life also fails to accept responsibility for personal well-being and fails to develop potential. These people deny themselves the freedom to make mistakes and to fail; they become impatient, harsh, and demanding with themselves. They set standards that cannot be met. Self-consciousness and observation turn to self-contempt and self-defeat. This results in a further loss of self-trust.

These self-ideals or goals are often silent assumptions, and the person may not be immediately aware of them. They reflect high expectations and are unrealistic. The person who judges performance by such unreasonable and inflexible standards cannot live up to these ideals and, as a result, experiences guilt and low self-esteem. These inner dictates have been described as the "tyranny of the *shoulds*," and some of the common ones are identified in Box 17-5.

The person who overemphasizes unrealistic rules or ideals often thinks as follows: "Everyone should love me. If someone doesn't love me, I have failed. I have lost the only thing that really matters. I am unlovable. There is no point in going on. I am worthless." This inner punishment results in feelings of depression and despair.

Relentlessly striving for such ideals only interferes with other activities, such as living a healthy life and having satisfying relationships with other people. These predisposing factors lay the groundwork for feelings of low self-esteem.

BOX 17-5 UNREALISTIC SELF-EXPECTATIONS: THE TYRANNY OF THE "SHOULDS"

I should have the utmost generosity, consideration, dignity, courage, and unselfishness.
I should be the perfect lover, friend, parent, teacher, student, and spouse. Everyone should love me.
I should be able to find a quick solution to every problem.
I should never feel hurt; I should always be happy and serene.
I should assert myself; I should never hurt anybody else.
I should always be at peak efficiency. I should not be tired, get sick, or make mistakes.

From Horney K: *Neurosis and human growth,* New York, 1950, WW Norton.

Factors Affecting Role Performance

Gender roles. Another source of strain can come from values, beliefs, behaviors, and stereotypes about gender roles. For example, women may be perceived to be less competent, less independent, less objective, and less logical than men. Men may be perceived to be lacking in interpersonal sensitivity, warmth, and expressiveness, and stereotyped masculine traits may be perceived as more desirable than stereotyped feminine characteristics.

To the extent that these perceptions reflect societal standards of gender-role behavior, both women and men are put in role conflict by the difference in the standards. A woman who adopts behaviors that are considered desirable for a man risks criticism for her failure to be appropriately feminine. If she adopts behaviors seen as feminine, she is lacking in the values associated with masculinity.

Likewise, if a man adopts the behaviors seen as desirable for a woman, his masculinity and sexuality may be questioned, and his contributions may be devalued or ignored. If he adopts the behaviors associated with masculinity, he risks not being able to express warmth, tenderness, and responsiveness.

> **Critical Reasoning** Compare the value that two different cultures place on feminine and masculine roles and traits.

Work roles. Women are in the minority in the highest-status and highest-paying occupations. In U.S. society, women are socialized to seek an ideal that includes marriage, children, higher education, and satisfying work outside the home. They are increasingly expected to perform in both "feminine" and "masculine" spheres.

This can have negative aspects. First, it can potentially replace the traditional woman's role with another, equally confining one. As the new role is valued, the traditional roles of wife and mother become devalued. Second, although women are expected to assume more "masculine" qualities, there is a smaller trend for men to assume more "feminine" behaviors. Third, the woman who seeks such an expanded role is faced with reconciling the often conflicting goals of work, marriage, homemaking, and parenting. **To promote mental health, nurses should encourage both men and women to maximize individual potential rather than adjust to gender role stereotypes.**

Factors Affecting Personal Identity. Constant parental intervention can interfere with adolescent choices. Parental distrust may lead children to wonder whether their own choices are correct and to feel guilty if they go against parental ideas. It also may devalue children's opinions and lead to indecisiveness, impulsiveness, and acting out.

When the parent does not trust the child, the child ultimately loses respect for the parent. It has been found that parents and children typically do not disagree on significant issues, such as war, peace, race, or religion. Instead, personal and narrow concerns such as dating, a party, use of the car, curfews, hairstyles, or homework create the primary conflict areas between parents and youth.

Peers also may create problems that inhibit identity development. Adolescents want to belong, to feel needed and wanted. The peer group, with its rigid standards of behavior, gives them this feeling and provides a bridge between childhood and adulthood. Adolescents lose themselves in the fads and the language of the group. However, the group is often a cruel testing ground that can hurt as much as it helps. Taught to be competitive, young people compete with their friends, putting them down to bring themselves up.

Membership in the peer group is bought at a high price; adolescents must surrender much of their identity to belong. Often, belonging to the group involves open destruction of self-esteem and insistence on conformity. Adolescents involved in sexual relationships introduce further uncertainty into their lives, which can interfere with development of a stable self-concept.

> **Critical Reasoning** Discuss how belonging to a group affects an adolescent's identity.

Precipitating Stressors

Trauma. Specific problems with self-concept can be brought on by almost any difficult situation to which the person cannot adjust. **Patients who suffer traumatic injury are at increased risk of developing a range of psychiatric disorders — most commonly depression and anxiety.**

Trauma such as physical, sexual, or psychological abuse in childhood has been reported by most patients with dissociative symptoms, depersonalization disorder, or dissociative identity disorder. Some patients report no abuse but have experienced a trauma they perceived as life threatening to themselves or to someone else, such as a near-drowning, witnessing a violent crime, or being a victim of a terrorist act. Dissociation is more likely to be experienced by individuals who have experienced previous trauma.

> **QUALITY AND SAFETY ALERT**
> - Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and the role that trauma has played in their lives.
> - It tries to change the question from, "What's wrong with you?" to one that asks, "What has happened to you?"

Role Strain. People who undergo stress in fulfilling expected roles are said to experience role strain. **Role strain** is the frustration felt when the person is torn in opposite directions or feels inadequate or unsuited to enact certain roles.

In the course of a lifetime, a person faces many role transitions that may require new knowledge and changes in behavior. The two categories of role transitions are developmental and health-illness. Each of these can precipitate a threat to one's self-concept.

Developmental transitions. Developmental transitions are normal changes associated with growth. Various developmental stages can precipitate threats to self-identity. Adolescence is perhaps the most critical period, because it is a time of upheaval, change, anxiety, and insecurity. A serious threat to identity in adulthood is cultural discontinuity. This occurs when a person moves from one cultural setting to another and experiences emotional upheaval.

Problems within the social structure, such as political turmoil, economic depression, and high unemployment, can pose threats to one's self-concept. In late maturity and old age, self-concept problems again arise. Retirement and increasing physical disability are problems for which people must work out adaptive responses.

Health-illness transitions. Health-illness transitions involve moving from a well state to an illness state. Some stressors can cause disturbances in body image and related changes in self-concept. One threat is the loss of a major body part, such as an eye, breast, or leg. Disturbances also may result from a surgical procedure in which the relationship of body parts is disturbed. The results of the surgical intervention may be either visible, as with a colostomy or gastrostomy, or invisible, as with a hysterectomy or gallbladder removal.

Changes in body size, shape, or appearance can threaten the person's self-perceptions. Threats to body image can result from a pathological process that causes changes in the structure or function of the body, such as arthritis, multiple sclerosis, Parkinson disease, cancer, pneumonia, or heart disease. The failure of a body part, such as with paralysis, is particularly difficult to integrate into one's self-perceptions. The physical changes associated with normal growth and development also may pose problems, as may some medical or nursing procedures such as enemas, catheterizations, suctioning, radiation therapy, dilation and curettage, and organ transplantation.

All these stressors can pose a threat to body image, with resultant changes in self-esteem and role perception. Factors that influence the degree of threat to body image are listed in Table 17-2.

Biological Stressors. Physiological (biological) stressors may disturb a person's sense of reality, interfere with an accurate perception of the world, and threaten ego boundaries and identity. Such stressors include oxygen deprivation, hyperventilation, biochemical imbalances, severe fatigue, and sensory and emotional isolation. Alcohol, drugs, and other toxic substances also may distort self-concept. Usually these stressors produce only temporary changes.

Appraisal of Stressors

Whether the problem in self-concept is precipitated by psychological, sociological, or physiological stressors, the critical element is the patient's perception of the threat. When assessing behaviors and formulating a nursing diagnosis, the nurse must continue to validate observations and inferences to establish a mutual, therapeutic relationship with the patient.

TABLE 17-2 FACTORS INFLUENCING SELF-CONCEPT BASED ON HEALTH-ILLNESS TRANSITIONS

FACTOR	QUESTION
Meaning of the threat for the patient	Does it threaten the patient's ideal of youth or wholeness and decrease self-esteem?
Degree to which the patient's pattern of adaptation is interrupted	Does it jeopardize the patient's security and self-control?
Coping capacities and resources available	What is the response of significant others, and what help is offered?
Nature of the threat, extent of change, and rate at which it occurs	Does the change involve many small adjustments over time or a great and sudden adjustment?

Critical Reasoning The incidence of breast cancer is high in the United States. What strategies are women using to promote adaptive self-concept responses?

Coping Resources

It is important that the nurse and patient review possible coping resources. **All people, no matter how disturbing their behavior, have some areas of personal strength.** These might include the following:

- Sports and outdoor activities
- Hobbies and crafts
- Expressive arts
- Health and self-care
- Education or training
- Vocation or position
- Special aptitudes
- Intelligence
- Imagination and creativity
- Interpersonal relationships

When the patient's positive aspects become evident, the nurse should share these observations with the patient to expand the patient's self-awareness and suggest possible areas for future intervention.

Coping Mechanisms

Short-Term Defenses. An identity crisis may be resolved with either short- or long-term coping mechanisms. These are used to ward off the anxiety and uncertainty of identity confusion. The four categories of short-term defenses are activities that:

1. Provide temporary escape from the identity crisis
2. Provide temporary substitute identities
3. Temporarily strengthen or heighten a diffuse sense of self
4. Represent short-term attempts to make an identity out of meaninglessness and identity diffusion—to assert that the meaning of life is meaningless itself

The first category of **temporary escape** includes activities that seem to provide intense immediate experiences. These experiences so overwhelm the senses that the issue of identity literally does not exist because the person's entire being is occupied with "right now" sensations. Examples include drug experiences, loud rock concerts, fight clubs, fast car and motorcycle riding, some forms of hard physical labor, exercise or sports, and even obsessive television watching.

The category of **temporary substitute identity** is derived from being a "joiner"; the identity of a club, group, team, movement, or gang may serve as a basis for self-definition. People temporarily adopt the group definition as their own identity in a type of devotion to the larger entity. Temporary substitute identities also can be obtained by playing a certain role within a group, such as clown, bully, or chauffeur, or by buying objects that are marketed with ready-made identities. Thus a certain type of cologne, make of car, or article of dress implies a built-in personality people can adopt as their own.

The third category of defenses involves **confronting or challenging something** to feel more intensely alive. This is evident in risk taking for its own sake, which creates a feeling of bravado. Competitive activities, such as sports, academic achievement, and popularity contests, also fit into this category. The idea is that competition and comparison with an outsider more sharply define the sense of self. Another example is bigotry and prejudice. By adopting a bigoted stance toward some group or scapegoat, the person can temporarily strengthen self-esteem or ego integrity.

The final category tries to devise an identity from the **meaninglessness of life.** It helps to explain why people indulge with such fervor in fads that seem so meaningless to others. The sheer force of commitment to fads is an attempt to transform them into something meaningful.

Long-Term Defenses. Any of the short-term defenses may develop into a long-term one that results in maladaptive behavior. Another type of long-term resolution is **identify foreclosure.** This occurs when people adopt the "ready-made" type of identity desired by others without really coming to terms with their own aspirations or potential. This is not a desirable long-term resolution.

Another maladaptive defense is the formation of a **negative identity** that is at odds with the values of society. In this case the person tries to define the self in an antisocial way. The choice of a negative identity is an attempt to retain some mastery in a situation in which a positive identity does not seem possible. The person may be saying, "I would rather be somebody bad than nobody at all." The following clinical example describes the negative identity assumed by an adolescent with a medical diagnosis of conduct disorder—undersocialized, aggressive.

CLINICAL EXAMPLE

Ken was a 17-year-old boy referred to the local community mental health center by his high school nurse. She made the referral after attending a team conference at school about Ken's repeated behavioral problems. He had a history of aggressive and destructive behavior, poor peer relationships, and low academic performance. The school had suspended him on three occasions, and the result of the team conference was to expel him for the remainder of the school year.

Mr. P, a psychiatric nurse at the mental health center, established a contract to work with Ken and his family. He noted that Ken was an obese young man who took little interest in his appearance. His dress was sloppy, his complexion unclean, and his hair oily. He sat slumped in the chair in a disinterested and slightly defiant posture.

As Ken talked about himself, he complained of many pressures he experienced in his part-time job at a local hardware store. He thought the work was too difficult and tiring and that he was qualified for better and more prestigious work. When asked for specifics, he could not identify another job in particular.

He also complained of a great deal of harassment from his family. His mother and father had been married for 31 years, and he was the only child of the marriage. His mother worked part-time at a bakery, and his father was recently retired from his job as a supervisor at a local utility company, where he was highly regarded.

Ken said that his father "always had things for me to do." He described how his father signed him up for various team sports—baseball, basketball, football—without acknowledging how much Ken hated sports and how uncoordinated he was. His father also stressed good grades and the necessity of college for success in life.

Ken described his mother as passive and polite and said he had little respect for her. He said his aggressive outbursts occurred both at home and at school—whenever he was frustrated. People reacted by staying out of his way. He said he never hurt anyone with his temper. He mostly destroyed property and objects.

Ken avoided the subject of peers, but when asked about friends, he said that he "hung out" with a couple of boys in the neighborhood. They were older than he. Most had dropped out of high school and were employed in odd jobs. He denied drug use but said he drank heavily, especially on weekends. He said he had no girlfriends and wasn't interested in complicating his life "with some chick."

Selected Nursing Diagnoses

- Disturbed personal identity related to fear of failure, as evidenced by aggressive and destructive behavior and poor school performance
- Interrupted family processes related to conflict with parents, as evidenced by avoidance and lack of communication

Ken displays many of the behaviors characteristic of a negative identity. The nurse working with Ken explored his underlying feelings and self-perceptions. Great anger with his father began to surface, and Ken was able to verbalize it. Because he was the only son, he believed he was competing with his father and had to live up to his father's ideals. Ken feared failing in trying to adopt a positive identity and resented the identity his father was trying to impose on him. He thought he had no part in defining it and that it did not represent his real self.

Ego Defense Mechanisms. Patients with alterations in self-concept may use a variety of ego-oriented mechanisms to protect themselves from confronting their own inadequacies. **Typical ego defense mechanisms include fantasy, dissociation, isolation, projection, displacement, splitting, turning anger against the self, and acting out.** These are described in Chapter 15. Other, more damaging coping mechanisms also can be used to protect self-esteem, including obesity, anorexia, promiscuity, chronic overworking, delinquency, crime, drug use, family violence, incest, and suicide.

DIAGNOSIS

Self-concept is a critical aspect of one's overall personality adjustment. Problems with self-concept are associated with feelings of anxiety, hostility, and guilt. These often create a circular, self-propagating process that ultimately results in maladaptive coping responses (Figure 17-3).

Nursing Diagnoses

Most people who express dissatisfaction with life, display deviant behavior, are intolerant of others, or have difficulty functioning in social or work situations have problems related to self-concept. **The primary NANDA International (NANDA-I) nursing diagnoses related to alterations in self-concept are disturbed body image, readiness for enhanced self-concept, low self-esteem (chronic, situational, risk for situational), ineffective role performance, and disturbed personal identity.**

Examples of expanded nursing diagnoses related to self-concept are presented in Table 17-3. However, alterations in self-concept affect all aspects of a person's life. Therefore the nurse may identify many additional problems.

Maladaptive responses indicating alterations in self-concept can be seen in a variety of people experiencing threats to their physical integrity or self-system. These nursing diagnoses are not limited to the psychiatric setting and do not have a discrete category of medical diagnoses associated with them.

Medical Diagnoses

Because they pertain to basic personality structure and feelings about oneself, problems with self-concept can emerge with many neurotic and psychotic disorders. Such problems may be related to all the diagnostic categories identified in the *Diagnostic and Statistical Manual of Mental Disorders,* ed 4, text revision (*DSM-IV-TR;* American Psychiatric Association, 2000), because all these disorders ultimately reflect one's view of self.

Some medical diagnoses deserve particular attention, because their dominant features include alterations in

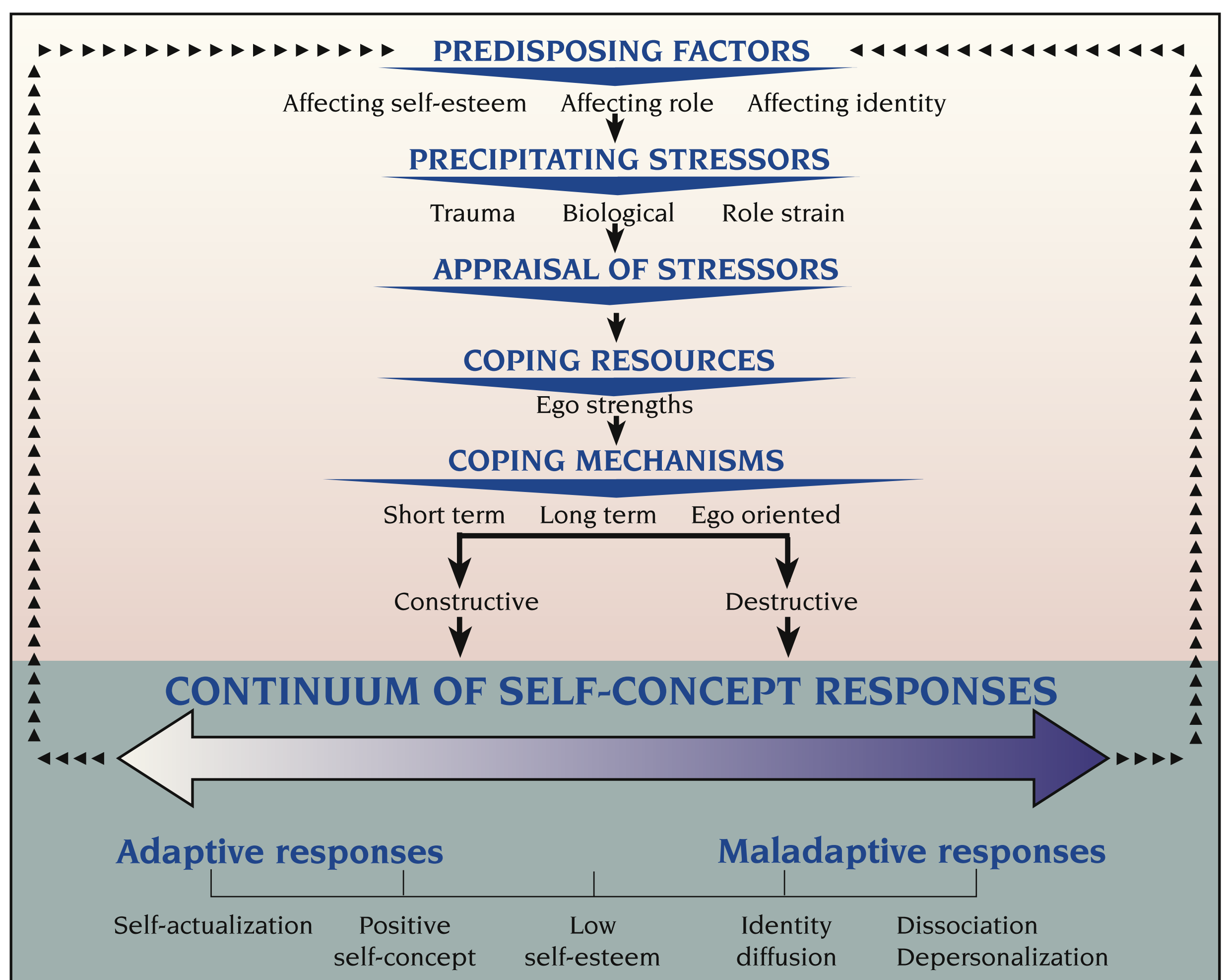

FIG 17-3 Stuart Stress Adaptation Model as related to self-concept responses.

self-concept. **Related medical diagnoses include identity problem, dissociative amnesia, dissociative fugue, dissociative identity disorder (also known as multiple personality disorder), and depersonalization disorder.** The definitions of some of these terms are presented in Table 17-3.

OUTCOMES IDENTIFICATION

The **expected outcome** when working with a patient who has a maladaptive self-concept response is as follows: ***The patient will obtain the maximum level of self-actualization to realize his potential.***

Goals should be as clear and explicit as possible. They should identify realistic steps that the patient can accomplish. In this way the patient's self-confidence will increase, and this will build self-esteem. **These goals should emphasize strengths instead of weaknesses.** If they are mutually identified, they will motivate and help the patient assume increased responsibility for behavior. Following are examples of goals related to role performance:

Long-term goal. Ms. P will resolve role conflict by achieving greater congruency between work and family roles.

Short-term goals

After 1 week

- Ms. P will describe her responsibilities in her work and home roles.
- She will identify aspects of these roles that provide her with satisfaction.
- She will identify areas of role incompatibility.

TABLE 17-3 NURSING DIAGNOSES AND MEDICAL TERMS RELATED TO *Self-Concept Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Disturbed body image	Disturbed body image related to fear of becoming obese, as evidenced by refusal to maintain body weight within normal limits
	Disturbed body image related to leukemia chemotherapy, as evidenced by negative feelings about one's body
	Disturbed body image related to cerebrovascular accident, as evidenced by lack of acceptance of body limitations
Readiness for enhanced self-concept	Readiness for enhanced self-concept related to birth of child, as evidenced by enrollment in parenting classes
Chronic or situational low self-esteem	Situational low self-esteem related to death of spouse, as evidenced by withdrawal from others and feelings of hopelessness
	Chronic low self-esteem related to overly high self-ideals, as evidenced by depressed mood and withdrawal from activities
Ineffective role performance	Ineffective role performance related to incompatibility of newly assumed work and family roles, as evidenced by feelings of frustration and criticism of others
	Ineffective role performance related to incongruence of cultural and self-role expectations about aging, as evidenced by feelings of frustration and criticism of others
Disturbed personal identity	Disturbed personal identity related to unrealistic parental expectations, as evidenced by running away from home
	Disturbed personal identity related to drug toxicity, as evidenced by confusion and loss of impulse control
MEDICAL TERM	**DEFINITION***
Dissociative amnesia	Occurs when a person blocks out certain information, usually associated with a stressful or traumatic event, leaving him or her unable to remember important personal information. The degree of memory loss goes beyond normal forgetfulness and includes gaps in memory for long periods of time or of memories involving the traumatic event.
Dissociative fugue	People with this disorder temporarily lose their sense of personal identity and impulsively wander or travel away from their homes or places of work. They often become confused about who they are and might even create new identities but they show no outward signs of illness.
Dissociative identity disorder (multiple personality disorder)	The disease where simultaneously two or more personalities exist within a person, and in some specific circumstances, or frequently these personalities, one or others, take control of the person's behavior and activities.
Depersonalization disorder	Occurs when a person persistently or repeatedly has a sense that things around them are not real, or when they have the feeling that they are observing themselves from outside their own body. Such feelings can be very disturbing.

Nursing Diagnoses–Definitions and Classification 2012-2014. Copyright © 2012, 1994-2012 by NANDA International. Used by arrangement with Blackwell Publishing Limited, a company of John Wiley & Sons, Inc.

*Sources: http://my.clevelandclinic.org/disorders/dissociative_disorders/hic_dissociative_amnesia.aspx; http://my.clevelandclinic.org/disorders/dissociative_disorders/hic_dissociative_fugue.aspx; http://www.dissociativeidentitydisorder.net; http://www.mayoclinic.com/health/depersonalization/DSO1149.

After 2 weeks

- She will describe three alternative ways of increasing the complementarity of the roles.
- She will discuss the advantages and disadvantages of each alternative.

After 3 weeks

- She will take the necessary measures to implement one of the identified alternatives.

Outcome indicators related to self-esteem from the Nursing Outcomes Classification (NOC) project are presented in Box 17-6 (Moorhead et al, 2008).

PLANNING

The nurse's focus is to help patients understand themselves more fully and accurately so that they can direct their own lives in a more satisfying way. This means helping patients strive toward a clearer, deeper experience of their feelings, wishes, and beliefs; a greater ability to tap their resources and use them for constructive ends; and a clearer perception of their direction in life, assuming responsibility for themselves, their decisions, and their actions.

Self-awareness is crucial for bringing about changes in self-concept, and certain conditions or events do stimulate self-awareness. This may occur when stimuli from the body are intensified, such as in states of pain, fatigue, or anger, or when stimuli from the environment are decreased, such as in sensory deprivation or isolation.

Self-awareness may be triggered when something unexpected or extraordinary takes place, when the person has succeeded or failed, or when people are confronted with themselves by looking in a mirror, listening to their voice on a tape recorder, or reading an old letter. Special occasions, such as birthdays, anniversaries, New Year's Eve, or a death, may stimulate introspection. It also may be initiated when others direct their attention to the person through conversation or touch.

Once people begin to look at and analyze themselves, changes in the self become possible. Often these changes are the result of feelings of failure, unhappiness, anxiety, inadequacy, doubt, or perceived discrepancies between one's concept of self and the demands of the environment or the expectations of others.

Usually changes in the self occur only as a result of experiences and occur gradually. Occasionally, however, a change may take place suddenly. A traumatic experience may force a person to see that something drastic must be done. The nurse should take all these factors into consideration when planning nursing care.

Similarly, the family of origin is a source of many people's self-esteem. Adult contact with parents and siblings can correct misconceptions underlying low self-esteem and allow more positive beliefs. Learning to interact with family members with closeness, but without the problems of fusion and emotionality, can help a more mature pattern to develop.

Family relationships would therefore be an appropriate focus for patient education. A Patient Education Plan using family systems is presented in Table 17-4.

IMPLEMENTATION

The mutually identified goals can be reached by a problem-solving approach that focuses primarily on the present, removes much of the responsibility from the nurse, and actively engages the patient in working on personal difficulties. **This approach requires that the patient first develop insight into his problems and then take action to make lasting behavioral changes.**

The outcome is an increase in the patient's self-confidence and self-esteem. The nurse thus must incorporate both the responsive (insight-oriented) and the action (action-oriented) dimensions of the therapeutic relationship, described in Chapter 2. The focus of this approach is on the patient's cognitive appraisal of life, which may contain faulty perceptions, beliefs, and convictions. Awareness of feelings and emotions is also important, because they too may be subject to misconceptions.

Only after examining the patient's cognitive appraisal of the situation and related feelings can one gain insight into the problem and bring about behavioral change. Thus the interventions build progressively on five aspects of care:

- **Level 1—expanded self-awareness**
- **Level 2—self-exploration**
- **Level 3—self-evaluation**
- **Level 4—realistic planning**
- **Level 5—commitment to action**

BOX 17-6 NOC OUTCOME INDICATORS FOR SELF-ESTEEM

Verbalizations of self-acceptance
Acceptance of self-limitations
Maintenance of erect posture
Maintenance of eye contact
Description of self
Regard for others
Open communication
Fulfillment of personally significant roles
Maintenance of grooming and hygiene
Balance of participation and listening in groups
Confidence level
Acceptance of compliments from others
Expected response from others
Acceptance of constructive criticism
Willingness to confront others
Description of success in work or school
Description of success in social groups
Description of pride in self
Feelings about self-worth

From Moorhead S et al, editors: *Nursing outcomes classification*, ed 4, St Louis, 2008, Mosby.
NOC, Nursing outcomes classification.

TABLE 17-4 PATIENT EDUCATION PLAN

Improving Family Relationships

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Define the concept of self-differentiation within one's family of origin.	Discuss the differences between high and low levels of self-differentiation. Ask the patient to identify level of functioning among family members.	Patient identifies functioning level in family of origin.
Describe the characteristics of emotional fusion, emotional cutoff, and triangulation.	Analyze types and patterns of family relationships. Diagram family patterns.	Patient describes interactional patterns within family. Patient identifies own roles and behavior
Discuss the role of symptom formation and symptom bearer in a family.	Sensitize the patient to family dynamics and manifestations of stress. Encourage communication with family of origin.	Patient recognizes family contribution to the stress of individual members. Patient contacts family members.
Describe a family genogram and show how it is constructed.	Use a blackboard to map out a family genogram. Assign family genogram as homework.	Patient obtains factual information about family. Patient constructs family genogram.
Analyze need for objectivity and responsibility for changing one's own behavior and not that of others.	Role play interactions with various family members. Encourage testing out new ways of interacting with family members.	Patient demonstrates a higher level of differentiation in family of origin.

These principles of nursing care for self-concept problems use a problem-solving approach in a progressive sequence. They focus primarily on the level of the patient. However, they may be implemented with group or family interventions, and the nurse is expected to include the patient's family, significant others, and community supports whenever possible.

Very few empirical studies have assessed the treatment of the medical diagnoses associated with alterations in self-concept. Treatments currently used include cognitive and behavioral approaches and psychopharmacology. **Clinical findings are inconsistent and do not meet standards that would establish them as empirically supported treatments.**

Level 1: Expanded Self-Awareness

To avoid anxiety, most people resist change. In general, change in the self is easier when there is no threat. Threat forces people to defend themselves; perceptions are narrowed, and the individuals have difficulty forming new perceptions of themselves.

To expand the patient's self-awareness and reduce the element of threat, the nurse should adopt an accepting attitude. Acceptance allows the patient the security and freedom to examine all aspects of the self, including positive and negative qualities. Listening to the patient with understanding, responding nonjudgmentally, expressing genuine interest, and conveying a sense of caring and sincerity establish the basis of a therapeutic relationship.

Creating a climate of acceptance allows previously denied experiences to be examined. This broadens the patient's concept of self and helps the patient accept all aspects of the personality. It also indicates that the patient is a valued person who is responsible for himself and is able to help himself. This is important because the nurse must work with whatever ego strength the patient possesses.

Most patients seen in clinics, in the general hospital, and in the community setting have good ego strength. However, people who are hospitalized may have limited ego resources. Psychotic patients experiencing depersonalization and identity confusion often present difficult challenges for the nurse. They tend to isolate themselves and withdraw from reality, so little ego strength is available for problem solving.

For such patients, expanding self-awareness means first **confirming the patient's identity.** The nurse should provide supportive measures to decrease the panic level experienced by these patients. Additional interventions related to anxiety and psychotic states are described in Chapters 15 and 20.

The nurse can spend time with the patient in an undemanding way. Initially the nurse may accept the patient's need to remain nonverbal or may attempt to clarify and understand the patient's verbal communication. Attempts should be made to prevent the patient from being isolated by establishing a simple routine for the patient. If the patient displays bizarre behavior, such as inappropriate laughing or mannerisms, the nurse can set limits on the behavior. It is important to orient the patient frequently to reality and to reinforce appropriate behavior.

The patient should be helped to increase activities that **provide positive experiences.** Movement therapy is a goal-directed way to develop identity, body image, and ego structure. It is predominantly a nonverbal therapy because the emphasis is on movement, not on what the person says.

Depersonalization often leads to poor hygiene and an unkempt personal appearance. Nurses can help patients who are unable to care for themselves by using patience and repetition to establish health routines. Through verbal and nonverbal messages, nurses can encourage patients to care for themselves and take pride in their appearance, reinforcing any progress made.

TABLE 17-5 NURSING INTERVENTIONS IN ALTERATIONS IN SELF-CONCEPT AT LEVEL 1

Goal: Expand the Patient's Self-Awareness

PRINCIPLE	RATIONALE	NURSING INTERVENTIONS
Establish an open, trusting relationship.	Reduces the threat that the nurse poses to the patient and helps the patient broaden and accept all aspects of the personality.	Offer unconditional acceptance. Listen to the patient. Encourage discussion of thoughts and feelings. Respond nonjudgmentally. Convey to the patient that the patient is a valued person who is responsible for and able to help himself.
Work with whatever ego strength the patient has.	Some degree of ego strength, such as the capacity for reality testing, self-control, or a degree of ego integration, is needed as a foundation for later nursing care.	Identify the patient's ego strength. Guidelines for the patient with limited ego resources are as follows: 1. Begin by confirming the patient's identity. 2. Provide support measures to reduce the patient's level of anxiety. 3. Approach the patient in an undemanding way. 4. Accept and attempt to clarify any verbal or nonverbal communication. 5. Prevent the patient from isolating himself. 6. Establish a simple routine for the patient. 7. Set limits on inappropriate behavior. 8. Orient the patient to reality. 9. Reinforce appropriate behavior. 10. Gradually increase activities and tasks that provide positive experiences for the patient. 11. Help the patient in personal hygiene and grooming. 12. Encourage the patient to care for himself.
Maximize the patient's participation in the therapeutic relationship.	Mutuality is needed for the patient to assume responsibility for behavior and maladaptive coping responses.	Gradually increase the patient's participation in decisions that affect care. Convey to patients that they are responsible persons.

Another possible nursing intervention is photographic self-image review. This involves taking photographs of patients and then discussing them. This intervention helps in establishing a nurse-patient relationship and mutually exploring some aspects of the self.

Mutuality is often difficult to establish with a patient who is experiencing depersonalization. Initially the nurse will determine appropriate activities and incorporate the patient into them without asking for a response. Gradually, however, the nurse can expect greater participation and can involve the patient in decision-making. Table 17-5 summarizes the nursing interventions that are appropriate to level 1.

Sometimes the nurse's attitudes or behaviors can block patients from expanding their own self-awareness. These behaviors can take the form of criticism, belittlement, condescension, indifference, or insincerity. An impersonal attitude can decrease the patient's self-esteem. Excessive demands or direct challenges to self-concept can result in further withdrawal.

Nurses should not allow patients to remain alone or inactive, should not attempt to shame patients into improving their habits, and should not assume total care for patients. If nurses instead strive to foster acceptance of the patients, they remove themselves as a source of threat and encourage patients to lower their defenses. Patients are then prepared to take the next step in problem solving.

> **Critical Reasoning** How do you think the nurse's level of self-esteem affects nursing interventions in patients' self-concept responses?

Level 2: Self-Exploration

At level 2 of intervention, nurses encourage patients to examine feelings, behavior, beliefs, and thoughts, particularly in relation to the current stressor. Patients' feelings may be expressed verbally, nonverbally, symbolically, or directly. For example, structured writing activities, such as journaling, letters, poetry, and prose, can be used to facilitate self-examination.

Acceptance continues to be important, because when nurses accept patients' feelings and thoughts, they are helping them accept themselves as well. Nurses should facilitate the expression of strong emotions, such as anger, sadness, and guilt. In a sense, patients' emotions or affect serves as clues to inner thoughts and current behavior.

Patients who focus attention on the meaning that experiences have are clarifying their perceptions and concept of self and their relationship to surrounding people and events. The nurse can elicit the patients' perception of strengths and weaknesses and have the patients describe their self-ideal. The patients can be made aware of self-criticisms.

It is important for nurses to accept and deal with their own feelings before becoming involved in the self-exploration of others. Self-awareness limits the potential negative effects of countertransference in the relationship. It also allows nurses to demonstrate authentic behavior that in turn can be elicited and reinforced in the patient.

Often patients experience difficulty in discussing or describing their feelings. This may be because society tends to discourage self-revelation or because some patients are honestly out of touch with their inner self. In such cases, nurses can use themselves therapeutically through purposeful self-disclosure, such as in sharing feelings, verbalizing how they might feel in the situation, or mirroring their perception of patients' feelings. In this way, nurses can help patients explore maladaptive thinking.

The nurse must be careful not to reinforce the patient's self-pity by responding with sympathy. Patients often deny any personal responsibility for their situation, and they often fail to see how their own behavior may have precipitated the problem. Examples include patients who seek treatment because of things that have happened to them (e.g., being abandoned by a spouse, being fired by a boss, failing out of school) and patients who seek help because of things that have not happened (e.g., not being happy, not having friends). These patients fail to see that they have a choice in life and that personal growth and satisfaction involve both risk and responsibility.

The nurse can clarify with patients that they are not helpless or powerless. They are powerless only when they give up control and responsibility for their behavior. **Patients must accept responsibility for the logical consequences of the things they choose to do or not to do.** Only if patients fully understand the implications of their actions and the scope of their choices can they set goals, explore alternatives, and effect change.

In stressing the importance of behavior, the nurse helps patients see that they choose to behave in certain ways. If patients project their problems onto the environment, the nurse can discuss with them the difficulty in changing other people and explore the possibilities of changing their own selves. This means helping patients realize that when they say "I can't" they really mean "I don't want to."

Nurses should not give the impression that they have the power to change patients' lives. That power lies with the patients alone. However, nurses can help patients maximize their strengths, use available resources, and see that life involves more than misery and pain.

Self-exploration does not take place only within the one-to-one relationship. Family sessions and group meetings can help clarify how the patient appears to others. These meetings can supplement individual sessions with the patient, and similar nursing interventions can be applied within family or group therapy.

Regardless of the setting, the nurse collects information on patients' thoughts about themselves, logical or illogical reasoning, and reported or observed reactions. Interventions at this level should help patients progress from denying or attributing contradictory feelings to the external situation to recognizing a major conflict within themselves. Table 17-6 summarizes the nursing interventions appropriate to level 2.

> **Critical Reasoning** Do you believe that contemporary society encourages or discourages personal responsibility for behavior? Defend your point of view.

Level 3: Self-Evaluation

Level 3 involves hard work for patients as they critically examine their own behavior, accept the consequences for it, and judge whether it is the best possible choice. At this point the problem should be clearly defined and patients should be helped to understand that their beliefs influence their feelings and behavior.

The cognitive behavioral strategies described in Chapter 27 are very useful at this time. Only by actively and systematically challenging their faulty beliefs and perceptions can patients hope for change (Box 17-7). Previously identified misperceptions and distortions should be evaluated, and irrational beliefs and unrealistic self-ideals should be identified and analyzed. Negative thinking can be reduced through the use of affirmations and thought-stopping techniques.

The patient's hopelessness should be countered by exploring areas of realistic hope. Hope is critical to the recovery process (Stuart, 2010). The behaviors that interfere with effective functioning should be put in perspective so that patients can see that the maladaptive behavior is only a small part of their total personality.

Success and failure must be placed in perspective. Failures occur every day and are a natural part of human activity. Failure may be caused by one's own mistakes, a lack of motivation, or circumstances beyond one's control. Whatever the reason, failure is the unavoidable outcome of human effort. The problem arises when people are labeled or label themselves as failures. As an inherent part of life, failure should be seen as either a neutral concept or a positive one for the learning experience it provides.

Unrealistic self-ideals, dependency patterns, and denial are all potential areas that can be analyzed. The patient can be helped to realize that all behavior and coping responses have positive and negative consequences. Contrasts can be drawn between behavior that is destructive or sabotaging and behavior that is productive, enhancing, or growth producing.

Patients must see that they act in self-defeating ways because they receive some "payoff" or personal gain from it. Patients are probably well aware of the drawbacks of their maladaptive coping responses, but the payoff, or **secondary gains,** may be less obvious. Some common secondary gains are:

- Procrastination
- Avoiding risks
- Retreating from the present
- Evading responsibility for one's actions
- Avoiding working or having to change
- Being taken care of

TABLE 17-6 **NURSING INTERVENTIONS IN ALTERATIONS IN SELF-CONCEPT AT LEVEL 2**

Goal: Encourage the Patient's Self-Exploration

PRINCIPLE	RATIONALE	NURSING INTERVENTIONS
Help patient accept his own feelings and thoughts.	When nurses show interest in and accept the patient's feelings and thoughts, they are helping the patient to do so as well.	Attend to and encourage the patient's expression of emotions, beliefs, behavior, and thoughts—verbally, nonverbally, symbolically, or directly. Use therapeutic communication skills and empathic responses. Note the patient's use of logical and illogical thinking and reported and observed emotional responses.
Help patient clarify self-concept and relationship to others through self-disclosure.	Self-disclosure and understanding of one's self-perceptions are prerequisites for bringing about future change. This may in itself reduce anxiety.	Elicit the patient's perception of the self's strengths and weaknesses. Help the patient to describe the self-ideal. Identify self-criticisms. Help the patient describe how he believes he relates to other people and events.
Be aware and have control of one's own feelings.	Self-awareness allows the nurse to model authentic behavior and limits the potential negative effects of countertransference in the relationship.	Be open to and accept one's own positive and negative feelings. Practice therapeutic use of self by sharing one's own feelings with the patient, verbalizing how another might have felt, or mirroring one's perception of the patient's feelings.
Respond empathically, not sympathetically, emphasizing that the power to change lies with the patient.	Sympathy can reinforce self-pity. The nurse should communicate that the patient's life situation is subject to his own control.	Use empathetic responses, and monitor oneself for feelings of sympathy or pity. Reaffirm to the patient that he is not powerless in the face of problems. Convey that the patient is responsible for his own behavior, including choice of maladaptive or adaptive coping responses. Discuss the scope of the patient's choices, areas of ego strength, and coping resources that are available. Use the support systems of family and groups to facilitate the patient's self-exploration. Help the patient recognize the nature of conflict and the maladaptive ways in which the patient tries to cope with it.

BOX 17-7 **A PATIENT SPEAKS**

We all write our own biographies, framing the narrative in ways that are congruent with the self we know and the one we want to be. It isn't that we lie to ourselves and to others, only that there are so many ways to interpret and assemble the facts of our lives.

So, for example, a woman who suffers some traumatic event like incest or rape can tell the story two ways. In one version it's the central fact of her life, the one she can never forget and never get past. It's a story of victimization that builds on itself until it defines who she is and what she can do. In another account it's a terrible event that marked her life but not her identity. It's a tale of transcendence in which the past isn't denied or forgotten; it simply doesn't form the core of the narrative she has constructed.

How we write the script depends on who we are and how we internalize the events of our world. Obviously, some stories are more psychologically functional than others. But every story changes with time, not just because memories grow dim but because we ourselves change, and the story we need to tell us where we've been and who we are now is different today that it was yesterday. It's when the tale remains fixed that therapy can be most effective by helping us to reframe the narrative to focus on change rather than stasis, on strength rather than weakness.

From Rubin L: *The man with the beautiful voice: and more stories from the other side of the couch,* Boston, 2003, Beacon Press.

Payoffs specific to the patient's problem should be identified. For example, possible secondary gains from being obese include having people feel sorry for you, having an excuse for not dating or not being married, being the focus of dieting attention, or being easily recognized and noticed when with other people.

Possible secondary gains for an adult who remains dependent on parents might include not having to make one's own decisions, having someone else to blame if things go wrong, being protected from risks and venturing out in the world, not establishing lasting intimate relationships, or not having

TABLE 17-7 NURSING INTERVENTIONS IN ALTERATIONS IN SELF-CONCEPT AT LEVEL 3

Goal: Assist the Patient's Self-Evaluation

PRINCIPLE	RATIONALE	NURSING INTERVENTIONS
Help the patient define the problem clearly.	Only after the problem is accurately defined can alternative choices be proposed.	Identify relevant stressors with the patient and the patient's appraisal of them. Clarify that the patient's beliefs influence feelings and behaviors. Mutually identify faulty beliefs, misperceptions, distortions, illusions, and unrealistic goals. Mutually identify areas of strength. Place the concepts of success and failure in the proper perspective. Explore the patient's use of coping resources.
Explore the patient's adaptive and maladaptive coping responses to the problem.	Examine the coping choices the patient has made and evaluate their positive and negative consequences.	Describe to the patient how all coping responses are freely chosen and have both positive and negative consequences. Contrast adaptive and maladaptive responses. Mutually identify the disadvantages of the patient's maladaptive coping responses. Mutually identify the advantages, or secondary gains, of the patient's maladaptive coping responses. Discuss how these secondary gains have perpetuated the maladaptive response. Use a variety of therapeutic skills: facilitative communication, supportive confrontation, role clarification, and the transference and countertransference reactions occurring in the one-to-one relationship.

to establish one's own identity but rather adopting the values and goals of others.

The nurse becomes more active at this level of intervention by confronting, interpreting, persuading, and challenging. The goal is to increase the patient's objectivity in dealing with stressors. For example, the nurse can show the patient that a person can nurture and gratify as well as anger and frustrate, because both negative and positive qualities coexist in the same person.

Supportive confrontation may be particularly effective in pointing out inconsistencies in words and actions. The climate of acceptance established by the nurse in level 1 and the empathic communication developed in level 2 provide a basis for confrontation in level 3. This groundwork is necessary to prevent premature confrontation, which can be destructive.

The nurse may use role theory during this level by identifying behaviors, clarifying expectations, and specifying goals related to the patient's roles in life. Role playing may be particularly effective in providing the patient with feedback and increasing insight. Through it, patients may become more objective about the irrationality and self-destructiveness of their self-criticisms.

Another therapeutic intervention for promoting self-esteem in elderly persons is the use of reminiscence. **Reminiscence** involves thinking about or relating past experiences, especially those that are personally significant. It has been used to help patients gain a sense of integrity, enhance self-esteem, and stimulate thinking about oneself. As such, it provides nurses with an opportunity to focus, reflect, and reinforce their patients' uniqueness and enhance their sense of self-worth. Reminiscence is discussed in more detail in Chapter 37.

The nurse-patient relationship is a rich source of information for the patient. Within this relationship the patient is enacting and experiencing many problem areas, and the nurse can use this as a "teachable moment." The nurse can observe how the patient reacts in the one-to-one situation and can share reactions with the patient to give feedback on how the patient affects others.

The nurse's therapeutic use of self includes the analysis of **transference** and **countertransference** reactions (see Chapter 2). When a block arises in the relationship or anxiety increases, the nurse should explore its meaning with the patient. The nurse should confront the problem and openly discuss it with the patient. This also can be done in family or group therapy sessions.

During this level of intervention, the patient and nurse critically evaluate the patient's behavior. Misperceptions, unrealistic goals, and distortions of reality are explored. This allows the patient to progress to the next level of problem solving. Table 17-7 summarizes the nursing interventions appropriate to level 3.

> **Critical Reasoning** Think of one of your less desirable habits. What payoff or personal gain does it provide you?

Level 4: Realistic Planning

The nurse and patient are now ready to identify possible solutions or alternatives. This begins by exploring solutions attempted in the past and evaluating their effectiveness. Patients who have inconsistent perceptions are faced with several choices. They can change their perceptions and beliefs to bring them closer to a reality that cannot be changed. Alternatively, they may seek to change their environment to bring it in line with what they believe.

When patients' behavior is inconsistent with their self-concept, they can change the behavior, change the beliefs underlying their self-concept so that they include the behavior, or change their self-ideal while leaving their self-concept intact. At this time, all possible alternatives and solutions should be openly discussed with the patient. Nurses must be careful not to use their influence to persuade the patient to do anything that represents the nurse's values rather than the patient's.

The nurse helps the patient develop realistic goals. If they are within the patient's reach, the patient's efforts can be supported. If the patient has conflicting goals, the nurse helps identify which are more realistic by discussing the emotional and practical consequences of each.

For example, the patient may be encouraged to give up superhuman standards for judging one's own behavior. Such standards set the patient up for failure. The patient may need to lower the self-ideal. The patient should be encouraged to renew involvement with life and to pursue new experiences for their growth potential.

Role rehearsal, role modeling, and role playing may be used.

- In **role rehearsal,** people imagine how a particular situation might take place and how their role might evolve. They mentally enact their role and try to anticipate the responses of significant others. Role rehearsal is important in anticipating and planning the course of future action.
- **Role modeling** occurs when patients first watch someone else playing a certain role and are then able to understand and copy those behaviors. The person observed may be the nurse, a family member, a group member, or a peer. The nurse can help patients in their role learning by modeling behavior such as expression of feelings, specific socialization skills, or realistic self-expectations.
- Proceeding one step further, the nurse and patient may **role play** or act out certain situations to develop alternative solutions.

Visualization also can be used to enhance self-esteem through goal setting. Through the conscious programming of desired change with positive images, expectations are molded. Strong, positive expectations can then become self-fulfilling. To use visualization, the nurse should do the following:

1. Ask the patient to select a positive, specific goal, such as, "I will call a friend and suggest we go out together."
2. Help the patient to relax, using a relaxation technique (Chapter 15).
3. Have the patient repeat the goal phrase several times slowly.
4. Have the patient close his eyes and visualize the goal written on a piece of paper.
5. Have the patient, while relaxed, imagine accomplishing the goal.

The patient should then describe feelings when the desired goal is reached and how other people respond to the patient. In this way the patient can gain positive control over life.

Table 17-8 summarizes the nursing interventions appropriate to level 4. **The patient should choose a plan that includes a clear definition of the desired change.** Converting a talking decision into an action decision is the final, but most important, step.

Level 5: Commitment to Action

The nurse helps patients become committed to their decisions and then achieve their goals through behavior change. The patient's development of self-awareness, self-understanding, and insight is not the ultimate desired outcome of the nursing therapeutic process. Insight alone does not make problems disappear or transform one's world in magical ways. Although patients may have obtained a high level of insight, they may nevertheless continue to function at a minimum level. Such patients may be able to discuss the nature of their problems and the contributing influences, but the problems continue to be unresolved.

Some patients use their insights to resist moving forward and avoid the hard work involved in making behavioral changes. The value of having patients gain insight and increase their self-understanding is that they can gain perspective on why they behave the way they do and what must be done to break maladaptive patterns.

QUALITY AND SAFETY ALERT

- In working with patients and families, it is critical to remember that insight alone is not sufficient.
- Insight or understanding of one's problems must be followed by change in behavior to be meaningful.
- Behavior change takes time.

Providing opportunity for the patient to experience success is essential at this time. To help patients commit themselves to their goals, nurses can openly and honestly describe to patients the healthy parts of their personalities and how, by using these parts, they can achieve their goals. The nurse should reinforce the patient's strengths or skills and provide opportunities to use them whenever possible.

Sometimes the lack of vocational or social skills is a cause of low self-esteem. If so, nursing intervention can be directed toward gaining vocational assistance for the patient. Group and family involvement may be helpful in raising self-esteem. The experience of being accepted by others, the sense of belonging and being important to others, and the opportunity to develop interpersonal competence all can enhance self-esteem.

At this point the patient needs much support and positive reinforcement in effecting and maintaining change. For many

TABLE 17-8 NURSING INTERVENTIONS IN ALTERATIONS IN SELF-CONCEPT AT LEVEL 4

Goal: Help the Patient Formulate a Realistic Plan of Action

PRINCIPLE	RATIONALE	NURSING INTERVENTIONS
Help the patient identify alternative solutions.	Only when all possible alternatives have been evaluated can change be effected.	Help the patient understand that one can change only oneself, not others. If the patient holds inconsistent perceptions, help the patient see that one can change one's beliefs or ideals to bring them closer to reality and change the environment to make it consistent with one's beliefs. If the patient's self-concept is not consistent with behavior, the patient can change behavior to conform to self-concept, change the beliefs underlying self-concept to include one's behavior, or change the self-ideal. Mutually review how coping resources may be better used by the patient.
Help the patient develop realistic goals.	Goal setting that includes a clear definition of the expected change is necessary.	Encourage the patient to formulate his own (not the nurse's) goals. Mutually discuss the emotional, practical, and reality-based consequences of each goal. Help the patient clearly define the concrete change to be made. Encourage the patient to pursue new experiences for growth potential. Use role rehearsal, role modeling, role playing, and visualization when appropriate.

patients this means breaking chronic behavior patterns and exposing themselves to real risk. The patient must actively maintain the processes learned to avoid slipping back to the previous behavior. Doing this is difficult and requires that the patient build on the progress made in the other levels.

Successful change is a continuing process of modifying not only one's behavior but also one's environment to help ensure that the change to new ways of behaving is permanent. Otherwise a relapse will occur. The nurse serves as a transition between the pain of the past and the positive gratification of the future.

Both nurse and patient must allow sufficient time for change. A significant period may be required for patterns that developed over months or years to be broken and for new ones to be established.

The nurse's role now becomes less active and directive and more confirming of the value, potential, and accomplishments of the patient. A Nursing Treatment Plan Summary for maladaptive self-concept responses is presented in Table 17-9.

EVALUATION

Problems with self-concept are prominent in many psychological disorders. To evaluate the success or failure of the nursing care given, each phase of the nursing process should be reviewed and analyzed by the nurse and patient. The nurse's assessment should include the objective and the observable behaviors, as well as the subjective perceptions of the patient.

- Did the nurse explore the patient's strengths and weaknesses and elicit the patient's self-ideal?
- Was information obtained on the patient's body image, feelings of self-esteem, role satisfaction, and sense of identity?
- Did the nurse compare responses with the patient's behavior, and were any inconsistencies or contradictions identified?
- Was the nurse aware of any personal affective response to the patient, and how did this affect the ability to be therapeutic?

The nurse should have adopted a problem-solving approach that placed responsibility for growth on the patient. The most fundamental nursing action should have been to create a climate of acceptance that confirmed the patient's identity and conveyed a sense of value or worth. In expanding the patient's self-awareness, the following should be evaluated:

- How effective was the nurse in promoting full and pertinent self-disclosure?
- Was the nurse able to show authentic behavior in the relationship and share thoughts and reactions?
- What interventions were used, and which ones were helpful (e.g., validation, reflection, confrontation, suggestion, role clarification, role playing)?
- Did the nurse progress on the basis of the patient's readiness and motivation?
- Was the patient able to transfer new perceptions into possible solutions or alternative behavior?
- Did they both allow sufficient time for changes to occur?

The degree of overall success achieved through nursing care is determined by eliciting the patient's perception of personal growth and comparing the patient's behavior with the healthy personality described in this chapter. Success has been achieved if the patient's potential has been maximized.

TABLE 17-9 NURSING TREATMENT PLAN SUMMARY

Maladaptive Self-Concept Responses

Nursing Diagnosis: Chronic or situational low self-esteem

Expected Outcome: The patient will obtain the maximum level of self-actualization to realize potential.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will establish a therapeutic relationship with the nurse.	Confirm the patient's identity. Provide supportive measures to decrease level of anxiety. Set limits on inappropriate behavior. Work with whatever ego strengths the patient has. Reinforce adaptive behavior.	Mutuality is necessary for the patient to assume responsibility for behavior.
The patient will express feelings, behaviors, and thoughts related to the present stressor.	Help the patient express and describe feelings and thoughts. Help the patient identify self-strengths and weaknesses, self-ideals, and self-criticisms. Respond empathically, emphasizing that the power to change lies within the patient.	Self-disclosure and understanding are necessary to bring about change. The use of sympathy is not therapeutic because it can reinforce the patient's self-pity. The nurse should communicate that the patient is in control.
The patient will evaluate the positive and negative consequences of self-concept responses.	Identify relevant stressors and the patient's appraisal of them. Clarify faulty beliefs and cognitive distortions. Evaluate advantages and disadvantages of current coping responses.	Only after the problem has been defined can alternative choices be examined. It is then necessary to evaluate the positive and negative consequences of current patterns.
The patient will identify one new goal and two adaptive coping responses.	Encourage the patient to formulate a new goal. Help the patient clearly define the change to be made. Use role rehearsal, role modeling, and visualization to practice the new behavior.	Only after alternatives have been explored can change be effected. Goal setting specifies the nature of the change and suggests possible new behavioral strategies.
The patient will implement the new adaptive self-concept responses.	Provide opportunity for the patient to experience success. Reinforce strengths, skills, and adaptive coping responses. Allow the patient sufficient time to change. Promote group and family involvement. Provide the appropriate amount of support and positive reinforcement for the patient to maintain progress and growth.	The ultimate goal in promoting the patient's insight is to have the patient replace the maladaptive coping responses with more adaptive ones.

LEARNING FROM A CLINICAL CASE OUTCOME

1. How has her childhood experience shaped her self-concept, body image, self-ideal, self-esteem, and personal identity?

A person who has been sexually abused by an adult, especially a parent, often sees themselves as shameful, an object to be exploited, inadequate and unacceptable. Her body image was damaged by these childhood experiences and much of her coping is focused on making her body acceptable. Her perception of her self is that she should only serve others, not taking her own needs into consideration. This woman struggles with low self-esteem. She therefore works long hours and takes little time to relax and enjoy her life. She has limited self-awareness and does not perceive of herself as having unique value.

2. How do the concepts of identity diffusion, dissociation, and depersonalization manifest in her behavior?

During this patient's early childhood, she used the defense of dissociation to cope with her father's sexual abuse. Her mother denied the truth, further alienating this patient's perceptions of reality. Now with increasing stress within her current life and family, these previously used defenses are returning and creating symptoms of serious mental illness. She uses identity fusion as well as identity diffusion by completely ignoring her daughters distress regarding her high risk pregnancy but becoming very involved with her sons "coming out," insisting that he come to live with her. At its most severe, she develops amnesia, not remembering buying clothes and losing her way

LEARNING FROM A CLINICAL CASE OUTCOME—cont'd

while driving, becoming disoriented in her own community. She feels very "alien" from herself, which she also felt as a child.

3. What precipitating stressors does she describe and how do they threaten her "idealized self"?

She has tried very hard to live up to her 'idealized self" working long hours and keeping her personal appearance immaculate. She was trying to make herself worthy of respect. She also has continued to devote herself to her children by supporting them financially into their adulthood trying to "buy' their love, which has put great financial stress on her life. Each of her children now has a personal issue that is threatening her need for a "perfect" life.

4. What medical and nursing diagnoses would be appropriate for helping her?

The patient was diagnosed with dissociative identity disorder with episodes of dissociative amnesia. The nursing diagnoses were body image, disturbed, coping ineffective, and communication impaired verbal. In working with her over time, the advanced practice nurse used the 5 levels described in the chapter to provide personal growth and behavior change through expanded awareness (level 1), self-exploration (level 2), self-evaluation (level 3), realistic planning (level 4), and commitment to action.

Case Outcome

After six months of psychotherapy the patient and her husband decided to make some significant changes in their lives. They found an old cottage in a small town and began work on renovating it. They did much of the work together and traveled to auctions to buy antiques. They sold their large house and decided to move 75 miles away. The patient would telecommute to work, processing loans, and managing her staff electronically.

Through the process, she began to evaluate her childhood realistically and accept herself and her positive and negative experiences. She was able to develop a more realistic "self-ideal," no longer feeling like she had to be perfect to deserve the love of others. She and her husband felt that their adult children were too dependent on them both economically and emotionally, and thought the move would encourage their children to be more independent. Downsizing meant she did not feel the economic pressure of the large house and the cottage felt cozy and welcoming. The dissociative episodes occurred less frequently and eventually stopped completely. She began to feel like she was really living her life, perhaps for the very first time. She began to relax and allowed herself to be less than perfect, enjoying her life in a new and more meaningful way.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Monica Molloy, APRN

Last week one of my patients died. I have been a nurse for 20 years. I have experienced patients' deaths—many different kinds of deaths, some of them seemingly senseless. I think particularly of young patients with head injuries from motorcycle or automobile accidents. But I understood those deaths. I understood the concept of an accident. What I don't understand is the concept of murder.

In November a woman was sitting apart from most of the members of a therapy group I lead with a graduate nursing student. I asked her why she didn't join the circle. She replied she was afraid the group didn't want her near them; she thought the odor of her cancer would offend them. When the women in the group responded that they hadn't noticed any odor, she seemed to accept the reassurance offered, but she continued to sit apart. Last week, that woman was murdered.

She was a homeless woman, one of the women who embarrass us as a society. She lived in the Family Center of the homeless shelter. I'll call her C. I first met her 2 years ago, when the group began. I remember one group session in particular when she and another shelter guest talked about trust issues in the homeless community. Then she moved away.

This past fall she returned to the shelter. In addition to neurofibromatosis, she now had cancer. She looked different; she had lost nearly 40 pounds. She had been discharged from a local hospital to the shelter. Despite her willingness to take a risk and to disclose her fears about the odor she thought she had, she essentially remained alone and apart.

C's death has given me one more opportunity to examine what it is to practice psychiatric nursing in the community. When nurses practice in inpatient environments, one of our fundamental responsibilities is to ensure patient safety. Sometimes that safety is interpersonal, and sometimes it is environmental. Among the homeless population, environmental safety is tenuous at best. One goal for the group intervention in the shelter community is to enable the women to use themselves and each other as resources to create their own safety zone. Somehow that didn't work with C.

The day after her death, the graduate nursing student and I spent some time with the women in the Family Center community. We went there to be with the women to provide support. We also went there to grieve. And perhaps most of all, we went there to try to answer some questions for ourselves, the same questions all clinicians ask when a patient dies: Did we miss some signs? Could we have done something different?

C's death is mentioned in the group weekly now. New guests use her death to reify their fears about being homeless, as a metaphor for their own alienation experience. Through her death, C has left a mark on that group and that community. I don't understand the concept of murder any better. I do understand more about the concept of alienation. Acknowledging alienation is a first step to creating a sense of personal safety. It is fundamental to the practice of psychiatric nursing in the community. I learned that from C, and for that I will always be grateful.

CHAPTER IN REVIEW

- Self-concept is defined as all the notions, beliefs, and convictions that constitute a person's self-knowledge and that influence relationships with others. The self-concept emerges or is learned through each person's internal experiences, relationships with other people, and interactions with the outer world.
- Parental influence is strongest during early childhood and continues to have a significant impact through adolescence and young adulthood. Over time, however, the power and influence of friends and other adults increase, and they become significant others to the person.
- One's needs, values, and beliefs strongly influence perceptions. People with positive self-concepts function more effectively. Negative self-concept is correlated with personal and social maladjustment.
- Body image is the sum of the conscious and unconscious attitudes one has toward one's own body.
- The self-ideal is the person's perception of how to behave, based on certain personal standards. It must be neither too high and demanding nor too vague and shadowy, yet it must be high enough and defined enough to give continuous support to self-respect.
- Self-esteem is a person's personal judgment of self-worth, based on how well behavior matches up with self-ideal. Self-esteem increases with age and is most threatened during adolescence, when concepts of self are being changed and many self-decisions are made.
- Roles are sets of socially expected behavior patterns associated with a person's functioning in different social groups. On the basis of perception of role adequacy in the most important roles, a person develops a level of self-esteem.
- Identity is the awareness of being oneself derived from self-observation and judgment. The person with a strong sense of identity sees himself as a unique individual. In adolescence the crisis of identity versus identity diffusion occurs. Achieving identity is a prerequisite for establishing an intimate relationship.
- All behavior is motivated by a desire to enhance, maintain, or defend the self, so the nurse has much information to evaluate. The nurse also must go beyond objective and observable behaviors to the patient's subjective and internal world.
- Low self-esteem indicates self-rejection and self-hate, which may be a conscious or unconscious process expressed in direct or indirect ways.
- Identity diffusion is the failure to integrate various childhood identifications into a unified adult identity. Personality fusion is a person's attempt to establish a sense of self by fusing with, attaching to, or belonging to someone else.
- Dissociation and depersonalization are states of acute mental decompensation in which certain thoughts, emotions, sensations, or memories are compartmentalized because they are too overwhelming for the conscious mind to integrate. In severe forms, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception.
- Self-esteem is partly an inheritable trait, and genetic as well as environmental influences are very important.
- Gender and work roles can be a source of stress. To promote mental health, nurses should encourage both men and women to maximize individual potential rather than adjust to gender role stereotypes.
- Specific problems with self-concept can be brought on by almost any difficult situation to which the person cannot adjust. Role strain is the frustration felt when one is torn in opposite directions or feels inadequate or unsuited to enact certain roles. The two categories of role transitions are developmental and health-illness.
- All people, no matter how disturbing their behavior, have some areas of personal strength.
- An identity crisis may be resolved with either short-term or long-term coping mechanisms. These are used to ward off the anxiety and uncertainty of identity confusion.
- Typical ego defense mechanisms include fantasy, dissociation, isolation, projection, displacement, splitting, turning anger against the self, and acting out.
- Most people who express dissatisfaction with life, display deviant behavior, are intolerant of others, or have difficulty functioning in social or work situations have problems related to self-concept.
- Primary NANDA-I nursing diagnoses related to alterations in self-concept are disturbed body image, readiness for enhanced self-concept, low self-esteem (chronic, situational, risk for situational), ineffective role performance, and disturbed personal identity. These nursing diagnoses are not limited to the psychiatric setting and do not have a discrete category of medical diagnoses associated with them.
- Medical diagnoses include identity problem, dissociative amnesia, dissociative fugue, dissociative identity disorder (multiple personality disorder), and depersonalization disorder.
- The expected outcome of nursing care is that the patient will obtain the maximum level of self-actualization to realize his potential.
- The nurse's focus is to help patients understand themselves more fully and accurately so that they can direct their own lives in a more satisfying way.
- The mutually identified goals can be reached by a problem-solving approach that focuses primarily on the present and actively engages the patient in working on personal difficulties. This approach requires that the patient first develop insight into problems and then take action to effect lasting behavioral changes.
- The focus of this approach is on the patient's cognitive appraisal of life, which may contain faulty perceptions, beliefs, and convictions. Awareness of feelings and emotions is also important, because they too may be subject to misconceptions. Only after examining the patient's cognitive appraisal of the situation and related feelings can one gain insight into the problem and bring about behavioral change.

CHAPTER IN REVIEW—cont'd

- Interventions include helping the patient expand self-awareness and engage in self-exploration, self-evaluation, realistic planning, and commitment to action. Insight must be followed by lasting behavior change.
- The degree of success achieved through nursing care is determined by eliciting patients' perceptions of their own growth and comparing their behavior with characteristics of a healthy personality.

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CHAPTER

18

Emotional Responses and Mood Disorders

Gail W. Stuart

Lying awake, calculating the future,
Trying to unweave, unwind, unravel
And piece together the past and the future,
Between midnight and dawn, when the past is all deception,
The future futureless…

T. S. Eliot

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive emotional responses.
2. Identify behaviors associated with emotional responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to emotional responses.
4. Describe coping resources and coping mechanisms related to emotional responses.
5. Formulate nursing diagnoses related to emotional responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to emotional responses.
7. Identify expected outcomes and short-term nursing goals related to emotional responses.
8. Develop a patient education plan to enhance social skills.
9. Analyze nursing interventions related to emotional responses.
10. Evaluate nursing care related to emotional responses.

Variations in emotions and mood are a natural part of life. They indicate that a person is perceiving the world and responding to it. Extremes in mood also are linked with extremes in human experience, such as creativity, madness, despair, ecstasy, romanticism, personal charisma, and interpersonal destructiveness.

Mood is a prolonged emotional state that influences the person's whole personality and life functioning. It is similar to the terms *feeling state* and *emotion*. Like other aspects of the personality, emotions or moods serve an adaptive role. **The four adaptive functions of emotions are social communication, physiological arousal, subjective awareness, and psychodynamic defense.**

CONTINUUM OF EMOTIONAL RESPONSES

Emotions such as fear, joy, anxiety, love, anger, sadness, and surprise are all normal parts of the human experience. The problem arises in trying to evaluate when a person's mood or emotional state is maladaptive, abnormal, or unhealthy.

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

She was referred from a local college and they wanted her to be seen right away. They were concerned because she has been exercising for hours each day. She had a sudden weight loss and they were thinking she might have anorexia.

She appeared in bright pink pants, orange flowered top, and heavy makeup. She was delightful and charming, but after 10 minutes she started to cry. She said that she was very confused. At first she was feeling just fine, but now she was very upset. Her mother was traveling to her college and planned on staying a couple of days. She was concerned that her mother might have a wreck while driving to see her. Then she changed the subject and began talking very fast about a friend who had had a car wreck a year ago that was fatal. Her mother would be traveling on the same interstate highway and the same thing might happen to her mother. She said she worries about it all the time and has not been able to sleep much in the past few weeks.

Again, almost as quickly, she began talking about her boyfriend whom she would see in a month. He was attending another college and was coming for a party weekend. She said no one has ever loved her the way he does. He treats her like a queen. She then went back to talking about the friend who had died in the car crash, saying that she had had a premonition that something bad was going to happen. She said she is psychic that way and knows what is going to happen in other people's lives.

She began to cry, mumbling that she should have been able to save her friend's life. She should have been able to tell her that something bad was going to happen. Maybe her friend wouldn't have gone on the trip. Maybe she would still be alive. She should have helped her.

Case Critical Reasoning Questions

1. What behaviors would you include in your assessment?
2. What medical and nursing diagnoses should be considered?
3. What medications might be prescribed for this patient?
4. What interventions would be implemented in the acute, continuation, and maintenance phases of treatment?

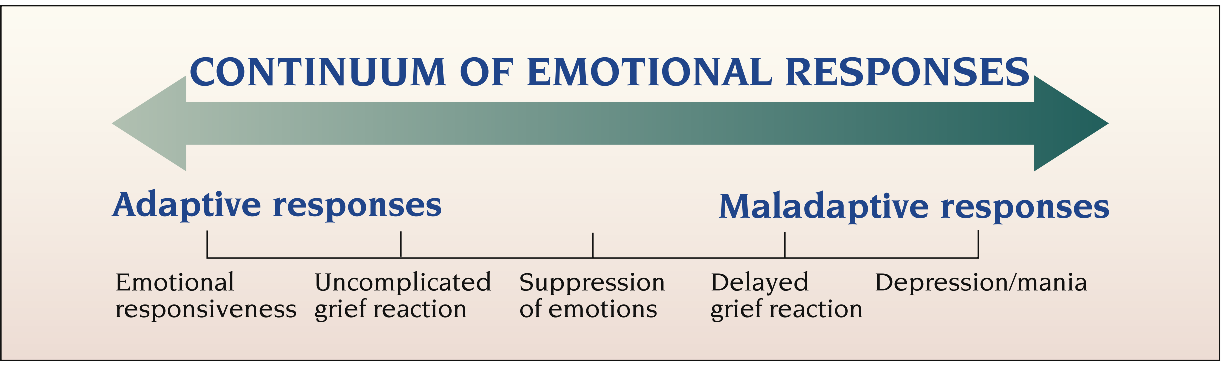


FIG 18-1 Continuum of emotional responses.

Grief, for example, is a healthy, adaptive, separating process that attempts to overcome the stress of a loss. Grief work, or mourning, is not a pathological process; it is an adaptive response to a real stressor. The absence of grieving in the face of a loss suggests maladaptation.

The continuum of emotional responses is shown in Figure 18-1.

- **At the adaptive end is emotional responsiveness.** It implies an openness to and awareness of feelings. In this way, feelings provide us with valuable learning experiences. They are barometers that give us feedback about ourselves and our relationships, and they help us function more effectively.
- **Also adaptive in the face of stress is an uncomplicated grief reaction.** Such a reaction implies that the person is facing the reality of the loss and is immersed in the work of grieving.
- **A maladaptive response is the suppression of emotions.** This may be a denial of one's feelings or a detachment from them. A temporary suppression of feelings may at times be necessary to cope, as in an initial response to a death or tragedy.
- **Delayed grief reaction also is maladaptive.** It involves a prolonged suppression of emotion that interferes with effective functioning.
- **The most maladaptive emotional responses are depression and mania seen in bipolar disorder.** Severe mood disturbances are recognized by their intensity, pervasiveness, persistence, and interference with social and physiological functioning.

Grief Reactions

Grief **is the subjective state that follows loss.** It is one of the most powerful emotional states and affects all aspects of a person's life. It forces the person to stop normal activities

and focus on present feelings and needs. Most often, it is the response to the loss of a loved person through death or separation, but it also can follow the loss of something tangible or intangible that is highly regarded. It may be a valued object, a cherished possession, an ideal, a job, or status.

As a response to the loss of a loved one, grief is a universal reaction. As a person's dependence on others grows, the chance increases that the person will at some point face loss, separation, and death, which elicit intense feelings of grief. The capacity to form warm, satisfying relationships with others makes a person vulnerable to sadness, despair, and grief when those relationships are terminated.

As a natural reaction to a life experience, grief is universal; however, the way in which it is expressed is culturally determined. Grief involves stress, pain, suffering, and an impairment of function that can last for days, weeks, or months. Understanding the stages of grief and its symptoms is important because of grief's effect on both physical and emotional health.

The ability to experience grief is gradually formed in the course of normal development and is closely related to the capacity for developing meaningful relationships. Grief responses may be adaptive or maladaptive.

- **Uncomplicated grief is an adaptive response.** It runs a consistent course that is modified by the abruptness of the loss, the person's preparation for the event, and the significance of the lost object. It is a self-limited process of realization; it makes real the fact of the loss.
- **Delayed grief reaction is maladaptive.** Something is preventing the grief from running its normal course. Persistent absence of any emotion signals a delay in the work of mourning. This delay may occur in the beginning of the mourning process, slow the process once it has begun, or both. The delay and rejection of grief may occasionally last for many years.
- **Bereavement and loss also can be seen in the maladaptive response of depression.** It is an abnormal extension or overelaboration of sadness and grief (Kendler et al, 2008).

The emotions associated with the loss may be triggered by a deliberate recall of circumstances surrounding the loss or by a spontaneous occurrence in the patient's life. A classic example of this is the anniversary reaction, in which the person experiences incomplete or abnormal mourning at the time of the loss, only to have the grieving response recur at anniversaries of the original loss.

Depression

Depression is the oldest and most common psychiatric illness. The word **depression** is used in a variety of ways. It can refer to a sign, symptom, syndrome, emotional state, reaction, disease, or clinical entity (Ayuso-Mateos et al, 2010). In this chapter depression is viewed as a clinical disorder that is severe, maladaptive, and incapacitating.

Depression may range from mild and moderate states to severe states with or without psychotic features. **Psychotic depression is uncommon, accounting for fewer than 10% of all depressions.** Depression can begin at any age, and symptoms develop over days, weeks, and months.

BOX 18-1 SOCIOCULTURAL CONTEXT OF CARE

How Does Culture Impact Depression?

In some cultures, disturbances of mood are viewed as moral problems, whereas in others they are repressed or seen as a sign of personal failure or lack of personal strength. This can lead some cultures to deny or minimize this aspect of personal distress.

In the United States, the prevalence of depression is associated with income inequality: the more unequal it is, the higher the depression prevalence (Messias et al, 2011). Racial and ethnic minorities are less likely to receive appropriate care because of underdiagnosis and undertreatment (Kozhimannil et al, 2011). Other barriers to care include lack of insurance, scarcity of minority providers, and distrust of care providers. Clearly, clinicians need to work collaboratively with their patients, as well as with culture brokers and colleagues from other cultural communities, not only to better understand and identify their patients' problems and eliminate disparities in care but also to uncover cultural resources that can complement and perhaps supplant conventional treatment.

Approximately one of eight adults experiences major depression during their lifetime. Depression affects 14 million people each year, 70% of whom are women. Complications include significant marital, parental, social, and work difficulties. It has been estimated that depression costs the U.S. economy $43 billion in worker absenteeism, lost productivity, and health care.

The lifetime risk for major depression is 7% to 12% for men and 20% to 30% for women. Among women, rates peak between adolescence and early adulthood. This difference holds true across cultures and continents. Other risk factors include a history of depressive illness in first-degree relatives and a history of major depression.

As a psychiatric illness, depression exists in all countries. The World Health Organization has identified depression as the number one psychiatric cause of disability in the world and has projected that it will rank second in the world as a cause of disability by 2020.

Culture affects the symptomatic expression, clinical presentation, and effective treatment of depression (Jang et al, 2010) (Box 18-1). Culture has an effect on the neural systems, psychological states, and interpersonal patterns that exist throughout one's life, and cultural variations in family and child-rearing practices shape one's view of the world. Culture provides a release for emotional expression and also can influence one's source of distress, the form of illness experienced, modes of coping with distress, help-seeking behavior, and social response.

There have been changes in attitudes about the causes and treatment of depression among the American public in the past decade. More people now believe in a biological basis for the disorder (Blummer and Marcus, 2009). This

TABLE 18-1 COMORBIDITY OF DEPRESSION AND OTHER PSYCHIATRIC ILLNESSES

COMORBID CONDITION	MAJOR DEPRESSIVE DISORDER IN LAST 12 MONTHS (%)
Alcohol use disorder	14
Drug use disorder	5
Nicotine dependence	26
Any anxiety disorder	36
Any personality disorder	38

may lead to more effective outreach, prevention, and education efforts.

Most untreated episodes of major depression last 6 to 24 months. Some people have only a single episode of major depression and return to presymptomatic functioning. **However, more than 50% of those who have one episode will eventually have another, and 25% of patients will have chronic, recurrent depression.**

Depression often occurs along with other psychiatric illnesses (Table 18-1). Up to 40% of patients with major depressive disorders have histories of one or more nonmood psychiatric disorders that significantly impair their quality of life. These statistics underscore the importance of this health problem and suggest the need for timely diagnosis and treatment. **Unfortunately, only one third of all people with depression seek help, are accurately diagnosed, and obtain appropriate treatment** (Mojtabai, 2009).

A high incidence of depression is found among all patients hospitalized for medical illnesses. Its intensity and frequency are higher in more severely ill patients (Lin et al, 2010; Fallon, 2011). These depressions are largely unrecognized and untreated by general health care providers.

Studies suggest that about one third of medical inpatients report mild or moderate symptoms of depression, and up to one fourth have major depression. **Medical conditions often associated with depression include diabetes, cancer, stroke, epilepsy, multiple sclerosis, Parkinson disease, cardiac disease, end-stage renal disease, and a variety of endocrine disorders.**

QUALITY AND SAFETY ALERT

- Depression is commonly seen with many major medical illnesses, resulting in increased health care use, role impairment, disability, and work absence in persons with chronic physical illness.
- Depression also often occurs with other psychiatric illnesses.
- Women of childbearing age face the highest demographic risk for depression.

Depressive conditions are highly prevalent in primary care settings. It is one of the most common clinical problems. One of every five patients seeing a primary care practitioner has significant symptoms of depression and one in ten patients meet criteria for major depressive disorder (Halaris, 2011). Yet health care providers fail to diagnose major depression in their patients up to 50% of the time.

Given the prevalence and disability associated with depression, the U.S. Preventive Services Task Force (2010) has recommended screening of adults for depression in primary care settings that have systems in place to ensure accurate diagnosis, effective treatment, and responsive follow-up.

It is particularly important to screen for depression among women of reproductive age, especially those who have children or plan to become pregnant. This is because major depression during pregnancy can result in negative fetal outcomes, impaired neurocognitive and socioemotional development of the child, and increased risks of mental and medical disorders in the offspring later in life (Bansil et al, 2010). Simply stated, children of depressed mothers suffer. Yet, with appropriate diagnosis, mothers can be successfully treated, with improved functioning in their offspring (Pilowsky et al, 2008).

Critical Reasoning A patient who just had cardiac surgery comes for a follow-up visit and tells the physician he is feeling depressed. He is told that depression is a normal response to cardiac illness and he will get over it in time. Do you agree? If not, what nursing actions are indicated?

Bipolar Disorder

In the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR;* American Psychiatric Association, 2000), the major mood disorders are separated into two groups—bipolar and depressive disorders—based on the involvement of manic and depressive episodes over time.

- **Major depression may involve a single episode or a recurrent depressive illness but does not include a manic episode.**
- **Bipolar disorder includes one or more manic episodes, with or without a major depressive episode.**

Manic episodes can vary in intensity from moderate manic states to severe and panic states with psychotic features. **Mania** is characterized by an elevated, expansive, or irritable mood. **Hypomania** is a clinical syndrome that is similar to but not as severe as mania.

Bipolar disorders are less common than depressive disorders. It is estimated that 2.6% of the adult population has bipolar disorder (Wieseke et al, 2011). **Risk factors are being female and having a family history of bipolar disorder.**

Most people start showing signs of bipolar disorder in their late teens (average age at onset, 21 years). The data suggest that people younger than 50 years of age are at higher risk of a first attack, whereas those who already have the disorder face increased risk of a recurrent manic or depressive episode as they grow older (Sorrell, 2011).

On average, a person is free of symptoms for about 5 years between the first and second episodes. The interval between episodes may shorten over time, especially if treatment is

BOX 18-2 FACTS ABOUT MOOD DISORDERS

Major Depressive Disorder

Major depression accounts for more bed days (people out of work and in bed) than any other "physical" disorder except cardiovascular disorders, and it is more costly to the economy than chronic respiratory illness, diabetes, arthritis, or hypertension.

Psychotherapy alone helps some depressed patients, especially those with mild to moderate symptoms.

Depression can be treated successfully by antidepressant medications in 65% of cases.

The success rate of treatment increases to 85% when alternative or adjunctive medications are used or psychotherapy is combined with medications.

Bipolar Disorder

Bipolar disorder is associated with twice as many lost workdays (65) compared with major depression (27) per year.

Bipolar disorder is often misdiagnosed as attention deficit hyperactivity disorder (ADHD) in children.

Effective medications, often used in combination with psychotherapy, allow 75% to 80% of manic-depressive patients to lead essentially normal lives.

discontinued too soon. It is estimated that a person with bipolar disorder will have an average of eight to nine mood episodes during his or her lifetime.

Bipolar disorders are associated with increased premature mortality secondary to general medical illnesses (Roshanaei-Moghaddam and Katon, 2009; Weber et al, 2011). Unhealthy lifestyle, biological factors, adverse medication effects, and disparities in health care are contributing factors. Additional facts about depressive and bipolar disorders are presented in Box 18-2.

QUALITY AND SAFETY ALERT

- As many as 60% to 70% of individuals with bipolar disorder meet diagnostic criteria for a lifetime history of substance abuse or dependence.
- The risk for alcohol or drug abuse is six to seven times greater among people with bipolar disorder.

ASSESSMENT

Behaviors

Behaviors Associated With Delayed Grief Reaction. Delayed grief reactions may be expressed by excessive hostility and grief, prolonged feelings of emptiness and numbness, an inability to cry or express emotions, low self-esteem, use of present tense instead of past when speaking of the loss, persistent dreams about the loss, retention of clothing of the deceased, an inability to visit the grave of the deceased, and projection of living memories onto an object held in place of the lost one. The following clinical example illustrates some of the behaviors associated with a delayed grief reaction.

CLINICAL EXAMPLE

Ms. G was a 38-year-old married woman with no history of depression. She came to the local health center complaining of severe throbbing headaches, difficulty falling asleep, fitful and disturbing dreams when asleep, and poor appetite. She said she felt "disgusted" with herself and "useless" to her family.

Her family history revealed that she had three children: two boys and a girl. Her elder son, 20 years old, was attending college out of state, and her daughter, 19 years old, was living with a girlfriend in the same city. Her younger son was killed in an automobile accident 2 years earlier, at 15 years of age. She described him as her "baby" and expressed much guilt for contributing to his death. She scolded herself for allowing him to drive to the beach for the weekend with friends and said she now worries a great deal about her other two children. She said she was trying to protect them from the dangers of the world, but they resented her advice and concern.

On questioning, Ms. G reported that these feelings of sadness and guilt had emerged in the last month and seemed to be triggered by the graduation of her son's high school class.

Selected Nursing Diagnosis

- Complicated grieving related to son's death, as evidenced by somatic complaints and feelings of sadness and guilt.

In this example, Ms. G was experiencing a delayed grief reaction precipitated by the event of her deceased son's would-be graduation. She had failed to progress through mourning after her son's death and was just now beginning grief work.

Behaviors Associated With Depression. The behaviors associated with depression vary. Sadness and slowness may predominate, or agitation may occur. **The key element of a behavioral assessment is change.** Depressed people change their usual patterns and responses. This often leads them to seek help.

Behaviors associated with depression include affective, physiological, cognitive, and behavioral responses. Box 18-3 presents the spectrum of possible behaviors. Not all patients experience all of these behaviors.

The most common and central behavior is that of depressed mood. This is not necessarily described by the patient as depression but rather as feeling sad, blue, down in the dumps, unhappy, or unable to enjoy life. Crying often occurs. On the other hand, some depressed people do not cry and describe themselves as "beyond tears." The mood disturbance of the depressed patient resembles that of normal unhappiness multiplied in intensity and duration.

Another mood that often accompanies depression is **anxiety:** a sense of fear and intense worry. Both depression and anxiety may show diurnal variation, that is, a pattern whereby certain times of the day, such as morning or evening, are consistently worse or better.

Other patients may initially deny their anxious or depressed moods but do identify a variety of **somatic complaints.** These might include gastrointestinal distress, chronic

BOX 18-3 BEHAVIORS ASSOCIATED WITH DEPRESSION

Affective
Anger
Anxiety
Apathy
Bitterness
Dejection
Denial of feelings
Despondency
Guilt
Helplessness
Hopelessness
Loneliness
Low self-esteem
Sadness
Sense of personal worthlessness

Physiological
Abdominal pain
Anorexia
Backache
Chest pain
Constipation
Dizziness
Fatigue
Headache
Impotence
Indigestion
Insomnia
Lassitude
Menstrual changes
Nausea
Overeating
Sexual nonresponsiveness
Sleep disturbances
Vomiting
Weight change

Cognitive
Ambivalence
Confusion
Inability to concentrate
Indecisiveness
Loss of interest and motivation
Pessimism
Self-blame
Self-deprecation
Self-destructive thoughts
Uncertainty

Behavioral
Aggressiveness
Agitation
Alcoholism
Altered activity level
Drug addiction
Intolerance
Irritability
Lack of spontaneity
Overdependency
Poor personal hygiene
Psychomotor retardation
Social isolation
Tearfulness
Underachievement
Withdrawal

or intermittent pain, irritability, palpitations, dizziness, appetite change, lack of energy, change in sex drive, or sleep disturbances. The person often focuses on these symptoms because they are more socially acceptable than the profound feeling of sadness, inability to concentrate, or loss of pleasure in usual activities.

In addition, the physical symptoms may help the person with depression explain why nothing is fun anymore. When patients have a range of somatic symptoms, the nurse should carefully evaluate these complaints but also should return to the issues of mood and loss of interest, thus considering the possible diagnosis of depression.

Two subgroups of major depressive disorder deserve special attention.

Postpartum onset. Postpartum mood symptoms are divided into three categories based on severity: blues, depression, and psychosis.

1. Postpartum blues **are brief episodes, lasting 1 to 4 days.** They occur in about 50% to 80% of women within 1 to 5 days of delivery. Women have labile mood and tearfulness. Treatment consists of reassurance, social support, adequate sleep, and time to resolve this normal response.
2. Postpartum depression **may occur from 2 weeks to 12 months after delivery but usually occurs within 6 months.** The risk of postpartum depression is 10% to 15%, but the rate is higher for women with a history of psychiatric disorders. Treatment with medication and psychotherapy is indicated for postpartum depression, because treatment has positive effects on both mother and baby (Meltzer-Brody et al, 2008; Pilowsky et al, 2008).
3. Postpartum psychosis **typically begins 2 to 3 days after delivery, with highest risk during the first month.** It can be divided into depressed and manic types. The incidence of postpartum psychosis is low, and the prognosis is good for acute postpartum psychosis if it is treated at its onset. Psychiatric hospitalization is usually required to protect the mother and her baby (Friedman et al, 2009). Many patients go on to develop bipolar disorder (Spinelli, 2009). The recurrence rate is 33% to 51%, underscoring the importance of early intervention.

Seasonal pattern. Seasonal affective disorder (SAD) **is depression that comes with shortened daylight in winter and fall and disappears during spring and summer.** It is characterized by hypersomnia, lethargy and fatigue, increased anxiety, irritability, increased appetite with carbohydrate craving, and often weight gain. It is related to abnormal melatonin metabolism. Two to three times as many people experience the winter recurrence of seasonal depressive symptoms as those who exhibit behaviors severe enough to meet diagnostic criteria.

Critical Reasoning Conditions of light and darkness have often been noted to affect mood. Evaluate your own environment for exposure to light. Compare it with a hospital environment.

Suicide. **The potential for suicide should always be assessed in those with severe mood disturbances.** Suicide and other self-destructive behaviors are discussed in detail in Chapter 19. Previous suicide attempts and poor social support indicate risk, however **the time spent depressed is a major factor in determining long-term risk of suicide** (Holma et al, 2010).

QUALITY AND SAFETY ALERT

- Approximately 15% of severely depressed patients commit suicide.
- Between 25% and 50% of patients with bipolar disorder attempt suicide at least once.

The intensity of anger, guilt, and worthlessness may precipitate suicidal thoughts, feelings, or gestures, as illustrated in the following clinical example.

CLINICAL EXAMPLE

Mr. W was a 68-year-old man who lived alone. His son and daughter were married and lived in the same state. His wife had died 2 years before, and since that time his children had often asked him to move in with either of them. He consistently refused to do this, believing that he and his children needed privacy in their lives. Six months before, he was diagnosed as having advanced prostatic cancer with metastasis. After the diagnosis and because of increasing disability, he left his job and began to receive disability compensation. He visited his children and their families about twice each month and kept his regularly scheduled visits with the medical clinic.

The nurses and physicians at the clinic noted that he was "despondent and withdrawn" but thought this was a normal reaction to his diagnosis and family history. No interventions were implemented based on his emotional needs. A week after attending the clinic for a routine follow-up visit, he went to the cemetery where his wife was buried and at her gravestone shot himself in the head. The groundskeeper of the cemetery heard the shot, discovered what had happened, and called an ambulance. Mr. W was taken to the emergency room of the nearest hospital and, with prompt medical care, survived the suicide attempt.

Selected Nursing Diagnoses

- Risk for suicide related to feelings of depression, as evidenced by gunshot to the head.
- Hopelessness related to medical diagnosis of metastatic cancer, as evidenced by withdrawal and despondency.

This example highlights three important points:

1. **Medical illness often involves a loss of function, body part, or appearance; therefore all medically ill patients should be assessed for depression.**
2. **All people experiencing depression and despair have the potential for suicide; therefore all depressed patients should be assessed for suicide.**
3. **Nurses should intervene with nursing actions that can be preventive, curative, or rehabilitative, based on the nursing assessment and diagnosis.**

Behaviors Associated With Bipolar Disorder. **Manic behavior, the essential feature of bipolar disorder, is a distinct period of intense psychophysiological activation.** Some of these behaviors are listed in Box 18-4. **The predominant mood is elevated or irritable.** It is accompanied by one or more of the following symptoms: hyperactivity, the undertaking of too many activities, lack of judgment in anticipating consequences, pressured speech, flight of ideas, distractibility, inflated self-esteem, and hypersexuality.

If the mood is elevated or euphoric, it can be infectious. Patients report feeling happy, unconcerned, and carefree. Although such experiences seem desirable, the person also has no concern for reality or the feelings of others. **Patients may have misperceptions about their power and importance and may involve themselves in senseless, irresponsible, or risky activities.**

Alternatively, the mood may be irritable, especially when plans are blocked. Patients can be argumentative and provoked by seemingly harmless remarks. Self-esteem is inflated during a manic episode, and as the activity level increases, feelings about the self become increasingly disturbed. **Grandiose symptoms are evident.** The patient is willing to undertake any project possible.

BOX 18-4 BEHAVIORS ASSOCIATED WITH BIPOLAR DISORDER

Affective
Elation or euphoria
Expansiveness
Humorousness
Inflated self-esteem
Intolerance of criticism
Lack of shame or guilt

Physiological
Dehydration
Inadequate nutrition
Little need of sleep
Weight loss

Cognitive
Ambitiousness
Denial of realistic danger
Easily distracted
Has flights of ideas
Thoughts of grandiosity
Has illusions
Lack of judgment
Loose associations

Behavioral
Aggressiveness
Excessive spending
Grandiose acts
Hyperactivity
Increased motor activity
Irresponsibility
Irritability or argumentativeness
Poor personal grooming
Provocativeness
Sexual overactivity
Increased social activity
Verbosity

In contrast to depressed patients, bipolar patients are extremely self-confident, with an ego that knows no bounds; they are "on top of the world." Accompanying this magical omnipotence and supreme self-esteem is a lack of guilt and shame. Often they deny realistic danger. The patient's boundless energy and inability to anticipate consequences often lead to irresponsible activities and excessive spending, as well as problems of a sexual, aggressive, or possessive nature.

Bipolar patients have abundant energy and heightened sexual appetite. **Physical changes** they experience are caused by inadequate nutrition, partly because manic patients have no time to eat. Serious weight loss is also related to their insomnia and overactivity. Extremely manic patients may become dehydrated and require prompt attention.

The person with bipolar illness may exhibit disturbed speech patterns. As mania intensifies, formal and logical speech is replaced by loud, rapid, and confusing language. This is often referred to as **pressured speech.** As the activated state increases, speech includes numerous plays on words and irrelevancies that can escalate to **loose associations** and **flight of ideas** (see Chapter 6). Some of these behaviors are seen in the following clinical example.

CLINICAL EXAMPLE

Mr. B was a 30-year-old Hispanic single man who was admitted to the psychiatric unit of the local community hospital. He had been hospitalized 2 years before for problems related to alcoholism. He was accompanied to the hospital by a friend who lived with him. His friend said that for the past 2 months Mr. B had been "running on

10 cylinders instead of 4." He slept and ate little and talked constantly, sometimes so fast that no one could understand what he was trying to say. He had redecorated his bedroom in the apartment twice and had gone into debt buying a new wardrobe. His friend brought him in because his behavior was becoming more erratic and his physical condition was getting worse.

The nurse who admitted Mr. B asked about his social relationships. He revealed that his girlfriend of 7 years had left him 6 months earlier for another man. He said that initially he thought she would "see the light," but she had refused to see him since then. Mr. B said this "upset" him a little at the time, but he was sure it was for the best and there were plenty of other women waiting for him.

Selected Nursing Diagnosis

- Risk for self-directed violence related to interpersonal rejection, as evidenced by agitated behavior and lack of self-care.

Another behavior associated with bipolar disorder is lability of mood with rapid shifts to periods of depression. This accounts for patients who are alternately happy and sad. There may be feelings of guilt and thoughts of suicide.

Manic episodes are very likely to recur. **About 75% of bipolar patients have more than one manic episode, and almost all those with manic episodes also have depressive episodes.** However, the duration and severity of the manic episodes vary among patients, as do the intervals between relapses and recurrences.

Finally, disturbances of mood are interrelated with self-esteem problems and disrupted relationships. Multiple aspects of the patient's life are affected, including **physical health**. Hypertensive crises, irritable bowel syndrome, coronary occlusions, rheumatoid arthritis, migraine headaches, and various dermatological conditions can occur with severe mood disturbances.

Predisposing Factors

Genetics. Both heredity and environment play an important role in severe mood disturbances (Zimmermann et al, 2011). Major depression and bipolar disorder are familial disorders, and their familiarity primarily results from genetic influences.

The lifetime risk is 20% for relatives of people with depression and 24% for relatives of people with bipolar disorder. The lifetime risk for mood disorders in the general population is 6%. A person who has an identical (monozygotic) twin with an affective disorder has a two to four times greater risk for the disorder than if the sibling were a fraternal (dizygotic) twin or nontwin. Therefore good evidence exists for the role of genetic factors in mood disorders (Breen et al, 2011; Hamilton, 2011).

Object Loss Theory. **The object loss theory refers to traumatic separation of the person from significant objects of attachment, particularly loss during childhood as a predisposing factor for adult depressions.** It proposes that a child has ordinarily formed a tie to a significant other by 6 months of age, and if that tie is broken in early life, the child experiences separation anxiety, grief, and mourning. **This mourning in the early years can predispose the child to psychiatric illness, or it can be beneficial and help develop resilience.**

This theory also focuses attention on the negative impact of maternal depression on infants and children. This is expressed by the infant as flat affect, lower activity, disengagement, and difficulty in being consoled. Among older children it is seen as sadness, submissive helplessness, and social withdrawal.

Poorer maternal and fetal outcomes are associated with maternal depression (Pilowsky et al, 2008; Bansil et al, 2010). This underscores the need for early interventions by nurses for parents experiencing depression and for their children (Horowitz et al, 2009; Connelly et al, 2010).

QUALITY AND SAFETY ALERT

- Children of depressed parents have a three to four times higher than average rate of adjustment problems, including a range of emotional disorders.

Personality Organization Theory. **The personality organization view of mood disorders focuses on the major psychosocial variable of low self-esteem.** The patient's self-concept is an underlying issue, whether it is expressed as dejection and depression or as overcompensation with supreme competence, as displayed in manic and hypomanic episodes. **Threats to self-esteem arise from poor role performance, perceived low-level everyday functioning, and the absence of a clear self-identity.**

There are three forms of personality organization that could lead to depression (Arieti and Bemporad, 1980). They emphasize the critical importance of self-concept and the patients' appraisal of their life situation.

- One type occurs because the patient has relied on another for self-esteem and personal satisfaction. Clinging, passivity, manipulativeness, and avoidance of conflict are seen, along with a lack of personal goals and a predominant focus on problems.
- A second type results when a person realizes that a desired but unrealistic goal may never be accomplished. This person sets unrealistic goals and evaluates them with an all-or-nothing standard. Much time is spent in wishful thinking and introverted searches for meaning.
- The third type is seen in people who experience emptiness, hypochondriasis, pettiness in interpersonal relationships, and a harsh, critical attitude toward themselves and others. Their illness appears to be preceded by a severe blow to their self-esteem.

Cognitive Model. The cognitive model proposes that people experience depression because their thinking is disturbed (Beck et al, 1979; Beck, 2008). **Depression is seen as a cognitive problem arising from a person's negative view of self, the world, and the future.**

The depression-prone person, according to this theory, is likely to explain an adverse event as a personal shortcoming. For example, the deserted husband believes that "she left me because I'm unlovable" instead of considering other possible alternatives, such as personality incompatibility, the wife's own problems, or her change of feelings toward him. As he focuses on his personal deficiencies, they expand to the point where they completely dominate his self-concept. He can think of himself only in a negative way and is unable to acknowledge his strengths, achievements, and abilities. This negative set is reinforced when he interprets all experiences as further proof of his deficiencies. Comparisons with other people further lower his self-esteem, and every encounter with others becomes a negative experience. His self-criticisms increase as he views himself as deserving of blame.

Depressed patients become dominated by pessimism. Their predictions tend to be overgeneralized and extreme. Because they see the future as an extension of the present, they expect their failure to continue permanently. Thus pessimism dominates their activities, wishes, and expectations.

Depressed people are capable of logical self-evaluation when not in a depressed mood or when only mildly depressed. When depression does occur, after some precipitating life stressors, the negative cognitive set makes its appearance. As depression develops and increases, the negative thinking increasingly replaces objective thinking.

Although the onset of the depression may appear sudden, it develops over weeks, months, or even years, as each life experience is interpreted as further evidence of failure. As a result of this tunnel vision, depressed people become hypersensitive to experiences of loss and defeat and oblivious to experiences of success and pleasure. They have difficulty acknowledging anger because they think they are responsible for, and deserving of, insults from others and problems encountered in living.

Along with low self-esteem, they experience apathy and indifference. They are drawn to a state of inactivity and withdraw from life. They lack spontaneous desire and wish only to be passive. Because they expect failure, they lack the ordinary energy to even make an effort.

Suicidal wishes can be seen as an extreme expression of the desire to escape. Suicidal patients see their life as filled with suffering, with no chance of improvement. Given this negative mind set, suicide seems a rational solution. It promises to end their misery and relieve their families of a burden, and they begin to believe that everyone would be better off if they were dead. The more they consider the alternative of suicide, the more desirable it may seem, and as life becomes more hopeless and painful, the desire to end it becomes stronger.

> **Critical Reasoning** Relate the cognitive model of depression to the saying, "mind over matter."

Learned Helplessness-Hopelessness Model. Helplessness is a "belief that no one will do anything to aid you." Hopelessness is a "belief that neither you nor anyone else can do anything." **This theory proposes that it is not trauma that produces depression but the belief that one has no control over important outcomes in life** (Seligman, 1975; Abramson et al, 1989).

Learned helplessness is both a behavioral state and a personality trait of one who believes that control over reinforcers in the environment has been lost. These negative expectations lead to hopelessness, passivity, and an inability to assert oneself.

- **People who are resistant to depression have high self-efficacy and have experienced mastery in life.** Their childhood experiences proved to them that their actions were effective in producing gratification and removing annoyances.
- **People who are susceptible to depression have low self-efficacy and have had lives without mastery.** Their experiences caused them to believe that they were helpless and incapable of influencing their sources of suffering, and they developed no coping responses against failure.

Behavioral Model. **The behavioral model views people as being capable of exercising control over their own behavior** (Lewinsohn et al, 1979). They do not merely react to external influences; they select, organize, and transform incoming stimuli. Thus people are not viewed as powerless objects controlled by their environments; nor are they absolutely free to do whatever they choose. Rather, people and their environments affect each other.

The concept of reinforcement is crucial to this view of depression. Person-environment interactions with positive outcomes provide positive reinforcement. Such interactions strengthen the person's behavior. Little or no rewarding interaction with the environment causes the person to feel sad. **The key assumption in this model is that a low rate of positive reinforcement leads to depressive behaviors.**

Two elements of this model are important. One is that the person may fail to produce appropriate responses that will result in positive reinforcement. The other is that the environment may fail to provide reinforcement and thus worsen the patient's condition. This occurs because depressed patients are often deficient in the social skills needed to interact with others effectively. In turn, other people find the behavior of depressed people distancing, negative, or offensive and therefore often avoid them as much as possible.

Depression is likely to occur if the following positively reinforcing events are absent:

- **Competence experiences**
- **Rewarding social interactions**
- **Enjoyable leisure time**
- **Productive activity/work**

These may be described by phrases such as "being with friends," "being relaxed," "doing my job well," "being sexually attractive," and "doing things my own way."

Depression also can occur if the following punishing events are present:

- **Marital or interpersonal conflict**
- **Work or school problems**

- **Negative living arrangements**
- **Lack of social support/community**

The behavioral model of depression emphasizes an active approach. **Treatment is aimed at helping the person increase the quantity and quality of positively reinforcing events and decrease punishing events.**

> **Critical Reasoning** How many positively reinforcing events have you experienced this month? How many punishing events? Relate these to your overall mood.

Biological Model. The biological model explores chemical changes in the body during depressed states. **No single biochemical model adequately explains the causes of mood disorders.**

Abnormalities are seen in many body systems during a depressive illness, including electrolyte disturbances (especially of sodium and potassium); neurophysiological alterations; dysfunction and faulty regulation of autonomic nervous system activity; adrenocortical, thyroid, and gonadal changes; and neurochemical alterations in the neurotransmitters, especially in the biogenic amines, which act as central nervous system and peripheral neurotransmitters. The biogenic amines include three catecholamines—dopamine, norepinephrine, and epinephrine—as well as serotonin and acetylcholine (Krishnan and Nestler, 2010).

Endocrine system. **Some symptoms of depression that suggest endocrine changes are decreased appetite, weight loss, insomnia, diminished sex drive, gastrointestinal disorders, and variations of mood.** Mood changes also have been observed with a variety of endocrine disorders, including Cushing disease, hyperthyroidism, and estrogen therapy (Howland, 2010). Further support for this theory is evident in the high incidence of depression during the postpartum period, when hormonal levels change.

Current study of neuroendocrine factors in mood disorders emphasizes the disinhibition of the hypothalamic-pituitary-adrenal (HPA) axis and the hypothalamic-pituitary-thyroid (HPT) axis. Two tests based on the neuroendocrine theory and performed clinically may prove to be useful in diagnosing affective illnesses.

- The first is the corticotropin-releasing factor stimulation test, which evaluates the pituitary's ability to respond to corticotropin-releasing hormone (CRH) and secrete sufficient amounts of adrenocorticotropic hormone (ACTH) to induce normal adrenal activity.
- The second is the thyroid-releasing hormone (TRH) infusion test, which assesses the pituitary's ability to secrete sufficient amounts of thyroid-stimulating hormones (TSHs) to produce normal thyroid activity.

These tests may be helpful in differentiating unipolar from bipolar depression and mania from schizophrenic psychosis.

Cortisol. **Many depressed patients exhibit hypersecretion of cortisol.** This fact has been used in the dexamethasone suppression test (DST). (Dexamethasone is an exogenous steroid that suppresses the blood level of cortisol.) The DST is based on the observation that, in patients with biological depression, late-afternoon cortisol levels are not suppressed after a single dose of dexamethasone. However, many physical illnesses and some medications can interfere with the test results.

Neurotransmission. One of the dominant theories in the neurobiology of mood disorders is the **dysregulation hypothesis.** It proposes that a problem exists in several of the neurotransmitter systems.

Substantial evidence exists for abnormal regulation of the serotonin (5-HT) neurotransmitter system (Figure 18-2). This dysregulation is in the amount or availability of 5-HT, the sensitivity of its receptors in relevant regions of the brain, and its balance with other neurotransmitters and brain chemicals.

Behavior. 5-HT has an important role in brain functions such as aggression, mood, anxiety, psychomotor activity, irritability, appetite, sexual activity, sleep/wakefulness, circadian and seasonal rhythms, neuroendocrine function, body temperature, cognitive function, and pain perception—processes that are abnormal in people with depression.

Biochemistry. There is decreased 5-HT availability in patients with depression. Too little 5-HT, its precursor (tryptophan), or its major metabolite (5-HIAA) is found in the cerebrospinal fluid or blood of people with depression and in the postmortem brains of depressed people who died of other causes or who committed suicide.

Neuroendocrine. 5-HT has an important role in the secretion of growth hormone, prolactin, and cortisol, all of which are found to be abnormal in people with depression.

Treatment. Most clinically effective biological antidepressant agents, such as drugs and electroconvulsive therapy (ECT), have been found to enhance the neurotransmission of 5-HT, although the mechanisms of their actions differ.

Brain imaging. Computed tomography (CT) and magnetic resonance imaging (MRI) studies find various abnormalities in the structure of brains in people with mood disorders.

- **MRI studies of depressed patients show a decrease in the size of the hippocampus.** This supports the hypothesis that increased levels of stress hormones are associated with damage to the hippocampus (a limbic structure involved in learning and memory).
- **MRI studies of bipolar patients show that brain structures responsible for human mood are larger.** Specifically, the amygdala (the limbic structure responsible for modulating feelings of aggression, anger, love, and shyness) is especially large, perhaps accounting for some of the heightened emotionality and problematic behaviors seen in manic patients.

Positron emission tomography (PET) studies of mood disorders show decreased frontal lobe brain metabolism (hypometabolism), which is more pronounced on the left hemisphere in depression and on the right hemisphere in mania. This means that the frontal lobes, which have an important role in intellectual and emotional activities, are not using as much glucose as they should (Figure 18-3).

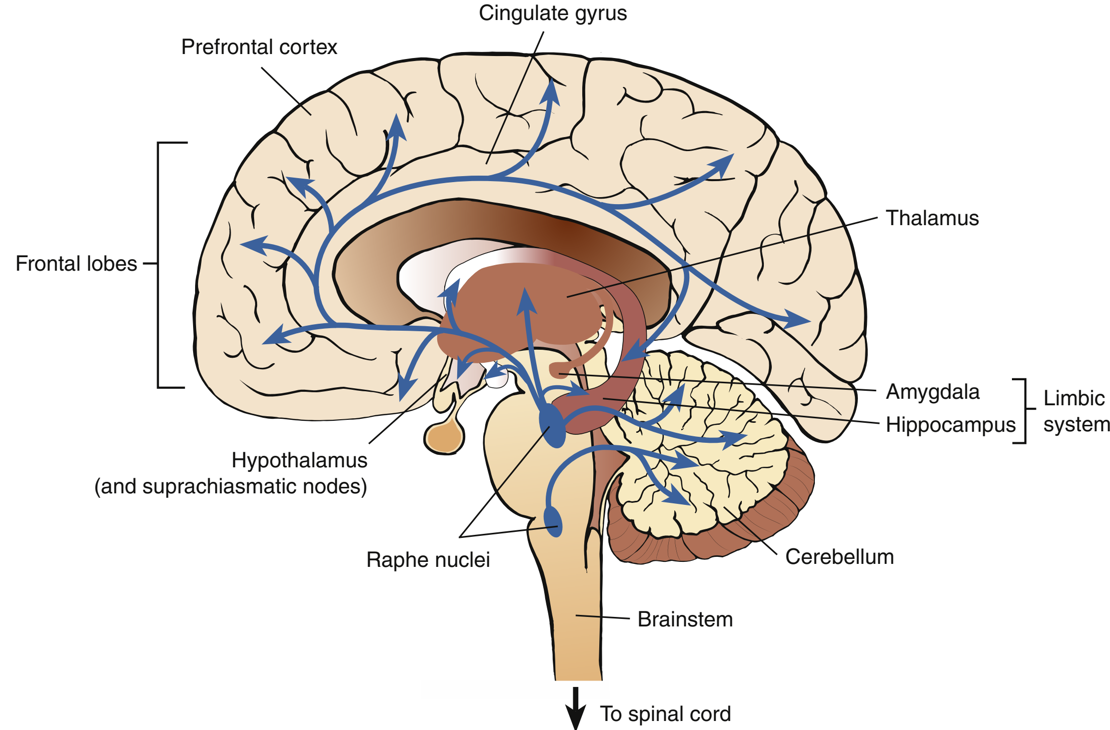


FIG 18-2 The serotonin neurotransmitter system implicated in depression.

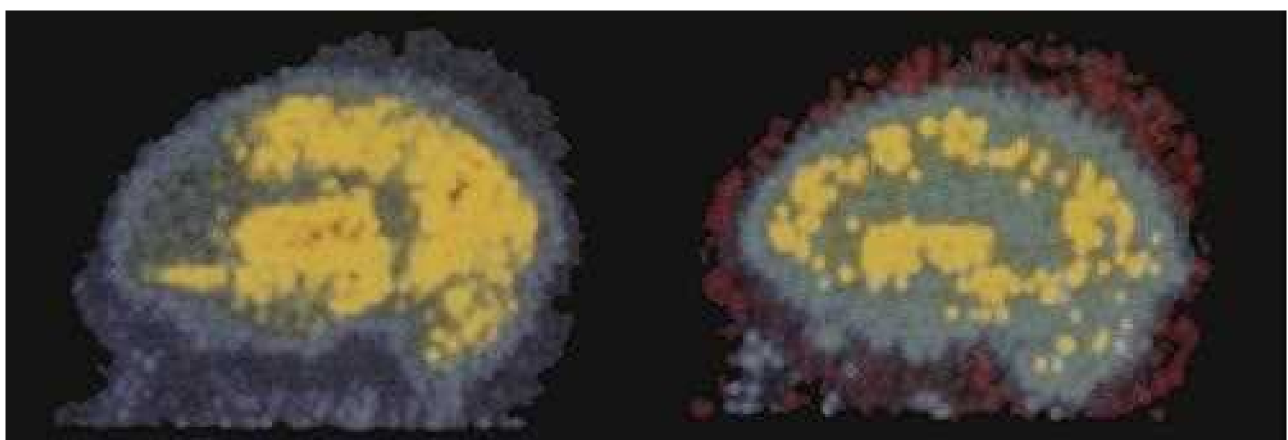


FIG 18-3 Positron emission tomography (PET) scan of glucose use in depressed subject *(figure on left)* showing frontal hypometabolism *(left side of figure).* This improves after treatment with antidepressant medication *(figure on right)*; note increased glucose metabolism in frontal lobe *(left side of figure).*

Prefrontal cortex (PFC) hypometabolism affects the function of many brain structures that are connected with the PFC by way of the 5-HT system. These interconnections contribute to the varied symptoms of depression (Table 18-2). Also, the amygdala shows increased blood flow, which is associated with intrusive ruminations in people with severe recurrent depression and a family history of mood disorders.

There are several important implications of viewing depression as a brain-based illness of the PFC.

- Cognitive and interpersonal therapies may be viewed as PFC rehabilitation because they substitute for, then gradually bring back on line, some of the behaviors and cognitions compromised by PFC hypoactivity.
- Viewing depression as a disease with identified regional brain dysfunction helps destigmatize depression and reintegrate mood disorders into general health care.
- Changes in brain metabolism identified by neuroimaging studies may help with the understanding of how psychosocial stressors such as grief (a hyperactivity in the PFC) may evolve into the clinical syndrome of depression (a hypoactivity in the PFC).

Biological rhythms. Mood disorders show variations in physiological and psychological functions. Affective illnesses

TABLE 18-2 PREFRONTAL CORTEX AND SEROTONIN INTERCONNECTIONS: IMPLICATIONS IN DEPRESSION

INTERCONNECTED BRAIN STRUCTURES	HYPOTHESIZED ROLE OF THESE INTERCONNECTIONS IN DEPRESSION
Prefrontal Cortex	Covering the frontal lobes, it is unique within the central nervous system (CNS) for its strong interconnections with all other areas of the brain; it receives information that has already been processed by other sensory areas and then merges this information with other emotional, historical, or relevant information, thus attending to both feelings and intellect.
Limbic System Structures	The prefrontal cortex modulates limbic system activities (emotional and instinctive) by way of the following three structures:
Hippocampus	Major importance in cognitive function, including memory
Amygdala	Major importance in modulating feelings such as aggression, anger, love, and shyness
Cingulate gyrus	Involved in motivation and interest
Brainstem	Responsible for regulating the general state of arousal and tone of brain function; also the location of structures that manufacture various neurotransmitters, such as serotonin (5-HT), norepinephrine (NE), and dopamine (DA).
Raphe Nuclei	Located in the brainstem, they manufacture 5-HT; they also modulate excessive stimuli and the organization and coordination of appropriate responses to these stimuli.
Hypothalamus	This interconnection allows for direct prefrontal input into neuroendocrine function by way of the hypothalamic-pituitary axis (HPA).
Suprachiasmatic Nucleus	Located in the hypothalamus, it regulates circadian (24-hour) rhythms and circannual rhythms; thus it is also implicated in seasonal affective disorder (SAD).

are usually recurrent, with episodes often occurring and remitting spontaneously.

Two subtypes of mood disorders are specifically cyclical in nature:

- **Bipolar disorder with rapid cycling**—cycles may last for days, weeks, months, or years.
- **Depressive disorder with seasonal patterns** (SAD)—cycles occur annually in the same season each year as people react to changes in environmental factors, such as climate, latitude, or light.

People who are depressed or manic have certain characteristic changes in biological rhythms and related physiology. For instance, body temperature and certain hormones reach their peak earlier than normal; some depressed patients are more sensitive to the absence of sunlight than nondepressed people; and many depressed people experience circadian rhythm disturbances, such as diurnal variation and early-morning awakening.

The neurotransmitter **melatonin** (a synthesis of serotonin in the pineal gland) is secreted with darkness and suppressed with bright light. It regulates hypothalamic hormones involved in the generation of circadian rhythms and the synchronization of these rhythms to variations in environmental light.

The human sleep cycle is linked to the timing of human circadian rhythms and to malfunctions in the brain's ability to follow environmental cues. These include light and darkness; unusual environmental situations, such as long, dark winters in northern latitudes; and disturbances in the intensity of the circadian rhythm, such as those caused by sleep problems, body temperature changes, mood cycling, and abnormalities of the endocrine system (hormones such as cortisol and thyrotropin).

Sleep problems in depression involve the timing of rapid eye movement (REM) sleep. Normally on falling asleep, the brain cycles through each stage of sleep for 60 to 90 minutes before it reaches stage 5 or REM (dream sleep). The time between the beginning of sleep and the occurrence of the first REM period is called REM latency.

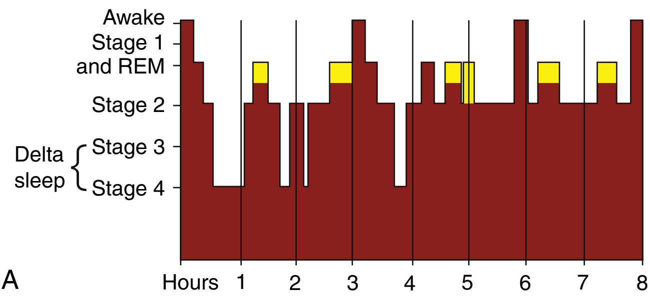
Depressed patients reach REM too early in the night (in just 5 to 30 minutes); spend less time in the more refreshing slow-wave stages of sleep (stages 3 and 4); spend too much time in REM sleep (up to twice as long as the first REM period in nondepressed people); and have increased periods of either very light sleep or awakenings during the night (Figure 18-4). This explains why depressed patients complain of feeling tired and unrefreshed after a night's sleep. They experience a decrease in total sleep time, an increase in the percentage of dream time, difficulty in falling asleep, and an increased number of spontaneous awakenings.

QUALITY AND SAFETY ALERT

- Sleep electroencephalogram (EEG) studies are abnormal in 90% of depressed patients.
- Sleep loss for individuals with bipolar disorder can trigger mania.

Disruption of both sleep and circadian rhythms also occur in bipolar disorder. Specifically, sleep-wake disturbances have the following characteristics:

- Decreased need for sleep is a marker of the manic state.
- Impaired sleep and sleep deprivation can induce manic episodes.
- Total sleep time is a predictor of future manic episodes.
- Total sleep time may be a marker of treatment response.



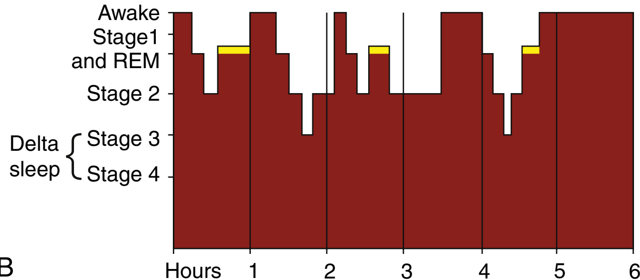


FIG 18-4 **A,** Normal sleep architecture. **B,** Depressed sleep architecture. Yellow areas indicate rapid eye movement (REM) sleep.

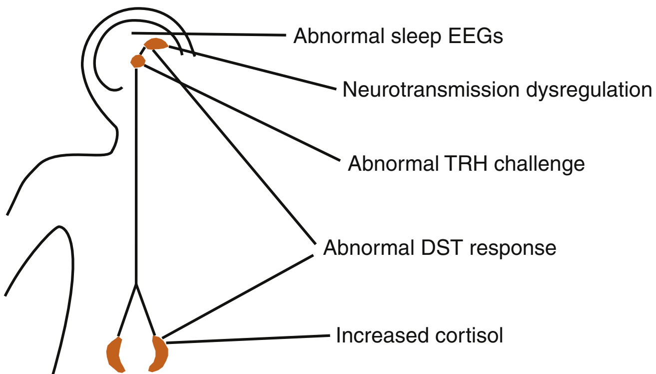


FIG 18-5 Biological factors related to depression. *DST,* dexamethasone suppression test; *EEGs,* electroencephalograms; *TRH,* thyroid-releasing hormone.

QUALITY AND SAFETY ALERT

- Early detection, aggressive treatment of acute episodes, and adequate long-term treatment of mood disorders can delay or prevent a progressively deteriorating course of illness.

Critical Reasoning A pastor preaches about how depression results from "poor moral character" and "personal weakness." How would you respond?

Given the importance of sleep in all phases of bipolar disorder, appropriate evaluation and management of sleep disturbances is a required aspect of care (Plante and Winkelman, 2008).

Kindling. When an animal's brain is given intermittent and repeated stimulation by low-level electrical impulses or low-dose chemicals such as cocaine, the result is an increased responsiveness to stable, low doses of the stimulation over time, resulting eventually in seizures. A similar response can be elicited by environmental stimulation. **This sensitizing phenomenon is known as kindling.**

Ultimately the animal becomes so sensitive that seizures continue to occur spontaneously after the stimulation is discontinued, demonstrating "behavioral sensitization." It is suggested that kindling is the basis of addictive disorders and cycling and recurrent psychiatric disorders.

Psychosocial stressors in genetically vulnerable individuals may precipitate early episodes of mania and depression, but later episodes can occur in the absence of any apparent external stimulus and with greater frequency and intensity over time. Additional evidence of a role for kindling in mood disorders is seen in medication treatments. Drugs used to treat bipolar disorder affect kindling: lithium blocks behavioral sensitization, and the anticonvulsants block kindling itself.

Mood disorders occur because many integrated control systems are disrupted, as seen in the dysregulation of neurotransmitter systems. Because the causes are diverse, the treatments also must be diverse and specific to the biopsychosocial needs of the individual patient. Some of the biological bases of depression are shown in Figure 18-5.

Precipitating Stressors

Disturbances of mood can be a specific response to stress. There are two major types of stress. The first, the stress of **major life events,** is evident to other people. The second type is the **minor stress or irritations of daily life** that a person may feel but that may not be as obvious to others. These are the small disappointments, frustrations, criticisms, and arguments that occur on a daily basis. However, when accumulated over time and in the absence of positive events, they can make one prone to depression.

Work and family life stress can be major or minor. Stressors that may produce disturbances of mood include loss of attachment, major life events, role strain, and physiological changes.

Loss of Attachment.

Loss can precipitate depression. The loss may be real or imagined and may include loss of love, a person, physical functioning, status, or self-esteem. Many losses take on importance because of their symbolic meaning, which makes the reactions to them appear out of proportion to reality. In this sense, even an apparently pleasurable event, such as moving to a new home, may involve the loss of old friends, warm memories, and neighborhood associations.

Loss of hope is another significant stressor that is often overlooked. Because of the actual and symbolic issues involved in loss, the patient's perception is of primary importance.

The intensity of grief becomes meaningful only when the person understands earlier losses and separations. People

reacting to a recent loss often behave as they did in previous separations. The intensity of the present reaction becomes more understandable with the realization that the reaction is to earlier losses as well.

By definition loss is negative, a deprivation. **The ability to sustain, integrate, and recover from loss is a sign of personal maturity and growth.**

An uncomplicated grief reaction is the process of normal mourning or simple bereavement. **Mourning** includes a complex sequence of psychological processes. It is accompanied by anxiety, anger, pain, despair, and hope. The sequence is not a smooth, unvarying course. It is filled with turmoil, regressions, and potential problems. Factors that influence the outcome of mourning are listed in Box 18-5.

These factors should be assessed by the nurse for each person experiencing a loss. **Two of the factors—the nature of the relationship with the lost person or object and the mourner's perception of the preventability of the loss—have been identified as prime predictors of the intensity and duration of the bereavement.** Concurrent crises, the circumstances of the loss, and a pathological relationship with the lost person or object are other factors that contribute to a failure to resolve grief.

Inhibiting factors. Loss of a loved one is a major stressor that precipitates grief reactions. Most people resolve this loss through simple bereavement and do not experience pathological grief or depression. However, various external and internal factors can inhibit mourning.

An external factor may be the immersion of the mourner in practical, necessary tasks that accompany the loss but are not directly connected to the emotional fact of the loss. These tasks may include funeral arrangements, unfinished business of the deceased, or a search for immediate employment. All these tasks foster **denial of the loss.**

Denial also may be encouraged by cultural norms that minimize or negate the finality of the loss. The U.S. norm of "courage in the face of adversity" can prevent an open display of grief.

BOX 18-5 FACTORS THAT INFLUENCE THE MOURNING PROCESS

- Childhood experiences, especially the loss of significant others
- Losses experienced later in life
- History of psychiatric illness, especially depression
- Occurrence of life crises before the loss
- Nature of the relationship with the lost person or object, including kinship, strength of attachment, dependency needs, and ambivalence
- Process of dying (when applicable), including age of deceased, timeliness, previous warnings, preparation for bereavement, expression of feelings, and preventability of the loss
- Social support systems
- Secondary stresses
- Emergent life opportunities

Mourning may be inhibited when the bereaved **lack grieving support from their social network.** Grieving is suppressed when significant others discourage the mourners' expression of sadness, anger, and guilt; block their review of the lost relationship; and attempt to orient them too quickly to the future. The **use of tranquilizers and antidepressant medications** also may suppress normal grief and encourage pathological reactions.

Internal factors that inhibit mourning are often fostered by a society that encourages the control and **concealment of feelings.** Crying, for example, may be seen as weakness, especially in men. Grief and anger are particularly repressed in U.S. society, and this repression can create many emotional problems.

Finally, the relationship between loss and depression is complex:

- Loss and separation events are possible precipitating stressors of depression.
- Loss and separation are not present in all depressions.
- Not all people who experience loss and separation develop depression.
- Loss and separation are not specific to depression but may act as precipitating events for a variety of psychiatric and medical illnesses.
- Loss and separation may result *from* depression.

Life Events. **Adverse life events can precipitate depression.** Such events include loss of self-esteem, interpersonal problems, socially undesirable occurrences, and major life disruptions. Events perceived as undesirable are most often the precipitants of depression.

Exit events (separations and losses) more often than entrance events (additions and introductions) are followed by worsening of psychiatric symptoms, physical health changes, impairment of social role performance, and depressive illnesses. **Exit events overlap with the psychiatric concept of loss.**

Certain types of events also may prove to be more important than others. For example, **childhood physical and sexual abuse** has been found to be associated with a high incidence of depressive symptoms in women. In addition, the presence of **multiple family disadvantages,** such as marital or family disruption, parental physical illness, poor physical care of child and home, social dependence, family overcrowding, and poor parenting in early life, have been found to be associated with depression in adulthood.

Any conclusions about life events should be made with caution. All people experience stressful life events, but not all people become depressed. This suggests that specific events can contribute only partially to the development of depression.

Role Strain. In analyzing social role stressors, much of the focus is on women (McGuire et al, 2008; Horowitz et al, 2009; Wang et al, 2011). This is because depression occurs more often among women. There is also increasing interest in gender socialization processes and women's changing roles.

Role strain in **marriage** is a major stressor related to depression for both men and women. Research suggests that being married has a protective effect for males but not for

females. Another role-related risk factor for women is exposure to chronic stressors, such as those experienced in their **caregiving roles.** Specific psychosocial and biological challenges include the following:

- The perinatal period, with its sleep-disrupting infant care demands, which comes immediately after hormonal, biochemical, and social disruptions associated with pregnancy
- The largely female caretaking role for spouses and parents with age- or Alzheimer-related dementias, which can cause the same sleep disruption experienced by mothers of infants
- In achievement-motivated women, who are taking needed time from sleep in order to juggle full-time family and social roles in addition to work and educational commitments
- Shift work that does not follow a forward rotation (days to evenings to nights) with adequate adjustment for each shift change

If these special stressors for women are combined with other rhythm-disrupting processes, such as seasonal light changes, and other risk factors for depression, such as family history and inadequate support systems and primary relationships, a woman has a gender- and role-based risk for depression.

> **Critical Reasoning** Describe how the early socialization of young girls in contemporary society might affect their cognitive and emotional coping responses. Compare this with the experiences of young boys.

Physiological Changes. Mood states are affected by a wide variety of physical illnesses and medications (Table 18-3). Drug-induced depressions can follow treatment

TABLE 18-3 PHYSICAL ILLNESS AND MEDICATIONS ASSOCIATED WITH DEPRESSIVE AND BIPOLAR DISORDERS

DEPRESSIVE DISORDER	BIPOLAR DISORDER
Physical Illness	
Infectious	
Influenza	Influenza
Viral hepatitis	St. Louis encephalitis
Infectious mononucleosis	Q fever
General paresis (tertiary syphilis)	General paresis (tertiary syphilis)
Tuberculosis	
Endocrine	
Myxedema	Hyperthyroidism
Hypothyroidism	
Cushing disease	
Addison disease	
Diabetes mellitus	
Neoplastic	
Occult abdominal malignancies (e.g., carcinoma of head of pancreas)	
Carcinoid	
Oat cell carcinoma	
Rheumatologic	
Systemic lupus erythematosus	Systemic lupus erythematosus
Chronic fatigue syndrome	Rheumatic chorea
Fibromyalgia	Multiple sclerosis
Rheumatoid arthritis	Diencephalic and third-ventricle tumors
Neurological	
Multiple sclerosis	
Cerebral tumors	
Sleep apnea	
Dementia	
Parkinson disease	
Nondominant temporal lobe lesions	
Cardiovascular	
Stroke	
Coronary artery disease	
Nutritional	
Pellagra	
Pernicious anemia	
Metabolic	
Electrolyte disturbance	
Renal failure	
Gastrointestinal	
Irritable bowel syndrome	
Cirrhosis	
Hepatic encephalopathy	
Medications	
Alcohol	Amphetamines
Alpha-methyldopa	Cocaine
Amphetamine withdrawal	Levodopa
Benzodiazepines	Methylphenidate
Cycloserine	Monoamine oxidase inhibitors
Glucocorticoids	Steroids
Levodopa	Thyroid hormones
Neuroleptics	Tricyclic antidepressants
Physostigmine	
Propranolol	
Reserpine	
Sedative-hypnotics	
Steroidal contraceptives	

with antihypertensive drugs, particularly reserpine, and the abuse of addictive substances, such as amphetamines, barbiturates, cocaine, and alcohol.

Depression may occur secondary to medical illnesses, including viral infections, nutritional deficiencies, endocrine disorders, anemias, and central nervous system disorders such as multiple sclerosis, tumors, and cerebrovascular disease (Carroll and Rado, 2009).

Depression in the elderly is particularly complex because the differential diagnosis often involves organic brain damage and clinical depression (see Chapter 37). In the United States, there is a tendency to overdiagnose arteriosclerosis and senility in people over age 65 years, without recognizing that depression may show itself by a slowing of psychomotor activity. Lowered intellectual function and a loss of interest in sex, hobbies, and activities may be taken as signs of brain disease instead of depression.

Mania also can be a secondary reaction to taking drugs, particularly steroids, amphetamines, and tricyclic antidepressants. It can be triggered by infections, neoplasms, and metabolic disturbances.

QUALITY AND SAFETY ALERT

- Most chronic debilitating illnesses, whether physical or psychiatric, are accompanied by depression.
- People with early signs of senile brain changes, vascular disease, or other neurological diseases of aging may be more at risk for depression than the general population.

Appraisal of Stressors

Predisposing and precipitating factors that are biological, sociocultural, and psychosocial interact in the development of mood disorders. This emphasizes the importance of assessing the individual's appraisal of the life situation and related stressors. **Table 18-4 summarizes causative theories of mood disorders.**

Coping Resources

Personal resources include one's socioeconomic status (income, occupation, social position, education), family (nuclear, extended), social support networks, and community and health care assets (Box 18-6). **The far-ranging effects of the social determinants of health, including poverty, discrimination, inadequate housing, substandard education, and social isolation are very serious.** Therefore nursing interventions that foster the person's ability to cope with life's disruptions are very important. **Risk factors for depression are listed in Box 18-7.**

Coping Mechanisms

Uncomplicated grief reactions can be normal mourning or simple bereavement. Mourning includes all the psychological processes set in motion by the loss. Mourning begins with the **introjection** of the lost object. In grieving, the person's feelings are directed toward a mental image of the loved one.

TABLE 18-4 SUMMARY OF CAUSATIVE MODELS OF MOOD DISORDERS

MODEL	MECHANISM
Genetic	Transmission through heredity and family history
Object loss	Separation from loved one and disruption of attachment bond
Personality organization	Negative self-concept and low self-esteem influence belief system and appraisal of stressors
Cognitive	Hopelessness experienced because of negative cognitive set
Learned helplessness-hopelessness	Belief that responses are ineffectual and that reinforcers in the environment cannot be controlled
Behavioral	Loss of positive reinforcement in life
Biological	Impaired monoaminergic neurotransmission
Life stressors	Response to life stress from four possible sources: loss of attachment, life events, role strain, and physiological changes
Integrative	Interaction of biopsychosocial predisposing and precipitating factors

BOX 18-6 A FAMILY SPEAKS

It's hard for me to imagine how life could be so bad that my beautiful and loving 22-year-old daughter couldn't get out of bed in the morning and cried most of the day. It all started when she quit college and returned home and told us about the biggest mistake she had made in her life. While at school, she accidentally got pregnant and then had an abortion. Since that event, she said she had felt worthless, immoral, and extremely guilty.

We talked about it, and I suggested that she get help. She saw two different mental health professionals but dropped out of therapy with each one after only a couple of visits. Then one of my friends recommended a nurse who specializes in working with women with depression. My daughter saw her twice each week initially, then once each week, and finally monthly. My daughter was able to open up to this nurse, and together they worked at changing my daughter's negative thoughts, feelings, and behaviors. She kept a diary and began to call friends and socialize once again.

Today, 8 months later, my daughter has a job and is going to college part-time in the evenings. Sometimes when I look at her, she seems like a different person to me—so much more grown up and mature. I'm sorry for her pain, but I know that now she is a stronger and wiser person for having endured it.

BOX 18-7 RISK FACTORS FOR DEPRESSION

- Prior episodes of depression
- Family history of depression
- Prior suicide attempts
- Female gender
- Age at onset younger than 40 years
- Postpartum period
- Medical comorbidity
- Lack of social support
- Stressful life events
- Personal history of sexual abuse
- Current substance abuse

Thus the mechanism of introjection serves as a buffering mechanism.

Through reality testing the person realizes that the loved person or object no longer exists, and then the emotional investment is withdrawn. The ultimate outcome is that reality wins out, but this is accomplished slowly over time. When the mourning work is completed, the ego becomes free to invest in new objects.

A delayed grief reaction uses the defense mechanisms of denial and suppression in an attempt to avoid intense distress. Specific defenses used to block mourning are **repression, suppression, denial,** and **dissociation.** Denial of the loss results in profound feelings of guilt, anger, and despair that focus on the person's own unworthiness.

DIAGNOSIS

The diagnosis of mood disturbances depends on an understanding of many interrelated concepts, including anxiety and self-concept. One task of the nurse in formulating a diagnosis is to determine whether the patient is experiencing primarily a state of anxiety or depression. It is often difficult to distinguish between the two, because they may coexist in one patient and have similar behaviors. The differences between anxiety and depression are presented in Chapter 15 (see Table 15-3).

Figure 18-6 presents the Stuart Stress Adaptation Model with the continuum of emotional responses. The maladaptive responses are a result of anxiety, hostility, self-devaluation, and guilt. This model suggests that nursing care should be centered on increasing self-esteem and encouraging expression of emotions.

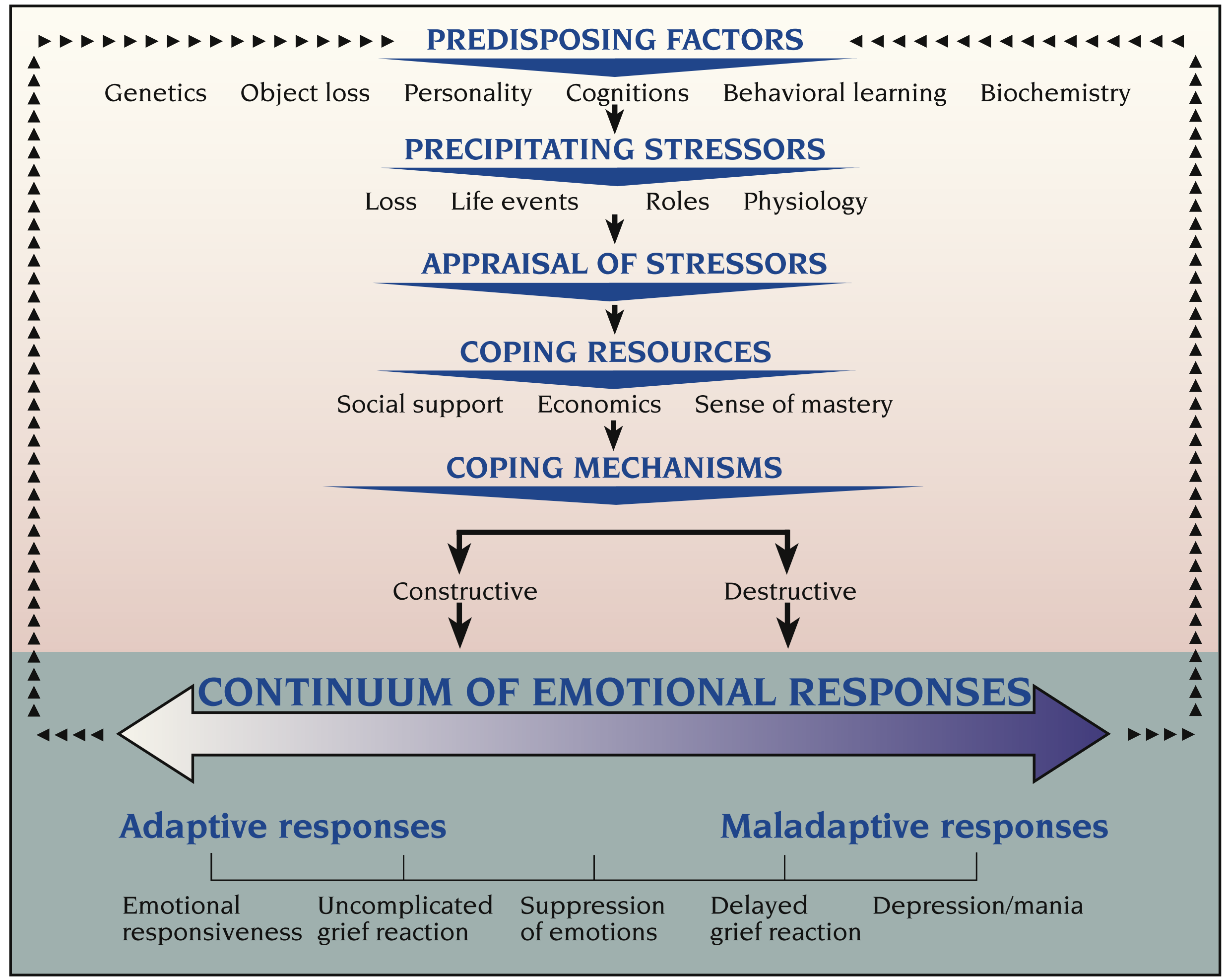


FIG 18-6 The Stuart Stress Adaptation Model as related to emotional responses.

TABLE 18-5 **NURSING DIAGNOSES AND TERMS RELATED TO *Emotional Responses***

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Complicated grieving	Complicated grieving related to death of sister, as evidenced by self-devaluation, sleep disturbance, and dejected mood
Hopelessness	Hopelessness related to loss of job, as evidenced by feelings of despair and development of ulcerative colitis
Powerlessness	Powerlessness related to new role as parent, as evidenced by apathy, uncertainty, and overdependency
Spiritual distress	Spiritual distress related to loss of child in utero, as evidenced by self-blame, somatic complaints, and pessimism about the future
Risk for self-directed violence	Risk for self-directed violence related to rejection by boyfriend, as evidenced by self-destructive acts
Risk for suicide	Risk for suicide related to impending divorce, as evidenced by giving away personal possessions and purchasing a handgun
MEDICAL TERM	**DEFINITION***
Bipolar disorder	A condition in which people go back and forth between periods of a very good or irritable mood and depression. The "mood swings" between mania and depression can be very quick.
Manic episode	This is a part of a type of bipolar disorder. It is characterized by a period of time when an elevated, expansive or notably irritable mood is present, lasting for at least one week. These feelings must cause difficulty or impairment in occupational, social, educational or other important functioning.
Cyclothymic disorder	A mild form of bipolar disorder (manic depressive illness) in which a person has mood swings over a period of years that go from mild depression to euphoria and excitement.
Major depressive disorder	This is sometimes called clinical depression. True clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or longer. It can occur once or repeatedly over the course of a lifetime.
Dysthymic disorder	A chronic type of depression in which a person's moods are regularly low. However, symptoms are not as severe as with major depression.

Nursing Diagnoses–Definitions and Classification 2012-2014. Copyright © 2012, 1994-2012 by NANDA International. Used by arrangement with Blackwell Publishing Limited, a company of John Wiley & Sons, Inc.
*Sources: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001924; http://psychcentral.com/disorder/sx9.htm; http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002517; http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001941; http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001916/.

Nursing Diagnoses

The primary NANDA International (NANDA-I) nursing diagnoses related to maladaptive emotional responses are complicated grieving, hopelessness, powerlessness, spiritual distress, risk for suicide, and risk for self-directed violence. Examples of expanded nursing diagnoses are presented in Table 18-5.

Critical Reasoning How do you think "spiritual distress" relates to mood disorders?

Medical Diagnoses

Primary *DSM-IV-TR* diagnoses include bipolar I and II disorders, cyclothymic disorder, major depressive disorder, and dysthymic disorder (APA, 2000).

- **Cyclothymia** is a disorder resembling bipolar disorder but with less severe symptoms, characterized by repeated periods of nonpsychotic depression and hypomania for at least 2 years.
- **Dysthymia** is a milder form of depression lasting 2 or more years. It is a chronic condition, and many patients with dysthymia eventually develop major depressive episodes.

The definitions for some of these medical terms are presented in Table 18-5.

OUTCOMES IDENTIFICATION

The **expected outcome** when working with a patient with a maladaptive emotional response is as follows: ***The patient will be emotionally responsive and return to a preillness level of functioning.***

Goals of nursing care for patients with severe mood disturbance have the following aims:

- To allow recognition and continuous expression of feelings, including denial, hopelessness, anger, guilt, blame, helplessness, regret, hope, and relief, within a supportive therapeutic atmosphere
- To allow for gradual analysis of stressors while strengthening the patient's self-esteem
- To increase the patient's sense of identity, control, awareness of choices, and responsibility for behavior
- To encourage healthy interpersonal ties with others
- To promote understanding of maladaptive emotions and to acquire adaptive coping responses to stressors

Specific short-term goals should be developed based on the behaviors of the patient, present areas of difficulty, and relevant stressors. Goal setting should involve a holistic view of the patient and the patient's world.

Goals will most likely need to be developed regarding the patient's self-concept, physical status, behavioral performance, expression of emotions, and relationships. All these areas can directly relate to the mood disturbance. **The patient's participation in setting these goals can be a significant first step in regaining mastery over life.**

Outcome indicators related to grief resolution from the Nursing Outcomes Classification (NOC) project are presented in Box 18-8 (Moorhead et al, 2008).

PLANNING

In planning care, the nurse's priorities are as follows:

- **Modify the patient's maladaptive emotional responses.**
- **Restore the patient's occupational and psychosocial functioning.**
- **Improve the patient's quality of life.**
- **Minimize the likelihood of relapse and recurrence.**

Treatment for depressive and bipolar disorders consists of three phases: acute, continuation, and maintenance (Figure 18-7). Understanding the phases of treatment for mood disorders is critically important. The nurse should discuss them with the patient and family so that they may join in the therapeutic alliance and have clear expectations about the goals and course of treatment.

Acute Treatment Phase

The goal of acute treatment is to eliminate the symptoms. If patients improve with treatment, they are said to have had a therapeutic response. Successful acute phase treatment restores patients to a symptom-free state and to the level of functioning they had before the illness. **This phase usually lasts 6 to 12 weeks.** If patients are symptom free at the end of that time, they are in **remission.** They then must enter the continuation phase of treatment.

Continuation Treatment Phase

The goal of continuation treatment is to prevent relapse, which is the return of symptoms, and to promote recovery. Recovery is a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential (USDHHS, 2006).The risk of relapse is very high in the first 4 to 6 months after remission. **This phase usually lasts 4 to 9 months.** If a patient has a severe or recurring mood

BOX 18-8 NOC OUTCOME INDICATORS FOR GRIEF RESOLUTION

Resolves feelings about loss
Expresses spiritual beliefs about death
Verbalizes reality of the loss
Verbalizes acceptance of the loss
Describes meaning of the loss
Participates in planning funeral
Discusses unresolved conflict(s)
Reports absence of somatic distress
Reports decreased preoccupation with the loss
Maintains living environment
Maintains personal grooming and hygiene
Reports adequate sleep
Reports adequate nutrition intake
Reports normal sexual desire
Seeks social support
Shares loss with significant others
Reports involvement in social activities
Progresses through stages of grief
Expresses positive expectations about the future

From Moorhead S et al, editors: *Nursing outcomes classification (NOC),* ed 4, St Louis, 2008, Mosby.

Rights were not granted to include this figure in electronic media.
Please refer to the printed publication.

FIG 18-7 The phases of treatment for mood disorders. (From Kupfer DJ: *J Clin Psychiatry,* 53[suppl]: 28, 1991.)

disorder then he or she will enter the maintenance phase of treatment.

Maintenance Treatment Phase

The goal of maintenance treatment is to prevent recurrence, or a new episode of illness. Both pharmacological and cognitive behavioral maintenance therapies are effective in preventing new episodes or lengthening the interval between episodes in depressive and bipolar disorders. **In the maintenance phase, patients may be on medication indefinitely.**

> **QUALITY AND SAFETY ALERT**
>
> - One of the greatest mistakes in the treatment of mood disorders is failure to continue a successful treatment for a long enough period of time.

> **Critical Reasoning** Your patient tells you she stopped taking her medicine after 2 months because she was feeling better. What would you tell her, based on your understanding of the treatment phases of depression?

IMPLEMENTATION

Maladaptive emotional responses can vary in intensity from mild to severe. They are often recurrent conditions. They can occur in any setting and can accompany existing medical problems.

The treatment of mood disturbances can take place in various settings: at home, at an outpatient facility, or in a hospital. The best treatment setting for the patient depends on the severity of the illness, available support systems, and resources of the treatment facility.

Help provided when maladaptive patterns are developing is likely to be more acceptable and effective than help given after these patterns have become established. **Early diagnosis and treatment are associated with more positive outcomes.**

Nursing interventions must reflect the complex, multicausal nature of mood disorders and address all maladaptive aspects of a person's life. Intervening in as many areas as possible should have the best potential for modifying maladaptive responses and alleviating severe mood disturbances. The aim of these nursing interventions is to teach the patient new coping responses and increase the satisfaction gained from interacting with the world.

Affective interventions are necessary because patients with mood disturbances have difficulty identifying, expressing, and modulating feelings. Feelings that are particularly problematic are hopelessness, sadness, anger, guilt, and anxiety. A range of interventions is available to the nurse in meeting patient needs in this area. Box 18-9 identifies nursing interventions used to facilitate grief work. These are from the Nursing Interventions Classification (NIC) project (Bulechek et al, 2008).

> **BOX 18-9 NIC INTERVENTIONS RELATED TO GRIEF WORK FACILITATION**
>
> **Definition**
>
> Assistance with the resolution of a significant loss
>
> **Activities**
>
> - Identify the loss.
> - Assist the patient to identify the nature of the attachment to the lost object or person.
> - Assist the patient to identify the initial reaction to the loss.
> - Encourage expression of feelings about the loss.
> - Listen to expressions of grief.
> - Encourage discussion of previous loss experiences.
> - Encourage the patient to verbalize memories of the loss, both past and current.
> - Make empathetic statements about grief.
> - Encourage identification of greatest fears concerning the loss.
> - Instruct in phases of the grieving process, as appropriate.
> - Support progression through personal grieving stages.
> - Include significant others in discussions and decisions, as appropriate.
> - Assist patient to identify personal coping strategies.
> - Encourage patient to implement cultural, religious, and social customs associated with the loss.
> - Communicate acceptance of discussing loss.
> - Answer children's questions associated with the loss.
> - Use clear words, such as *dead* or *died*, rather than euphemisms.
> - Encourage children to discuss feelings.
> - Encourage expression of feelings in ways comfortable to the child, such as writing, drawing, or playing.
> - Assist the child to clarify misconceptions.
> - Identify sources of community support.
> - Support efforts to resolve previous conflict, as appropriate.
> - Reinforce progress made in the grieving process.
> - Assist in identifying modifications needed in lifestyle.

From Bulechek GM, Butcher HK, Dochterman JM, editors: *Nursing interventions classification (NIC),* ed 5, St Louis, 2008, Mosby.
NIC, Nursing interventions classification.

Intervening to guide patients in managing their emotions requires self-understanding by the nurse. Whether the interventions will be therapeutic depends greatly on the nurse's values regarding the various emotions, the nurse's emotional responsiveness, and the nurse's ability to offer genuine respect and nonjudgmental acceptance. **Nurses must be able to experience feelings and express them appropriately if they expect to help patients.**

To successfully implement nursing actions related to the patient's affective needs, the nurse must use a variety of communication skills (see Chapter 2). Particularly important are empathy skills; reflection of feeling; open-ended, feeling-oriented questions; validation; self-disclosure; and confrontation. The patient with a severe mood disturbance will challenge the nurse's therapeutic skills and test the nurse's caring and commitment.

TABLE 18-6 **SUMMARIZING THE EVIDENCE ON *Mood Disorders***

DISORDER	TREATMENT
Major depressive disorder	The first-line psychopharmacological treatment of major depression is by selective serotonin reuptake inhibitors (SSRIs)—fluoxetine, sertraline, paroxetine, citalopram, and escitalopram; serotonin norepinephrine reuptake inhibitors (SNRIs)—venlafaxine and duloxetine; and other compounds, including bupropion and mirtazapine. Behavior therapy, cognitive behavioral therapy, and interpersonal psychotherapy all reduce symptoms of depression and maintain their effects well after treatment has ended. Combined psychosocial and psychopharmacological treatment is more effective than either treatment alone for chronically and recurrently depressed patients.
Bipolar disorder	Individual and group psychoeducation that provides information to bipolar patients and their families about the disorder, its pharmacological treatment, and treatments' side effects leads to lower rates of recurrence and greater adherence to pharmacological treatment. Cognitive behavioral therapy is associated with better medication adherence and significantly fewer recurrences and rehospitalizations. A combination of interpersonal therapy and social rhythm therapy is most effective during the maintenance treatment period. Marital and family therapy may be effective combined with pharmacotherapy to reduce recurrences and improve medication adherence and family functioning. Lithium, divalproex, carbamazepine, risperidone, ziprasidone, olanzapine, quetiapine, and aripiprazole are all effective in treating acute mania. Lithium, olanzapine, olanzapine-fluoxetine, quetiapine, lamotrigine, tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), fluoxetine, and pramipexole have efficacy in treating acute bipolar depression. Lithium, lamotrigine, olanzapine, and aripiprazole are effective with many patients in preventing relapse.

From Nathan P, Gorman J: *A guide to treatments that work,* ed 3, New York, 2007, Oxford University Press.

Physiological treatments include physical care, psychopharmacology, and somatic therapies. They begin with a thorough physical examination and health history to identify health problems and current treatments or medications that may be affecting the patient's mood. The indications for physiological treatment include symptoms that will respond to physiological measures, greater severity of illness, suicidal potential, and need for speed in recovery.

Cognitive and behavioral interventions have proven efficacy for both depressive and bipolar disorders (Christopher et al, 2009; Beltman et al, 2010). When intervening in the cognitive area, nurses have three major aims:

- **To increase the patient's sense of control over goals and behavior**
- **To increase the patient's self-esteem**
- **To help the patient modify dysfunctional thinking patterns**

Practice guidelines have been developed for the treatment of mood disorders (APA, 2010). **Empirically validated treatments for major depressive disorder and bipolar disorder are summarized in Table 18-6** (Nathan and Gorman, 2007).

Patient Safety

The nurse's first course of action is to ensure patient safety. Environmental interventions are needed when the patient's environment is highly dangerous, impoverished, aversive, or lacking in personal resources.

Hospitalization is definitely indicated when suicide is deemed to be a risk. In the presence of rapidly progressing symptoms and in the absence of support systems, hospitalization is strongly indicated. Nursing care in this case means protecting patients and assuring them that they will not be allowed to harm themselves.

Patients with depressive and bipolar disorders must always be assessed for possible suicide because these conditions are often life threatening. Bipolar patients show poor judgment, excessive risk taking, and an inability to evaluate realistic danger and the consequences of their actions. Specific interventions for suicidal patients are described in Chapter 19.

QUALITY AND SAFETY ALERT

- In caring for the patient with a severe mood disorder, highest priority should be given to the potential for suicide.
- Patients with depression are at particular risk when they appear to be coming out of their depression, because they may then have the energy and opportunity to kill themselves.
- In an acute manic episode, immediate measures must be taken to prevent death.

Intervening in Depressive Disorder

Nurse-Patient Relationship. Depressed patients resist involvement through withdrawal and nonresponsiveness. Because of their negative views, they tend to remain isolated, verbalize little, think that they are unworthy of help, and form dependent attachments.

In working with depressed patients, the nurse's approach should be quiet, warm, and accepting. The nurse should demonstrate honesty, empathy, and compassion. Admittedly, it is not always easy to give warm, personal care to a person who is unresponsive and detached. The nurse may feel angry, resent the patient's helplessness, or fear rejection. Patience and a belief in the potential of each person to grow and change are needed. If this is calmly communicated, both verbally and nonverbally, in time the patient may begin to respond.

Nurses should avoid assuming an overaggressive or lighthearted approach with the depressed person. Comments such as "You have so much to live for," "Cheer up—things are sure to get better," or "You shouldn't feel so depressed" convey little understanding of and respect for the patient's feelings. They will create more distance and block the formation of a relationship.

Also, nurses should not sympathize with the patient. Subjective overidentification by nurses can cause them to experience similar feelings of hopelessness and helplessness and seriously limit their ability to help.

Rapport is best established with the depressed patient through shared time, even if the patient talks little, and through supportive companionship. The very presence of the nurse indicates belief that the patient is a valuable person.

The nurse should adjust to the depressed patient's pace by speaking more slowly and allowing more time to respond. The patient should be addressed by name, talked with, and listened to. By studying the patient's life and interests, the nurse might select topics that lay the foundation for more meaningful discussions.

Physiological Treatments. When depressed, the patient may forget to attend to physical well-being or may not be capable of self-care. The more severe the depression, the more important is the physical care. For example, the nurse may need to monitor the diet of a patient who has no appetite and consequently has lost weight. Staying with the patient during meals, arranging for preferred foods, and encouraging frequent small meals may be helpful. Recording intake and output and weighing the patient daily will help evaluate this need.

Sleep disturbances typically occur. It is best to plan activities according to each patient's energy levels; some feel best in the morning and others in the evening. A scheduled rest period may be helpful, but patients should not be encouraged to take frequent naps or to remain in bed all day.

Patients with depression experience less stage 3 and stage 4 sleep, and because these stages depend on the period of wakefulness, napping may worsen sleep disturbances. For many patients, eating regularly, staying active during waking hours, and cutting back on caffeine (especially late in the day) may promote more normal sleep patterns.

The patient's physical appearance may be neglected, and all movements may be slowed. **Nurses may have to help with bathing or dressing.** They should do this matter-of-factly, explaining that help is being offered because the patient is unable to do it independently right now. Cleanliness and interest in appearance can be noticed and praised.

Nurses must allow patients to help themselves whenever possible. Often nurses might rush the patient or do a task themselves to save time, but this does not facilitate the patient's recovery and should be avoided.

Psychopharmacology. Antidepressant medications are the drug of choice to treat patients with depression. They are particularly indicated in severe and recurrent depression. Use of benzodiazepines should be minimized.

Antidepressant medications are equally effective in treating depression, with an overall success rate of 60% to 80%. Many antidepressant medications are available (Table 18-7), and new ones are released each year**. Antidepressant medications are discussed in detail in Chapter 26.**

Despite the treatment success achieved with antidepressant drugs, they have limitations. **Their therapeutic effects usually begin only after 2 to 6 weeks.** They also have side effects that can deter some patients from staying on their medication.

Early discontinuation of antidepressant therapy is widespread in the treatment of depression (Warden et al, 2009; Chen et al, 2010). Therefore patient education is essential.

QUALITY AND SAFETY ALERT

- Tricyclic antidepressants are lethal at high doses.
- They also have dangerous cardiac side effects.

Another major problem with the tricyclic antidepressants is their toxicity, which makes them particularly dangerous for people most in need of them: suicidal patients. The newer selective serotonin reuptake inhibitor (SSRI) antidepressants are safer in the event of an overdose.

It is difficult to predict who will respond to which drug (Simon and Perlis, 2010). Fortunately, those who do not benefit from one antidepressant often do well when switched to another.

Critical Reasoning What would you say to a patient who tells you that she doesn't want to take medicines for her depression because they are addictive?

Somatic and alternative therapies. A number of somatic and alternative therapies are used to treat depression.

- **Electroconvulsive therapy (ECT)** is used with depressed patients, particularly those with recurrent depressions and resistance to drug therapy. ECT is a specific therapy for patients with severe depressions who have somatic delusions and delusional guilt accompanied by a lack of interest in the world, suicidal ideation, and weight loss.
- **Sleep deprivation therapy** may be effective in treating depression. Research indicates that depriving some depressed patients of a night's sleep improves their clinical condition (Howland, 2011). How sleep deprivation works is not known, and the duration of improvement varies.

TABLE 18-7 **ANTIDEPRESSANT DRUGS**

GENERIC NAME (TRADE NAME)	USUAL ADULT DAILY DOSE (MG/DAY)*	PREPARATIONS
Selective Serotonin Reuptake Inhibitors (SSRIs)		
Citalopram (Celexa)	20-40	PO, L
Escitalopram (Lexapro)	20-40	PO, L
Fluoxetine (Prozac)	20-60	PO, L
Fluvoxamine (Luvox)	100-200	PO
Fluvoxamine maleate (Luvox CR)	100-200	PO
Paroxetine (Paxil)	20-50	PO, CR, L
Sertraline (Zoloft)	50-200	PO, L
Other Antidepressant Drugs		
Bupropion (Wellbutrin)	150-450†	PO, SR, XR
Maprotiline (Ludiomil)	50-200	PO
Mirtazapine (Remeron)	15-45	PO, ODT
Vilazodone (Viibryd)	10-40	PO
Serotonin Antagonist and Reuptake Inhibitors (SARIs)		
Nefazodone (Serzone)	300-500	PO
Trazodone (Desyrel)	150-300	PO
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)		
Desvenlafaxine (Pristiq)	50	PO
Duloxetine (Cymbalta)	20-60	PO
Milnacipran (Savella)	12-100	PO
Venlafaxine (Effexor)	75-375	PO, XR
Tricyclic Antidepressant Drugs (TCAs)		
Tertiary (Parent)		
Amitriptyline (Elavil)	150-300	PO, IM
Amoxapine (Asendin)	200-300	PO
Clomipramine (Anafranil)	100-250	PO
Doxepin (Sinequan)	150-300	PO, L
Imipramine (Tofranil)	150-300	PO
Trimipramine (Surmontil)	150-300	PO
Secondary (Metabolite)		
Desipramine (Norpramin)	150-300	PO, L
Nortriptyline (Pamelor)	50-150	PO, L
Protriptyline (Vivactil)	15-60	PO
Tetracyclics		
Amoxapine (Asendin)	150-300	PO
Maprotiline (Ludiomil)	75-200	PO
Monoamine Oxidase Inhibitors (MAOIs)		
Isocarboxazid (Marplan)	20-60	PO
Phenelzine (Nardil)	45-90	PO
Selegiline (Eldepryl, Emsam)	20-50	PO, TS
Tranylcypromine (Parnate)	20-60	PO

*Dosage ranges are approximate; initiate at lower dose for most patients.
†Antidepressants with a ceiling dose because of dose-related seizures.
CR, Controlled release; *IM*, intramuscular; *L*, oral liquid; *ODT*, orally disintegrating tablet; *PO*, oral tablet/capsule; *SR*, sustained release; *TS*, transdermal system patch; *XR*, extended release.

- **Phototherapy,** or light therapy, is a physiological treatment in which patients are exposed to bright artificial light for a specified amount of time each day. Phototherapy appears to be effective in the short-term treatment of mild to moderate SAD (Howland, 2009).
- Other somatic treatments include transcranial magnetic stimulation (TMS), cranial electrotherapy stimulation (CES), vagus nerve stimulation (VNS), and deep brain stimulation (DBS).
- Complementary and alternative therapies include acupuncture, yoga, and herbal products.

BOX 18-10 A PATIENT SPEAKS

When in depression, this faith in deliverance, in ultimate restoration, is absent. The pain is unrelenting, and what makes the condition intolerable is the foreknowledge that no remedy will come—not in a day, an hour, a month, or a minute. If there is mild relief, one knows that it is only temporary; more pain will follow. It is hopelessness even more than pain that crushes the soul.

So the decision making of daily life involves not, as in normal affairs, shifting from one annoying situation to another less annoying—or from discomfort to relative comfort, or from boredom to activity—but moving from pain to pain. One does not abandon, even briefly, one's bed of nails, but is attached to it wherever one goes. And this results in a striking experience—one which I have called, borrowing military terminology, the situation of the walking wounded. For in virtually any other serious sickness, a patient who felt similar devastation would be lying flat in bed, possibly sedated and hooked up to the tubes and wires of life-support systems, but at the very least in a posture of repose and in an isolated setting. His invalidism would be necessary, unquestioned, and honorably attained.

However, the one suffering from depression has no such option and therefore finds himself, like a walking casualty of war, thrust into the most intolerable social and family situations. There he must, despite the anguish devouring his brain, present a face approximating the one that is associated with ordinary events and companionship. He must try to utter small talk, and be responsive to questions, and knowingly nod and frown and, God help him, even smile. But it is a fierce trial just attempting to speak a few simple words.

From Styron W: *Darkness visible*, New York, 1992, Vintage Books.

Somatic therapies are discussed in detail in Chapter 29. Complementary and alternative therapies are discussed in detail in Chapter 30.

Expressing Feelings. **Initially the nurse must express hope for depressed patients.** Demoralization is a part of depression. Therefore patients have a genuine need for believing that things will improve. **The nurse should reinforce that depression is a self-limited disorder and that the future will be better.** This can be expressed calmly and simply. The intent is not to cheer the patient but to offer hope that, although recovery is a slow process involving weeks or months, the patient will feel progressively better.

The nurse may acknowledge that at this time the patient may not be able to take comfort from this reassurance. For the depressed, only the depression is real; past or future happiness is an illusion (Box 18-10). By affirming belief in recovery, however, the nurse may make the patient's existence more tolerable. This discussion is a way of acknowledging the patient's pain and despair while also conveying a sense of hope in recovery. It is not the premature reassurance of "Don't worry, everything's going to be just fine." It is an openness to the patient's feelings and acknowledgment of them.

This is a very important first step. It lets the patient see that the present state is not permanent. **It directs the thoughts of the depressed patient beyond the present to genuine hope for tomorrow.**

Nursing actions in this area should convey that expressing feelings is normal and necessary. Blocking or repressing emotions is partly responsible for the patient's present pain. Nurses can help patients realize that their overwhelming feelings of dejection and worthlessness are defenses that prevent them from dealing with their problems.

Encouraging a patient to express unpleasant or painful emotions can reduce their intensity and make the patient feel more alive and masterful. Therefore nursing care should be directed toward helping the patient experience feelings and express them.

Cognitive Strategies. Depressed patients often see themselves as victims of their moods and environment. They do not see their behavior and their interpretation of events as possible causes of depression. They assume a passive stance and wait for someone or something to lift their mood. One task of the nurse, therefore, is to move patients beyond their limiting preoccupation to other, more positive aspects of their world. To do this, the nurse must progress gradually.

The first step is to help patients explore their feelings and their view of the problem. The nurse accepts the patient's perceptions but does not accept the patient's conclusions. Together they redefine the problem to give the patient a sense of control, a feeling of hope, and a realization that change may indeed be possible.

Nursing actions should then focus on modifying the patient's thinking. Depressed patients are dominated by negative thoughts. Often, despite a successful performance, the patient will view it negatively. Cognitive changes may be brought about in a variety of ways, as described in Chapter 27.

Often, negative thinking is an automatic process of which the patient is not even aware. The nurse can help patients identify their negative thoughts and decrease them through thought stopping or substitution. The patient also can be encouraged to increase positive thinking by reviewing personal assets, strengths, accomplishments, and opportunities.

Next, the patient can be helped to examine the accuracy of perceptions, logic, and conclusions. Misperceptions, distortions, and irrational beliefs become evident. The patient also should be helped to move from unrealistic to realistic goals and to decrease the importance of unattainable goals.

All these actions enhance the patient's self-understanding and increase self-esteem (Forsyth et al, 2010). More detailed interventions related to alterations in self-concept, which are inherent in disturbances of mood, are explored in Chapter 17.

Also, because the depressed patient tends to be overwhelmed by despair, it is important to limit the amount of negative evaluation in which the patient engages. One way is to involve the patient in productive tasks or activities. Another way is to increase the level of socialization. These benefit the

patient in two ways: they limit the time spent on brooding and self-criticism, and they provide positive reinforcement.

Intervening in Bipolar Disorder

Nurse-Patient Relationship. **Patients with bipolar illness may be very talkative and need simple explanations and concise, truthful answers to questions.** Although manic patients may appear willing to talk, they often resist involvement through manipulation, testing limits, and superficiality. Their hyperactivity, short attention span, flight of ideas, poor judgment, lack of insight, and rapid mood swings all present special problems to the nursing staff.

Manic patients can be very disruptive to a hospital unit and resist engagement in therapy. They may dominate group meetings or therapy sessions by their excessive talking and manipulation of staff or patient groups. By identifying a vulnerable area in another person or a group's area of conflict, manic patients are able to exploit others. This provokes defensive and angry responses.

Nurses are particularly susceptible to these feelings because they often have the most contact with patients and the responsibility for maintaining the psychiatric unit. When anger is generated, therapeutic care breaks down. Thus the behavior of a manic patient acts as a diversionary tactic. By alienating themselves, patients can avoid exploring their own problems.

It is important for nurses to understand how manic patients are able to manipulate others and their reasons for doing so. The treatment plan for these patients should be thorough, well coordinated, and consistently implemented.

Constructive limit setting on manic patients' behavior is an essential part of the plan. The entire treatment team must be consistent in their expectations of these patients, and progressive limits must be set as situations arise. Other patients also may be encouraged to carry out the agreed limits. Pressure applied by peers can sometimes be more effective than pressure applied by the staff. Frequent staff meetings are recommended to improve communication, share understanding of the manic patient's behavior, and ensure steady progress.

One goal of nursing care is to increase the patient's self-control, and this should be kept in mind when setting limits. Patients need to see that they can monitor their own behavior and that the staff is there to help them. Also, the nurse should point out the many positive aspects of their behavior. The ability to be outgoing, expressive, and energetic is a coping strength that can be maximized.

Physiological Treatments. **Manic patients primarily need protection from themselves.** They may be too busy to eat or to take care of themselves. Eating problems can be handled in the same way as with depressed patients. Manic patients may sleep very little, so rest periods should be encouraged, along with baths, soft music, and whirlpools. These patients also may need help in selecting clothes and maintaining hygiene. Setting limits and using firm actions are effective in physical care.

Psychopharmacology. **Lithium is the drug of choice in the treatment of mania.** It can reduce the risk of relapse in bipolar disorder. Lithium's neuroprotective (reducing neurotoxicity) and neurotropic (promoting neurogenesis) cellular effects suggest that it may be "brain healthy" for patients with mood disorders. **Anticonvulsants, calcium channel blockers, and atypical antipsychotic medications are treatment alternatives for bipolar disorder** (Table 18-8). **Mood stabilizing medications are discussed in detail in Chapter 26.**

QUALITY AND SAFETY ALERT

- Care must be taken regarding the narrow therapeutic index of lithium, which requires frequent checks of blood levels and careful patient monitoring.
- Caution must be used when prescribing antidepressants to patients with bipolar disorder, because they may be switched into mania by these drugs.

Nonadherence is a major problem among patients with bipolar disorder, and it limits the effectiveness of the medications (Darling et al, 2008). This underscores again the importance of the nurse-patient alliance in identifying treatment goals and strategies and the need for patient education.

Critical Reasoning Your patient with bipolar disorder tells you that she has stopped taking her medication because she misses the highs that she used to feel and the extra energy she used to have. What would your educational approach be to help her comply with treatment?

Somatic therapy. ECT may be used to treat the manic or depressive phase of bipolar disorder if it does not respond to medication.

Expressing Feelings. Manic patients may have the opposite problem from patients with depression in that they are often too expressive of their feelings. **These patients are often hyperverbal and need help from the nurse in pacing and moderating their expression.** The nurse must be careful not to criticize or negate the feelings expressed.

Helping patients to speak more slowly and to follow one line of thought is an important area for nursing intervention. Manic patients need feedback on the intensity of their self-expressions and the impact of their behavior on other people.

Social skills modeling and reinforcement are nursing care activities that can be incorporated into the daily routine. Setting limits, giving simple directions, and keeping focused are other useful nursing interventions.

When the nurse accepts without criticism the anger, despair, or anxiety expressed by the patient, the patient sees that expressing feelings is not always destructive or a sign of weakness. Sometimes, however, patients' expression of anger changes their cognitive set from self-blaming to blaming others. It may allow them to view themselves as more effective because it connotes power, superiority, and mastery. How this anger is expressed is important, because aggressive behavior can be destructive and can further isolate them.

Many patients who experience both depressive and manic emotional states have problems with expressing anger and

TABLE 18-8 MOOD-STABILIZING DRUGS

GENERIC NAME (TRADE NAME)	USUAL ADULT DOSE (mg/day)*	PREPARATIONS
Antimania		
Lithium (Eskalith, Lithobid)	600-2400	PO, CR, SR
Lithium citrate	600-2400	L/S
Anticonvulsants		
Valproic acid (Depakene), valproate (Depacon), divalproex (Depakote)	15-60 mg/kg/day	PO, L/S, ER, IM
Lamotrigine (Lamictal)	300-500	PO, Ch
Carbamazepine (Tegretol)	200-1600	PO, Ch
Oxcarbazepine (Trileptal)	600-2400	PO, S
Topiramate (Topamax)	200-400	PO
Tiagabine (Gabitril)	4-32	PO
Calcium Channel Blockers		
Verapamil (Calan)	240	PO
Nifedipine (Adalat, Procardia)	60-180	PO
Atypical Antipsychotic Drugs		
Aripiprazole (Abilify)	5-30	PO, IM, L
Risperidone (Risperdal, Risperdal Consta, M-Tabs)	1-8	PO, L, L-A, ODT
Olanzapine (Zyprexa, Zydis)	5-20	PO, ODT, IM
Quetiapine (Seroquel)	150-750	PO
Ziprasidone (Geodon)	40-160	PO, IM, L
Asenapine (Saphris)	10	ODT

Ch, Chewable tablets; *CR*, controlled release; *ER*, sustained release; *IM*, intramuscular injection; *L*, oral liquid, elixir; *L-A*, long-acting injectable preparation; *L/S*, liquid/syrup; *ODT*, orally disintegrating tablets; *PO*, oral tablets or capsules; *S*, suspension; *SR*, slow release.
*The dosage range is approximate and must be individualized for each patient.

need to learn assertive behavior and anger management techniques. These important areas of nursing intervention are explored in Chapter 30.

Cognitive Strategies. **Cognitive therapy and other psychosocial interventions enhance relationship functioning and life satisfaction among patients with bipolar disorder.** Manic patients need to gain control over their thoughts and behaviors. Here, however, the challenge is to bring together a patient's scattered thoughts and ideas to help the patient engage in adaptive, goal-directed behavior.

The communication skills of focusing, clarifying, and confrontation are useful in redirecting a patient's self-expressions. Once this is done, the nurse can begin to help the patient modify dysfunctional thinking. Manic patients often have problems of grandiose thoughts, overestimation of self, and unrealistic pursuits. As in depression, cognitive interventions can help the patient evaluate these thought problems and identify more realistic and ego-supportive goals.

It is also important for the nurse to realize the meaning, nature, and value the bipolar patient places on behavior and mood change. For example, research has shown that patients with bipolar disorder perceive positive short- and long-term effects from their illness. These include increases in productivity, creativity, sensitivity to surroundings, social friendliness, and sexual intensity.

These effects can provide a great deal of secondary benefit from the illness and can be powerful reinforcers of maladaptive responses, thus making change more difficult. For some patients at some times, the perceived positive consequences of the illness may outweigh their perception of the negative consequences.

Common Interventions for Both Depressive and Bipolar Disorders

Behavioral Change. The ability to accomplish tasks and be productive depends on various factors that apply to patients with both depression and bipolar disorder. **In promoting behavior change, the nurse should use strategies related to readiness to change, motivational interviewing, and decisional balance interventions.** These are described in Chapter 27.

Expectations and goals should be small enough to ensure success, relevant to the patient's needs, and focused on positive activities. Box 18-11 presents a list of potentially rewarding activities. Attention should be focused on the task at hand, not on what has yet to be done or was done incorrectly in the past.

Finally, positive reinforcement should be based on actual performance. If such an approach is used consistently over time, the nurse can expect the patient to demonstrate increasingly productive behavior.

Occupational and recreational activities can be helpful, as can physical exercise. Jogging, walking, swimming,

BOX 18-11 LIST OF POTENTIALLY REWARDING ACTIVITIES FOR PATIENTS WITH MOOD DISORDERS

- Plan something you will enjoy.
- Go on an outing (a walk, a shopping trip, a picnic).
- Go out for entertainment.
- Go to a meeting, lecture, or class.
- Attend a social gathering.
- Play a sport or game.
- Spend time on a hobby or project.
- Entertain yourself by reading, listening to music, or watching television.
- Do something just for yourself (take a bath, cook something special).
- Spend time just relaxing (thinking, napping, daydreaming).
- Care for yourself or make yourself attractive.
- Complete a routine or unpleasant task.
- Do a job well.
- Cooperate with someone else on a common task.
- Do something special for someone else.
- Seek out people (make a call, stop by, make a date).
- Initiate conversation (e.g., at a store, party, or class).
- Discuss an interesting or amusing topic.
- Express yourself openly, clearly, or frankly.
- Play with children or animals.
- Compliment or praise someone.
- Physically show affection or love.
- Accept praise, compliments, or attention.

bicycling, and aerobics are popular forms of exercise that may be incorporated in a regular program of activity. They are beneficial because they improve the patient's physical condition, release emotions and tensions, and can have an antidepressant effect (Sidhu et al, 2009).

Successful behavior is a powerful reinforcer and antidepressant. This idea does not occur to depressed patients, who use their despondent mood as a rationalization for inactivity. They instead believe that once their mood lifts, they will be productive again. Such an idea is consistent with a negative cognitive set and a sense of helplessness. However, inactivity prevents satisfaction and social recognition. Thus it reinforces a depressive state. Likewise, overactivity or uncompleted activity lowers the self-evaluation of manic patients.

Nursing interventions should focus on activating the patient in a realistic, goal-directed way. Directed activities, strategies, or homework assignments mutually determined by the nurse and patient can help build alternative coping responses. This work should be sensitive to the patient's culture, values, and treatment goals.

Many depressed patients benefit from nursing actions that encourage them to redirect their self-preoccupation to interests in the outside world. The timing of these interventions is crucial. Patients should not be forced into activities too soon. Also, they will not benefit from coming into contact with too many people. Rather, the nurse should encourage activities gradually and suggest more involvement on the basis of the patient's energy level.

For severely depressed patients who are hospitalized, a structured daily program of activities can be beneficial. Because these patients lack motivation and direction, they are slow to initiate actions. The nurse should take into consideration the patient's tolerance to stress and probability of succeeding. The particular task should be neither too difficult nor too time-consuming. Success tends to increase expectations of success, and failure tends to increase hopelessness.

Bipolar patients usually need little encouragement to become involved with others. Because of their short attention span and restless energy, however, they cannot deal with complicated projects. They need tasks that are simple and can be completed quickly. They need room to move about and furnishings that do not overstimulate them.

Relaxation techniques also may help both manic and depressed patients deal with their anxiety and tension and obtain more pleasure from life. Reducing anxiety to tolerable levels broadens one's perceptual field and allows the nurse to intervene in the cognitive and behavioral areas. Nursing actions used to reduce anxiety are described in Chapter 15.

> **Critical Reasoning** What physiological changes occur as a result of exercise? Relate these to what is currently known about the biology of depression.

Social Skill Building. Social factors play a major role in the causation, maintenance, and resolution of mood disorders. **Both depressed and bipolar patients have problems interacting socially.** Appropriate socialization can provide increased self-esteem and a sense of self-efficacy through the social reinforcers of approval, acceptance, recognition, and support.

A major problem is that patients with maladaptive emotional responses are less accomplished in social interaction. Others may avoid them because of their self-absorption, pessimism, or elation.

One nursing action that can help patients with this problem is social skill building. A Patient Education Plan for enhancing social skills is presented in Table 18-9. It applies to patients with either depression or bipolar illness.

Involvement with others often is a result of shared activities. The nurse can work with the patient to identify recreational, career, cultural, religious, and personal interests and how to pursue these interests through community groups, organizations, and clubs. Women's groups, single-parent groups, jogging clubs, church groups, and neighborhood associations are all opportunities. Although this may appear to be a simple nursing intervention, it often challenges the nurse's creativity and knowledge of resources.

Family and Group Involvement. In addition to a one-to-one relationship, patients with maladaptive emotional responses can benefit from family and group work (Leahy-Warren et al, 2011). **Social support from family and friends**

TABLE 18-9 **PATIENT EDUCATION PLAN**

Enhancing Social Skills

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Describe behaviors that interfere with social interaction.	Instruct the patient on corrective behaviors.	Patient identifies problematic and more facilitative behaviors.
Discuss positive social skills that could be used by the patient.	Model effective interpersonal skills for the patient.	Patient describes specific skills that could be acquired.
Analyze the way in which the patient could incorporate these specific skills.	Use role playing and guided practice to allow patient to test these new behaviors.	Patient shows beginning skill in assumed social behaviors.
Encourage patient to test new skills in other situations.	Give the patient homework assignments to do in one's natural environment.	Patient discusses ability to complete the assigned tasks.
Discuss generalization of new skills to other aspects of the patient's life and functioning.	Give feedback, encouragement, and praise for newly acquired social skills and their generalization.	Patient is able to integrate the new social behaviors in social interactions with others.

is a critical aspect in both prevention of and recovery from mood disorders.

Behaviors associated with depression and mania may be inadvertently supported by other family members. The patient's problems in human relationships can be examined in light of family patterns, and all members should be expected to take responsibility for their share of the continuing pattern.

Family and friends may reinforce and support the patient's maladaptive behavior. Much attention and secondary gain are usually received from others, who respond by being helpful, nurturing, or annoyed. When the patient acts in a more adaptive way, however, attention may be minimal.

Therefore one goal of family involvement is to have the family reinforce adaptive behaviors and ignore maladaptive mood responses. Another goal is to **reduce family burden.** For example, when caregivers of patients with bipolar illness experience a high burden, patient outcome and medication adherence are adversely affected.

Nursing care must address the needs of patients and families for specific education concerning mood disorders. **A psychoeducational model can be used with families who help patients deal with their illness** (Shimazu et al, 2011). The overall goal of such a program is to improve patient and family functioning and decrease symptomatology by increasing a sense of self-worth and control for both patients and families.

Specific information about the impact of mood disorders on family life can be outlined, along with suggestions and strategies designed to help family members cope more effectively with mood disorders. **Families as resources, caregivers, and collaborators are discussed in Chapter 10.**

Group therapy can provide many benefits. A format for group treatment of patients with depression or bipolar illness can have the aim of increasing self-worth and self-esteem through identification with the group and awareness of personal strengths (Castle et al, 2010). Specifically, group members can do the following:

- Learn more about their own behavior and relationships with others based on feedback from the group.
- Increase social support through group relatedness.
- Gain a heightened sense of identity, self-understanding, and control over their own lives.
- Realize that other people have problems similar to their own, which helps reduce their sense of loneliness and isolation, thereby also decreasing feelings of hopelessness, helplessness, and powerlessness.
- Learn new ways to cope with stress from others in the group.
- More realistically modify their perceptions and expectations of self and others.
- Allow for the expression of feelings of hopelessness and frustration within the supportive context of the group.

Education. **Another important aspect of nursing care related to mood disorders is mental health education of the public about the nature, extent, and treatments available for depressive and bipolar disorders.** Despite the prevalence of treatments, most people with these illnesses do not seek treatment because they do not know that they have a treatable disease or because they perceive stigma surrounding psychiatric illnesses. Outreach targeted to ethnic and racial minority communities is a particular need.

The most important information that the nurse can communicate through mental health education includes the following:

- **Mood disorders are a medical illness, not a character defect or weakness.**
- **Recovery is the rule, not the exception.**
- **Mood disorders are treatable illnesses, and an effective treatment can be found for almost all patients.**
- **The goal of intervention is not just to get better, but also to get and stay completely well.**

Education for health care providers should emphasize screening for mood disorders and early diagnosis and treatment. For example, earlier age at onset of untreated depression has been associated with more impaired social and occupational functioning, poorer quality of life, greater medical and psychiatric comorbidity, a more negative view of life and the self, more lifetime depressive episodes, greater symptom severity, and more suicide ideation and attempts.

Education for patients should focus on relapse prevention. Remaining on medication and engaging in psychosocial interventions can help to prevent relapse in both depression and bipolar illness. Awareness of the early signs of relapse and specific triggers is especially important in helping the patient seek out care.

A Nursing Treatment Plan Summary for patients with maladaptive emotional responses is presented in Table 18-10.

EVALUATION

The effectiveness of nursing care is determined by changes in the patient's maladaptive emotional responses and the effect they have on functioning. Problems related to self-concept and interpersonal relationships merge and overlap. Because all people experience life stress and related losses, the nurse can ask a fundamental question related to evaluation: "Did I assess the patient for problems in this area?"

Supervision and peer support groups can be helpful to the nurse working with patients with mood disorders. Of particular significance are the many special aspects of transference and countertransference that may occur. The patient's heightened attachment and dependency behaviors and lowered defensiveness can lead to intense **transference reactions** that should be worked through. Themes of loss and fear of loss, control of emotions and lack of control, and ambivalence predominate. Termination of the nurse-patient relationship may be difficult because the patient experiences it as another loss that requires mourning and integration.

Countertransference can be related to the nurse's own bereavements; attitudes about anger, guilt, sadness, and despair; ability to confront these emotions openly and objectively; and most importantly, conflicts about death and loss. Difficulties with any of these issues can be evident in avoidance behavior, preoccupation with fantasies, blocking of feelings, or shortening of sessions.

Nursing care will be more appropriate and effective if the nurse is aware of these issues and sensitive to personal feelings and conflicts regarding loss. Supervision and peer support groups can be of great help in this area.

TABLE 18-10 NURSING TREATMENT PLAN SUMMARY

Maladaptive Emotional Responses

Nursing Diagnosis: Hopelessness

Expected Outcome: The patient will be emotionally responsive and return to preillness level of functioning.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient's environment will be safe and protective.	Continually evaluate the patient's potential for suicide. Hospitalize the patient when there is a suicidal risk. Help the patient move to a new environment when appropriate (new job, peer group, family setting).	All patients with severe mood disturbances are at risk for suicide; environmental changes can protect the patient, decrease the immediate stress, and mobilize additional resources.
The patient will establish a therapeutic relationship with the nurse.	Use a warm, accepting, empathic approach. Be aware of and in control of your own feelings and reactions (anger, frustration, sympathy). ***With the depressed patient:*** Establish rapport through shared time and supportive companionship. Give the patient time to respond. Personalize care as a way of indicating the patient's value as a human. ***With the manic patient:*** Give simple, truthful responses. Be alert to possible manipulation. Set constructive limits on negative behavior. Use a consistent approach by all health care team members. Maintain open communication and sharing of perceptions among team members. Reinforce the patient's self-control and positive aspects of patient behavior.	Both depressed and manic patients resist becoming involved in a therapeutic alliance; acceptance, persistence, and limit-setting are necessary.
The patient will be physiologically stable and able to meet self-care needs.	Help the patient meet self-care needs, particularly in the areas of nutrition, sleep, and personal hygiene. Encourage the patient's independence whenever possible. Administer prescribed medications and somatic treatments.	Physiological changes occur in disturbances of mood; physical care and somatic therapies are required to overcome problems in this area.
The patient will be able to recognize and express emotions related to daily events.	Respond empathically, with a focus on feelings rather than facts. Acknowledge the patient's pain and convey a sense of hope in recovery. Help the patient experience feelings and express them appropriately. Help the patient in the adaptive expression of anger.	Patients with severe mood disturbances have difficulty identifying, expressing, and modulating feelings.

Continued

TABLE 18-10 NURSING TREATMENT PLAN SUMMARY—cont'd

Maladaptive Emotional Responses—cont'd

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will evaluate thinking and correct faulty or negative thoughts.	Review the patient's conceptualization of the problem, but do not necessarily accept the patient's conclusions. Identify the patient's negative thoughts and help to decrease them. Help increase positive thinking. Examine the accuracy of perceptions, logic, and conclusions. Identify misperceptions, distortions, and irrational beliefs. Help the patient move from unrealistic to realistic goals. Decrease the importance of unattainable goals. Limit the amount of negative personal evaluations the patient engages in.	This will help increase sense of control over goals and behaviors, enhance self-esteem, and modify negative expectations.
The patient will implement two new behavioral coping strategies.	Assign appropriate action-oriented therapeutic tasks. Encourage activities gradually, escalating them as the patient's energy is mobilized. Provide a tangible, structured program when appropriate. Set goals that are realistic, relevant to the patient's needs and interests, and focused on positive activities. Focus on present activities, not past or future activities. Positively reinforce successful performance. Incorporate physical exercise in the patient's care plan.	Successful behavioral performance counteracts feelings of helplessness and hopelessness.
The patient will describe rewarding social interactions.	Assess the patient's social skills, supports, and interests. Review existing and potential social resources. Instruct and model effective social skills. Use role playing and rehearsal of social interactions. Give feedback and positive reinforcement of effective interpersonal skills. Intervene with families to have them reinforce the patient's adaptive emotional responses. Support or engage in family and group therapy when appropriate.	Socialization is an experience incompatible with withdrawal; it increases self-esteem through the social reinforcers of approval, acceptance, recognition, and support.

LEARNING FROM A CLINICAL CASE OUTCOME

1. What behaviors would you include in your assessment?

This patient has significantly increased her level of exercise. She has had a sudden weight loss. In addition, she is talking very rapidly and seems pressured to continue. She is sleeping very little. Her mood is labile with fear, excitement, and crying in rapid succession. Her clothing is colorful, and she changes topics often while speaking.

2. What medical and nursing diagnoses should be considered?

The medical diagnosis that should be considered is bipolar disorder. This young woman appears to be experiencing a manic episode. The possible nursing diagnoses are Ineffective coping, Communication, verbal, impaired; Sleep pattern, disturbed.

3. What medications might be prescribed for this patient?

This patient will likely be prescribed a mood-stabilizing drug, such as the antimania drug, lithium, or the anticonvulsant, Depakote. In this situation, Depakote might be the first choice, because the dose can be rapidly increased and the patient can be stabilized more quickly. She may be offered an antidepressant after her mania has subsided. It will not be a tricyclic.

4. What interventions would be implemented in the acute, continuation, and maintenance phases of treatment?

During the acute phase, this patient's safety is of utmost importance. She may need to be hospitalized if her safety cannot be assured outside the hospital. Her mania needs to be treated successfully, and she needs to return to more normal sleeping and eating patterns. During the continuation phase, this patient and her family need to be educated about her illness, its impact, and treatment. If she learns to recognize the early signs of depression and mania, she can hopefully prevent future recurrences of this potentially serious illness. Patient education is key. During the maintenance phase, this young woman needs to be helped to create a new vision for her life. She needs to understand how to integrate this illness into her life while also achieving some of her life goals. She now has a chronic illness that should be considered when making important life decisions.

Case Outcome

The patient's mother was called and arrived within the hour. It was fortunate that she was there. She confirmed that her brother (the patient's uncle) had been diagnosed with bipolar disorder a few weeks earlier. She moved the patient into her hotel room with the patient's agreement. The young woman was started on a mood stabilizer, which she tolerated very well. After a week, her mother decided that her daughter should take a medical leave from college and return to their hometown until they were better able to manage the illness. The patient enrolled in a local college and transferred her credits there. She successfully graduated and adjusted to taking maintenance medication for her illness. She has educated herself about it and participates actively in her treatment. She hopes one day to marry and have children and worries about passing on her disorder.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Virginia A. Reuger, MSN, RN, C

Sure, you read about therapeutic interactions in your nursing textbooks, but every person is not the same, so the only way you learn is by doing, by experiencing. Rarely in school do we have the time to become overly involved with our patients. We are taught on our psychiatric rotation not to let the boundaries between self and others become blurred. Yet the dynamics of a therapeutic relationship are not real until we come face to face with the situation.

It happened to me soon after I started working in a psychiatric hospital. I was working as a staff nurse on the intensive care unit. I was assigned to the next admission. From the intake sheet, I could see it was another depressed, suicidal patient. But when Ms. R and her husband walked onto the unit, I was immediately drawn to her with an empathic feeling. She was tiny and frail looking; her face was thin and drawn. Her long, dark hair partially hid her face. She ignored introductions and stared at the floor. My initial challenge was to establish trust to open channels of communication, assess her suicide potential, and provide a secure environment. Her potential for self-harm was quite high. She was put on strict suicidal precautions.

Initially, working with Ms. R required observations of her appearance, gestures, and interests as well as nonverbal communication. I often had to make inferences, and I shared these with her. I felt like she was testing the waters of trust. She would often wrap herself up in her pink blanket and rock back and forth during our interactions. I found myself wondering what she was thinking.

One day during our time together, I asked her about how it felt to be depressed. For her it was the beginning of self-disclosure. She was able to acknowledge her fear and pain and unmet needs. She talked about what it was like growing up in New York City, living in rat-infested row houses. Her father worked at a bakery, and sometimes their only food was the bread he brought home. She had two brothers and two sisters. Eventually she told me that her uncle and grandfather lived with them, too. As she learned to trust me, she disclosed sexual abuse from her uncle and grandfather. At times the details became so vivid that she trembled as she cried. It is hard to express, but there was a sense that we were making contact.

We talked about her present life, her frigidity, her 6-year-old daughter, and the nightmares. She often remarked that her husband and daughter would be better off without her. She believed she could not have a "normal life." Ms. R was very bright and talented. She had many hobbies. We started concentrating on these things. I knew her self-esteem was low, and this was the start of some good work.

But being her primary nurse and assigned to her one-to-one daily made me realize I was becoming enmeshed in the situation. I went to my nurse manager for supervision. We discussed several options. I questioned whether I was helping her. I think sometimes nurses want to feel like omnipotent rescuers. I was not sure whether I was fostering independence or dependence. It was important to acknowledge my feelings to someone else openly, to discuss them, and then to move on.

Even though I felt a bond, I had to help Ms. R find strength on her own. We discussed her upcoming discharge date; we talked about priorities and decisions she had made. We talked about good choices, bad choices, and no choices. She had suffered many setbacks, but she was making plans.

I remember staying late the day of her discharge to say goodbye. Ms. R sent me cards at the hospital, dropped gifts off at the admissions office for me, and once tried to reach me at home. It was difficult not to acknowledge these things; I wanted so much to talk to her, but I knew the boundaries of a therapeutic relationship, and I knew she would be fine. I did talk to her outpatient therapist, and he told me she had completed a course in sign language (during her stay, she had befriended a deaf elderly woman) and was also attending clown school, something she had always wanted to do—to make people laugh and feel good.

In psychiatric nursing, it is important to remember that the art is to offer what you can without dictating the results while recognizing that you are not the only one to contribute to a person's health and happiness. I learned this important lesson from Ms. R.

CHAPTER IN REVIEW

- Mood is a prolonged emotional state that influences the person's whole personality and life functioning.
- The four adaptive functions of emotions are social communication, physiological arousal, subjective awareness, and psychodynamic defense.
- The continuum of emotional responses ranges from the most adaptive state of emotional responsiveness to the more maladaptive states of delayed grief reaction, depression, and mania.
- Grief is the subjective state that follows loss. As a natural reaction to a life experience, grief is universal; however, the way it is expressed is culturally determined. Uncomplicated grief is adaptive; delayed grief reaction is maladaptive.
- Depression may range from mild and moderate states to severe states with or without psychotic features. Psychotic depression accounts for fewer than 10% of all depressions.
- The lifetime risk for major depression is 7% to 12% for men and 20% to 30% for women.
- Most untreated episodes of major depression last 6 to 24 months.
- More than 50% of those who have had an episode of depression will eventually have another, and 25% of patients will have chronic, recurrent depression.
- Depression is a common accompaniment of many major medical illnesses. One of every five patients seeing a primary care practitioner has significant symptoms of depression. However, only one third of all people with depression seek help, are accurately diagnosed, and obtain appropriate treatment.
- The U.S. Preventive Services Task Force recommends screening adults for depression in primary care settings that have systems in place to ensure accurate diagnosis, effective treatment, and responsive follow-up.

CHAPTER IN REVIEW—cont'd

- Major depression may involve a single episode or a recurrent depressive illness but does not include a manic episode. Bipolar disorder includes one or more manic episodes, with or without a major depressive episode.
- Mania is characterized by an elevated, expansive, or irritable mood. Hypomania is a clinical syndrome that is similar to but not as severe as mania.
- Risk factors for bipolar disorder are being female and having a family history of bipolar disorder. Many patients with bipolar disorder meet criteria for substance use disorder.
- The key element of a behavioral assessment is change; depressed people change their usual patterns and responses. The most common and central behavior is that of the depressive mood. Some patients may initially deny their anxious or depressed moods but identify a variety of somatic complaints.
- Postpartum blues are brief episodes, lasting 1 to 4 days, of labile mood and tearfulness that occur in about 50% to 80% of women within 1 to 5 days after delivery.
- Postpartum depression may occur from 2 weeks to 12 months after delivery but usually within 6 months.
- The incidence of postpartum psychosis is low, and the symptoms typically begin 2 to 3 days after delivery. The period of risk for postpartum psychosis is within the first month after delivery.
- Seasonal affective disorder (SAD) is depression that comes with shortened hours of daylight in winter and fall and disappears during spring and summer.
- The potential for suicide always should be assessed in severe mood disturbances. About 15% of severely depressed patients commit suicide, and between 25% and 50% of patients with bipolar disorder attempt suicide at least once.
- The essential feature of mania is a distinct period of intense psychophysiological activation. Other behaviors found in mania include lability of mood with rapid shifts to brief depression.
- About 75% of manic patients have more than one episode, and almost all those with manic episodes also have depressive episodes.
- Current evidence suggests a significant genetic role in the cause of recurrent depression and bipolar disorder. Other predisposing factors affecting emotional responses include the object loss theory, personality organization theory, cognitive model, learned helplessness-hopelessness model, and behavioral model.
- Mood disorders occur because integrated biological control systems are disrupted, as evidenced by dysregulation in neurotransmitter systems, particularly serotonin, and by the fact that the brain mechanisms that control hormonal balance and biological rhythms are implicated in mood disorders. Brain imaging finds abnormalities in the structure of brains in people with mood disorders.
- Two mood disorders are cyclical in nature—bipolar disorder with rapid cycling, and depressive disorder with seasonal patterns (SAD). Sleep studies are abnormal in 90% of depressed patients. Sleep loss can trigger mania in those with bipolar disorder.
- Precipitating stressors include loss of attachment, life events, role strain, and physiological changes. Mood states are affected by a wide variety of medications and physical illnesses. Most chronic debilitating illnesses, whether physical or psychiatric, are accompanied by depression.
- Uncomplicated grief reactions can be normal mourning or simple bereavement. A delayed grief reaction uses the defense mechanisms of denial and suppression in an attempt to avoid intense distress. Specific defenses used to block mourning are repression, suppression, denial, and dissociation.
- Primary NANDA-I nursing diagnoses related to maladaptive emotional responses are complicated grieving, hopelessness, powerlessness, spiritual distress, risk for suicide, and risk for self-directed violence.
- Medical diagnoses include bipolar I and II disorders, cyclothymic disorder, major depressive disorder, and dysthymic disorder.
- Cyclothymia is a disorder resembling bipolar disorder but with less severe symptoms; it is characterized by repeated periods of nonpsychotic depression and hypomania for at least 2 years.
- Dysthymia is a milder form of depression lasting 2 or more years.
- The expected outcome of nursing care is that the patient will be emotionally responsive and return to a preillness level of functioning.
- In planning care, the nurse's priorities are the reduction and ultimate removal of the patient's maladaptive emotional responses, restoration of the patient's occupational and psychosocial functioning, improvement in the patient's quality of life, and minimization of the likelihood of relapse and recurrence.
- Treatment consists of three phases: acute, continuation, and maintenance.
- The goal of acute treatment is to eliminate the symptoms.
- The goal of continuation treatment is to prevent relapse, which is the return of symptoms, and to promote recovery.
- The goal of maintenance treatment is to prevent recurrence, or a new episode of illness.
- Early diagnosis and treatment are associated with more positive outcomes.
- Nursing interventions must reflect the complex, multicausal nature of the model and address all maladaptive aspects of a person's life.
- In caring for patients with a severe mood disorder, highest priority should be given to the potential for suicide. These patients are at particular risk when they appear to be coming out of their depression, because they may then have the energy and opportunity to kill themselves. Acute manic states are also life threatening.
- Nursing interventions address nurse-patient relationships, physiological treatments, expressing feelings, cognitive strategies, behavioral change, social skill building, family and group involvement, and education.
- Supervision and peer support groups can be helpful to the nurse who is working with patients with mood disorders. Of particular significance are the many special aspects of transference and countertransference that may occur.

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CHAPTER

19

Self-Protective Responses and Suicidal Behavior

Gail W. Stuart

Out, out brief candle!
Life's but a walking shadow, a poor player
That struts and frets his hour upon the stage
And then is heard no more. It is a tale
Told by an idiot, full of sound and fury,
Signifying nothing.

William Shakespeare, Macbeth, Act V

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive self-protective responses.
2. Identify behaviors associated with self-protective responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to self-protective responses.
4. Describe coping resources and coping mechanisms related to self-protective responses.
5. Formulate nursing diagnoses related to self-protective responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to self-protective responses.
7. Identify expected outcomes and short-term nursing goals related to self-protective responses.
8. Develop a patient education plan to promote compliance with health care treatment.
9. Analyze nursing interventions related to self-protective responses.
10. Evaluate nursing care related to self-protective responses.

Life is full of risk. People must choose the amount of danger to which they are willing to expose themselves. Sometimes these choices are conscious and rational; other risk-taking behaviors are unconscious. Most people go through life accepting some risks as part of their daily routine while carefully avoiding others.

Even though life is risky, most societies have a norm that defines the degree of danger to which people may expose themselves. This norm varies by age, gender, socioeconomic status, and occupation. In general, the very young, the elderly, and women are seen as needing to be protected from harm. Some risk takers are admired, particularly athletes, military personnel, those with dangerous occupations, and those who place themselves in danger to help others. At the same time, feelings of admiration may be accompanied by fear and perplexity about the danger-seeking behavior.

CONTINUUM OF SELF-PROTECTIVE RESPONSES

Protection and survival are fundamental needs of all living things. **On a continuum of self-protecting responses, self-enhancement and growth-promoting risk taking are the most adaptive responses, whereas indirect self-destructive**

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

A mother calls the pediatric primary care office and wants to bring her daughter, Kara, in to be seen. She says something isn't right. Kara, age 15, refused to go to school. Lately she has been acting strangely, staying in her room on her computer and not letting anyone in her bedroom.

The mother says her daughter used to take good care of herself, had many friends and liked socializing. But lately she has gained weight, stopped going out, and doesn't care about her appearance. Her mother has even had to tell her to take a shower and wash her hair. Kara was a good student; now her grades are poor. She just doesn't seem to care. Recently her boyfriend's family moved away to seek a job in another state, and Kara hasn't heard from him. The mother says her beautiful child has turned into someone else, and she is worried.

After talking with the mother you ask her to wait in the waiting room. Kara is in the exam room, and you ask her to remove her clothing and put on a gown. At first she refuses, but at your insistence she agrees. She appears very hostile, and you begin to better understand her mother's concern.

When you return to the exam room, Kara opens the gown and exposes cuts she has made with a razor blade on her body—her wrists, thighs, breasts, and hips all have long superficial cuts. She is very angry and says, "There, is that what you want to see?"

When you ask her what has happened, she says she hates herself and hates her life. She says her boyfriend told everyone she was a slut and they are making fun of her on Facebook. She doesn't want to live anymore. When you ask her if she has thoughts of hurting herself further, she says she is going to hang herself as soon as she gets a chance; she just hopes she has the guts to do it.

You call and ask for another staff member to come into the exam room, telling your colleague not to let the girl out of the room and to sit within arm's length of her. Then you go to the desk and call the Mobile Crisis Unit. You return to the exam room and stay with the patient until the emergency responders arrive. You ask your colleague to take the mother into another exam room and tell her what is happening.

Case Critical Reasoning Questions

1. What are Kara's predisposing risk and protective factors?
2. What behaviors suggest changes in her neurotransmitters?
3. What is her precipitating stressor and maladaptive coping mechanism?
4. What would be the goals of her treatment?

behavior, self-injury, and suicide are maladaptive responses. Self-destructive behavior may be direct or indirect.

- **Direct self-destructive behavior** includes any form of suicidal activity, such as suicide ideation, threats, attempts, and completed suicide. The intent of this behavior is death, and the person is aware of the desired outcome.
- **Indirect self-destructive behavior** is any activity that is harmful to the person's physical well-being and potentially may result in death. The person may be unaware of this potential and may deny it if confronted. Examples include eating disorders, abuse of alcohol and drugs, cigarette smoking, reckless driving, gambling, criminal activity, sexual promiscuity, socially deviant behavior, participation in high-risk sports, and noncompliance with medical treatment.

Theories of self-destructive behavior overlap with those of self-concept (see Chapter 17) and disturbances in mood (see Chapter 18). To think about or attempt destruction of the self, the person must have low self-regard. **Low self-esteem leads to depression, which is always present in self-destructive behavior.** The range of self-protective responses is shown in Figure 19-1.

The levels of behavior in the continuum may overlap. For instance, the girl who learns and excels at gymnastics is building her self-esteem and projecting a positive self-concept. However, if she tries movements she is not prepared for and does not take safety measures, her behavior becomes self-injurious or indirectly self-destructive. Similarly, a diabetic man who has never complied completely with his prescribed diet and medication regimen may become discouraged and intentionally take an overdose of insulin. The nurse must be alert to subtle shifts in mood and behavior of patients when assessing maladaptive self-protective responses.

Critical Reasoning Where do you think patients' requests for assisted suicide fall in the continuum of self-protective responses?

Epidemiology of Suicide

Worldwide, at least 1000 suicides occur each day. Suicide is the leading cause of death, outnumbering homicide or war-related deaths. Most people with suicide ideation, plans, and attempts receive no treatment (Bruffaerts et al, 2011).

In the United States more than 36,000 people complete the act of suicide each year, an average of one person every 15 minutes. In 2008, 8.3 million adults reported having suicidal thoughts (Centers for Disease Control and Prevention, 2011).

Suicide is the tenth leading cause of death, outnumbering homicide, which is the fifteenth leading cause of death in the United States (American Association of Suicidology, 2011). The actual number of suicides may be two to three times higher because of underreporting. In addition, many single-car accidents and homicides are, in fact, suicides.

Additional statistics regarding suicide in the United States include the following:

- **The highest suicide rate for any group in the United States is among people older than age 80 years.** Elderly adults have a rate of suicide almost 50% higher than that of the nation as a whole (all ages).

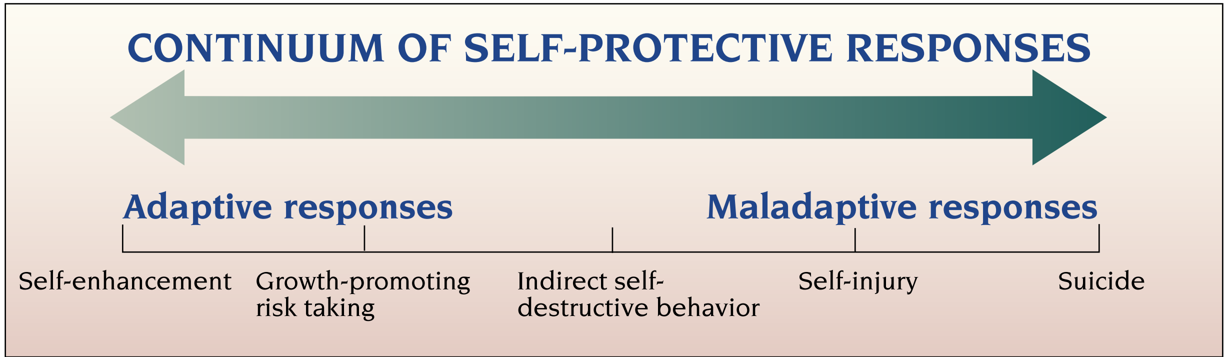

FIG 19-1 Continuum of self-protective responses.

BOX 19-1 SOCIOCULTURAL CONTEXT OF CARE

Suicide Among Minority Groups

Suicide rates can be viewed as a reflection of the many stressors faced by minority groups within contemporary U.S. culture. The following statistics call for an agenda of prevention and intervention:

- Among American Indians/Alaskan Natives ages 15 to 34 years, suicide is the second leading cause of death.
- Suicide rates among American Indian/Alaskan Native adolescents and young adults ages 15 to 34 years are 1.8 times higher than the national average for that age group.
- Hispanic, female high school students in grades 9 through 12 reported a higher percentage of suicide attempts than their white, non-Hispanic or black, non-Hispanic counterparts.

From Centers for Disease Control and Prevention (CDC): *Suicide: facts at a glance,* Summer 2009. Accessed October 2011 at www.cdc.gov.

- **Suicide is the third leading killer of young people.** The rate of suicide among youth has tripled in the past 30 years. Teen suicide in the United States is almost five times as common among boys as among girls. Reports of suicide among young children are rare, but suicidal behavior is not. As many as 12,000 children ages 5 to 14 years are hospitalized in the United States every year for deliberate self-destructive acts.
- **The incidence of suicide varies among cultural groups** (Box 19-1). Suicide is more common among whites than African Americans at all ages.
- **Males commit the overwhelming majority of completed suicides; women attempt suicide three times more often then men.**
- **Suicide is the fourth leading cause of death for women between the ages of 15 and 44 years,** exceeding deaths due to homicide, cerebrovascular disease, or diabetes (LaVonne and Karch, 2010).
- **Guns account for half of all completed suicides** (Ilgen et al, 2008). Women tend to use potentially less lethal means, such as medications and wrist slashing. One third of all women and more than half of those 15 to 29 years of age who complete suicide use guns.

Critical Reasoning What factors might contribute to the high rate of suicide among white elderly males?

ASSESSMENT

Behaviors

Noncompliance/Nonadherence. It has been estimated that one half of patients do not comply with their health care treatment plan. This level of **noncompliance** or **nonadherence** is the same for those with physical illnesses and those with psychiatric illnesses. Noncompliance accounts for 125,000 deaths annually and contributes to 10% to 25% of hospital and nursing home admissions.

People who do not comply with recommended health care activities are generally aware that they have chosen not to care for themselves. They usually have a reason for noncompliance, such as not having symptoms, not being able to afford the treatment they need, not understanding the treatment, or not having time. Patients also may minimize the seriousness of their problems. Many chronic illnesses are characterized by long periods of stability, during which the person may not be aware of discomfort. This reinforces the noncompliant behavior.

The most prominent behavior associated with noncompliance is refusal to admit the seriousness of the health problem. This **denial** interferes with acceptance of treatment. Another aspect of noncompliance is that **guilt** about not following health care recommendations also may interfere with obtaining regular care.

Noncompliant people are also struggling for **control.** Serious illness is often seen as an attack on the person and a betrayal by the body. Patients need to reassert their control and prove that they are still master of their fate. Most chronically ill people need to test the limits of their control and the validity of the prescribed self-care regimen. The following clinical example illustrates the problem of noncompliance with a prescribed health care regimen.

CLINICAL EXAMPLE

Ms. C was a 61-year-old, white, married woman who had been in good health most of her life. She had three grown children who had left home and established their own

families. She and her husband were both looking forward to his retirement in 6 months. They planned to buy a recreational vehicle and travel around the United States.

The nurse practitioner did a complete physical examination each time Ms. C was seen. On her most recent visit, laboratory studies revealed an elevated blood glucose level. Her diagnosis was diabetes mellitus, adult onset. Ms. C was told that her condition was not serious and could be controlled by diet. She was 20 pounds (9 kg) overweight and was advised that she needed to lose the excess weight. She was instructed about her diet, how to test her urine, and the possible complications of diabetes.

Ms. C was frightened about her condition but did not mention this because no one else seemed very concerned. At first she was conscientious about following her diet and testing her urine. She felt very well and was proud when she lost 5 pounds. As time went on, Ms. C began to wonder whether she was really so sick. She had never felt ill.

On her husband's birthday, she fixed a special dinner and baked a cake. She decided she deserved a reward for "being good" and did not follow her diet. She anxiously tested her urine at bedtime, and it was negative. Then her son and his family visited for a week. She fixed all their favorite foods and ate with them. She still felt fine and decided she did not need to test her urine. When it was time for her next checkup, she postponed calling the nurse practitioner. She was very busy preparing for retirement travel.

Selected Nursing Diagnosis

- Noncompliance related to fear of the diagnosis of diabetes, as evidenced by lack of adherence to medical treatment plan

Critical Reasoning Do you think that noncompliance can ever be an adaptive response? Why or why not?

Self-Injury. Society accepts some forms of self-harm as normal. Examples of culturally sanctioned forms include body piercing, cosmetic eyebrow plucking, circumcision, nail biting, and tattoos. **Self-injury** is the act of deliberate harm to one's own body. **The injury is done to oneself, without the aid of another person, and the injury is severe enough to cause tissue damage.** Common forms of self-injurious behavior include cutting and burning the skin, banging the head and limbs, picking at wounds, and chewing fingers.

Many nurses mistake self-injury for potential suicide. In fact, they are two separate phenomena. Usually the lethality of self-injury is low, and patients who self-injure typically want relief from the tension they feel rather than to kill themselves. Self-injury also differs from other self-destructive behaviors such as bingeing, drug abuse, smoking, and high-risk activities. Self-injury is a contained event that occurs in a short time span and with an awareness of the consequences of the act.

Self-injurious behavior may be categorized by the type of patient and the clinical context in which the behavior occurs:

- **People with mental retardation.** The mentally retarded may have outward-directed aggression along with self-injurious behavior.
- **Psychotic patients.** Self-injuring acts among psychotic patients tend to be sporadic and often occur in response to command hallucinations or delusions.
- **Prison populations.** Self-injury in prisons is difficult to assess because of poor documentation, drug use, and undiagnosed psychiatric disorders. Many self-injurious events among prisoners may be intentionally manipulative, designed to force transfer to a less restrictive facility.
- **Character disorders, particularly borderline personality disorder.** These patients are often young and female and have a poor tolerance of anxiety and anger; also included are patients with eating disorders.

Suicidal Behavior. Suicidal behavior is usually divided into the categories of suicide ideation, suicide threats, suicide attempts, and completed suicide.

Suicide ideation **is the thought of self-inflicted death, either self-reported or reported to others.** Suicide ideation can be *passive,* when there are only thoughts of suicide with no intent to act, or *active,* when there are thoughts and plans of causing one's own death.

Suicide threat **is a warning, direct or indirect, verbal or nonverbal, that a person is planning to take his or her own life.** It may be subtle but usually occurs before overt suicidal activity takes place. The suicidal person may make statements such as the following:

- "Will you remember me when I'm gone?"
- "Take care of my family for me."
- "I won't be in your way much longer."
- "There's nothing more that I can do."
- "I just can't deal with things anymore."

Nonverbal communication often reveals the suicide threat. The person may give away prized possessions, make a will or funeral arrangements, or withdraw from friendships and social activities. Less often, a person may make a direct verbal suicide threat. The threat is an indication of the ambivalence that is usually present in suicidal behavior. It represents the hope that someone will recognize the danger and rescue the person from self-destructive impulses. It also may be an effort to discover whether anyone cares enough to prevent the person from self-harm.

Suicide attempt **is any self-directed action taken by a person that will lead to death if not stopped.**

In the assessment of suicidal behavior, much emphasis is placed on the lethality of the method threatened or used. Although all suicide threats and attempts must be taken seriously, vigilant attention is needed when the person is planning or tries a highly lethal method, such as gunshot, hanging, or jumping. Less lethal methods include carbon monoxide and drug overdose, which allow time for discovery once the suicidal action has begun. Assessment of the suicidal person

QUALITY AND SAFETY ALERT

- All suicidal behavior is serious, whatever the intent.
- Suicide ideation, threats, and attempts all require the nurse's highest priority.

also includes whether the person has made a specific plan and whether the means to carry out the plan are available.

The most suicidal person is one who has all of the following:

- **A highly lethal method** (e.g., a gunshot to the head)
- **A specific plan** (e.g., as soon as one's spouse goes shopping)
- **The means readily available** (e.g., a loaded gun in a desk drawer)

Such a person is exhibiting little ambivalence about a suicide plan. On the other hand, the person who contemplates taking a bottle of aspirin if the situation at work does not improve soon is communicating an element of hope. This person is really asking for help in coping with a poor work situation. The following clinical example illustrates the behavior of a suicidal person.

CLINICAL EXAMPLE

Mr. Y was a 52-year-old African-American man employed in the foundry of a large steel mill. He had worked for the company for 20 years. He lived in a rented room in a blue-collar neighborhood near the mill. Most of his neighbors were Appalachian white and southern African-American families who had moved to the community to work at the mill. The neighborhood had an undercurrent of racial tension, but Mr. Y was not involved in conflicts with his neighbors. He had separated from his wife before moving to the community and had no close friends or family. The separation resulted from his violent behavior related to drinking binges.

The occupational health nurse, Ms. G, saw Mr. Y when he came to the employee health clinic following a 6-week absence from work. He had been hospitalized for broken ribs and a concussion after he was beaten and robbed by a gang of adolescents in an alley behind his home. Ms. G was familiar with this patient because he had participated in the company's employee assistance program for persons with alcoholism.

When she saw him in the clinic, she immediately noted that he appeared depressed. His face was expressionless, his posture was slumped, and he had lost weight. He appeared disheveled, which was a change from his usual neat appearance. His speech was slow and halting and so soft that he could barely be heard.

He told Ms. G that he had a request to make of her. He knew from past conversations that she was an animal lover. He wanted her to take his pet dog, Rover, because he did not feel able to care for the dog adequately and the neighbors who kept Rover while he was in the hospital had neglected the dog. Ms. G was very concerned about Mr. Y and asked him how he was spending his time. He said he kept the television on and he thought a lot. When asked, he said he felt "too shaky" to go outside unless he absolutely had to. He thought the boys who attacked him were still in the neighborhood.

Ms. G asked if he had thought about harming himself. Mr. Y looked startled and then admitted that he saw no other solution to his problem. "It makes sense. I don't have anybody. If you take Rover, I can go." With further questioning he admitted that he had a loaded revolver at home and planned to use it after he left the clinic. Ms. G realized that Mr. Y needed help immediately and initiated plans for hospitalization.

Selected Nursing Diagnoses

- Risk for suicide related to impoverished social environment, as evidenced by intent to kill self with a gun
- Powerlessness related to recent neighborhood attack, as evidenced by expressed feelings of despair and hopelessness

Completed suicide, or simply suicide, is death from self-inflicted injury, poisoning, or suffocation where there is evidence that the decedent intended to kill himself or herself. Completed suicide may take place after warning signs have been missed or ignored. Some people do not give any easily recognizable warning signs.

Research done on completed suicide has of necessity been retrospective. However, it can be informative to interview survivors. This procedure is known as the **psychological autopsy** (Innamorati et al, 2008). It is a retrospective review of the person's behavior before the suicide. Table 19-1 compares the characteristics of suicide completers and suicide attempters based on this process.

Significant others of suicidal people, including people who have survived a suicidal attempt, have many feelings about this behavior. An element of hostility exists in suicidal behavior. Often the message to significant others, stated or implied, is "You should have cared more." At times, when the person survives the attempt, this message may be transmitted in a manipulative way.

An example is the adolescent girl who discovers that her boyfriend is dating someone else and takes an overdose of over-the-counter sleeping pills. If she sets the scene so that she will almost inevitably be discovered and makes sure that her boyfriend hears of her behavior, she is behaving in a hostile, manipulative way. A remorseful response by the boyfriend would be reinforcing and would increase the likelihood that she will repeat the behavior.

It is important to treat all suicide attempts seriously and to help the patient develop healthier communication patterns. People who do not really intend to die may do so if they are not discovered in time.

TABLE 19-1 CHARACTERISTICS OF SUICIDE COMPLETERS AND ATTEMPTERS

SUICIDE COMPLETERS	SUICIDE ATTEMPTERS
Three times as likely to be men	Mainly women younger than 40 years of age
Usually have depression and/or alcohol or substance abuse	Less likely to have depression and other psychiatric conditions; more likely to have personality disorders
Plan the suicide act	Act impulsively
Use highly lethal method	Use method with low lethality
Select a setting where they are unlikely to be interrupted	Act in the presence of or notify others

When suicide is successful, the survivors are left with many feelings that they cannot communicate to the involved object, the dead person (Box 19-2). This may lead to an unresolved grief reaction, depression, social stigma, and suicidal ideation. Some suicide prevention centers have become involved in **postvention,** in which survivors are helped, either individually or in groups, to express their feelings and work through their grief.

In summary, the suicidal patient may have many different clinical behaviors. Mood disturbances are often present, as are somatic complaints. Feelings of hopelessness and helplessness are important in explaining suicidal ideation. Nurses should take a careful medical and psychiatric history, paying specific attention to the mental status examination (described in Chapter 6) and the psychosocial history, and should evaluate the patient for recent losses, life stresses, and substance use and abuse.

Nature of the Assessment

Most people who commit suicide have visited a primary care provider, emergency department (ED), or psychiatric outpatient service in the weeks before their death. Errors in recognition and inadequate assessment likely contribute to a number of these deaths. Adequate screening, protection of the patient, and acceptable treatment could prevent these occurrences (Reid, 2010).

Suicidal patients often present initially in the ED. About 666,000 people visited EDs for nonfatal, self-inflicted injuries in 2008 (Centers for Disease Control and Prevention, 2011). As many as 1 in 10 people who end their lives by suicide are seen in the ED within 2 months of dying, but many of them are never assessed for suicide risk (Pompili et al, 2011).

Psychiatric evaluation of suicide attempters in the ED should include the use of a standardized tool to evaluate suicide ideation and suicide risk (Pompili et al, 2009). After completing the assessment, the nurse should document the following (Scott and Resnick, 2009):

- That a suicide risk assessment was conducted
- Risk factors found to be present
- Interventions taken to address the risk factors
- Level of risk determined (minimal, moderate, or high)
- Factors that might protect the patient against suicide

Directly questioning the patient about suicidal thoughts and plans will not cause the patient to take suicidal action. Rather, most people want to be prevented from carrying out their self-destruction. Most patients are relieved to be asked about these feelings (Crawford et al, 2011).

In asking about suicide, nurses can begin with general questions, such as the following:

- "Have you ever felt that life was not worth living?"
- "Did you ever wish that one morning you would just not wake up?"

These can be followed by more specific questions, such as

- "Have you been thinking about death recently?"
- "Have you ever thought about harming yourself?"

If the patient has had thoughts of death, self-harm, or suicide, the nurse must then ask more focused and direct questions about the method, plan, and means. A tool used in one inpatient setting is presented in Figure 19-2. Other suicide assessment tools also are available (Young and Erwin, 2008; Hermes et al, 2009).

BOX 19-2 A FAMILY SPEAKS

My husband died last year. He didn't commit suicide, but he took his own life just as surely as if he had pulled the trigger of a gun. Only his weapon was a cigarette. You see, 2 years ago his doctor discovered a cancer lesion on his lung. At that time my husband was told he needed to lose weight, cut down on his drinking, and most of all, stop smoking. But my husband wasn't a very good patient.

Sometimes I blame myself for not doing more. I nagged for a while, but that only seemed to make our marriage worse. My husband said that what he did with his life was his own choice and that his father had smoked all of his life and had lived until he was 84. My husband died at age 62.

One good thing has come out of this tragedy, however. My son has stopped smoking and has vowed he will never touch another cigarette for as long as he lives. That small goodness gives me comfort and some sense of hope.

QUALITY AND SAFETY ALERT

- It is essential that nurses have a systematic way of evaluating a patient for the risk of suicide.
- This requires the use of a standardized suicide assessment tool and safety plan.
- Merely asking a patient if he or she is suicidal does not meet the standard of care.
- Suicide assessments should occur regularly at critical points during hospitalization, including on admission, at discharge, and during changes in medications, treatments, mental status, and level of precautions.

Predisposing Factors

No one theory explains self-destructive behavior or guides therapeutic intervention. Behavior theory suggests that self-injury is learned and reinforced in childhood or adolescence. Psychological theory focuses on problems in early stages of ego development, suggesting that early interpersonal trauma and unmanaged anxiety may provoke episodes of self-injury. Interpersonal theory proposes that self-injury may result from interactions that leave the child feeling guilty and worthless.

Childhood trauma and a history of abuse or incest also may precipitate self-destructiveness if negative perceptions have been internalized (Bruffaerts et al, 2010). Other predisposing factors related to self-destructive behavior include the inability to communicate needs and feelings verbally; feelings of guilt, depression, and depersonalization; and fluctuating emotions.

Five predisposing factors—psychiatric diagnosis, personality traits and disorders, psychosocial factors and physical illness, genetic and familial variables, and biochemical factors—contribute to a biopsychosocial model for understanding self-destructive behavior throughout the life cycle.

Psychiatric Diagnosis. More than 90% of adults who end their lives by suicide have an associated psychiatric illness.

The four broad psychiatric disorders that put people at particular risk for suicide are mood disorders, substance abuse, schizophrenia, and anxiety disorders.

Suicide is the most serious complication of mood disorders; 15% of individuals with these illnesses end their lives by suicide. The time spent depressed is a major risk factor determining overall long-term risk (Holma et al, 2010). Suicide is particularly common among depressed elderly men. Patients with bipolar disorder and psychotic depression are at greatest risk. Many who die from suicide have a prior history of attempts,

Part I. Suicide Assessment

Directions:
A. Indicate date at the top of both parts.
B. Assess each factor and check one descriptor for each that best describes the patient.
C. "Current admission precipitated by suicide attempt" and "Attempt history" should be checked only once a day. Include those point values in the total score each shift.
D. Add all points to determine the score.
E. If unable to reassess and review plan, document reason, sign with time, and do not complete Part II.
F. Sign and time at bottom of each part completed.

Date:	Points		
	0	1	2
Suicidal ideation	No current suicidal thoughts ☐ Night ☐ Day ☐ Evening	Intermittent or fleeting suicidal thoughts ☐ Night ☐ Day ☐ Evening	Constant suicidal thoughts ☐ Night ☐ Day ☐ Evening
Suicide plan	No plan ☐ Night ☐ Day ☐ Evening	Has plan without access to planned method ☐ Night ☐ Day ☐ Evening	Has plan with actual or potential access ☐ Night ☐ Day ☐ Evening
Plan lethality (while in hospital)	No plan ☐ Night ☐ Day ☐ Evening	Low lethality of plan (e.g., superficial scratching, head banging, pillow over face, biting, holding breath) ☐ Night ☐ Day ☐ Evening	Highly lethal plan (e.g., cutting, overdose, hanging, jumping) ☐ Night ☐ Day ☐ Evening
Elopement risk	No elopement risk ☐ Night ☐ Day ☐ Evening	Low elopement risk ☐ Night ☐ Day ☐ Evening	High elopement risk ☐ Night ☐ Day ☐ Evening
Symptoms (check all that apply) Night Day Evening ☐ ☐ ☐ Impulsivity ☐ ☐ ☐ Shame ☐ ☐ ☐ Helplessness ☐ ☐ ☐ Anhedonia ☐ ☐ ☐ Hopelessness ☐ ☐ ☐ Guilt ☐ ☐ ☐ Anger/rage	0–2 symptoms present ☐ Night ☐ Day ☐ Evening	3–4 symptoms present ☐ Night ☐ Day ☐ Evening	>4 symptoms present ☐ Night ☐ Day ☐ Evening
Current morbid thoughts (e.g., reunion fantasies, preoccupation with death)	None/Rarely ☐ Night ☐ Day ☐ Evening	Frequently ☐ Night ☐ Day ☐ Evening	Constantly ☐ Night ☐ Day ☐ Evening
Agrees to a safety plan	Reliably agrees to a safety plan ☐ Night ☐ Day ☐ Evening	Agrees to a safety plan but is ambivalent or guarded ☐ Night ☐ Day ☐ Evening	Unwilling or unable to agree to a safety plan ☐ Night ☐ Day ☐ Evening
Refer to IOP Assessment HPI	Current admission precipitated by suicide attempt: ☐ 0 No ☐ 2 Yes	Attempt history: ☐ 0 No previous attempts	☐ 1 Past attempts
Clinician's subjective appraisal of risk:	Patient's replies not trustworthy, several nonverbal cues — 4 ☐ Night ☐ Day ☐ Evening Patient's replies questionably trustworthy, at least 1 nonverbal cue — 3 ☐ Night ☐ Day ☐ Evening Patient's replies trustworthy — 0 ☐ Night ☐ Day ☐ Evening		
Scoring key:	High potential = 10 or more Moderate potential = 7–9 Low potential = 4–6	**Total Score:** Night ____ Day ____ Evening ____	
☐ Unable to reassess and review plan with patient due to: ____ (Not necessary to complete Part II) Signature: ____ Time: ____ AM/PM			
☐ Unable to reassess and review plan with patient due to: ____ (Not necessary to complete Part II) Signature: ____ Time: ____ AM/PM			

Night: Signature/Title: ____ Time: ____ AM/PM

Day: Signature/Title: ____ Time: ____ AM/PM

Evening: Signature/Title: ____ Time: ____ AM/PM

FIG 19-2 Inpatient suicide/self-harm assessment tool and safety plan. (Courtesy of Medical University of South Carolina, Charleston, 2008.)

Continued

Part II. Safety Plan

Date:
What, if anything, is causing you to feel like hurting yourself? Record patient's response: ______
How can we recognize when you are feeling like hurting yourself? Record patient's response: ______
What helps you to calm down and feel safe? (e.g., talk 1:1, listen to music, write in journal, art work, exercise, PRN medication) Record patient's response: ______
How can we help you manage your safety? Record patient's response: ______
Indicate any changes in above responses on successive reassessments. Day: ☐ None or specify: ______ Evening: ☐ None or specify: ______

State nurse's intervention:	Night	Day	Evening	
	☐	☐	☐	Maintain current observation level, specify level: ______
	☐	☐	☐	Increase level of observation, specify level: ______
	☐	☐	☐	Conduct 1:1 interaction with patient
	☐	☐	☐	Offer/administer PRN medication
	☐	☐	☐	Other (specify): ______

Question	Night	Day	Evening
Does the patient acknowledge an understanding of the current safety plan?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the patient agree to contact staff if unable to maintain the safety plan?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Night: Patient's signature: ______
(If patient is unwilling or unable to sign, explain) ______

Day: Patient's signature: ______
(If patient is unwilling or unable to sign, explain) ______

Evening: Patient's signature: ______
(If patient is unwilling or unable to sign, explain) ______

Night: Signature/Title: ______ Time: ______ AM/PM

Day: Signature/Title: ______ Time: ______ AM/PM

Evening: Signature/Title: ______ Time: ______ AM/PM

FIG 19-2, cont'd Inpatient suicide/self-harm assessment tool and safety plan.

have explicitly communicated their intent, and have been in psychiatric treatment during the months before their death.

Alcohol use is associated with 25% to 50% of suicides. Among patients who are alcohol dependent, suicide often occurs late in the disease and is often related to some interpersonal loss or the onset of medical complications.

Among patients with schizophrenia, 40% report suicidal thoughts, 20% to 40% make unsuccessful suicide attempts, and 10% to 15% end their lives by suicide. The risk is greatest for patients with chronic recurring illness who are male, white, young, unmarried, unemployed, living alone, and depressed.

Anxiety disorders, particularly panic disorder and posttraumatic stress disorder, are associated with increased rates of suicidal ideation, suicide attempts, and completed suicide. Other disorders that are associated with high risk include eating disorders, body dysmorphic disorder, attention deficit/hyperactivity disorder, some personality disorders (borderline personality disorder and antisocial personality disorder), and conduct disorders in adolescents (Berk et al, 2009).

Personality Traits and Disorders. The four aspects of personality that are most closely associated with increased risk of suicide are **hostility, impulsivity, depression,** and **hopelessness**. These traits are important because they cross personality disorder diagnostic groups. The co-existence of antisocial

and depressive symptoms appears to be a particularly lethal combination in both adults and young people.

The association between hostility and suicide stems from the idea that the suicidal person turns rage inward against the self. Other studies have found that suicidal people are more socially withdrawn, have lower self-esteem, are less trusting of others, expect bad things to happen to them, feel powerless over their lives, and have a rigid and inflexible way of thinking.

> **Critical Reasoning** How might the personality traits of hostility, impulsivity, and depression contribute to the development of substance abuse?

Psychosocial Factors and Physical Illness. **Predisposing factors for suicide include loss, lack of social supports, negative life events, and chronic physical illness.** Recent bereavement, separation or divorce, early loss, and decreased social supports are all important factors related to potential suicide. Precipitants of suicidal behavior are often humiliating life events such as interpersonal problems, public embarrassment, loss of a job, or the threat of jail.

Knowing someone who attempted or committed suicide or exposure to suicide through the media may make one more vulnerable to self-destructive behavior. This seems to be a particularly important factor in cluster suicides. The strength of social supports is important (Hill, 2009). Evidence shows that the strength and quality of these supports are important to the onset of psychiatric problems, compliance with treatment, and response to therapeutic interventions.

Finally, diseases with chronic and debilitating courses often precipitate self-destructive behavior. The prevalence of physical illness varies from 25% to 70% among those who attempt suicide and appears to be an important factor in 10% to 50% of completed suicides. The suicide rate among recently discharged general hospital patients is almost three times higher than in the general population. The disorders most often associated with suicide include cancer, Huntington chorea, epilepsy, musculoskeletal disorders, peptic ulcer disease, and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS).

Genetic and Familial Variables. **A family history of suicide is a significant risk factor for self-destructive behavior.** This may be due to identification with and imitation of a family member who has committed suicide, family stress, or transmission of genetic factors (Wilcox et al, 2010). Families of suicide victims have a significantly higher rate of suicide than do families with members who are nonsuicidal but mentally ill (Perlis et al, 2010). In addition, monozygotic twins have a higher concordance rate for suicide than dizygotic twins.

> **QUALITY AND SAFETY ALERT**
> - The offspring of mood-disordered suicide attempters are at a markedly greater risk for suicide attempts themselves.

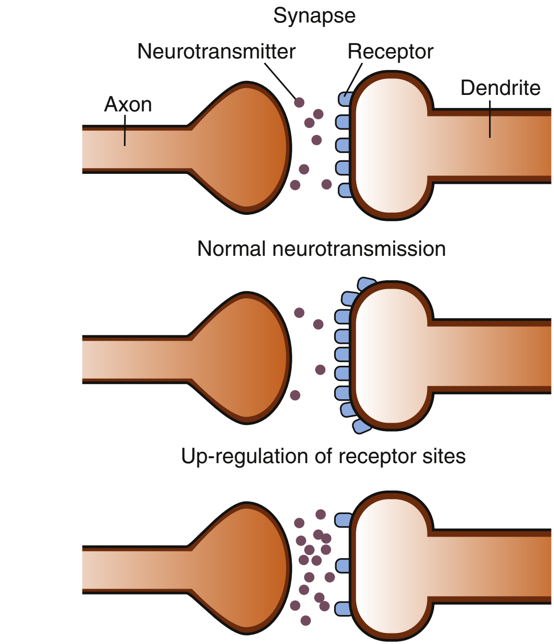

FIG 19-3 Levels of postsynaptic serotonin (5-HT) receptors. More receptors are present when there is too little 5-HT (upregulation), and fewer receptors when there is too much 5-HT (down-regulation).

Biochemical Factors. **Growing evidence shows an association between suicide or suicidal tendencies and a low level of the brain neurotransmitter serotonin (5-HT).** This comes from two main areas of study: an increased understanding of abnormal 5-HT transmission in the etiology of mental illness, particularly depression and schizophrenia, and a better appreciation that antidepressant drugs enhance the efficacy of serotonin.

Research suggests that 5-HT must be in balance to facilitate adaptive emotional responses. This balance can be assessed by measuring the amount of neurotransmitter produced and the amount of its metabolites (the leftover products of neurotransmitter breakdown, or turnover). The amount of the metabolite for serotonin, 5-hydroxyindoleacetic acid (5-HIAA), that can be measured in the blood and spinal fluid is an indication of the amount of 5-HT originally available in the brain.

The brain also attempts to regulate or balance neurotransmitter levels in another way. The available levels of 5-HT affect the number of postsynaptic 5-HT receptors in the brain. More of these receptors are present if there is too little 5-HT (up-regulation), and fewer are present if there is too much 5-HT (down-regulation) (Figure 19-3).

Mood disorders are proposed to be the result of an imbalance or deficiency of neurotransmitters, particularly 5-HT. Antidepressant drugs generally increase the amount or efficiency of 5-HT, thus increasing the amount of metabolites and affecting the number of 5-HT receptors.

A deficiency in 5-HT and its metabolite, 5-HIAA, and an increase in one of the 5-HT postsynaptic receptors (5-HT_{2A}) are implicated in suicidal behavior. For example, depressed patients with low 5-HT levels have stronger suicidal tendencies

BOX 19-3 RISK FACTORS IN THE ASSESSMENT OF THE SELF-DESTRUCTIVE PATIENT

Assessing Circumstances of an Attempt
- Precipitating humiliating life event
- Preparatory actions: acquiring a method, putting affairs in order, suicide talk, giving away prized possessions, suicide note
- Use of violent method or more lethal drugs/poisons
- Lethality of chosen method
- Precautions taken against discovery
- Change in treatment, provider, or setting

Presenting Symptoms
- Suicidal thoughts and plans
- Hopelessness
- Helplessness
- Self-reproach, feelings of failure and unworthiness
- Impulsivity
- Depressed mood
- Impaired problem solving
- Agitation and restlessness
- Anxiety/panic
- Persistent insomnia
- Weight change
- Poor personal hygiene
- Slowed speech, fatigue, social withdrawal
- Command hallucinations

Suicidal Behavior
- History of prior suicide attempt
- Aborted suicide attempt
- Self-injurious behavior
- Focused plan
- Lethality of method

Psychiatric Illness
- Mood disorders
- Alcoholism or other substance abuse
- Borderline or antisocial personality disorder
- Schizophrenia and other psychotic disorders
- Posttraumatic stress disorder
- Panic disorder
- Conduct disorders
- Early dementia and confusional states in the elderly
- Traumatic brain injury
- Combinations of these illnesses

Psychosocial History
- Recently separated, divorced, or bereaved
- Lack of social support
- Lives alone
- Unemployed, recent job change or loss
- Multiple life stresses (relocation, early loss, breakup of important relationship, school problems, threat of disciplinary crisis)
- Chronic medical illness
- Excessive drinking or substance abuse

Personality Factors
- Impulsivity, aggressivity, hostility
- Cognitive rigidity and negativity
- Low self-esteem

Family History
- Family history of suicidal behavior
- Family history of mood disorder, alcoholism, or both

than those with normal levels. Among people hospitalized for violent suicide attempts, those with low levels of 5-HIAA in their spinal fluid are 10 times more likely to kill themselves within 1 year. Similarly, patients with schizophrenia who have attempted suicide have significantly lower 5-HIAA concentrations than those who have not. In postmortem studies of the brains of suicide victims, researchers have discovered decreased 5-HT activity in the ventrolateral prefrontal cortex.

A combination of impulsive aggressiveness and feelings of hopelessness, associated with 5-HT deficiency, is more common in men than in women. This may explain why men kill themselves much more often than women, even though women have a higher rate of depression.

Critical Reasoning Do you believe that suicide is a fundamental human right and should be allowed by society? Why or why not?

Precipitating Stressors

Self-destructive behavior may result from any stress the person feels as overwhelming. Stressors are individualized, as is the person's ability to tolerate stress. All self-destructive behaviors may be seen as attempts to escape from uncomfortable or intolerable life situations. Anxiety is therefore central to self-destructive behavior.

The anxiety associated with a deliberate attempt at self-destruction is overwhelming. It is difficult to imagine if it has not been experienced. Most people cringe at merely thinking about their own deaths, much less actually engaging in the act. Self-death is experienced differently from the death of another, because self-death literally cannot be experienced.

In contrast, people who are engaged in gradual self-destructive behavior tend to deny their eventual death, usually believing that they can assume control at any time. This fantasy of control, although it relieves anxiety, also helps to perpetuate the behavior. When the sense of self-worth is extremely low, self-destructive behavior reaches its peak. At that point, suicidal behavior is likely. Suicide implies a loss of the ability to value the self at all.

Appraisal of Stressors

The specific prediction of suicide is not possible. However, one may foresee the likelihood of a suicidal act based on an assessment of a person's risk factors for suicide and behavior. **It is essential for the nurse to assess each patient for the suicidal risk factors** listed in Box 19-3. Risk factors for suicide in special populations are presented in Box 19-4.

BOX 19-4 RISK FACTORS FOR SUICIDE IN SPECIAL POPULATIONS

Hospitalized Depressed Patients
- High levels of anxiety
- First week of admission
- First month after discharge

Elderly Patients
- Death of a loved one

Patients with Alcoholism
- Loss of a close relationship in the previous 6 weeks
- Concurrent use of other drugs
- Late in the course of illness

Depressed Adolescents
- Loss of a significant relationship
- Co-morbid substance abuse
- Prior suicide attempt
- Family history of major depression
- Previous antidepressant treatment
- History of legal problems
- Handgun available in the house

QUALITY AND SAFETY ALERT

- The best predictor of suicide is a previous suicide attempt.

Coping Resources

Patients with chronic, painful, or life-threatening illnesses may engage in self-destructive behavior. Often these people consciously choose to kill themselves. Quality of life becomes an issue that overrides quantity of life. An ethical dilemma may arise for nurses who become aware of the patient's choice to engage in this behavior, which is often called *rational suicide*. The question of how to resolve this conflict has no easy answer. Nurses must resolve the conflict according to their own belief system.

Self-destructive behavior also is related to many social and cultural factors. The structure of society has a great influence on the individual. Society may either help and sustain individuals or lead them to self-destruction (Box 19-5).

Social isolation can lead to loneliness and can increase a person's vulnerability to suicide. People who are actively involved with others in their communities are more able to tolerate stress. Those who do not participate in social activities are more likely to turn to self-destructive behavior. Religious involvement is particularly supportive to many people during difficult times. **Factors that protect against suicide are presented in Box 19-6.**

Coping Mechanisms

A patient may use a variety of coping mechanisms to deal with self-destructive feelings, including **denial**, **rationalization**, **regression,** and **magical thinking.** These coping mechanisms may stand between the person and self-destruction.

BOX 19-5 A PATIENT SPEAKS

The following are notes left by patients who committed suicide.

- *Please forgive me and please forget me. I'll always love you. All I have was yours. No one ever did more for me than you; oh please pray for me, please.*
- *To Whom It May Concern,*
  I, Mary Smith, being of sound mind, do this day make my last will as follows: I bequeath my rings, diamond and black opal to my daughter-in-law, Doris Jones, and any other of my personal belongings she might wish. What money I have in my savings account and my checking account goes to my dear father, as he won't have me to help him. To my husband, Ed Smith, I leave my furniture and car.
- *I hate you and all of your family and I hope you never have peace of mind. I hope I haunt this house as long as you live here and I wish you all the bad luck in the world.*
- *Dear Daddy:*
  Please don't grieve for me or feel that you did something wrong, you didn't. I'll leave this life loving you and remembering the world's greatest father. I'm sorry to cause you more heartache, but the reason I can't live anymore is because I'm afraid. Afraid of facing my life alone without love. No one ever knew how alone I am. No one ever stood by me when I needed help. No one brushed away the tears. I cried for "help" and no one heard. I love you Daddy, Jeannie.

BOX 19-6 PROTECTIVE FACTORS AGAINST SUICIDE

- Ability to cope with stress
- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts
- Ongoing or continuing sense of hope in the face of adversity

From U.S. Public Health Service: *The Surgeon General's call to action to prevent suicide*, Washington, DC, 1999, U.S. Public Health Service.

They defend the person from strong emotional responses to life events that are a serious threat to the ego. If they are removed, underlying depression will become overt and may lead to suicidal behavior.

Suicidal behavior indicates the imminent failure of the coping mechanisms. A suicide threat may be a last-ditch effort to get enough help to be able to cope. Completed suicide represents the total failure of adaptive coping mechanisms.

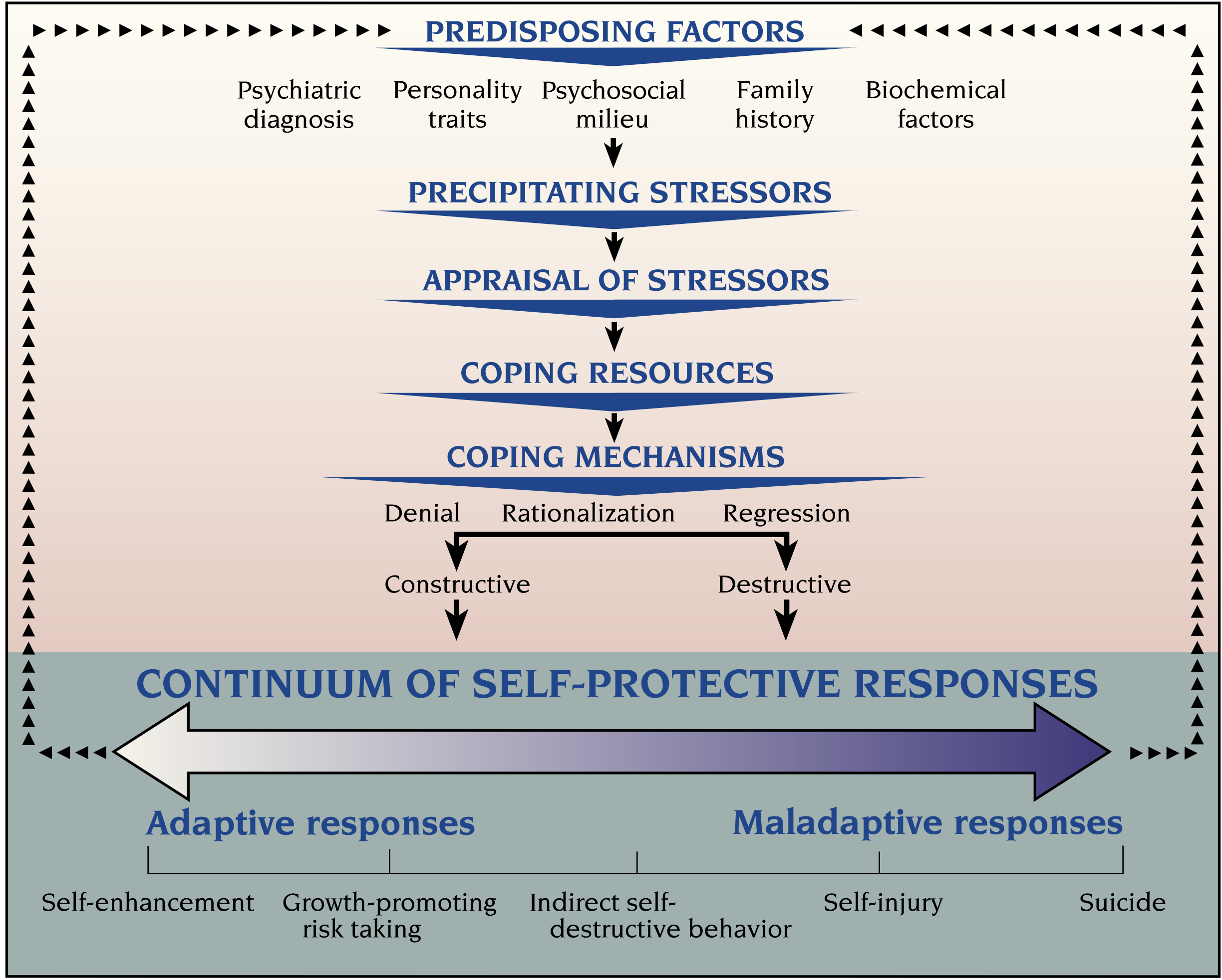

FIG 19-4 The Stuart Stress Adaptation Model as related to self-protective responses.

DIAGNOSIS

Nursing Diagnoses

When considering the nursing diagnosis of self-destructive behavior, the nurse must incorporate information about the seriousness and immediacy of the patient's harmful activity. The nurse must consider the information obtained in the assessment to identify accurately the patient's need for nursing intervention (Figure 19-4).

Validation of the nursing diagnosis with the patient is essential. However, denial is a prominent defense associated with most self-destructive disorders. The patient may not be able to agree with a statement that confronts this behavior. The primary concern is to communicate, through the diagnosis, the level of protection the patient needs.

Primary NANDA International (NANDA-I) nursing diagnoses related to maladaptive self-protective responses are risk for suicide, self-mutilation, noncompliance, and risk for self-directed violence. Because of the nature of the disorders associated with self-destructive behavior, other nursing diagnoses are often applied in the care of these patients. Examples of expanded nursing diagnoses related to self-protective responses are presented in the Detailed Diagnoses table (Table 19-2).

> **QUALITY AND SAFETY ALERT**
> - In the case of self-destructive behavior, caution is recommended in determining the level of risk.
> - It is better to overestimate the patient's level of risk than to allow serious injury to occur.

Medical Diagnoses

Suicidal behavior is not identified as a separate diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders,* ed 4, text revision (*DSM-IV-TR*; American Psychiatric Association, 2000). However, several medical diagnostic classifications of the *DSM-IV-TR* include actual or potential self-destructive behavior among their defining criteria.

The medical diagnoses in which this behavior is listed as possible include **anxiety disorders, bipolar disorder, major depression, noncompliance with treatment, schizophrenia, and substance use disorders.**

TABLE 19-2 NURSING DIAGNOSES RELATED TO *Self-Protective Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Risk for suicide	Risk for suicide related to loss of girlfriend, as evidenced by discussion of death and social withdrawal
Self-mutilation	Self-mutilation related to feelings of tension and worthlessness, as evidenced by cutting of arms and legs
	Self-mutilation related to command hallucinations, as evidenced by dissection of calf
Noncompliance	Noncompliance with taking antihypertensive medication related to asymptomatic behavior, as evidenced by unchanged elevation of blood pressure
	Noncompliance with 1800 calories/day diabetic diet related to denial of illness, as evidenced by gain of 10 pounds since last clinic visit
Risk for self-directed violence	Risk for self-directed violence related to loss of spouse, as evidenced by purchase of a gun and discussions of death
	Risk for self-directed violence related to phencyclidine (PCP) abuse, as evidenced by extreme psychotic disorganization and lack of body boundaries

OUTCOMES IDENTIFICATION

The **expected outcome** when working with a patient with maladaptive self-protection responses is as follows: ***The patient will not physically harm himself or herself.***

Careful setting of priorities is necessary with the self-destructive patient. **Highest priority should be given to preservation of life.** The nurse must identify goals related to immediately life-threatening behavior. For example, the actively suicidal person must first be prevented from acting on impulses.

In dealing with self-destructive behavior, the nurse and the patient may appear to have incompatible goals. Suicidal patients may resist attempts to protect them and may actively try to evade their observers. However, most of these patients have some ambivalence.

The nurse, in setting positive, life-preserving goals, is appealing to the healthy part of the person's self that wants to survive and be better able to cope with life. The very act of seeking help is an expression of this healthy aspect of the personality. The positive attitude of the nurse in setting constructive goals conveys a sense of hope to a patient who may be feeling hopeless. **Communicating hope is often the most therapeutic element in any nursing intervention with a suicidal patient.**

BOX 19-7 NOC OUTCOME INDICATORS FOR SUICIDE SELF-RESTRAINT

Expresses feelings
Expresses sense of hope
Maintains connectedness in relationships
Obtains assistance as needed
Verbalizes suicidal ideas
Controls impulses
Refrains from gathering means for suicide
Refrains from giving away possessions
Refrains from inflicting serious injury
Refrains from using nonprescribed mood-altering substances
Discloses plan for suicide if present
Upholds suicide contract
Maintains self-control without supervision
Refrains from attempting suicide
Obtains treatment for depression
Obtains treatment for substance abuse
Reports adequate pain control for chronic pain
Uses suicide prevention resources
Uses social support group
Uses available mental health care services
Plans for future

From Moorhead S et al, editors: *Nursing outcomes classification (NOC),* ed 4, St Louis, 2008, Mosby.
NOC, Nursing outcomes classification.

Outcome indicators related to suicide self-restraint from the Nursing Outcome Classification (NOC) project are presented in Box 19-7 (Moorhead et al, 2008).

PLANNING

The nursing care plan for the person with self-destructive behavior must focus first on protecting the patient from harm. In addition, the plan must address the factors that contributed to the patient's dangerous behavior. Later, the nurse can focus on the development of insight into the suicidal behavior and substitution of healthy coping mechanisms.

Suicidal patients can be treated in a variety of settings. The decision about which setting is most appropriate for a given patient is based on the assessment of risk (Mellesdal et al, 2010). The algorithm presented in Figure 19-5 begins with the issue of the nature of the suicidal ideation. **People who seem very intent and who have a specific plan for action and a lethal method should be admitted to an inpatient setting where they can be monitored closely.**

Despite greater awareness of suicide, prevention efforts, and effectiveness of interventions, success in treating suicidal behavior has been limited. Individuals seen in emergency settings after a suicide attempt are difficult to engage in treatment: up to 50% refuse outpatient care, and up to 60% drop out after one session (Lizardi and Stanley, 2010).

Treatment engagement is an important but often neglected aspect of care. **Motivational interviewing** (see Chapter 2) may improve engagement among suicide attempters. Brief interventions may be used in ED settings. Follow-up has also

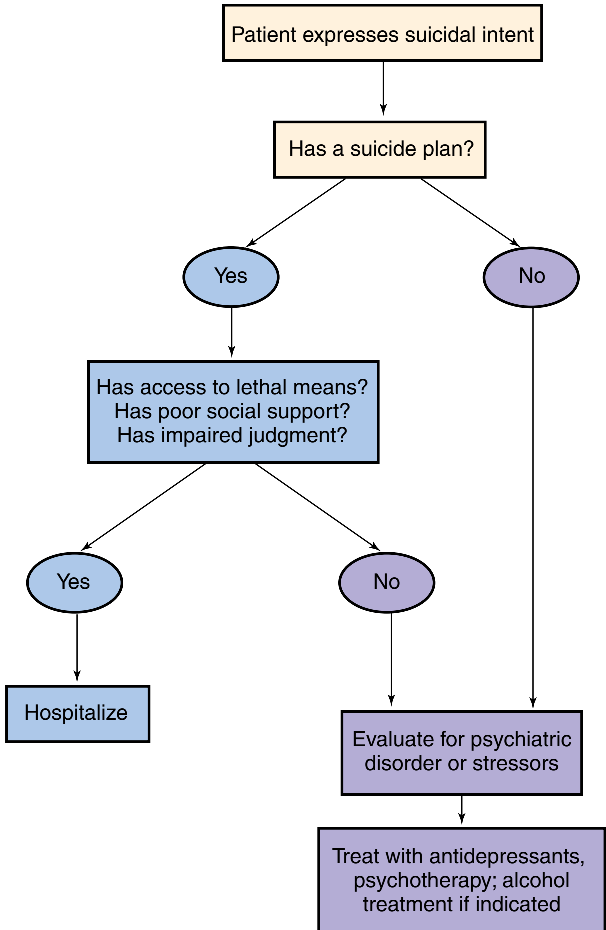

FIG 19-5 Clinical algorithm for planning treatment for the suicidal patient.

been a neglected aspect of care and can help reduce suicidal behavior.

Another important factor in determining the treatment setting is the patient's judgment. Anything that impairs a patient's judgment and rational decision-making capacity greatly increases the risk of a suicide attempt and is a good indication for inpatient treatment.

A final issue is the availability of a responsible family member or close friend who is willing to stay with the patient throughout the immediate crisis until the suicidal ideation abates. Sometimes this requires several family members taking shifts and watching the patient around the clock. In the final analysis, the safety of the patient is the top priority.

IMPLEMENTATION

Nurses must first consider their own responses to people who are trying to harm themselves (Mangnall and Yurkovich, 2008; Bosman and van Meijel, 2008). It can be difficult for a person who is happy and involved in life to imagine the depth of despair that leads to suicidal impulses or the lack of caring for the self that results in physically, psychologically, and socially damaging behavior, even if not immediately lethal.

On the other hand, nurses who are depressed and dissatisfied with their own lives may feel threatened by interactions with suicidal patients. These nurses may overidentify with the patient, which limits their ability to help. A therapeutic approach is empathic and nonjudgmental, with subjective responses limited by awareness of one's own feelings and attitudes.

All possible efforts must be made to protect patients and to motivate them to choose life. Nurses should align themselves with the patients' wish to live and then help them be responsible for their own behavior. However, nurses also must understand that some patients will choose death despite their best efforts to intervene. Nurses therefore must develop a realistic understanding of the patient's responsibility for life and accept the possibility of losing a suicidal patient even when the best nursing care is provided.

> **Critical Reasoning** A friend tells you that suicidal patients are intent on dying and will ultimately succeed despite all interventions. How would you respond?

Protection and Safety

The highest-priority nursing activity with self-destructive patients is to protect them from inflicting further harm on themselves and, if suicidal, from killing themselves. Lawsuits related to suicides began to increase in the 1980s and are now one of the most common reasons for litigation against nurses and hospitals. Suicide is the number one type of sentinel event reviewed by The Joint Commission. Psychiatric nurses must have a solid basis from which to approach risk reduction and suicide prevention (Cardell et al, 2009).

> **QUALITY AND SAFETY ALERT**
>
> Common avoidable causes of suicide in hospitals include the following:
> - Inadequate suicide assessment of the patient at intake, absent or incomplete reassessment, and lack of assessment at discharge
> - Unsafe environment of care
> - Insufficient orientation or training, incomplete competency review or credentialing, and inadequate staffing levels
> - Incomplete communication among caregivers
> - Inadequate care planning or care provision

The message of protection and safety is conveyed to patients verbally and nonverbally. Verbally, patients are told of the nurse's intention not to allow harm to come to them. The nurse might say, "I understand that you are feeling impulses to harm yourself. I will be here with you to help you control those impulses. I will do whatever is necessary to protect you and keep you safe. I'd like to talk with you about how you are feeling whenever you are able to share that with me."

The nonverbal communication should reinforce and agree with the verbal. Obviously, dangerous objects such as belts,

sharp implements, glass, and matches should be taken from the suicidal patient. It is impossible to make an environment perfectly safe. Even walls and floors can cause injury if patients throw themselves against them. However, the removal of dangerous objects gives a message of concern.

One-to-one observation of the suicidal patient also communicates caring. This observation should be carried out sensitively, with the nurse neither hovering over nor remaining aloof from the patient. The patient's nonverbal cues can guide the one-to-one interaction. It is important to remain alert until the mental health team and the patient agree that the self-destructive crisis is over.

Suicidal patients may appear to be feeling much better immediately before making an attempt. This is due to the feeling of relief experienced when the decision has been made and the plans finalized. Nurses have been fooled by this behavior pattern, and have relaxed their vigilance, only to have patients kill themselves when they are allowed to be alone for a moment.

An important aspect of protecting the patient is coming to an agreement about the nature of the therapeutic relationship. Often this has involved the use of contracts in which the patient agrees not to inflict self-harm for a specified period of time. Typically, the patient further agrees to contact the clinician if the patient is tempted to act on self-destructive impulses and to give away any possibly lethal articles, such as guns or pills.

Although no-suicide contracts have been used in clinical practice for many years, they have found to be NOT effective (Lynch et al, 2008; Reid, 2010)**.** One of their major limitations is that they are subjective rather than objective. In fact, studies of suicide attempters and inpatient suicides have shown that a significant number of these patients had a no-suicide contract in place at the time of their suicidal act. No-suicide contracts may aid in establishing a therapeutic alliance, but they are overvalued as a clinical or risk management technique.

QUALITY AND SAFETY ALERT

- No-suicide contracts should not be used.
- A thorough suicide risk assessment using a formal suicide assessment tool is an essential part of nursing care.
- The nurse must ensure that any lethal means of injury are removed from the patient's access. This may require asking family members or neighbors to intervene and remove the lethal articles so that they are not accessible to the patient.

The nurse can take additional steps to ensure the safety of a suicidal patient.

- **The patient should be supervised at all times.** The patient should never be left alone.
- **The nurse should monitor any medications the patient receives.** For example, tricyclic antidepressants are fatal in overdose. This suggests that the patient should have only a few days' supply if being treated with them as an outpatient. In contrast, the newer selective serotonin reuptake inhibitor (SSRI) antidepressants are safer in the event of an overdose. The nurse also should understand that the benzodiazepines may disinhibit a patient, thereby supporting impulsive behavior and resulting in less control over self-destructive impulses (see Chapter 26).

Critical Reasoning Your depressed patient has been prescribed a tricyclic antidepressant because it is less expensive than the newer antidepressants. However, she lives in a rural area and cannot have the prescription filled every few days. You are worried about potential overdose. What alternatives can you identify?

Finally, patients should not be discharged simply because they say that they feel better. Rather, there must be good reason to believe that the dangerous conditions that led to the attempt have improved and that the patient has a safe, real, and stable environment (Reid, 2009).

Increasing Self-Esteem

Self-destructive people have low self-esteem. The nurse may intervene by treating the patient as someone deserving attention and concern (Kool et al, 2009). Positive attributes of the patient should be recognized with genuine praise. An attempt to make up reasons to praise the patient is usually recognized as artificial and lowers the patient's self-esteem. The message is that the patient is so bad that one has to search for positive characteristics.

When getting to know the patient, the nurse should be alert to strengths that can be built on to provide the patient with positive experiences. **It is also important to reinforce reasons for living and to promote patients' realistic expectations based on their strengths.** Chapter 17 describes interventions the nurse can use to enhance a patient's self-esteem.

Regulating Emotions and Behaviors

Nursing care should be directed toward helping patients become aware of their feelings, label them, and express them appropriately. Anger is often a difficult feeling for these patients. The angry patient must be helped to deal constructively with anger through learning and using anger management skills (see Chapter 28). Anxiety also can be overwhelming. Chapter 15 discusses anxiety-reducing interventions.

It may be helpful to assist patients with self-destructive responses to explore the predisposing and precipitating factors influencing their behavior. **Once the acute crisis is over, the nurse can help the patient understand high-risk times and triggers, the feelings that are stimulated, dysfunctional thinking patterns, and resultant maladaptive coping responses.** Plans can then be made to test new coping mechanisms. For example, during times of stress, the patient can do the following:

- Increase involvement with others.
- Initiate a physical activity.

TABLE 19-3 PATIENT EDUCATION PLAN

Compliance Counseling

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Assess patient's knowledge of self-care activities.	Ask patient to describe usual diet, exercise, and medication patterns. Validate whether described behaviors match self-care instruction received in the past.	Patient describes unusual behavior. Patient repeats directions.
Identify areas in which patient behavior differs from healthy self-care practices.	Describe healthy self-care behavior to patient. Provide written patient education materials. Encourage patient to describe reasons for not performing recommended self-care.	Patient discusses compliance problems.
Discuss alternative approaches to self-care.	Help patient identify alternative self-care behaviors that would be more acceptable. Enable patient to talk about feelings related to illness and treatment regimen.	Patient decides on different approach and shares feelings related to illness.
Agree on a reward for compliant behavior.	Ask patient what reward the patient would choose for taking good care of self.	Patient identifies reward.
Reinforce.	Praise patient for making a commitment to a healthier lifestyle.	Patient recognizes renewed commitment to self-care.

- Engage in relaxation and tension-reducing activities.
- Process feelings by talking with someone or writing in a journal.

These and other examples of behavior change strategies are described in Chapter 27.

Mobilizing Social Support

Self-destructive behavior often reflects a lack of internal and external resources. **Mobilization of social support systems is an important aspect of nursing intervention.** Significant others have many feelings about the patient's self-destructive behavior. They need an opportunity to express their feelings and make realistic plans for the future.

Family members must be made aware of control issues and helped to encourage self-control by the patient. Both the patient and the family may need help to see that caring can be expressed by fostering self-care, as well as by providing care (Alexander et al, 2009).

Families of suicidal patients may be frightened of future suicidal activity. They need to be aware of behavioral clues that suggest suicidal thoughts and of community resources that can help with crises. Suicidal behavior often recurs. False reassurance should be avoided. A better approach is to foster improved communication and an ability to cope in the family. The nurse may help people sort out their feelings and may want to refer significant others for individual intervention or family therapy.

It has been estimated that each suicide intimately affects at least six other people. **If a patient commits suicide, it is important to intervene with the survivors, who may themselves be at risk for suicidal behavior.** They need someone who can listen to them and let them know that their feelings are not abnormal. They need to be able to discuss their beliefs about why the death occurred and helped to find some meaning in the experience. Family members should be encouraged to support one another and to seek help for their own feelings and responses (McDaid et al, 2008; Mitchell et al, 2009). Survivors are often stigmatized and may need assistance in dealing with this.

Community resources are important for the long-term care of the self-destructive person. Self-help groups may provide the recovering patient with needed peer support. Family therapy may help in the reintegration of a family group that has been disrupted by the patient's recent experiences. Community health nurses, clergy, and other community helpers can provide the patient and family with day-to-day support. The nurse may be active in explaining resources to the patient and initiating referrals to other agencies.

Patient Education

Patient education is an important nursing intervention. Education must be timed carefully, because patient readiness is essential if behavior change is to result. Patients who are noncompliant with prescribed health care regimens may not understand the nature of their problem. The nurse should assess the patient's knowledge and initiate appropriate teaching. A Patient Education Plan for a patient who is noncompliant with medical treatment is presented in Table 19-3.

Many patients are willing to participate in self-care if it makes sense to them. Teaching ways to monitor health status may be helpful. For example, if hypertensive patients learn to check their blood pressure, they can learn to associate their health care activities with their physiological response.

Patients who are following medication regimens, such as psychotropic medication for the previously suicidal patient, should know the prescribed dosage, frequency, and side effects. Information about how to handle any future crises should be provided to the patient. If the nurse has explained the possible reason for the patient's behavior, this may be reinforced at termination of the relationship to help the patient integrate the experience into his

BOX 19-8 GOALS OF THE NATIONAL STRATEGY FOR SUICIDE PREVENTION (NSSP)

- Promote awareness that suicide is a public health problem that is preventable.
- Develop broad-based support for suicide prevention.
- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, or suicide prevention services.
- Develop and implement suicide prevention programs.
- Promote efforts to reduce access to lethal means and methods of self-harm.
- Implement training for recognition of at-risk behavior and delivery of effective treatment.
- Develop and promote effective clinical and professional practices.
- Improve access to and community linkages with mental health and substance abuse services.
- Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
- Promote and support research on suicide and suicide prevention.
- Improve and expand surveillance systems.

From U.S. Department of Health and Human Services (USDHHS): *National strategy for suicide prevention: goals and objectives for action*, Rockville, Md, 2001, USDHHS, Public Health Service.

or her self-concept. Helping a patient work through self-destructive behavior can be an extremely rewarding aspect of psychiatric nursing.

Suicide Prevention

The National Strategy for Suicide Prevention (NSSP) (U.S. Department of Health and Human Services, 2001) was developed with the combined work of advocates, clinicians, researchers, and survivors. It laid out a framework for action and an array of services and programs to be set in motion for suicide prevention. The goals of the NSSP are listed in Box 19-8. Nurses also need to be aware of several specific strategies that may help prevent suicide and are listed in Box 19-9.

Nurses, as the largest group of health care providers, can play a major role in suicide prevention, education, and assessment (Aflague and Ferszt, 2010). Structured clinical training in evidence-based risk assessment and firearm injury prevention can improve detection, documentation, and management of patients at risk for suicide (McNiel et al, 2008; Tsai et al, 2011; Khubchandani et al, 2011). In a similar way, suicide awareness programs in the community can build resilience and social supports (Tsai et al, 2010).

Educational measures and suicide programs in schools are other helpful interventions. These programs try to break down taboos about suicide and describe the symptoms of depression to students, teachers, and parents. The development of prevention clinics in communities also may be helpful. Such clinics offer expert clinical assessment and treatment combined with strong community links, increased social supports, family education, and hotlines staffed with mental health professionals.

BOX 19-9 SUICIDE PREVENTION STRATEGIES

- Gun control and decreased availability of lethal weapons
- Limitations on the sale and availability of alcohol and drugs
- Increased public and professional awareness about depression and suicide
- Less attention to and reinforcement of suicidal behavior in the media
- Establishment of community-based crisis intervention clinics
- Campaigns to decrease the stigma associated with psychiatric care
- Increased insurance benefits for psychiatric and substance abuse disorders

Another effective suicide prevention strategy is telephone services that provide home assistance, needs assessment, and emotional support. In addition, education of the public and health care providers is needed to increase knowledge about the early warning signs of self-destructive behavior and implement effective treatment strategies.

A Nursing Treatment Plan Summary for patients with maladaptive self-protective responses is presented in Table 19-4.

EVALUATION

Evaluation of the nursing care of the self-destructive patient requires careful daily monitoring of the patient's behavior. Patient involvement in evaluation of progress can provide reinforcement and an incentive to work toward a goal. Modifications of the care plan are often necessary as patients reveal more of themselves and their needs to the nurse.

Unfortunately, self-destructive behavior tends to recur (Jacobs and Bostwick, 2009). Nurses sometimes become discouraged and angry with patients who return with the same behavior. When this occurs, nurses may be caught in the trap of feeling responsible for patient behavior. Nurses who have given the best nursing care possible have done as much as they can for the patient. It is impossible to change the total life situation for the patient. The nurse can help only to identify alternative behaviors and provide encouragement for change. If the patient returns, the nursing process must begin again with an attitude of hope that this time the patient will learn and grow more and be better able to live a satisfying life.

A final issue related to suicidal behavior is the impact of a completed suicide on the clinical staff. Psychiatric nurses will inevitably experience a patient suicide sometime in their careers. When a patient commits suicide, staff response can split the interdisciplinary treatment team. Thus interventions must be aimed not only at helping the individual clinician to

heal but also at preserving the integrity of the treatment team. The following activities can help this process:

- Have an immediate review of the event by the treatment team to acknowledge feelings and plan care for the other patients.
- In an inpatient setting, hold a patient community meeting to help patients accept the reality of the loss.
- Call an additional meeting of the treatment team 2 or 3 days after the suicide to further process the suicide.
- Conduct an in-house memorial service to facilitate grieving.
- Participate in a continuous quality improvement critical incident review to help staff members understand the suicide and objectively review the treatment.
- Identify opportunities for continuous process improvement.
- Acknowledge anniversary reactions.

If a variety of these activities are provided to promote healing of the treatment team, recovery can occur and growth can result.

TABLE 19-4 NURSING TREATMENT PLAN SUMMARY

Maladaptive Self-Protective Responses

Nursing Diagnosis: Risk for suicide

Expected Outcome: The patient will not physically harm self.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will not engage in self-injury activities.	Observe closely. Complete a suicide risk assessment. Remove harmful objects. Provide a safe environment. Provide for basic physiological needs. Do not leave the patient alone.	Highest priority is given to life-saving patient care activities. The patient's behavior must be supervised until self-control is adequate for safety.
The patient will identify positive aspects of self.	Identify patient's strengths. Encourage patient to participate in activities that patient likes and does well. Encourage good hygiene and grooming. Foster healthy interpersonal relationships.	Self-destructive behavior reflects underlying depression related to low self-esteem and anger directed inward.
The patient will implement two adaptive self-protective responses.	Facilitate the awareness, labeling, and expression of feelings. Help patient recognize unhealthy coping mechanisms. Identify alternative means of coping. Reward healthy coping behaviors.	Maladaptive coping mechanisms must be replaced with healthy ones to manage stress and anxiety.
The patient will identify two social support resources that can be helpful.	Help significant others communicate constructively with patient. Promote healthy family relationships. Identify relevant community resources. Initiate referrals to community resources.	Social isolation leads to low self-esteem and depression, perpetuating self-destructive behavior.
The patient will be able to describe the treatment plan and its rationale.	Involve patient and significant others in care planning. Explain characteristics of identified health care needs, nursing care needs, medical diagnosis, and recommended treatment and medications. Elicit responses to nursing care plans. Modify plan based on patient feedback.	Understanding of and participation in health care planning enhance compliance.

LEARNING FROM A CLINICAL CASE OUTCOME

1. What are Kara's predisposing risk and protective factors?

Her risk factors include self-injury, talk of suicide, loss of her boyfriend, depressed mood, hostility, secretiveness, low self-esteem, impaired problem-solving, social withdrawal, poor personal hygiene, and weight gain. She also displays hopelessness and impulsivity (cutting self-injury behavior). Her protective factors include her previous academic success and social network, maternal support, and her ongoing relationship with the pediatric primary care practice.

2. What behaviors suggest changes in her neurotransmitters?

She had a persistent change in mood, does not experience pleasure, and began to cut herself. She has isolated herself and has become withdrawn. Her cognitive performance has declined significantly. These changes in behavior indicate a possible change in the neurotransmitter serotonin.

3. What is her precipitating stressor and maladaptive coping mechanism?

The precipitating stressor is the loss of the relationship with her boyfriend and cyber-bullying by schoolmates. This needs to be reported to her school, because most schools take cyber-bullying and suicide contagion seriously and have a plan for intervention. She is using self-inflicted injury as a maladaptive coping mechanism, keeping it concealed by cutting in areas of her body that can easily be covered by her clothing.

LEARNING FROM A CLINICAL CASE OUTCOME—cont'd

4. What would be the goals of her treatment?

First, she must be kept safe, hospitalized, and placed on suicide precautions until her impulsivity, mood, and hostility improve. The staff will work with her to identify strengths and build her sense of self-worth. Antidepressant medication will help to improve the availability of neurotransmitters, allowing her to review her thinking patterns and the alternatives available to her. The staff is aware that when she begins to feel better she will be at high risk for suicide. Therefore her follow-up care must be carefully planned with full family support and a rapid transition to outpatient therapy.

Case Outcome

She was treated in an inpatient adolescent unit of a psychiatric hospital and successfully worked on goals to realistically assess and improve her self-concept. However, she required rehospitalization several months later when her mother discovered her bingeing and purging behavior. Her adolescence was difficult, with intermittent binge eating and drinking. By the age of 18, she had improved with the help of ongoing psychiatric care. She began attending the nearby community college and was a successful student. She learned to believe in herself again and was looking forward to a successful future. She was happy to leave her adolescence behind.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Philip Macaione, BS, RN

After 18 years of acute care nursing practice with a specialty in an intensive care unit, emergency room, and trauma nursing, I wanted a new challenge and began psychiatric nursing practice. Having had the opportunity to associate professionally with hundreds of patients over the years who were experiencing critical and life-threatening situations, I felt well equipped to deal with psychiatric emergencies until that seemingly routine day shift on an inpatient adult unit.

Ms. W had been committed to our unit as a dual-diagnosis patient. She was referred from our county emergency room. She had been found near-stuporous, wandering the city streets, and she was thought to be homeless. She was addicted to heroin, cocaine, and alcohol. She also had multiple personality disorder, anxiety disorder, major depression, and schizotypal disorder. She was 6 feet 2 inches tall and weighed more than 300 pounds.

Her hospital course over the past few days had been highlighted by her continuous acting-out behaviors. These included disrupting the milieu; verbal, physical, and sexual threats to others; seeking the medication of other patients; noncompliance with her treatment plan; and defiance of unit rules and policies. Needless to say, she was a nursing challenge and required a firm, consistent approach by the staff and a constant vigil over her behavior.

One morning her behavior deteriorated to the point where staff intervened by placing her in scrubs and escorting her to the seclusion room to maintain her safety and that of the other patients. I explained to her that during this time-out I would help her begin processing her behavior and identifying more effective coping strategies. I gave her a *prn* (as needed) medication for her agitation and anxiety and suggested that she begin writing her thoughts and feelings down in her journal. After about one-half hour, she verbally contracted for safety, seemed aware of her actions, and was resting quietly on her mattress. She also said that she was "feeling much better now" and thanked me for my help. I decided to put her on 15-minute checks but to leave her in open-door seclusion until we agreed that she was ready to return to the milieu. I remember thinking, "Wow, I did a good job with this patient, and she is really making progress."

After years of nursing practice, I notice that I have developed a sixth sense that tells me when something is just not right. On the surface, Ms. W seemed to be in control, but my sixth sense drew me back to the seclusion room only minutes after I had left her. As I walked into the room, I did a double take and thought to myself, "This can't be happening." Unfortunately, it was. Ms. W had managed, in the moments that had elapsed since I had left her side, to tear her journal into small pieces, place the scraps between her legs, and ignite them with a cigarette lighter we later discovered she had hidden in her vagina.

She was madly waving the fire between her legs to produce more flames. Her scrub pants and mattress were now on fire. At this point I just reacted. I ran to her, pulled away the mattress, patted down the flames on her pants, and yelled for help. The smoke alarm had gone off, and within seconds other staff members arrived. I instructed them to remove the patient to the corridor and give her first aid. This was no easy task given the patient's size and level of agitation. I then activated the fire procedure, grabbed the fire extinguisher, and returned to the seclusion room. I pulled the pin of the fire extinguisher, aimed, and released the foam. Within seconds, the fire was extinguished. The fire department had now arrived and moved in to deal with the smoldering mattress. Ms. W suffered no significant injuries.

I learned a great deal from this incident and think I am a better nurse because of it. The staff response and teamwork in reacting to this crisis were extraordinary. I also think that the many years of critical decision-making opportunities afforded me throughout my nursing practice made me well equipped to handle this emergency. Most of all, I have a greater appreciation and respect for the sixth sense of nurses, which may be the mark of truly competent nursing care.

CHAPTER IN REVIEW

- The continuum of self-protective responses ranges from the most adaptive states of self-enhancement and growth-promoting risk taking to the maladaptive responses of indirect self-destructive behavior, self-injury, and suicide.
- Direct self-destructive behavior is any form of suicidal activity, such as suicide ideation, threats, attempts, and completed suicide. Indirect self-destructive behavior is any activity that is harmful to the person's physical well-being and that potentially may result in death.
- Low self-esteem leads to depression, which is always present in self-destructive behavior.
- Suicide is the eleventh leading cause of death in the United States. The highest suicide rate for any group in the United States is among people older than age 80 years. Suicide is the third leading killer of young people. The majority of completed suicides are committed by males, even though women attempt suicide twice as often as men.
- About one half of patients do not comply with their health care treatment plan. This level of noncompliance is the same for those with physical illnesses and those with psychiatric illnesses.
- Self-injury is the act of deliberate harm to one's own body. Usually the lethality of self-injury is low, and patients who self-injure typically want relief from the tension they feel rather than to kill themselves.
- Suicide ideation is the thought of self-inflicted death, either self-reported or reported to others.
- A suicide threat is a warning, direct or indirect, verbal or nonverbal, that a person is planning to take one's own life.
- A suicide attempt is any self-directed actions taken by a person that will lead to death if not stopped. All suicide threats and attempts must be taken seriously. Vigilant attention is needed when the person is planning or tries a highly lethal method. Assessment of the suicidal person also includes whether the person has made a specific plan and whether the means to carry out the plan are available.
- The most suicidal person is one who has a highly lethal method, a specific plan, and the means readily available.
- Completed suicide, or simply suicide, is death from self-inflicted injury, poisoning, or suffocation where evidence indicates that the decedent intended to kill oneself.
- Directly questioning a patient about suicidal thought and plans will not cause the patient to take suicidal action.
- It is essential that nurses have a systematic way of evaluating a patient for risk of suicide. This requires the use of a standardized suicide assessment tool and safety plan. Merely asking a patient if he or she is suicidal does not meet the standard of care.
- Suicide assessments should occur regularly at critical points during hospitalization, including on admission, at discharge, and during changes in medications, treatments, mental status, and level of precautions.
- All access to lethal means of suicide must be removed.
- The four broad psychiatric disorders that put people at particular risk for suicide are mood disorders, substance abuse, schizophrenia, and anxiety disorders.
- The best predictor of suicide is a previous suicide attempt.
- The three aspects of personality that are most closely associated with increased risk of suicide are hostility, impulsivity, and depression.
- Predisposing factors for suicide include loss, lack of social supports, negative life events, and chronic medical illnesses. A family history of suicide is a significant risk factor for self-destructive behavior.
- A deficiency in serotonin (5-HT) and its metabolite, 5-hydroxyindoleacetic acid (5-HIAA), and an increase in one of the 5-HT postsynaptic receptors (5-HT_{2A}) are implicated in suicidal behavior.
- All self-destructive behaviors may be seen as attempts to escape from uncomfortable or intolerable life situations. People engaged in gradual self-destructive behavior tend to deny their eventual death, usually believing that they can assume control at any time.
- Patients with chronic, painful, or life-threatening illnesses may engage in self-destructive behavior. Self-destructive behavior is also related to many social and cultural factors.
- A patient may use a variety of coping mechanisms to deal with self-destructive feelings, including denial, rationalization, regression, and magical thinking. Suicidal behavior indicates the imminent failure of coping mechanisms.
- When considering the nursing diagnosis of self-destructive behavior, the nurse must incorporate information about the seriousness and immediacy of the patient's harmful activity. It is better to overestimate the patient's level of risk than to allow serious injury to occur. Primary nursing diagnoses are risk for suicide, self-mutilation, noncompliance, and risk for self-directed violence.
- Suicide is not identified as a separate diagnostic category in the *DSM-IV-TR*. Medical diagnostic classifications that include actual or potential self-destructive behavior are anxiety disorders, bipolar disorder, major depression, noncompliance with treatment, schizophrenia, and substance use disorders.
- The expected outcome of nursing care is that the patient will not physically harm himself or herself.
- Communicating hope is often the most therapeutic element in any nursing intervention with a suicidal patient. The nursing care plan for the person with self-destructive behavior must focus first on protecting the patient from harm. Nurses also must consider their own responses to people who are trying to harm themselves.
- Nursing interventions include protecting the patient and providing for safety, increasing self-esteem, regulating emotions and behaviors, mobilizing social support, educating the patient, and suicide prevention.
- Suicidal patients may appear to be feeling much better immediately before making an attempt.

CHAPTER IN REVIEW—cont'd

- No-suicide contracts are not effective and must not take the place of a thorough suicide risk assessment using a formal suicide assessment tool. The patient should be supervised at all times and never left alone. The nurse also should monitor any medications the patient receives.
- Evaluating nursing care requires daily monitoring of the patient's behavior. The nurse must not become discouraged if self-destructive behavior recurs but instead approach the patient with the hope that this time the patient will grow and be able to live a satisfying life.

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CHAPTER

20

Neurobiological Responses and Schizophrenia and Psychotic Disorders

Mary D. Moller

How do I get away from you—voices? How do I leave you behind me forever? You who echo my feelings, haunt my thoughts and ravage my nights.… How do I get away from you? I sing at the top of my voice and still I hear you. I talk loud and listen to people and still I hear you. Is there a me without you? No, the answer comes loud and clear, there is no me without you. As long as I have feelings you will be my echo. As long as I have thoughts you will be the ghost. As long as there is night you will be in the darkness.

Sharon LeClaire

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LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive neurobiological responses.
2. Identify behaviors associated with maladaptive neurobiological responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to maladaptive neurobiological responses.
4. Describe coping resources and coping mechanisms related to maladaptive neurobiological responses.
5. Formulate nursing diagnoses related to maladaptive neurobiological responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to maladaptive neurobiological responses.
7. Identify expected outcomes and short-term nursing goals related to maladaptive neurobiological responses.
8. Develop a family education plan to promote adaptive neurobiological responses.
9. Analyze nursing interventions related to maladaptive neurobiological responses.
10. Evaluate nursing care related to maladaptive neurobiological responses.

People often react to the word *psychosis* with fear and uncertainty. **Psychosis** refers to the mental state of not being in touch with reality. During an episode of psychosis, the person does not realize that others are not experiencing the same things and wonders why others are not reacting in the same way.

The overall goal of nursing care is to help the patient recognize the psychosis and develop strategies to manage the symptoms and achieve recovery. It is important to remember that these are complex neurobiological brain diseases affecting one's ability to perceive and process information. The behaviors associated with psychosis are difficult to understand, are usually severe, and can be long lasting. Box 20-1 describes one person's experience with psychosis.

Critical Reasoning Read the patient's description of psychosis in Box 20-1. Focus on identifying the feelings that might be associated with these experiences.

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

He had been a star athlete, smart and witty. He finished near the top of his class and had won a fellowship to study abroad next year. He wanted to teach in Africa and work for a nonprofit agency on water purification. It seemed an interesting issue and could be the beginning of an engineering graduate degree. But he had the summer to spend with his friends. They got an apartment near the beach and took jobs either bartending or waiting tables. They partied and smoked weed together, philosophizing about life and the future. On their days off, they surfed.

But gradually he became withdrawn. He came in late at night and then slept all the next day. His friends thought maybe he had a girlfriend. His room was filthy, and he stopped shaving. Finally, one day when he was out, they went into his room and saw that he had written on the walls and taped things to them. When he came home, they asked him what it was about. He told them that people were spying on him and he was sending them messages to stop. His friends called his parents.

He was initially given the diagnosis of brief psychotic episode. But his behavior continued to deteriorate. He communicated very little and at times made little sense. However, when he was started on olanzapine, he improved. Although his trip had to be cancelled, he did start graduate school, but he could take only one course at a time, and looming deadlines made it difficult for him to cope. He eventually had to drop out. He just couldn't keep up with the complexity of the work.

Eventually the diagnosis of schizophrenia was made. He had to stop taking olanzapine because his white blood cell count fell to a low level. He never adjusted to the other medications as well. The only job he could do was working for a landscaping company, and he didn't like the work. His mother grieved for her son and the promise of his young life. Her pregnancy with him had been hard; she had caught the flu that winter, and everyone in the family had had it. His childhood had seemed normal, except that now, looking back, she realized he would never let anyone take his picture. He refused to go to camp. But he had always led his football and basketball teams to victory, so he had seemed fine. Now she knew he wasn't.

When they placed him in special rehabilitation programs, he would just walk out and come home. He was not homicidal or suicidal, so no one could stop him. He simply refused to stay there. Then at home, he just sat for hours, watching television, eating, not doing or saying anything. He was mandated by the court to take his medication, and he would cooperate with that, but otherwise he just sat for hours.

Eventually, he began taking an atypical antipsychotic medication, and his symptoms improved, but he gained about 70 pounds, became diabetic, developed heart disease, and began using drugs. A group of addicts knew when his disability check came and hit him up for money. They would buy crack, marijuana, and alcohol with his money and come back to his place to smoke and drink with him. He thought they liked him. He thought they were his friends. The auditory hallucinations came back.

Case Critical Reasoning Questions

1. What positive and negative symptoms of schizophrenia did he exhibit?
2. How did his illness affect his social and occupational functioning?
3. What problems in cognitive functioning did he exhibit?
4. What impact did his illness have on his family?
5. How was his physical health affected?
6. What behavioral strategies would help this patient and his family?
7. Make a plan for each treatment phase of the Stuart Stress Adaptation Model.

BOX 20-1 A PATIENT SPEAKS

Psychosis is real. Its main feature is a loss of consciousness of the self in such a way that I can no longer discern my relationship to the reality that my body is in. This would not be destructive, except that I have done it inadvertently; I have done it without consciousness and have not provided for my body. My body, then, goes on without me. It wanders aimlessly and does not know to keep warm in the cold. It does not know how to avoid attack by violence. It does not know to protect itself from fire and deep water and the traffic that races down the highway.

My brain comes up with fantastical ideas about who I might be, since I am not there to tell it. Perhaps I am the Queen of Hearts, or a messenger from another planet, or even Jesus Christ himself. And why not? My brain distorts the reality of the senses: Is this burner hot or cold? Is this coat wet or dry? Is this chair a chair, or what exactly is this anyway, and for that matter, what in the world are you?

My brain chooses its manifestation according to what emotions were available to it when I was in charge. Only I am not there to add my discernment, my wisdom, and my awareness according to what I have learned. My brain goes haywire then. It has no person to guide it, no captain, no helm, and no rudder. It has no fingers at the keyboard.

What is this I, then, that is gone, and where did it go? It is consciousness. It is awareness. It is the presence of the I in me. It is ego. It is my separation. It is the part in me that tells me the difference between me and the world. It is the I-ness of me that holds me upright like a spine and says, "You will not fall into this tree, or this song, or this ocean of water or air, and it will not fall into you." The I that is gone is the intelligence that says I am me, and you are you.

From Corday R: *Psychosis, the inner experience*, Boulder, Colo, 1991, Common Loon Productions.

FIG 20-1 Continuum of neurobiological responses.

BOX 20-2 IMPACT OF SCHIZOPHRENIA ON THE INDIVIDUAL AND SOCIETY

- About 1 in every 100 people has schizophrenia, or 2.5 million people in the United States.
- In three of every four cases, the disease manifests between the ages of 15 and 34 years.
- Of those with schizophrenia, 95% have it for their lifetime.
- It affects people from all cultures, races, genders, economic classes, and levels of intelligence.
- More than 75% of taxpayer dollars spent on treatment of mental illness are used for people with schizophrenia.
- People with schizophrenia occupy 25% of all inpatient hospital beds.
- An estimated one third to one half of homeless people in the United States has schizophrenia.
- Schizophrenia is a chronic illness. It is five times more common than multiple sclerosis, six times more common than insulin-dependent diabetes, 60 times more common than muscular dystrophy, and 80 times more common than Huntington disease.
- Of patients with schizophrenia, 25% do not respond adequately to antipsychotic medication.
- Suicide is attempted by 10% to 20% of patients with schizophrenia, and 5% succeed.

CONTINUUM OF NEUROBIOLOGICAL RESPONSES

The range of neurobiological responses includes a **continuum from adaptive responses, such as logical thought and accurate perceptions, to maladaptive responses, such as thought distortions and hallucinations.** The symptoms of psychosis are at the maladaptive end of this continuum (Figure 20-1).

Schizophrenia is a serious and persistent neurobiological brain disease. It results in responses that can severely impair the lives of individuals, their families, and communities. Box 20-2 presents information on the impact of schizophrenia on the individual and society.

ASSESSMENT

Schizophrenia is one of a group of psychotic disorders. Other psychotic disorders include schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder *(folie a deux)*, psychotic disorder caused by a general medical condition, and substance-induced psychotic disorder (American Psychiatric Association, 2000).

Psychosis is sometimes present in other disorders, such as depression with psychotic features, manic episodes of bipolar disorder, posttraumatic stress disorder, delirium, and organic mental disorders.

About 50% of patients with schizophrenia have a co-occurring substance use disorder, most frequently alcohol or cannabis. These patients often have more severe symptoms; increased rates of hospitalization, violence, victimization, homelessness, and nonadherence to medication; and poor overall response to medication (Schmidt et al, 2011).

QUALITY AND SAFETY ALERT

- Screening for substance use is essential among those experiencing a psychotic illness.

The word *schizophrenia* is a combination of two Greek words, *schizein*, "to split," and *phren*, "mind." **This does not refer to a "split personality,"** as in multiple personality disorder, in which separate identities are present, but to the belief that a split has occurred between the cognitive and emotional aspects of the personality.

One way of categorizing the symptoms of schizophrenia lists them as positive symptoms **(exaggerated normal behaviors)** and negative symptoms **(diminished normal behaviors)** (Box 20-3). Another system defines five core symptom clusters, presented in Figure 20-2. This model incorporates the positive and negative symptoms of schizophrenia as well as other aspects, including cognitive symptoms, mood

symptoms, and some of the social and occupational dysfunctions common in schizophrenia.

Assessment involves understanding the way in which the brain processes information from the senses and the resulting behavioral responses. These behaviors are organized into the following categories:

- Cognition
- Perception
- Emotion
- Behavior and movement
- Socialization

Behaviors

Cognition. Cognition is the act or process of knowing. It involves awareness and judgment that allows the brain to process information in a way that provides accuracy, storage, and retrieval. People with schizophrenia are often unable to produce complex logical thoughts or express coherent sentences

BOX 20-3 POSITIVE AND NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

Positive Symptoms

An exaggeration or distortion of normal brain function; usually responsive to all categories of antipsychotic drugs

Psychotic Disorders of Thinking

Delusions (paranoid, somatic, grandiose, religious, nihilistic, or persecutory themes; thought broadcasting, insertion, or control)

Hallucinations (auditory, visual, tactile, gustatory, olfactory)

Disorganization of Speech and Behavior

Positive formal thought disorder (incoherence, word salad, derailment, illogicality, loose associations, tangentiality, circumstantiality, pressured speech, distractible speech, or poverty of speech)

Bizarre behavior (catatonia, movement disorders, deterioration of social behavior)

Negative Symptoms

A diminution or loss of normal brain function; usually unresponsive to traditional antipsychotics and more responsive to atypical antipsychotics

Problems of Emotion

Affective flattening: limited range and intensity of emotional expression

Anhedonia/asociality: inability to experience pleasure or maintain social contacts

Impaired Decision Making

Alogia: restricted thought and speech

Avolition/apathy: lack of initiation of goal-directed behavior

Attentional impairment: inability to mentally focus and sustain attention

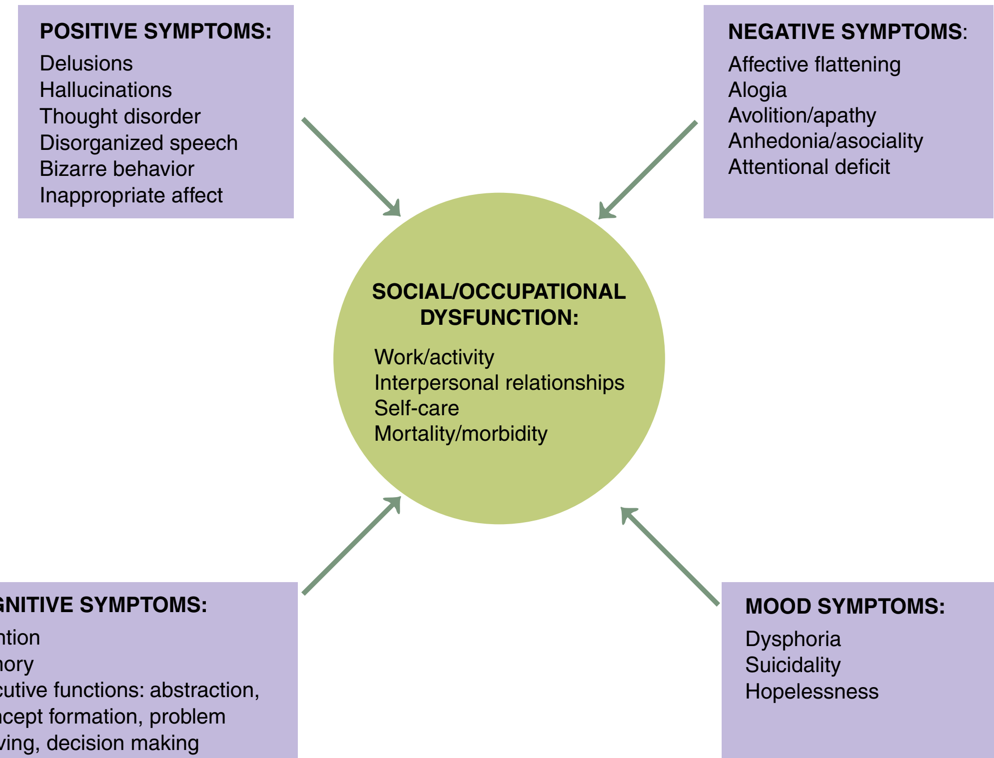

FIG 20-2 Core symptom clusters in schizophrenia. (Modified from Eli Lilly: *Schizophrenia and related disorders: a comprehensive review and bibliography slide kit,* Indianapolis, 1996, Lilly Neuroscience.)

because neurotransmission in the brain's information processing system is malfunctioning. These cognitive deficits are often present in patients who are at clinical high risk for psychosis before the onset of psychotic illness (Carrion et al, 2011).

Information processing involves the organization of sensory input by brain processes into behavioral responses (Figure 20-3). Sensory input from both internal and external senses is screened according to the focus of the person's attention and ability to remember, learn, discriminate, interpret, and organize information. The result is seen in the person's thinking, perceiving, feeling, behavior, and relatedness to others.

> **Critical Reasoning** Describe how your cognitive processing differs from that of someone of the opposite gender, an older generation, another ethnicity, and another socioeconomic class. What are the results of these differences?

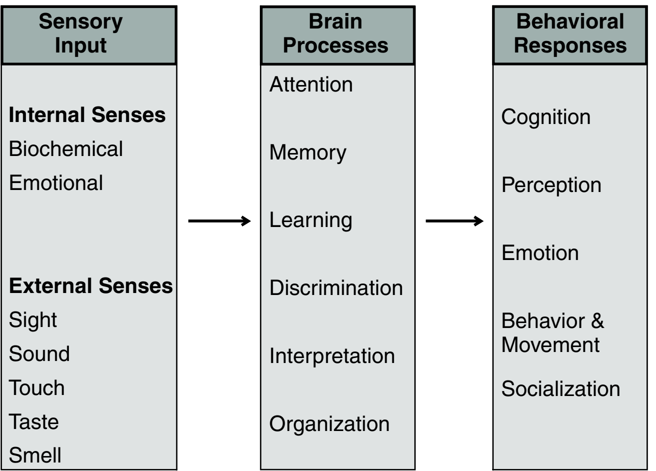

FIG 20-3 Brain information processing model.

The information processing of people with schizophrenia may be altered by brain deficits. However, interferences with cognitive function often keep people with schizophrenia from realizing that their ideas and behavior differ from those of others. This is particularly true in regard to their self-perception of worth and abilities and their interpretation of hallucinations and delusions.

People with schizophrenia tend to overestimate or underestimate their own capability. The abnormal brain dysfunction during an acute episode of schizophrenia makes it difficult for patients to realize that they need help. **This lack of insight is a neurological deficit involving the frontal and prefrontal lobes of the brain.** It is called **anosognosia,** a condition in which the patient does not recognize that there is anything wrong or that there are deficits of any kind (Amador, 2007).

Symptoms related to problems in information processing associated with schizophrenia are often called **cognitive deficits.** They include problems with cognitive functioning in all aspects of memory, attention, form and organization of speech, decision making, and thought content (Box 20-4).

Memory. **Memory** is the retention or storage of knowledge about the world. Memory is a biological function carried out in several parts of the brain. **Memory problems associated with schizophrenia can include forgetfulness, disinterest, difficulty learning, and lack of compliance.**

It is important for the nurse to understand the frustration these symptoms cause patients. They often ask whether they have done a task correctly or whether it is time to attend a group session. When people with schizophrenia repeatedly ask the same question, such as what time it is or how to get somewhere, it is important for the nurse to answer in a kind and matter-of-fact way that does not cause embarrassment or decrease the person's self-worth.

BOX 20-4 PROBLEMS IN COGNITIVE FUNCTIONING

Memory
Difficulty retrieving and using stored memory
Impaired short-term/long-term memory

Attention
Difficulty maintaining attention
Poor concentration
Distractibility
Inability to use selective attention

Form and Organization of Speech (Formal Thought Disorder)
Loose associations
Tangentiality
Incoherence/word salad/neologism
Illogicality
Circumstantiality
Pressured/distractible speech
Poverty of speech

Decision Making
Failure to abstract
Indecisiveness
Lack of insight (anosognosia)
Impaired concept formation
Impaired judgment
Illogical or concrete thinking
Lack of planning and problem-solving skills
Difficulty initiating tasks

Thought Content
Delusions
- Paranoid
- Grandiose
- Religious
- Somatic
- Nihilistic

Thought broadcasting
Thought insertion
Thought control

Attention. Attention is the ability to concentrate and focus on one activity. Disrupted attention does not allow one to pay attention, observe, focus, and concentrate on external reality. **Disturbances in attention are common in schizophrenia and include difficulty completing tasks, difficulty concentrating on work, and distractibility.** Distractibility refers to a patient's attention being drawn easily to irrelevant external stimuli such as noises, books being out of order on a bookshelf, or people passing by. In addition, the patient who is experiencing auditory hallucinations often is distracted by them and thus has problems with attention.

These problems are not constant and may fluctuate, depending on brain activity required. This creates frustration for the patient, who often complains about an inability to complete tasks because "my mind wanders." The nurse should be prepared to redirect the patient back to the task at hand. The nurse also will need to repeat directions often and in short, simple phrases.

Critical Reasoning The parents of a young man who has schizophrenia tell you that they are frustrated by their son's unwillingness to return to work. Based on your understanding of the cognitive disorders related to schizophrenia, how would you respond?

Form and organization of speech. Form and organization of speech are at the core of communication. Problems in information processing can result in incoherent communication. **Problems with form and organization of speech (formal thought disorders) may include loose associations, word salad, tangentiality, illogicality, circumstantiality, pressured speech, poverty of speech, distractible speech, and clanging.** These behaviors are described in Chapter 6. Box 20-5 presents nurse-patient dialogues that reflect problems in the form and organization of speech related to psychotic disorders.

Recognizing that speech is a sign of cognitive processing helps the nurse appreciate the difficulties a person with schizophrenia has in communicating clearly. The nurse will need to focus attention and use active listening to understand the patient. The nurse who tries to identify and clarify what a patient wants should not be afraid of offending the patient by clarifying the patient's understanding. It is essential to remember that the patient is trying to answer, no matter how difficult or bizarre the answer is. The nurses' responsibility is to identify one or two key verbal or nonverbal responses and seek validation.

Decision making. Decision making means arriving at a solution or making a choice. **Problems with decision making affect one's insight, judgment, logic, decisiveness, planning,**

BOX 20-5 FORM AND CONTENT OF SPEECH RELATED TO PSYCHOTIC DISORDERS

Loose Associations

Nurse: "Do you have enough money to buy that candy bar?"

Patient: "I have a real yen for chocolate. The Japanese have all the yen and have taken all our money and marked it. You know, you have to be careful of the Marxists because they are friends with the Swiss and they have all the cheese and all the watches and that means they have taken all the time. The worst thing about Swiss cheese is all the holes. People have to be careful about falling into holes."

Nurse: "It sounds like you are worried about your money."

Patient: "Yes, I have it all here in my wallet and you can't have it and the bank can't have it either."

Incoherence

Nurse: "What does your family like to do at Christmas?"

Patient: "I believe they took Christmas from the Russians to get all the cars into the ocean and make Jell-O. You could go and get the Christmas but you could not do it because the keylars have the fan."

Tangentiality

Nurse: "I'm interested in learning more about your landscape paintings."

Patient: "My interest in art goes back to my parents who lived on a farm in Indiana. They had lots of haystacks, kind of like they do in Ohio, but you know, the hay is different colors in different states so that gave me the ability to paint so many different colors of yellow. Some people do not really like bright yellow hay, but I do. If I make the hay really bright yellow, then I make the barns a dull red, because barns really should not be painted with bright red paint. Bright red should be saved for fire engines and fire hydrants and stop signs."

Illogical Speech

Nurse: "Do you think your medicine is helping you think more clearly?"

Patient: "I used to think my medicine helped me think. But I realized that it was me who took the medicine, so it wasn't the medicine that helped me think. Medicine cannot think, don't you realize that? Maybe you should take some medicine to help you think better. But if you do, I would have to give it to you because it is the fact I took it myself that my thinking is better, so, no, I do not think the medicine is helping me think better."

Distractible Speech

Nurse: "I would like to talk with you about your understanding of schizophrenia."

Patient: "I know it's got something to do with my brain. What perfume are you wearing? It must be from France. Is that where that picture was taken? Your hair is different than when that picture was taken. Was that about 4 years ago?"

Clang Associations

Patient 1: "I got a new shirt but the buttons became loose. Do you suppose Lucifer's buttons become lucent or are they lucid like Lucy's lucky ducky?"

Patient 2: "I want to sing ping pong that song wong kong long today hey way."

Poverty of Content of Speech

Nurse: "Do you want to go to the grocery store?"

Patient: "Yeah, uh huh, well what would I do with the, uh, the stuff that is over there on top of it? Do they, uh, have the, the, you know, the thing to do it with the wheels on the floor. I, uh, guess they should let me."

ability to carry out decisions, and abstract thought. Lack of insight is probably one of the greatest problems in schizophrenia, because patients generally do not believe that they are ill or different in any way.

Unfortunately, many clinicians confuse lack of insight with denial and treat people who have schizophrenia as if their symptoms were intentional and in their control. When decision making includes cognitive deficits, the patient makes decisions based on incorrect inferences yet cannot understand that the judgment was faulty.

Some people with schizophrenia are simply unable to make a decision. For them, life is difficult at best. They wrestle with even simple decisions such as which coffee cup to use. Plans based on faulty decision making are not successful. This symptom creates much of the frustration experienced by patients with schizophrenia.

Following through on decisions is also a problem for people who have schizophrenia. Often this is mistaken for lack of motivation. Motivation involves having a desire; patients with schizophrenia lack not the desire but the ability to follow through. People with schizophrenia typically have difficulty initiating tasks of any kind because of problems related to decision making.

Concrete rather than abstract thinking characterizes schizophrenia, particularly during acute episodes. As a result, patients often have difficulty with multiple-step commands. For example, if the nurse presents a patient with the daily schedule and at the same time gives directions about the time and place of group and occupational therapies, all the information will not be processed because the brain perceives an overload. Therefore the patient will probably miss one or more of the directions.

Another example of concrete thinking is difficulty with time management. People with schizophrenia describe this behavior as "trying to tell time with clocks that have no minute or second hands." This is why patients often are late or miss events and appointments altogether. This problem may create fear in patients who have to be alone for long periods or are required to be somewhere at specific times. Some patients have developed clever ways to determine time, such as getting watches with built-in alarms and monitoring certain television programs.

Difficulty managing money is another result of concrete thinking. People with schizophrenia often lose their ability to understand the concept of dollars and cents and are exploited by other people as a result. Patients may agree to buy items without having enough money just because they see *some* money in their wallet. They may not remember to pay for items they get in a store or may leave a restaurant without paying for the meal. Many patients get into legal trouble because of this cognitive problem.

Literal interpretation of words and symbols is one of the most problematic behaviors related to concrete thinking. People with schizophrenia have difficulty abstracting the English language. A patient's description of literal interpretation is presented in the following clinical example: "I was standing in the medication line, and the nurse asked me to take my pills. So I took the medicine cup and held it in my hand. The nurse asked me again to take my pills, and I did not know what to do. She began to lose her patience as I stood there holding the medicine cup. She then told me to put the pills in my mouth and to swallow them with the water she handed me. I could follow each of the instructions and eventually 'took my pills.'"

An example of literal interpretation of symbols is described by this patient: "It took me at least 15 minutes to walk down the street because I stopped every time the light changed from green to red. I did not understand that the traffic signal was only for cars."

Sometimes this problem advances to a point at which the patient interprets a metaphor literally, as seen in this example: "I remembered the expression 'step on a crack and break your mother's back.' One day I was walking down the street and stepped on a crack in the sidewalk. That same day my mother fell off a stepstool after getting a can of soup from the kitchen cupboard and fractured two vertebrae in her back. For 9 months I believed that I had caused this accident to happen." This is also called **magical thinking.**

Nursing implications regarding patient teaching for the person experiencing concrete thinking are profound. Consider this example: During the admission of a new patient, a nurse instructed the patient to collect a sterile urine specimen. The patient exhibited terror and strongly resisted. When the nurse gently asked the patient why he was so frightened, he replied, "I do not want to become sterile."

The role of the nurse is to help with decision making in a nonpunitive, supportive manner, recognizing that these symptoms represent neurological disabilities over which the patient has little control. The nurse functions in a rehabilitative role and needs to provide information as clearly and concretely as possible. The language used should involve simple words and short phrases that are easy to understand. The nurse also needs to seek validation regarding how instructions were heard to clarify confusion and misunderstanding.

> **Critical Reasoning** It is important to involve the patient in planning nursing care. Describe how you would accomplish this if the patient has cognitive problems that interfere with decision-making ability.

Thought content. Thought content is the final area for assessment of cognitive functioning. **Problems with thought content includes the presence of delusions in persons with psychosis.** A **delusion** is a personal belief based on an incorrect inference of external reality.

One of the mind's primary functions is to produce thoughts. Thoughts provide a sense of identity. Thoughts are a result of screening and filtering internal and external stimuli and the use of multiple feedback loops in the brain. Knowledge of the cognitive deficits already described helps the nurse understand why people with schizophrenia sometimes have beliefs different from those of other people. It also is important to realize that a delusion does not always last. It is

common for a belief to be fixed for only a few weeks or a few months, particularly in the less severe forms of schizophrenia.

The inability of the brain to process data accurately can result in paranoid, grandiose, religious, nihilistic, and somatic delusions. The delusions can be complicated further by **thought withdrawal, thought insertion, thought control, or thought broadcasting.** The various types of delusions are described in Chapter 6.

Delusions arise from one's brain physiology, current environmental stimuli, and the person's frame of reference regarding the world. Delusions can become connected to hallucinations. They may be a single thought, or they may pervade the person's entire cognitive process. They can represent a complete thought or only a part of an idea.

Delusions may be limited to a specific area of belief, such as family or religion, or they may extend into many areas of a person's life. Many patients have reported the relief they experienced as their symptoms remitted and they realized that their belief was really a delusion, just a symptom, not the true facts.

Perception. Perception is the identification and interpretation of a stimulus based on information received through sight, sound, taste, touch, and smell. **Perceptual problems are often the first symptoms in many brain illnesses.**

Hallucinations are false perceptual distortions that occur in maladaptive neurobiological responses. The patient actually experiences the sensory distortion as being real and responds accordingly. However, with a hallucination, there is no identifiable external or internal stimulus. Hallucinations can arise from any of the five senses, as described in Table 20-1.

Although hallucinations are most commonly associated with schizophrenia, only about 70% of people with this illness experience them. They also can occur in patients with a manic or depressive illness, delirium, organic mental disorder, or substance abuse disorder. It is important to understand that hallucinations and delusions can occur in any illness that disrupts brain function.

Finally, the nurse should distinguish between the auditory hallucinations that occur in schizophrenia and the **sensory and auditory flashbacks** that often occur in those with post-traumatic stress disorder, dissociative identity disorder, or borderline personality disorder, and in survivors of trauma and abuse. These are two very different symptoms.

> **Critical Reasoning** A young woman is hospitalized in a forensic psychiatric unit because she attempted to kill her preschool children. She says her dead mother's voice told her to do this because the devil would get them unless they were in heaven with her. Is this a delusion, a hallucination, or both?

Another category of perceptual behaviors involves sensory integration and includes pain recognition, soft neurological signs, right/left recognition, and recognition and perception of faces. Symptoms related to these perceptions are common in schizophrenia. Disruptions of sensory integration often lead to deliberate acts of self-harm, as described in the following clinical example.

TABLE 20-1 SENSORY MODALITIES INVOLVED IN HALLUCINATIONS

SENSE	CHARACTERISTICS
Auditory	Hearing noises or sounds, most commonly in the form of voices. Sounds that range from a simple noise or voice, to a voice talking about the patient, to complete conversations between two or more people about the person who is hallucinating. Audible thoughts in which the patient hears voices that are speaking what the patient is thinking and commands that tell the patient to do something, sometimes harmful or dangerous.
Visual	Visual stimuli in the form of flashes of light, geometric figures, cartoon figures, or elaborate and complex scenes or visions. Visions can be pleasant or terrifying, as in seeing monsters.
Olfactory	Putrid, foul, and rancid smells such as blood, urine, or feces; occasionally the odors can be pleasant. Olfactory hallucinations are typically associated with stroke, tumor, seizures, and the dementias.
Gustatory	Putrid, foul, and rancid tastes such as blood, urine, or feces.
Tactile	Experiencing pain or discomfort with no apparent stimuli. Feeling electrical sensations coming from the ground, inanimate objects, or other people.
Cenesthetic	Feeling body functions such as blood pulsing through veins and arteries, food digesting, or urine forming.
Kinesthetic	Sensation of movement while standing motionless.

CLINICAL EXAMPLE

During an initial physical assessment a nurse noted many superficial scars on the left arm of a young woman who had just completed an 8-week education program on symptom management in schizophrenia. The nurse said, "Tell me about those scars," to which the patient replied, "Before I knew it was okay to talk about my symptoms I often lost sensation in my left arm and hand and thought my arm was poisoned or dead. I tried to determine if I was alive or not. I could see myself walking and see and feel my right arm, so I thought I was probably alive, but I did not know for sure, so I used to take a knife and poke tiny holes in my skin. I could not feel the knife yet I saw blood. It was when I saw the blood that I knew I was still alive."

Selected Nursing Diagnosis

- Risk for self-mutilation related to perceptual disturbance, as evidenced by scars from past episodes of cutting left arm

Knowing that the parietal lobe is the major site of pain recognition helps the nurse see this as a neurobiologically based symptom. Visceral pain recognition involves integration of stimuli from the spinal cord through the brainstem, diencephalon, and cortex using intricate feedback circuits. People with schizophrenia generally have poor visceral pain recognition and need to have an in-depth assessment of physical complaints, as described by the patient in the next clinical example.

CLINICAL EXAMPLE

"I told my case manager that I had a stomachache, some diarrhea, and vomiting and felt like I had the flu. I had a fever, so she took me to the doctor, who said I probably had the flu and should just go home and rest. After a few days I got real sick and had to be taken to the emergency room, where they discovered my appendix had ruptured. I had to have a very long and complicated surgery."

It is not uncommon for people with schizophrenia to think they just have a bad cold and have it diagnosed as pneumonia. Unfortunately, the physical needs of psychiatric patients often can be neglected or disregarded by the individual, as well as by the health care system.

Sensory integration perceptions are included in standard neurological examinations under the category **soft signs,** meaning that they represent a neurological deficit in an undetermined location but are consistent with brain injury to the frontal or parietal lobes. These terms refer to the ability to identify objects by touch.

Box 20-6 lists several neurological soft and hard signs commonly seen in schizophrenia that should be assessed carefully during a baseline evaluation of each patient. Problems in these functions contribute to difficulty with fine motor actions of the hand, and the patient may appear clumsy. Problems with right/left discrimination also contribute to a lack of coordination and ability to carry out directions involving concepts of right and left.

Misidentification and misperception of faces can contribute to fear, aggressiveness, withdrawal from interactions, and hostility. This symptom also involves self-recognition and often is present when patients refuse to look in a mirror or avoid eye contact.

Environmental factors can stimulate hallucinations. In general, objects that are reflective, such as television screens, photo frames, and fluorescent lights, can contribute to visual hallucinations. Auditory hallucinations can be caused by excessive noise and by sensory deprivation. The nurse should be acutely aware of environmental stimuli and the patient's response or lack of response. Patients may withdraw from sensory stimuli in an attempt to decrease sensory responses.

About 90% of people who experience hallucinations also have delusions, whereas only 35% of those who experience delusions also have hallucinations. Approximately 20% of patients have mixed sensory hallucinations, usually auditory and visual.

BOX 20-6 PREFRONTAL CORTICAL DYSFUNCTION IN SCHIZOPHRENIA

Neurological Soft Signs

- Astereognosis: Inability to recognize objects by the sense of touch (e.g., differentiating a nickel from a dime)
- Agraphesthesia: Inability to recognize numbers or letters traced on the skin
- Dysdiadochokinesia: Impairment of the ability to perform smooth, alternating movements (e.g., turning the hand face up and face down rapidly)
- Mild muscle twitches, choreiform and ticlike movements, grimacing
- Impaired fine motor skills and abnormal motor tone
- Increased rate of eye blinking
- Abnormal smooth pursuit eye movements (SPEMs): Difficulty following movement of objects

Neurological Hard Signs

- Loss of function, weakness, diminished reflexes, paralysis caused by a cerebrovascular accident, tumor, traumatic injury, etc.

Emotion. Emotions are described in terms of mood and affect. **Mood** is an extensive and sustained feeling tone that can be experienced for a few hours or for years and affects a person's world view. **Affect** refers to behaviors such as hand and body movements, facial expression, and pitch of voice that can be observed when a person is expressing and experiencing feelings and emotions.

Terms related to affect include **broad, restricted, blunted, flat,** and **inappropriate** (see Chapter 6). What is considered normal varies greatly among cultures. *Broad* or *restricted* affect is usually considered to be within the range of normal, whereas *blunted, flat,* or *inappropriate* affect represents symptoms of an underlying problem. **Disorders of affect refer to the expression of emotion, not the experience of emotion.** Patients describe affective symptoms in the following examples:

- "I remember trying to smile for 3 years, but my face did not work."
- "My face was as stiff as your fingers would be if you tied them to popsicle sticks for 3 months and then tried to use them to thread a needle."

Patients describe frustration with these affective symptoms because other people assume that they do not experience any emotion. As a result, patients are often misjudged as appearing bored, disinterested, or unmotivated.

Emotion refers to moods and affects that are connected to specific ideas. Emotions are generated from an interplay of neural activity among the hypothalamus, limbic structures (amygdala and hippocampus), and higher cortex centers. The hypothalamus, in addition to its hormonal functions, is the emotional coordinating center.

Emotions can be hyperexpressed (too much) or hypoexpressed (too little). **People with schizophrenia commonly have symptoms of hypoexpression.** Some patients perceive

that they no longer have any feelings and that they have a decreased ability to feel intimacy and closeness. Problems of emotion usually seen in schizophrenia include the following:

- **Alexithymia:** difficulty naming and describing emotions
- **Anhedonia:** inability or decreased ability to experience pleasure, joy, intimacy, and closeness
- **Apathy:** lack of feelings, emotions, interests, or concern

In addition to problems with emotions and affect, people with schizophrenia also can have mood disorders. A diagnosis of schizoaffective disorder is given to the patient who meets the diagnostic criteria for schizophrenia as well as those for bipolar disorder or major depression.

QUALITY AND SAFETY ALERT

- A major depression develops in up to 60% of people with schizophrenia.
- The risk of suicide in persons with schizophrenia is 16 times greater than in the general population.

Understanding the effect of brain malfunctions on the emotions and affect of the person with schizophrenia is important for promoting communication and problem solving. People with brain illnesses often have an uncanny ability to sense the emotions of others, yet they may have difficulty identifying their own emotions. This creates special problems in caring for the patient and requires nurses to be aware of and in control of their own emotional reactions.

Caregivers often confuse feelings that are a direct result of brain malfunction and those that are an indirect product of social difficulties resulting from illness. Examples of feelings that are a direct result of brain malfunction include paranoid hostility and emotional flattening. An example of feelings that are an indirect product of social difficulties caused by illness is frustration over not being able to achieve one's potential. When patients and caregivers have difficulty identifying feelings and emotions, barriers to good communication often result.

Behavior and Movement. Definition of "normal" behavior and movement is based on culture, age appropriateness, and social acceptability. Maladaptive neurobiological responses cause behaviors and movements that are odd, unsightly, confusing, difficult to manage, dysfunctional, and puzzling to others. With exploration, many behaviors can be explained and movements can be understood. Some make sense based on the information provided by the patient or the patient's neurobiological illness.

Critical Reasoning Describe unusual behaviors or movements that you have observed in patients with maladaptive neurobiological responses. Were you able to discover the reason for them? Can you think of possible explanations for wearing several layers of clothing in very hot weather? Refusing to bathe? Hugging oneself and rocking?

Maladaptive behaviors in schizophrenia include deteriorated appearance, lack of persistence at work or school, avolition, repetitive or stereotyped behavior, aggression, agitation, and negativism. Deterioration in appearance includes disheveled and dirty clothes, sloppy and unkempt appearance, poor or absent personal grooming, and lack of personal hygiene. This is often the first set of symptoms to occur and is a signal to the family that something is happening to their loved one.

Lack of persistence at work or school typically accompanies deterioration in appearance. As problems in brain function begin to appear, the cognitive skills seem to "short circuit," and the person can no longer perform routine tasks. As deterioration continues, the person begins to experience **avolition,** which means lack of energy and drive. This is a result of the brain changes (that may be occurring rapidly) and of frustration with inability to accomplish tasks that required little effort in the past. Unfortunately, at this point, most people with schizophrenia are mislabeled as lazy, disinterested, and unmotivated.

As deterioration continues, patients often engage in repetitive or stereotyped behaviors. These appear similar to obsessive-compulsive behavior but are related to a private meaning rather than to thoughts. Examples include having to eat foods in a certain way, wearing only certain clothes, walking four steps forward and one step back, or being able to drink only half a glass of water at a time.

The terms aggression, agitation, and the potential for violence are often used to describe a person with schizophrenia. However, **people experiencing psychoses are not typically violent.** Those who do become violent usually have stopped taking their medications or have been abusing substances.

Agitation is common for anyone who is living with a chronic illness for which there is no cure. It is important to identify and document situations that seem to trigger agitated behavior. People who have schizophrenia tend to become agitated when experiencing performance anxiety, particularly when they have difficulty carrying out tasks that previously were easy to do.

Abnormal behaviors and movements in schizophrenia are summarized in Box 20-7.

Maladaptive movements associated with schizophrenia include catatonia, abnormal eye movements, grimacing, apraxia/echopraxia, abnormal gait, mannerisms, and extrapyramidal side effects of psychotropic medications. **Catatonia** is a stuporous state in which the patient may require complete physical nursing care, similar to that for a comatose patient, sometimes with unpredictable outbursts of aggressive behavior or strange posturing.

Abnormal eye movements include difficulty following a moving target, absence or avoidance of eye contact, decreased or rapid eye blinking, and frequent staring. These are common oculomotor symptoms found in 40% to 80% of people with schizophrenia.

Grimacing refers to abnormal facial movements that are beyond the patient's control and are not caused by psychotropic medications.

BOX 20-7 ABNORMAL BEHAVIORS AND MOVEMENTS IN PATIENTS WITH SCHIZOPHRENIA

Behaviors
Appearance inappropriate for environment
Aggression/agitation/violence
Repetitive or stereotyped behavior
Avolition
Lack of persistence at work or school

Movements
Catatonia, waxy flexibility, posturing
Extrapyramidal side effects of psychotropic medications
Abnormal eye movements
Grimacing
Apraxia/echopraxia
Abnormal gait
Mannerisms

Apraxia is difficulty carrying out a purposeful, organized task that is somewhat complex, such as dressing. **Echopraxia** is purposeless imitation of movements made by other people. This symptom may not always be purposeless but can illustrate a delusion, as described by the patient in the following clinical example.

CLINICAL EXAMPLE

"I thought the nurse was my mirror and I had to do what the mirror showed me, so I copied everything she did. As long as I could see her I could feel connected to myself and my surroundings, but she did not understand how important it was for me to be around her and watch what she did. Of course I could not explain what was happening to me at the time because I was psychotic, so she put me in seclusion and restraints."

Selected Nursing Diagnosis

- Disturbed thought processes related to maladaptive information processing, as evidenced by belief that the nurse was a mirror

Staggering, intentional stepping, and walking with the toes touching the ground first are abnormal gaits common in people with schizophrenia. Mannerisms involve gestures that seem contrived and are not appropriate to the situation, such as stopping in the middle of a sentence to whirl two fingers around.

Socialization. Socialization is the ability to form cooperative and interdependent relationships with others. This was placed last among the five major brain functions because problems with the other functions must be understood to appreciate the relational consequences of maladaptive neurobiological responses. Social problems are often the major source of concern to families and health care providers, because these tangible effects of illness are often more prominent than the symptoms related to cognition and perception.

Social problems may result from the illness directly or indirectly. Direct effects occur when symptoms prevent the person from socializing within accepted sociocultural norms or when motivation deteriorates, resulting in social withdrawal and isolation from life's activities. **Behaviors directly causing these problems include inability to communicate coherently, loss of drive and interest, deterioration of social skills, poor personal hygiene, and paranoia.**

Indirect effects on socialization are secondary consequences of the illness. An example is low self-esteem related to poor academic and social achievement. Significant social discomfort and further social isolation may result. **Specific problems in the development of relationships include social inappropriateness, disinterest in recreational activities, inappropriate sexual behavior, and stigma-related withdrawal by friends, families, and peers.**

Social inappropriateness relates directly to cognitive deficits and results in behaviors such as suddenly beginning loud evangelistic prayer in public, toileting in public, standing in the middle of a street trying to direct traffic, dressing bizarrely, and engaging in intimate conversation with total strangers. Social inappropriateness often involves bizarre sexual behavior, such as public masturbation, running nude in the street, or making inappropriate sexual advances.

Stigma also presents major obstacles to developing relationships and adversely affects quality of life. It is a major cause of the social isolation of people with schizophrenia, and it often spreads to the whole family, who may be having their own schizophrenia-related social problems stemming from embarrassment about having the illness in the family (Marcussen et al, 2010; McCann et al, 2011). They may avoid talking about it, or if they do want to talk, they may not know how to broach the subject. Stigma and rejection may discourage them from talking.

Family members may feel like social outcasts for having this illness in the family (see Chapter 10). One family member explained, "For the rest of my life, I will be dealing not only with the heartbreak of my brother's illness but also with negative response, stigma, and ignorance in my hometown that affects me deeply."

Critical Reasoning Describe your own attitudes and behaviors and those of your peers toward people who have maladaptive neurobiological responses and their families.

Physical Health

Individuals with schizophrenia have higher morbidity and mortality because of physical illness (Lawrence et al, 2010; Platt et al, 2010; Jeste et al, 2011). These conditions, especially obesity and its cardiovascular consequences, lead to the well-documented **shortening of the average life span in persons with schizophrenia by about 20 years.** In addition, persons with schizophrenia who are hospitalized for medical or surgical reasons have twice the chance of adverse events, associated with poorer clinical and economic outcomes.

Part of the problem is the high-risk lifestyle of persons with schizophrenia, which includes sedentary living, smoking, unhealthy dietary habits, and obesity. This can result in diabetes, hypertension, and coronary artery disease (Megna et al, 2011). Atypical antipsychotics also contribute to these medical conditions.

In addition, there is a serious **disparity of health care for patients with severe mental illness,** with neither the primary care system nor the mental health system providing basic physical health screening, treatment, and monitoring for these individuals (Kreyenbuhl et al, 2010; Minsky et al, 2011).

Thus it is essential that nurses complete a thorough biological assessment of these patients (see Chapter 5) to fully evaluate their physical health needs (Roberts and Bailey, 2011). This assessment should include scheduling of cancer screening, vision tests, and other preventive examinations. Then a biopsychosocial treatment plan should be developed that ensures adequate monitoring of body mass index, plasma glucose level, lipid profiles, and signs of prolactin elevation or sexual dysfunction, among other indicators.

QUALITY AND SAFETY ALERT

- A thorough biological assessment must be part of the treatment strategy for patients with schizophrenia given their higher morbidity and mortality based on their prevalent and often untreated physical illnesses.

Predisposing Factors

Schizophrenia is a neurodevelopmental brain disorder. No one thing causes schizophrenia. It is the end result of a complex interaction among thousands of genes and many environmental risk factors, none of which on its own causes schizophrenia. Schizophrenia is a *complex neurobiological* disorder of brain neurotransmitter circuits, neuroanatomical deficits, neuroelectrical abnormalities, and neurocirculatory dysregulation. These ultimately lead to a miswired brain and clinical symptoms (Gilmore, 2010).

Genetics. Genetics plays a role in schizophrenia but it is difficult to separate out the influence of genetics and the environment. The aim of genetic research is to eventually map the genetic susceptibility for schizophrenia and then develop genetic interventions as treatment modalities. The specific genetic defects that cause schizophrenia have not yet been identified, but progress has been made toward identifying the mechanisms and potential gene locations (MacDonald and Schulz, 2009).

The most significant risk factor for developing schizophrenia is having a first-degree relative with schizophrenia. Family, twin, and adoption studies have shown an increased risk for the disease in people with both a first-degree relative (parent, sibling, offspring) or a second-degree relative (grandparents, aunts and uncles, cousins, grandchildren) with schizophrenia (Gottesman et al, 2010). More than 40% of monozygotic twins of those with schizophrenia are also affected. However most people with schizophrenia do not have an affected relative, and while the overall genetic contribution to schizophrenia may be large, the contribution of specific genes is very small.

Schizophrenia is caused by the interaction of a variety of mechanisms that are biological, environmental, and experiential. Children who have a biological parent with schizophrenia and are adopted at birth by a family with no incidence of the disorder have the same risk as if their biological parents had raised them. There is evidence for both a genetic predisposition for the disorder and an influence of environmental or random factors, as evidenced by studies of identical twins, who share 100% of genes but only a 50% risk for schizophrenia.

Neurobiology. Studies show anatomical, functional, and neurochemical abnormalities in the living and postmortem brains of people with schizophrenia. Research suggests that the prefrontal cortex and the limbic cortex may never fully develop in the brains of persons with schizophrenia. **The two most consistent neurobiological research findings in schizophrenia are decreased brain volume and alterations of many neurotransmitter systems.**

The decreased brain volume includes decreases in both gray matter and white matter (neuronal axons) (Arnsten, 2011). This is due to faulty myelination occurring at about age 6 years and again at about age 13 years and relates to a theory of abnormal pruning of neurons during adolescence (Faludi and Mirnics, 2011).

Particular attention has been focused on the following:

- **Frontal cortex**, implicated in the negative symptoms of schizophrenia
- **Limbic system** (in the temporal lobes), implicated in the positive symptoms of schizophrenia
- **Neurotransmitter systems** connecting these regions, particularly dopamine and serotonin, and more recently, glutamate

Therefore psychotic behaviors may be related to lesions in the frontal, temporal, and limbic regions of the brain and to dysregulation of neurotransmitter systems connecting these regions.

Imaging studies. Computed tomography and magnetic resonance imaging studies of brain structure show **decreased brain volume in people with schizophrenia** (Figure 20-4). Findings include:

- Larger lateral and third ventricles
- Decreased gray matter volume in the hippocampus, caudate nucleus, thalamus, insula, anterior cingulate gyrus, inferior frontal gyrus, and cerebellum
- Atrophy in the frontal lobe and limbic structures (particularly the hippocampus and amygdala)
- Increased size of sulci (fissures) on the surface of the brain

These findings suggest loss or underdevelopment of brain tissue. Enlarged ventricles have been associated with two indicators of poor prognosis: early age at onset and poor premorbid functioning (functioning before the first diagnosis).

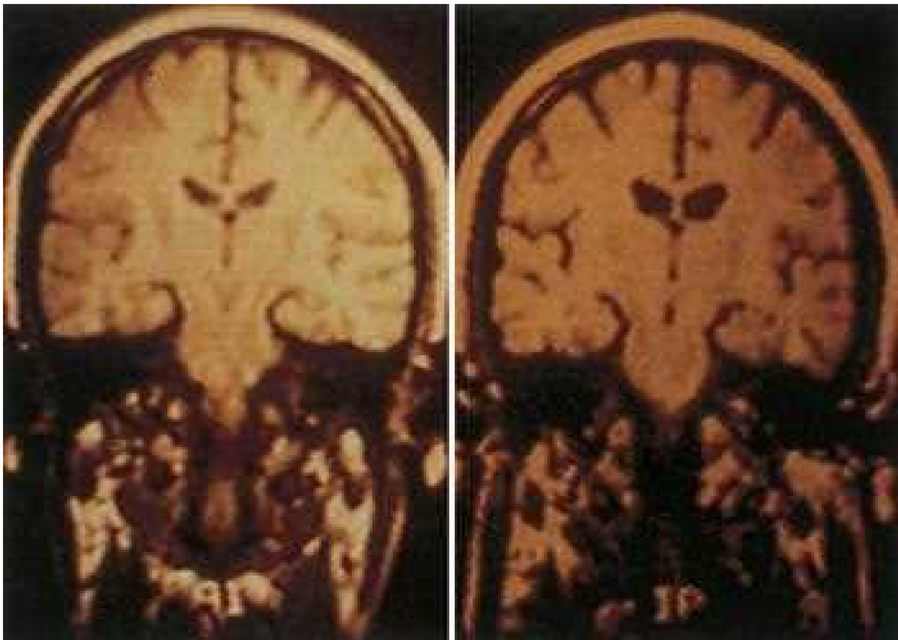

FIG 20-4 Magnetic resonance imaging scans through the bodies of the lateral ventricles in a pair of monozygotic twins who are discordant for schizophrenia. Note the increase in the cerebrospinal fluid spaces in the twin with schizophrenia *(right)* compared with the unaffected twin *(left).* (From Roberts GS, Leigh PN, Weinberger DR: *Neuropsychiatric disorders*, London, 1993, Mosby-Wolfe.)

Positron emission tomography scans usually demonstrate decreased cerebral blood flow to the frontal lobes during specific cognitive tasks in people with schizophrenia. This frontal hypometabolism is thought to account for some problems with attention, planning, and decision making (Figure 20-5).

The thalamus lies in the center of the brain, near the temporal lobes and hippocampus; it regulates sensory input and serves as a filter or relay station between the cerebral cortex and the rest of the brain (see Box 5-2 in Chapter 5). It appears to be smaller than average and to have reduced activity in some schizophrenic patients. This may explain some problems in sensory filtering and information processing in many people with schizophrenia.

The basal ganglia, part of the extrapyramidal system, are responsible for various aspects of movement, such as the inhibition of unwanted movement and the promotion of motor learning and planning. They also may play a role in cognitive function with their rich connectivity to the frontal lobes. The basal ganglia are overactive in people with schizophrenia, perhaps accounting for movement and speech abnormalities.

Neurotransmitter studies. Research in the area of neurotransmission has led to the **dysregulation hypothesis** of schizophrenia, which states that it is caused by a persistent impairment in one or more neurotransmitter or neuromodulator homeostatic regulatory mechanisms resulting in unstable or erratic neurotransmission. This theory proposes that the mesolimbic area has overactive dopamine pathways, whereas the dopamine pathways in the prefrontal mesocortical areas are hypoactive, and that an imbalance exists between dopamine and serotonin neurotransmitter systems (and probably between others as well).

Dopamine has been implicated longer than any other chemical substance in neurotransmitter studies of schizophrenia. This is because it has long been known that mind-altering drugs such as amphetamines and cocaine increase brain levels of dopamine and produce psychosis and because early on it was understood that the conventional antipsychotic drugs exert their therapeutic effects by blocking dopamine receptors.

Dopamine is important in responses to stress and has many connections to the limbic system. The prefrontal cortex has few dopamine receptors of its own, but it may regulate dopamine in other circuits in the brain. Also, dopamine is present at high levels in the brain during late adolescence, when schizophrenia usually first appears.

Dopamine is found in three parts of the brain:

- **Substantia nigra** motor center, affecting movement and coordination
- **Midbrain,** involving emotion and memory
- **Hypothalamic-pituitary** connection, involving emotional responses and stress-coping patterns

Dopamine has four major pathways in the brain (Figure 20-6):

1. **Mesocortical pathway:** innervates the frontal lobes
   a. *Function:* insight, judgment, social consciousness, inhibition, and highest level of cognitive activities (reasoning, motivation, planning, decision making)
   b. *Abnormal function—negative symptoms:* affective flattening or blunting, poverty of speech or speech content, blocking, poor grooming, lack of motivation, anhedonia, social withdrawal, cognitive defects, and attention deficits

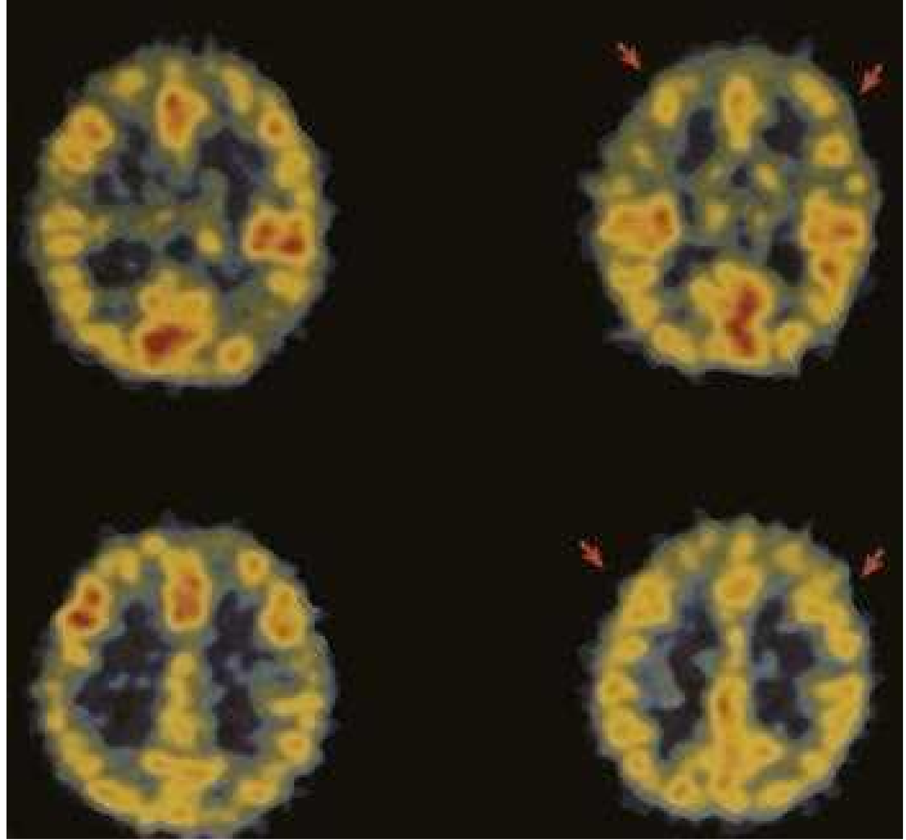

FIG 20-5 Blood flow demonstrated by positron emission tomography during the performance of the Wisconsin Card Sort Task (a task that activates the prefrontal cortex in normal subjects) in a twin with schizophrenia *(right column)* and an unaffected twin *(left column).* The arrows indicate the relatively focused failure of activation in the affected twin compared with the unaffected twin. (From Roberts GS, Leigh PN, Weinberger DR: *Neuropsychiatric disorders*, London, 1993, Mosby-Wolfe.)

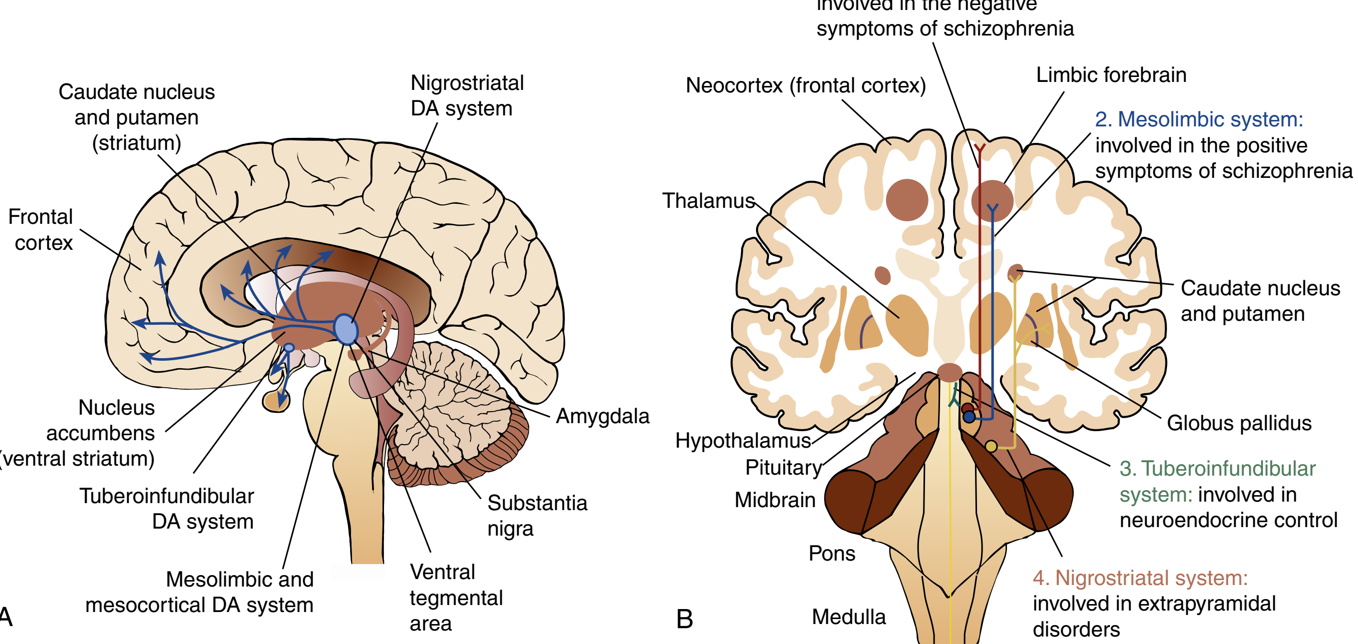

FIG 20-6 **A,** A midsagittal section shows the approximate anatomical routes of the four dopamine tracts. **B,** A coronal section shows the sites of origin and the targets of all four tracts. *DA,* Dopamine. (Modified from Kandel E, Schwartz J, Jessell T: *Principles of neural science,* ed 4, New York, 2000, McGraw-Hill.)

2. **Mesolimbic pathway:** innervates the limbic system
   a. *Function:* associated with memory, smell, automatic visceral effects, and emotional behavior
   b. *Abnormal function—positive symptoms:* hallucinations, delusions, disorganized speech, and bizarre behavior
3. **Tuberoinfundibular pathway:** originates in the hypothalamus and projects to the pituitary
   a. *Function:* endocrine function, hunger, thirst, metabolism, temperature control, digestion, sexual arousal, and circadian rhythms
   b. *Abnormal function:* implicated in some of the endocrine abnormalities seen in schizophrenia and some of the side effects of antipsychotic drugs, such as hyperprolactinemia
4. **Nigrostriatal pathway:** originates in the substantia nigra and terminates in the caudate nucleus–putamen complex (neostriatum)
   a. *Function:* innervates the motor and extrapyramidal systems
   b. *Abnormal function:* implicated in some of the movement side effects of antipsychotic drugs, such as tardive dyskinesia, akathisia, and dystonic reactions

Serotonin also has been implicated in schizophrenia. It has a modulating effect on dopamine. The first-generation atypical antipsychotic drugs are combination serotonin/dopamine blocking agents, explaining their improved efficacy over the typical antipsychotics. Blocking serotonin in the limbic system increases frontal dopamine with a net effect of improving negative symptoms.

Glutamate is the major excitatory neurotransmitter in the brain. Research on the effect of PCP (phencyclidine), a drug that seems to mimic the symptoms of schizophrenia in normal volunteers, has led to a better understanding of how glutamate interacts with dopamine. The function of glutamate's major receptor complex, *N*-methyl-D-aspartate (NMDA), is interrupted by PCP. This important brain communication system has been found to be abnormal in the prefrontal cortex and thalamus in postmortem studies of patients with schizophrenia.

Neurodevelopment. It also is believed that the multiple structural, functional, and chemical brain deviations seen in schizophrenia are usually present long before the symptoms appear, probably from the earliest years of life, and perhaps before birth. It is not clear whether these changes are caused by genetic programming defects or environmental injury or both, creating a vulnerability that remains dormant until later developmental events occur.

Some children with schizophrenia show subtle abnormalities involving attention, coordination, social ability, neuromotor functioning, and emotional responses long before they exhibit overt symptoms of schizophrenia (Schiffman et al, 2004). Other early childhood differences include excessive shyness, hyperactivity, bed-wetting, aggressiveness, poor concentration and coordination, tantrums, hand-washing compulsions, reversion to baby talk, and delays in learning to walk and speak.

In some monozygotic twin pairs, the twin with schizophrenia was noted to become permanently different from the unaffected identical twin by the age of 5 years, although symptoms of schizophrenia did not appear until young adulthood. Identification of these prodromal symptoms in children at risk for adult schizophrenia can result in early intervention strategies, perhaps avoiding or delaying the onset of illness or minimizing its effects.

The intrauterine environment and early infant events may be linked to the development of schizophrenia. Prenatal and perinatal complications and environmental exposures appear to have a stronger effect than individual genes: Prenatal exposure to infection or hypoxia increases the risk from 1 in 100 to between 2 and 4 in 100.

Research has found a greater frequency of prenatal and perinatal complications among people with schizophrenia, including preeclampsia, trauma, oxygen deprivation at the time of delivery, extreme prematurity, and maternal problems such as poor nutrition, stress, substance use (tobacco, alcohol, street drugs, or caffeine), viral infection, hypertension, depression, and use of teratogenic pharmacological agents.

This research suggests that some disruption in fetal neural development may change the way the brain matures throughout childhood and adolescence, affecting the myelination, migration, and interconnections of young neurons as they mature in utero and during the first few decades after birth and contributing to brain abnormalities commonly seen in schizophrenia (Moilanen et al, 2010).

Viral and Infection Theories. A search for the "schizophrenia virus" has been ongoing (Moreno et al, 2011). Evidence indicates that prenatal exposure to the influenza virus, particularly during the first trimester, may be one factor in the etiology of schizophrenia in some people but not in others (Brown and Derkits, 2010). This theory is supported by the fact that more people with schizophrenia are born in the winter or early spring and in urban settings, suggesting a potential impact of season and place of birth on the risk for schizophrenia.

Viral infections are more common in crowded places and in winter and early spring; viral infections may occur in utero or in early childhood in some vulnerable people. It also has been found that women with high levels of toxoplasma antibodies have a significantly higher risk of developing schizophrenia spectrum disorders (Pedersen et al, 2011).

Precipitating Stressors

Biological. One possible stressor is interference in a brain feedback loop that regulates the amount of information that can be processed at a given time. Normal information processing occurs in a predetermined series of neural activities. Visual and auditory stimuli are initially screened and filtered by the thalamus and sent for processing by the frontal lobe. If too much information is sent at once or if the information is faulty, the frontal lobe sends an overload message to the basal ganglia. The basal ganglia in turn send a message to the thalamus to slow down transmissions to the frontal lobe.

Decreased function of the frontal lobe impairs the ability of this feedback loop to perform. Less ability to regulate the

BOX 20-8 NEUROBIOLOGICAL RESPONSE SYMPTOM TRIGGERS

Health
Poor nutrition
Lack of sleep
Out-of-balance circadian rhythms
Fatigue
Infection
Central nervous system drugs
Lack of exercise
Barriers to accessing health care

Environment
Hostile/critical environment
Housing difficulties (unsatisfactory housing)
Pressure to perform (loss of independent living)
Changes in life events, daily patterns of activity
Interpersonal difficulties, disruptions in interpersonal relationships
Social isolation
Lack of social support
Job pressures (poor occupational skills)
Stigmatization
Poverty
Lack of transportation (resources)
Inability to get/keep a job

Attitudes/Behaviors
"Poor me" (low self-concept)
"Hopeless" (lack of self-confidence)
"I'm a failure" (loss of motivation to use skills)
"Lack of control" (demoralization)
Feeling overpowered by symptoms
"No one likes me" (unable to meet spiritual needs)
Looks/acts different from others who are of the same age, culture
Poor social skills
Aggressive behavior
Violent behavior
Poor medication management
Poor symptom management

basal ganglia is available, and ultimately the message to slow down transmissions to the frontal lobe never occurs. The result is **information-processing overload** and the neurobiological responses described at the beginning of this chapter.

Another possible biological stressor is the **abnormal gating mechanisms** that may occur in schizophrenia. Gating is an electrical process involving electrolytes. It refers to inhibitory and excitatory nerve action potentials and the feedback occurring within the nervous system related to completed nerve transmissions. Decreased gating is demonstrated by a person's inability to selectively attend to stimuli (Alsene and Backshi, 2011). For example, at a baseball game the person with schizophrenia would be unable to differentiate the noise from the crowd from the music, the team, or the public address system.

Normally when people hear a loud noise, they become startled; however, when the noise is repeated, the startle response is decreased. For example, if you hear a neighbor setting off firecrackers in celebration of the Fourth of July, you become startled; then if you hear a second explosion soon after, you are generally less startled. The person with schizophrenia is just as startled the second time and maybe even more so than the first. This inability to gate a noise stimulus causes people to become frightened in crowds or wherever they encounter increased noise.

Symptom Triggers. Certain stressors often precede a new episode of the illness. The word *trigger* is used to describe these stressors. **Common triggers of neurobiological responses related to health, environment, attitudes, and behaviors are listed in Box 20-8.** Patients with schizophrenia can learn to recognize triggers that they are particularly reactive to, and they can be taught to avoid them, if possible, and to contact their mental health care provider for help if they cannot.

Appraisal of Stressors

Stress Diathesis Model. **The Stress Diathesis Model proposes that schizophrenic symptoms develop based on the relationship between the amount of stress that a person experiences and an internal stress tolerance threshold.** This is an important model because it integrates biological, psychological, and sociocultural factors (Liberman et al, 1994). In this way, it is similar to the Stuart Stress Adaptation Model that is used as the organizing conceptual framework of this text (Figure 20-7).

Although no scientific research has shown that stress causes schizophrenia, it is clear that schizophrenia is a disorder that not only causes stress but is made worse by stress (van Os et al, 2010). Stress, one's appraisal of the stressor, and the problems associated with coping with the stress may predict the return of symptoms.

Coping Resources

Psychosis is a frightening and very upsetting illness that requires adjustment for both the patient and the family. Family resources, such as parental understanding of the illness, finances, availability of time and energy, and ability to provide ongoing support, influence the course of postpsychotic adjustment.

The postpsychotic adjustment process consists of four phases and may take 3 to 6 years (Moller and Zauszniewsky, 2011):

1. **Cognitive dissonance** (active psychosis): This involves achieving pharmacological efficacy to reduce symptoms and stabilize active psychosis by sorting out reality from unreality after the first episode. It can take 6 to 12 months.
2. **Attaining insight:** The beginning of insight occurs with the ability to make reliable reality checks. This takes 6 to 18 months and depends on medication efficacy and ongoing support.

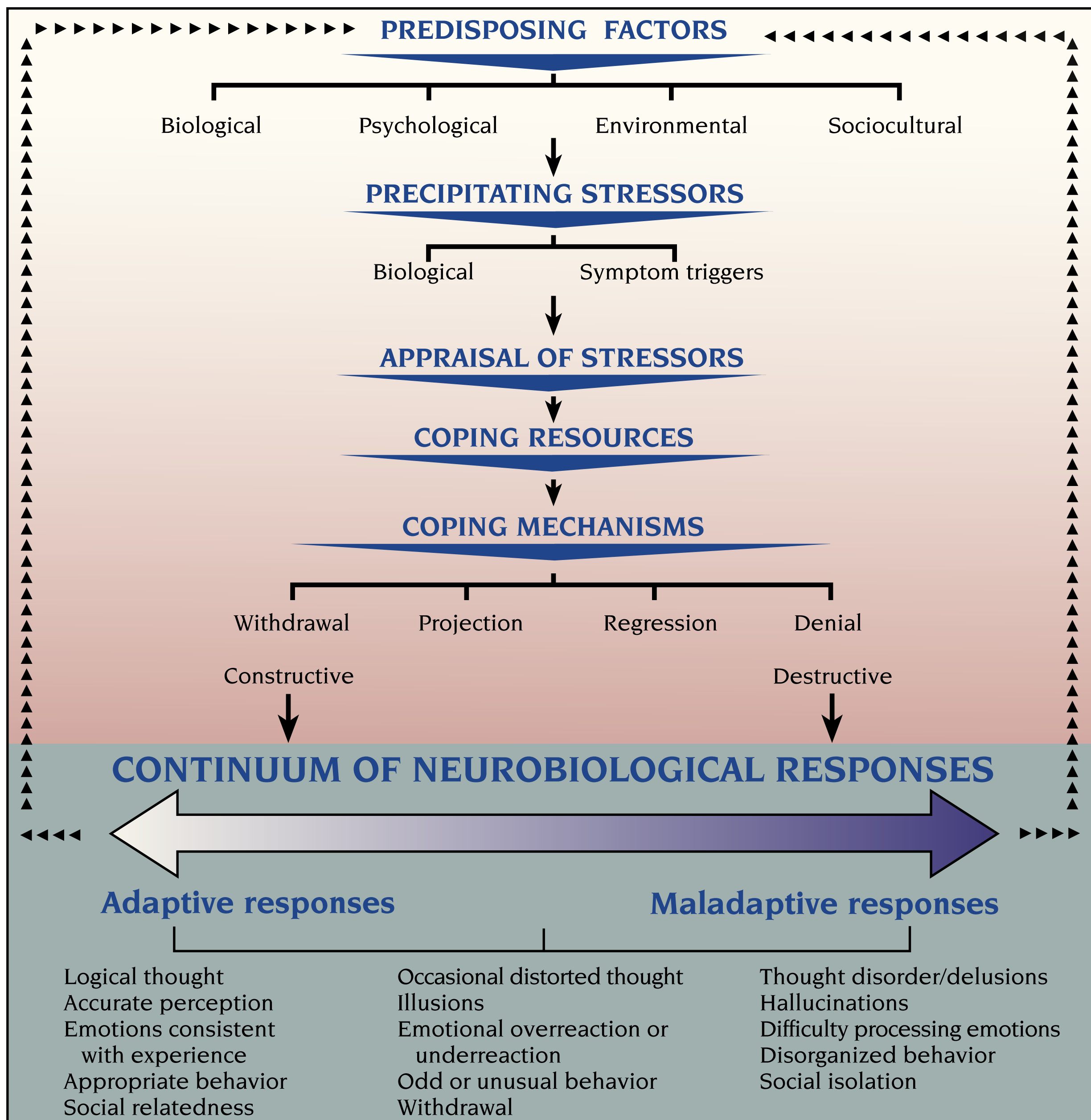

FIG 20-7 The Stuart Stress Adaptation Model as related to neurobiological responses.

3. **Cognitive constancy** (stability in all aspects of life): This includes resuming normal interpersonal relationships and reengaging in age-appropriate activities related to school and work. This phase lasts 1 to 3 years.
4. **Moving toward achievement of work or educational goals** (ordinariness): This includes the ability to consistently engage in and complete age-appropriate activities of daily living reflective of prepsychosis goals. This phase lasts at least 2 years.

Coping Mechanisms

In the active phase of psychosis, patients use several unconscious defense mechanisms in an attempt to protect themselves from the frightening experiences caused by their illnesses.

- **Regression** is related to information-processing problems and expenditure of large amounts of energy in efforts to manage anxiety, leaving little for activities of daily living.
- **Projection** is an effort to explain confusing perceptions by assigning responsibility to someone or something.
- **Withdrawal** is related to problems establishing trust and preoccupation with internal experiences.
- **Denial** is often used by patients and families. This is the same as the denial that occurs whenever one receives information that causes fear and anxiety (Saks, 2009).

It allows the person time to gather internal and external resources and then adapt to the stressor gradually.

In the postpsychotic adjustment process, patients actively use adaptive coping mechanisms as well. These include cognitive, emotional, interpersonal, physiological, and spiritual coping strategies that can serve as a basis for formulation of nursing interventions (Table 20-2). Supportive counseling has also been found to enhance coping (Rudnick and Martins, 2009).

DIAGNOSIS

Nursing Diagnoses

Nursing diagnoses take into account the functional level, stressors, and support systems of the patient and should be prioritized according to the patient's stage of illness (crisis, acute, maintenance, or health promotion). Nursing diagnoses associated with maladaptive neurobiological responses are presented in Table 20-3. **Primary NANDA International (NANDA-I) nursing diagnoses include impaired verbal communication, impaired social interaction, and risk for disturbed personal identity.**

Medical Diagnoses

The medical diagnoses associated with maladaptive neurobiological responses include the schizophrenias, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, and shared psychotic disorder. Selected medical terms are their definitions are presented in Table 20-3.

OUTCOMES IDENTIFICATION

The **expected outcome** for nursing care of the patient with maladaptive neurobiological responses is as follows: ***The***

TABLE 20-2 POSTPSYCHOTIC ADJUSTMENT: PROCESS COMPONENTS AND PATIENT CARE THEMES

	COGNITIVE DISSONANCE	INSIGHT	COGNITIVE CONSTANCY	ORDINARINESS
Emotional Component	Embarrassment Fear Lost self-confidence Frustration Cannot handle stress	Learning how to cope with life now	Importance of having a positive initial hospital experience Someone to be there for me (support system) Something to do with my time Treatment environment that feels safe Reassurance/encouragement Not having too much quiet time Being around people Having hope it will get better	Being able to think about the future Accomplishing life goals Having my own place to live
Cognitive Component	Fear of saying something wrong Confusion	Trying to figure out thoughts Doing my own reality checks Getting control of my symptoms Getting used to it Recognizing limitations	Something to distract me from the symptoms Accepting that I need treatment Getting back to what I used to do Thinking positively Learning I am not the only one with schizophrenia Having choices/control in my treatment	Managing my symptoms Finishing education Becoming employed
Interpersonal Component	Hard to go out in public and be around people Lost friends	Communicating with others	Having someone listen to me/understand me Someone to talk to about me Confiding in the counselor/therapist People need to be honest with reality Having people explain things Someone to talk to about general things Having help available when I first get sick	Doing what other people do
Physical Component	Takes all my energy Used drugs and alcohol	Taking time to stabilize from first episode	The right medication Taking care of my body Having a routine	
Spiritual Component				Prayer

patient will live, learn, and work at a maximum possible level of success, as defined by the individual.

Prevention of relapse and early intervention are key components of a successful outcome. **Relapse** is the return of symptoms severe enough to interfere with activities of daily living. Only thorough, ongoing symptom monitoring can prevent it. Planning therapeutic interventions depends on goals related to diagnosis and level of wellness.

Short-term goals identify the steps that will lead the patient to successfully accomplish the expected outcome. Examples include the following:

- The patient will initiate conversation with at least one person daily.
- The patient will participate in a medication education group weekly.
- The patient will identify medications and describe the prescribed dose, expected effects, possible side effects, and actions to take if questions arise.
- The patient will engage in a wellness lifestyle.
- The patient will describe the preferred living situation following hospital discharge.
- The patient will practice community living skills, such as food preparation, housekeeping, care of clothing, money management, and use of public transportation.

PLANNING

When a person is in the crisis or acute stage of illness, care is often given in a hospital. The overall goal is to help the patient reach stability while establishing a foundation for **recovery.** Because of the complex psychosocial needs of patients with maladaptive neurobiological responses, planning for discharge begins with admission. All patient resources must be evaluated. The family resources are particularly important, because families are the providers of care for the majority of patients with schizophrenia (Möller-Leimkühler and Wiesheu, 2011).

Federal law requires that patients and, with patients' permission, family members be present at treatment planning meetings. This provides a smooth transition from hospital to home. Recognizing the burden of caring for loved ones with schizophrenia, families must decide what resources they are able to use to assist the patient. These resources may include

TABLE 20-3 NURSING DIAGNOSES AND MEDICAL TERMS RELATED TO *Maladaptive Neurobiological Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Impaired verbal communication	Impaired verbal communication related to formal thought disorder, as evidenced by loose associations
Impaired social interaction	Impaired social interaction related to inadequate social skill, as evidenced by inappropriate sexual advances toward members of both genders
Risk for disturbed personal identity	Risk for disturbed personal identity related to physiological brain dysfunction, as evidenced by verbal reports of "hearing voices that say bad things about me," belief one is being persecuted and restricted thought and speech
MEDICAL TERM	**DEFINITION***
Catatonia	A syndrome seen most frequently in schizophrenia, characterized by muscular rigidity and mental stupor, posturing, and mutism, sometimes alternating with great excitement and confusion.
Paranoia	A type of schizophrenia characterized by systematized delusions or frequent auditory hallucinations and the projection of personal conflicts, which are ascribed to the supposed hostility of others. It can progress to aggressive acts believed to be performed in self-defense or as a mission.
Schizophreniform disorder	A serious mental disorder with symptoms similar to those of schizophrenia. The disorder, including its prodromal, active, and residual phases, lasts longer than 1 month but less than 6 months. Unlike schizophrenia, in which prodromal symptoms may develop over several years, schizophreniform disorder has a rather rapid period from the onset of prodromal symptoms to the point at which all criteria for schizophrenia are met.
Schizoaffective disorder	A mental condition that causes both a loss of contact with reality (psychosis) and mood problems.
Delusional disorder	Patients have with circumscribed symptoms of non-bizarre delusions, but without hallucinations, thought disorder, mood disorder, or significant flattening of affect.
Shared psychotic disorder (*folie a deux*)	A rare condition in which an otherwise healthy person (secondary case) shares the delusions of a person with a psychotic disorder (primary case), such as schizophrenia, who has well-established delusions.

Nursing Diagnoses—Definitions and Classification 2012-2014. Copyright © 2012, 1994-2012 by NANDA International. Used by arrangement with Blackwell Publishing Limited, a company of John Wiley & Sons, Inc.

*Sources: http://dictionary.reference.com; http://emedicine.medscape.com/article.com/article/2008351-overview; http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001927; http://my.clevelandclinic.org/disorders/psychotic_disorder/hic_shared_psychotic_disorder.aspx.

time, energy, knowledge, and money. The discharge plan must be based on the reality of available resources.

Care of the patient in the maintenance phase occurs at home or in another community setting. The focus of this phase is to assist with recovery. **Hope is an essential element in this process,** because regaining hope can be a turning point in a person's recovery (Lysaker et al, 2010).

A component of recovery is learning to identify symptom triggers and early symptoms. Successful recovery also involves the identification of symptom management techniques that reduce the potential for relapse and maintain stability. Additional information about the recovery of people with maladaptive neurobiological responses is included in Chapter 14.

It is important for nurses to be aware that, although effective treatments for schizophrenia are available, many people experiencing this serious brain disease are not receiving them (Kreyenbuhl et al, 2010). Thus the nurse has a significant responsibility to patients, families, and communities to educate, advocate, and promote effective treatment strategies for neurobiological illnesses.

When stability has been attained, the health promotion phase begins. The goal is to collaboratively develop and implement symptom management techniques that prevent relapse and promote recovery. **When patients and families recognize that recovery and relapse prevention are possible, they become empowered and can enjoy a quality of life that places the patient rather than the illness in control**.

IMPLEMENTATION

Interventions focus on the full range of psychosocial and biological treatments and must include the patient, family, and caretaker if possible. **The recovery plan should include interventions directed toward reducing symptoms of the disease; reducing disease and treatment burdens; and promoting health, wellness, optimal functioning, and quality of life** (Figure 20-8).

It is important to remember that the disabilities and resources of a particular patient are related to the type and location of the brain dysfunction. Therefore it is essential to assess mental status carefully to identify the person's strengths. For instance, some people with maladaptive neurobiological responses are highly intelligent but unable to express themselves well. Others may be artistically talented but not skilled at verbal communication. Exploring these areas of strength helps the nurse in planning individualized nursing interventions. The modality chosen should be based on predisposing factors, precipitating stressors, coping resources, coping mechanisms, and the patient's responses.

The core problems related to cognition, perception, emotion, behavior and movement, and socialization create significant difficulties for people with schizophrenia and affect the implementation of the nursing treatment plan. Table 20-4 outlines areas of difficulty and related nursing interventions in working with a patient who is experiencing psychosis. These issues must be addressed to maximize the patient's recovery and enhance compliance with the treatment plan.

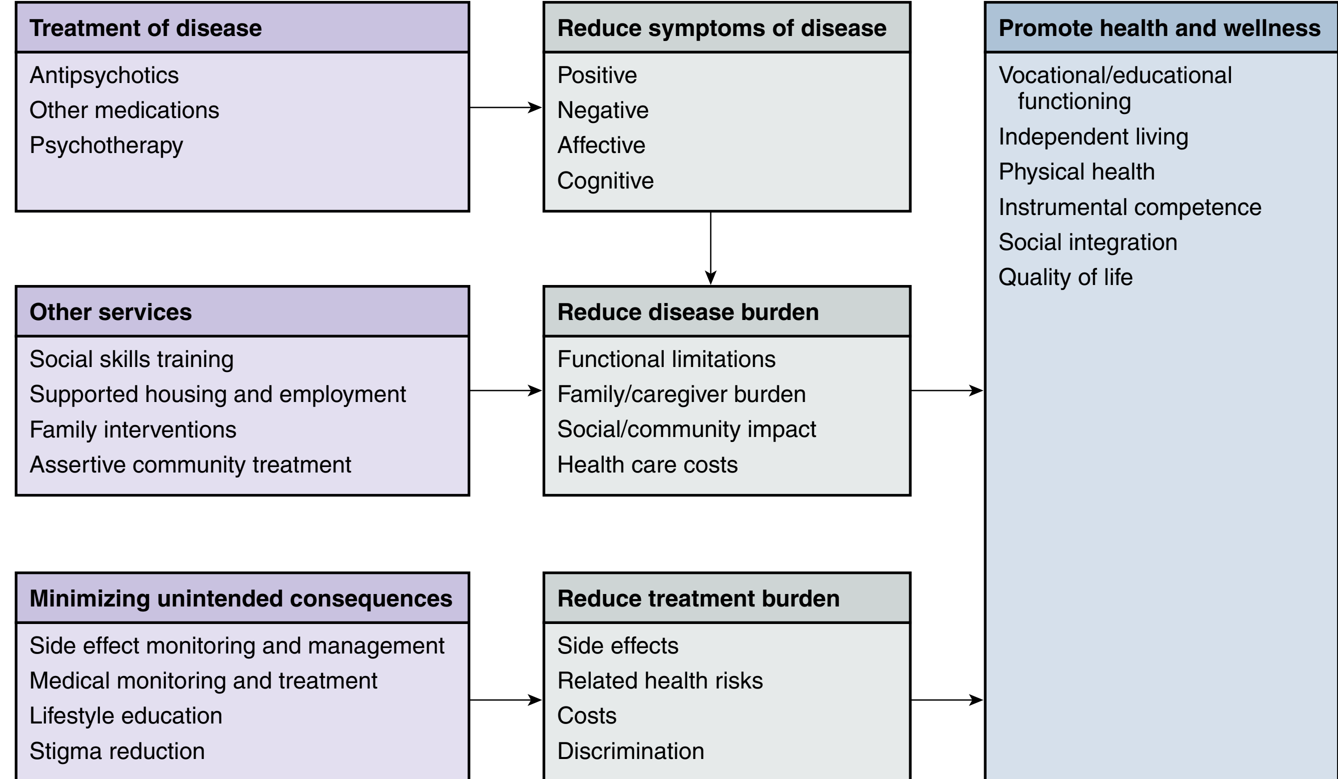

FIG 20-8 Optimizing treatment outcomes. (From Tandon R et al: Strategies for maximizing clinical effectiveness in the treatment of schizophrenia, *J Psychiatr Practice* 12:348, 2006.)

TABLE 20-4 BEHAVIORAL STRATEGIES FOR PEOPLE WITH PSYCHOSIS

AREAS OF DIFFICULTY	NURSING INTERVENTIONS
Anxiety	Teach patient the symptoms related to anxiety. Help patient identify what triggers anxiety. Help patient use symptom management techniques to cope with anxiety. Assess whether anxiety is a relapse trigger, and, if so, make a plan to reduce anxiety while it is still in the moderate stage.
Depression	Teach patient the symptoms related to depression. Help patient use symptom management techniques to cope with depression. Assess whether depression is a relapse trigger, and, if so, make a plan to reduce depression while it is still in a mild stage, because there is a high correlation between depression and being able to perform activities of daily living.
Inability to learn from experience	Review both positive and negative experiences. Identify what was successful in helping the patient achieve the desired goal and what was not successful.
Problems with cause-and-effect reasoning	Analyze each experience to see what went well and what did not. Help reasoning patient to sequence events leading to the outcome in each experience. Rehearsal may be helpful in enacting an event before it occurs.
Difficulty assessing passage of time	Teach patient how to use clocks to tell time. Teach patient to use environmental cues, such as the sun going down or a certain radio program, to orient to time of day. Help patient create and maintain a calendar of scheduled activities.
Concrete thinking	Realize that the patient sees every problem as having one solution. Teach patient to look at other possible solutions to problems. Realize that the patient often thinks there is only one way to do a task. Create alternative ways to approach situations.
Difficulty telling background from foreground information	Teach patient to distinguish between important and unimportant information. Teach patient to focus on only the important information. Help patient learn to avoid or minimize confusion caused by excess stimulation from noise and large crowds.
Slowed information processing	Give patient time to process and respond to information. Minimize anxiety to increase information-processing difficulties. Demonstrate genuine interest in trying to understand what patient is saying. Be clear and simple when communicating with patient.
Difficulty screening information to share	Teach patient to identify people who are safe to talk with about their illness. Teach patient to go to these people when symptoms are creating problems. Let patient know that you understand the illness and are a safe person to talk with.
Communication difficulties	Use active listening to understand the patient. Clarify what the patient is trying to tell you. Listen for the theme. Seek validation from patient on what is communicated. Help patient with vocabulary as needed. Use the literal meanings of words. Have patient repeat back what was heard. Help patient understand the words and phrases used.
Problems expressing needs	Help patient identify and prioritize needs. Help patient express needs in ways that others will understand. Role play conversations and practice negotiating with others.
Low self-concept	Help patient identify and maximize strengths and positive characteristics. Use role playing to handle common situations patient faces. Give positive feedback when patient handles a situation well. Analyze a problem to determine how it could have been better handled.
Forced isolation because of stigma	Maximize patient's understanding of the illness. Teach patient to minimize stigmatizing behaviors when possible. Identify comments that are difficult to handle. Teach ways to handle stigma and rude comments. Develop concrete humorous comebacks. Role play various situations with the nurse being the patient.

TABLE 20-4 BEHAVIORAL STRATEGIES FOR PEOPLE WITH PSYCHOSIS—cont'd

AREAS OF DIFFICULTY	NURSING INTERVENTIONS
Difficulty with perception and interpretation of sensory stimuli	Review problematic situations with patient. List and assess the thought processes in interpreting events. Help patient reality test and reframe problematic interpretations. Reinforce positive and productive processes.
Poor attention span and difficulty completing tasks	Help patient break tasks into small, sequential steps. Help patient keep focused on a single task, one step at a time. Do not emphasize completing the task. Give directions to patient one step at a time.
Inappropriate social behaviors	Identify patient's thought processes that led to the behavior. Ask patient about the behavior. Help correct inaccurate perceptions. Help patient identify undesirable outcomes of the behavior. Teach appropriate social skills.
Difficulty with decision making	Help patient determine desired outcomes. Help patient prioritize goals and categorize them as short term or long term. Help patient establish a time line for attainment of each goal. Help establish small, concrete steps to achieve desired goals. Ensure that these small steps are achievable by the patient and are congruent with culture and values.

The duration of untreated psychosis is generally long in schizophrenia, often 1 year or more. Therefore one of the most important findings is that a shorter duration of untreated psychosis is associated with greater response to antipsychotic treatment and improvements in positive and negative symptoms and functional outcomes (Buchanan et al, 2010; Dixon et al, 2010; Kreyenbuhl et al, 2010; Norman et al, 2011; McFarlane, 2011). **Empirically validated treatments related to schizophrenia are summarized in Table 20-5.**

QUALITY AND SAFETY ALERT

- Early diagnosis and early treatment are critical in shortening the course of psychotic illness and promoting recovery.
- Early intervention improves both prognosis and quality of life.

Interventions in the Crisis and Acute Phases

Unstable neurobiological responses require constant observation and monitoring of health, behavior, and attitudes. Nursing interventions in this phase should focus on restoring adaptive neurobiological responses while providing for the safety and well-being of the patient.

Patient Safety. **About 9% to 13% of patients with schizophrenia commit suicide, and 20% to 40% attempt suicide** (Hor and Taylor, 2010). Therefore it is important to maintain constant vigilance with the patient and carefully explain all actions involving the patient.

Patients may accidentally harm themselves because of impaired judgment or as a response to their hallucinations or delusions. For example, a patient with a badly abscessed tooth refused to go to the dentist. He was afraid the dentist would plant a radio in his tooth that would broadcast his thoughts to those who were trying to harm him. Unfortunately, patients often have difficulty distinguishing between people who are trying to help them and those who they believe want to harm them.

Staff can create safety issues for patients when they fail to respond to patient needs in a caring and appropriate manner. Patients should not feel threatened, belittled, anxious, ignored, rejected, or controlled by staff. Helping the patient reduce anxiety and feel safe and accepted decreases the incidence

TABLE 20-5 SUMMARIZING EVIDENCE-BASED TREATMENTS FOR *Neurobiological Responses*

DISORDER	TREATMENT
Schizophrenia	Both the typical and the atypical antipsychotic drugs improve psychotic symptoms in the acute phase of the illness and reduce risk of future relapse. The use of atypical antipsychotics is promising because of their reduced side effects and enhanced efficacy in some patients. The schizophrenia PORT recommends the following evidence-based psychosocial treatments: skills training, supported employment, cognitive behavioral therapy, behavior modification, social learning/token economy interventions, assertive community treatment, and family psychoeducation.

From Nathan P, Gorman J: *A guide to treatments that work,* ed 3, New York, 2007, Oxford University Press.
PORT, Patient Outcomes Research Team.

of harmful behaviors toward self and others. The ability of patients to be successful in later phases of recovery is directly related to their perception of their initial treatment experience.

QUALITY AND SAFETY ALERT

- Patient safety is the most important issue during the crisis and acute phases of illness due to high rates of suicide among those with psychosis.

Managing Delusions. Patients cope with delusions in several ways. Some adapt by learning to live with them. Others deny the presence of these troublesome symptoms. Still others seek to understand the symptom and become empowered to manage delusions when they occur.

The art of communicating with people who have delusions requires the development of trust. Patients with cognitive disorders have difficulty processing language; therefore the beginning of trust is more readily accomplished through nonverbal communication.

Patients with delusions perceive the environment as very stimulating. It is essential for the nurse to approach the patient with calmness and empathy. Patients report they can literally "feel the vibrations" of others and can "sense if the nurse is with me or against me." Once trust is established, the use of clear, direct, and simple statements becomes significant in communicating with people who have delusions.

Critical Reasoning Describe nonverbal nursing approaches that would foster the development of trust between a nurse and a delusional patient.

Patients with schizophrenia are very sensitive to rejection. When they sense anxiety and avoidance in the nurse, they often feel annoyed, inadequate, and hopeless. Sensing rejection by health care professionals also can lead to anger on the part of the patient.

With insight into the illness and symptoms, the patient can differentiate experiences with delusions from those that are reality based. In the meantime the nurse should not underestimate the power of a delusion and the patient's inability to differentiate the delusion from reality.

The intervention plan should be followed consistently by the entire treatment team. If the nurse resorts to "trying anything" to gain compliance, care will be inconsistent and will create an even more chaotic environment for the patient, who already has great difficulty identifying reality.

Box 20-9 identifies strategies that are helpful in working with a patient who is delusional. Box 20-10 identifies barriers to intervention for patients who are delusional.

Managing Hallucinations. Approximately 70% of hallucinations are auditory, 20% are visual, and the remaining 10% are gustatory, tactile, olfactory, kinesthetic, or cenesthetic. Therapeutic nursing interventions for hallucinations involve understanding the characteristics of the hallucination and identifying the related anxiety level. Table 20-6 describes intensity levels, characteristics, and observable behaviors commonly associated with hallucinations.

The goal of intervention with patients who are hallucinating is to help them increase awareness of these symptoms so that they can distinguish between the world of psychosis and the world of reality experienced by others without schizophrenia. The first step toward achieving this goal is facilitative communication. Unfortunately, patients who are experiencing these symptoms are often avoided, laughed at, or ignored when these symptoms emerge.

Learning about a person's hallucinations helps avoid the roadblocks to communication that these symptoms can create when unrecognized. Left unattended, hallucinations will continue and may escalate. Nurses may become so involved in planning what to say that they forget about the importance of listening. Listening and observing are the keys to successful intervention with a person who is hallucinating.

Hallucinations are very real to the person having them. The hallucinating person may have no way to know whether these perceptions are real, and it usually does not even occur to the person to verify the experience. Inability to perceive reality accurately makes life difficult. Therefore hallucinations can be considered problems needing a solution. This is best accomplished when the person can talk freely about the hallucinations.

Nurses also need to be able to talk about hallucinations because they are useful signs of the current level of symptoms in the ongoing monitoring of a psychotic illness. To do this, the patient needs to be comfortable telling the nurse about symptoms.

Patients often learn not to discuss their unusual experiences with anyone because they have received negative responses from people who think their ideas are strange. The experience of hallucinations can be especially troublesome for the patient who does not have anyone to talk to about them. Being able to talk about one's hallucinations is a greatly reassuring and self-validating experience. This discussion can take place only in an atmosphere of genuine interest and concern.

For those who have never experienced a hallucination, it can be difficult to understand that the person has no control over it. People with a true psychosis have no direct voluntary control over the brain malfunction that causes hallucinations. This means that they cannot just will them away. Ignoring hallucinations may increase the confusion of the already chaotic brain filled with delusional ideas and disjointed thoughts.

If the person is left alone to sort out reality without the input of trusted health care providers, the symptoms may become overwhelming. The discussion of hallucinations is a vital element in the development of reality-testing skills. Communicating at the time of the hallucination is particularly helpful. **Honesty, genuineness, and openness are the foundation for effective communication during hallucinations.**

BOX 20-9 STRATEGIES FOR WORKING WITH PATIENTS WHO HAVE DELUSIONS

Place the Delusion in a Time Frame and Identify Triggers

- Identify all of the components of the delusion by placing it in time and sequence.
- Identify triggers that may be related to stress or anxiety.
- If delusions are linked to anxiety, teach anxiety management skills.
- Develop a symptom management program.

Assess the Intensity, Frequency, and Duration of the Delusion

- Fleeting delusions can be worked out in a short time frame.
- Fixed delusions, endured over time, may have to be temporarily avoided to prevent them from becoming stumbling blocks in the relationship.
- Listen quietly until there is no need to discuss the delusion.

Identify Emotional Components of the Delusion

- Respond to the underlying feelings rather than the illogical nature of the delusions.
- Encourage discussion of fears, anxiety, and anger without assuming that the delusion is right or wrong.

Observe for Evidence of Concrete Thinking

- Determine whether the patient takes you literally.
- Determine whether you and the patient are using language in the same way.

Observe Speech for Symptoms of a Thought Disorder

- Determine whether the patient is exhibiting a thought disorder (talks in circles, goes off on tangents, easily changes subjects, or is unable to respond to your attempts to redirect).
- It may not be the appropriate time to point out discrepancy between fact and delusion.

Observe for the Ability to Accurately Use Cause-and-Effect Reasoning

- Determine whether the patient can make logical predictions based on past experiences.
- Determine whether the patient can conceptualize time.
- Determine whether the patient can access and meaningfully use recent and long-term memory.

Distinguish Between the Description of the Experience and the Facts of the Situation

- Identify false beliefs about real situations.
- Promote the patient's ability to reality test.
- Determine whether the patient is hallucinating, because this will strengthen the delusion.

Carefully Question the Facts as They Are Presented and Their Meaning

- Sometimes talking with the patient about the delusion will help the patient see that it is not true.
- If you take this step before the previous steps are completed, it may reinforce the delusion.

Discuss Consequences of the Delusion When the Person Is Ready

- After the intensity of the delusion lessens, discuss the delusion when the patient is ready.
- Discuss the consequences of the delusion.
- Allow the patient to take responsibility for behavior, daily activities, and decision making.
- Encourage the patient's personal responsibility for and participation in wellness and recovery.

Promote Distraction as a Way to Stop Focusing on the Delusion

- Promote activities that require attention to physical skills and will help the patient use time constructively.
- Recognize and reinforce healthy and positive aspects of the personality.

BOX 20-10 BARRIERS TO SUCCESSFUL INTERVENTION FOR DELUSIONS

Becoming Anxious and Avoiding the Person

Anxiety leads to annoyance, anger, a sense of hopelessness and failure, feelings of inadequacy, and potentially laughing at or discounting the patient.

Reinforcing the Delusion

Do not go along with the delusion, especially to get the cooperation of the patient.

Attempting to Prove the Person Is Wrong

Do not attempt a logical explanation.

Setting Unrealistic Goals

Do not underestimate the power of a delusion and the patient's need for it.

Becoming Incorporated into the Delusional System

This will cause great confusion for the patient and make it impossible to establish boundaries of the therapeutic relationship.

Failing to Clarify Confusion Surrounding the Delusion

If the complexity and many intricacies of the delusion are not clearly understood, the delusion will become more elaborate.

Being Inconsistent in Intervention

The intervention plan must be firmly adhered to; if you resort to "trying anything," approaches will become inconsistent and the patient will be less able to identify reality.

Seeing the Delusion First and the Person Second

Avoid making references such as "the person who thinks he's being poisoned."

TABLE 20-6 LEVELS OF INTENSITY OF HALLUCINATIONS

LEVEL	CHARACTERISTICS	OBSERVABLE PATIENT BEHAVIORS
Stage I: Comforting moderate level of anxiety Hallucination is generally pleasant.	The hallucinator experiences intense emotions, such as anxiety, loneliness, guilt, and fear, and tries to focus on comforting thoughts to relieve anxiety. The person recognizes that thoughts and sensory experiences are within conscious control if the anxiety is managed. **Nonpsychotic.**	Grinning or laughter that seems inappropriate Moving lips without making any sounds Rapid eye movements Slowed verbal responses as if preoccupied Silent and preoccupied
Stage II: Condemning severe level of anxiety Hallucination generally becomes repulsive.	Sensory experience is repulsive and frightening. The hallucinator begins to feel a loss of control and may attempt to distance self from the perceived source. Person may feel embarrassed by the sensory experience and withdraw from others. It is still possible to redirect the patient to reality. **Mildly psychotic.**	Increased autonomic nervous system signs of anxiety, such as increased heart rate, respiration, and blood pressure Attention span begins to narrow Preoccupied with sensory experience and may lose ability to differentiate hallucination from reality
Stage III: Controlling severe level of anxiety Sensory experiences become omnipotent.	Hallucinator gives up trying to combat the experience and gives in to it. Content of hallucination may become appealing. Person may experience loneliness if sensory experience ends. **Psychotic.**	Directions given by the hallucination followed rather than objected to Difficulty relating to others Attention span of only a few seconds or minutes Physical symptoms of severe anxiety, such as perspiring, tremors, inability to follow directions
Stage IV: Conquering panic level of anxiety Hallucination generally becomes elaborate and interwoven with delusions.	Sensory experiences may become threatening if person does not follow commands. Hallucinations may last for hours or days if there is no therapeutic intervention. **Severely psychotic.**	Terror-stricken behaviors, such as panic Strong potential for suicide or homicide Physical activity that reflects content of hallucination, such as violence, agitation, withdrawal, or catatonia Unable to respond to complex directions Unable to respond to more than one person

Modulation of sensory stimulation to an optimal level is another useful technique for helping the patient minimize the perceptual confusion (Buffum et al, 2009). Some patients do well with minimal environmental stimulation, whereas others find that noise and distraction help drown out the hallucinations. It is essential to find out how the patient has previously managed hallucinations.

Command hallucinations are hallucinations that tell the patient to take some specific action, such as to kill oneself or harm another. As such, they are potentially dangerous. They may lead a person to perform harmful acts, such as cutting off a body part or striking out at someone at the instruction of voices. Fear caused by these often frightening hallucinations also can lead to dangerous behaviors, such as jumping out a window. Because of the potential seriousness of this symptom, intervention is crucial.

QUALITY AND SAFETY ALERT

- It is important to assess for command hallucinations, because patients may respond to these by engaging in behavior that hurts themselves or others.

Intervening during the acute phase of hallucinations requires patience and the ability to spend time with the patient. Box 20-11 outlines strategies that are useful in working with patients who experience hallucinations. Adhering to the following four basic principles is helpful during this phase:

- Maintain eye contact
- Speak simply and in a slightly louder voice than usual
- Call the patient by name
- Use touch as appropriate

The patient needs sensory validation to override the abnormal sensory processes that are occurring in the brain. Traditional interventions have often focused on isolating the patient. However, isolating a person during this time of intense sensory confusion often reinforces the psychosis and therefore is not a recommended intervention. As with delusions, consistency is the essential ingredient to a successful intervention plan (Gerlock et al, 2010).

Psychopharmacology. Psychopharmacology is a major part of the treatment for maladaptive neurobiological responses. Medications include **typical and atypical antipsychotics;** their indications, side effects, and adverse reactions are described in Chapter 26. Drugs that are more site- and symptom-specific

BOX 20-11 STRATEGIES FOR WORKING WITH PATIENTS WHO HAVE HALLUCINATIONS

Establish a Trusting Interpersonal Relationship

If you are anxious or frightened, the patient will be anxious or frightened also.
Be patient, show acceptance, and use active listening skills.

Assess for Symptoms of Hallucinations, Including Duration, Intensity, and Frequency

Observe for behavioral clues that indicate the presence of hallucinations.
Observe for clues that identify the level of intensity and duration of the hallucination.
Help the patient record the number of hallucinations that are experienced each day.

Focus on the Symptom and Ask the Patient to Describe What Is Happening

Empower the patient by helping the patient understand the symptoms experienced or demonstrated.

Help the Patient Manage the Hallucinations

Encourage self-monitoring of what makes the voices better or worse.
Suggest helpful distractions, such as listening to music, keeping busy, using relaxation techniques.

Identify Whether Drugs or Alcohol Have Been Used

Determine whether the person is using alcohol or drugs (over-the-counter, prescription, or street drugs).
Determine whether these may be responsible for or exacerbate the hallucinations.

If Asked, Point Out Simply That You Are Not Experiencing the Same Stimuli

Respond by letting the patient know what is actually happening in the environment.
Do not argue with the patient about differences in perceptions.
When a hallucination occurs, do not leave the person alone.

Suggest and Reinforce the Use of Interpersonal Relationships as a Symptom Management Technique

Encourage the patient to talk to someone trusted who will give supportive and corrective feedback.
Help the patient in mobilizing social supports.

Help the Patient Describe and Compare Current and Past Hallucinations

Determine whether the patient's hallucinations have a pattern.
Encourage the patient to remember when hallucinations first began.
Pay attention to the content of the hallucination; it may provide clues for predicting behavior.
Be especially alert for command hallucinations that may compel the patient to act in a certain way.
Encourage the patient to describe past and present thoughts, feelings, and actions as they relate to hallucinations.

Help the Patient Identify Needs That May Be Reflected in the Content of the Hallucination

Identify needs that may trigger hallucinations.
Focus on the patient's unmet needs, and discuss the relationship between them and the presence of hallucinations.

Determine the Impact of the Patient's Symptoms on Activities of Daily Living

Provide feedback regarding the patient's general coping responses and activities of daily living.
Help the patient recognize symptoms, symptom triggers, and symptom management strategies.

and provide a better response with fewer side effects will ultimately improve patient adherence and patient outcome. Table 20-7 summarizes the medications most often prescribed for maladaptive neurobiological responses.

Cognitive Behavioral Therapy. Cognitive behavioral therapy (CBT) is effective as an adjunct to antipsychotic medication and remedial approaches, such as social skills training, in the management of residual symptoms of chronic schizophrenia (Kingdon et al, 2008; Pinninti et al, 2010).

CBT is a method of changing patients' thought processes, behaviors, and emotions (Chapter 27). Implementing CBT using a psychoeducational approach in addition to routine care can reduce the common positive psychotic symptoms of hallucinations and delusions in patients with chronic schizophrenia. It improves the coping of patients with schizophrenia through greater patient adherence and symptom management.

CBT techniques include development of trust, enhancing coping strategies, reality testing, and working with dysfunctional affective and behavioral reactions to psychotic symptoms. Four CBT principles for dealing with psychosis are as follows:

1. **Normalization:** the explanation of psychosis and how anyone can experience similar symptoms in extreme situations
2. **Universality:** the understanding that many people have experiences similar to the patient's
3. **Collaborative therapeutic alliance:** the patient is regarded not as a passive recipient but as an active collaborator in treatment
4. **Focus on life goals:** makes treatment meaningful to the patient

Other cognitive behavioral techniques include cognitive enhancement therapy and cognitive remediation. They specifically focus on improving cognitive deficits by targeting specific neuropsychological functions (Eack et al, 2009). Most cognitive remediation programs use three basic approaches:

1. **Compensatory strategies** that are based on the idea that there are alternative ways to perform a task
2. **Adaptive strategies** that refer to changes in the environment rather than the individual

TABLE 20-7 ANTIPSYCHOTIC DRUGS

GENERIC NAME (TRADE NAME)	USUAL ADULT DAILY DOSAGE RANGE (mg/day)
Atypical Drugs	
Aripiprazole (Abilify)	5-30
Asenapine (Saphris)	10-20
Clozapine (Clozaril)	100-900
Iloperidone (Fanapt)	12-24
Lurasidone (Latuda)	40-80
Olanzapine (Zyprexa)	5-20
Paliperidone (Invega)	3-12
Quetiapine (Seroquel)	150-750
Risperidone (Risperdal)	1-6
Ziprasidone (Geodon)	40-160
Typical Drugs	
Chlorpromazine (Thorazine)	200-1000
Fluphenazine (Prolixin)	2-60
Fluphenazine decanoate (Prolixin D)	12.5-50 every 2-4 weeks
Haloperidol (Haldol)	2-20
Haloperidol decanoate (Haldol D)	50-300 every 3-4 weeks
Loxapine (Loxitane)	20-100
Mesoridazine (Serentil)	75-300
Molindone (Moban)	50-225
Perphenazine (Trilafon)	8-32
Pimozide (Orap)	2-6
Prochlorperazine (Compazine)	5-10
Thioridazine (Mellaril)	200-800
Thiothixene (Navane)	5-30
Trifluoperazine (Stelazine)	5-20

3. **Drill and practice strategies** that assume that repeated exposure to an activity improves the skills needed to perform that task

BOX 20-12 A FAMILY SPEAKS

When our daughter, Sue, was in college, she began to change quite suddenly. She had been almost a perfect child. She got good grades all the way through high school, and we never worried that she would get into trouble. In fact, we used to feel sorry for our friends who suspected that their children were experimenting with drugs and sex, hanging out with wild friends, and failing at school.

What a shock it was when we visited Sue and she had completely changed. Her room was a mess. She was wearing sloppy clothes and obviously needed a bath. When we asked what was wrong, she denied there was a problem and then became angry and refused to say anything more to us at all. When we got home, we called a counselor at the college, who told us that Sue was about to flunk out. She had not been attending classes, and other students had been reporting that she was "living in her own world."

We returned to the college to take our daughter home. We immediately took her to a psychiatrist, who said that she was schizophrenic and referred her to a hospital. We were frightened, confused, and depressed. We had little understanding of schizophrenia, except that it is a terrible disease that people never recover from and they usually end up being in a hospital forever. We also felt guilty that we had perhaps failed Sue in some way.

What a relief it was to talk with her primary nurse. She immediately scheduled us for a family education group that met at the hospital. Every time that she was working when we visited, she made sure to spend time with us so we could ask questions, and we had a million of them. Most important, she told us about the National Alliance on Mental Illness. It was so reassuring to meet and talk with other family members who knew what we were going through. We know now that our daughter may never achieve the potential that we once thought she had, but she can lead a full and productive life. We continue to learn with her about how that will happen for her.

Interventions in the Maintenance Phase

Nursing interventions that focus on teaching self-management of symptoms and identifying symptoms associated with relapse are very useful in the maintenance phase. Patient teaching should involve caregivers whenever possible (Box 20-12). A Family Education Plan for understanding the world of psychosis is presented in Table 20-8. Patients and families also should be taught the five classic stages of relapse.

Stages of Relapse. The first two of the five stages of relapse do not involve symptoms that indicate psychosis. This is important, because intervening during these two stages is critical. In the first two stages, the patient is able to seek and to use feedback constructively.

Stage 1: Overextension. In this stage the patient complains of feeling overwhelmed. Symptoms of anxiety are intensified, and great energy is used to overcome them. Patients describe feeling overloaded or unable to concentrate on or complete tasks and tend to forget words in the middle of sentences. Other symptoms of overextension include increasing mental efforts to perform usual activities, decreasing performance efficiency, and easy distractibility.

Stage 2: Restricted consciousness. The previous symptoms of anxiety are joined by symptoms of depression. The depression is more intense than usual daily mood variations. There are added dimensions of appearing bored, apathetic, obsessional, and phobic. Somatization may occur. The patient seems to withdraw from everyday events and limits external stimulation as a way to protect against the upcoming loss of control.

Stage 3: Disinhibition. The first appearance of psychotic features occurs in this stage. Symptoms may resemble those of hypomania and usually include the emergence of hallucinations and delusions that the patient is no longer able to control. Previously successful defense mechanisms tend to break down.

Stage 4: Psychotic disorganization. In this stage, overtly psychotic symptoms occur. Hallucinations and delusions intensify, and the patient ultimately loses control. This stage is characterized by three distinct phases:

TABLE 20-8 FAMILY EDUCATION PLAN

Understanding Psychosis

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Describe psychosis.	Introduce participants and leaders. State purpose of group. Define terminology associated with psychosis.	The participant will describe the characteristics of psychosis.
Identify the causes of psychotic disorders.	Present theories of psychotic disorders. Use audiovisual aids to explain brain anatomy, brain biochemistry, and major neurotransmitters.	The participant will discuss the relationship between brain anatomy, brain biochemistry, and major neurotransmitters and the development of psychosis.
Define schizophrenia according to symptoms and diagnostic criteria.	Lead a discussion of the diagnostic criteria for schizophrenia. Show a film on schizophrenia.	The participant will describe the symptoms and diagnostic criteria for schizophrenia.
Describe the relationship between anxiety and psychotic disorders.	Present types and stages of anxiety. Discuss steps in reducing and resolving anxiety.	The participant will identify and describe the stages of anxiety and ways to reduce or resolve it.
Analyze the impact of living with hallucinations.	Describe the characteristics of hallucinations. Demonstrate ways to communicate with someone who is hallucinating.	The participant will demonstrate effective ways to communicate with a person who has hallucinations.
Analyze the impact of living with delusions.	Describe types of delusions. Demonstrate ways to communicate with someone who has delusions. Discuss interventions for delusions.	The participant will demonstrate effective ways to communicate with a person who has delusions.
Discuss the use of psychotropic medications.	Provide and explain handouts describing the characteristics of psychotropic medications prescribed for schizophrenia.	The participant will identify and describe the characteristics of medications prescribed for self/family member.
Describe the characteristics of relapse and the role of compliance with the therapeutic regimen.	Help participants describe their own experiences with relapse. Discuss symptom management techniques and the importance of complying with the therapeutic regimen.	The participant will describe behaviors that indicate an impending relapse and discuss the importance of symptom management and compliance with the therapeutic regimen.
Analyze behaviors that promote wellness.	Discuss the components of wellness. Relate wellness to the elements of symptom management.	The participant will analyze the effect of maintaining wellness on occurrence of symptoms.
Discuss ways to cope adaptively with psychosis.	Lead a group discussion focused on coping behaviors and the daily problems in living with psychosis. Propose ways to create a low-stress environment.	The participant will describe ways to modify lifestyle to create a low-stress environment.

1. The patient no longer recognizes familiar environments or people and may accuse family members of being impostors. Extreme agitation is possible. This phase is called **destructuring of the external world.**
2. The patient loses personal identity and may refer to himself in the third person. This is called **destructuring of the self.**
3. Total fragmentation, or total loss of the ability to differentiate reality from psychosis, may be called **loudly psychotic.** The patient experiences complete loss of control. Hospitalization is usually required at this point, and family members may have to enlist law enforcement officers to take the patient to the hospital. When this happens, it is extremely devastating and embarrassing to both the patient and the family.

Stage 5: Psychotic resolution. This stage usually occurs in the hospital. The patient is generally medicated and still experiencing psychosis, but the symptoms are "quiet." The person may appear to follow instructions in a robotic manner and often looks dazed. Unfortunately, many patients are discharged while in this stage because they are compliant or they no longer have insurance benefits.

> **Critical Reasoning** How would you approach a patient and family regarding the need for a change in the treatment plan at each stage of the relapse process? Why is it important to identify relapse as soon as possible?

An example of how well patients can recognize their symptoms compared with staff and families is described in the following clinical example.

CLINICAL EXAMPLE

During a class on relapse and symptom management, a patient was asked what symptoms caused his return to the hospital. The patient responded, "It was my red dots." When asked to explain, he said, "I see red dots all the time, but when they change in a way that I can no longer tell the difference between my red dots, brake lights of the car in front of me, or stop lights, I know it's time to go back to the hospital for a medication check." A staff member said, "So that's why you are always staring at the exit sign, because it's red?" The patient nodded, and the staff member continued with, "So why didn't you tell us?" The patient simply said, "You didn't ask."

This example clearly demonstrates the need to teach patients about symptoms that are indicative of relapse and also to ask what they already know about their own symptoms.

Managing Relapse. The key to managing relapse is awareness of the onset of behaviors indicating relapse. About 70% of patients and 90% of families are able to notice symptoms of illness recurrence, and almost all patients know when symptoms are intensifying.

A prodromal phase occurs before relapse. The **prodromal phase** is the time between onset of symptoms and the need for treatment. It can be as short as a week or as long as a month. It is essential that nurses collaborate with the patient, family, and other staff regarding the onset of relapse. Box 20-13 presents a guide for patients on how best to handle a potential relapse.

Identifying and managing behaviors and symptoms helps to decrease the number and severity of relapses. Teaching this to patients and families is a cost-effective intervention that can give them control over their lives and decrease the number and length of hospitalizations. Many studies have shown a decrease in relapse rates as a result of such psychoeducational interventions (Glynn et al, 2010).

QUALITY AND SAFETY ALERT

- After the acute phase of illness, recovery is based on helping the patient learn symptom triggers, the early signs of relapse, and effective symptom management techniques.

Tools such as the Moller-Murphy Symptom Management Assessment Tool (MM-SMAT) (Murphy and Moller, 1993) can help the patient self-report symptoms, difficulties in activities of daily living, problems with medications, and ways of managing symptoms. Once patients can validate their experiences, they are empowered to manage symptoms rather than have the symptoms rule their lives.

Critical Reasoning How can self-assessment of symptoms be an empowering experience for patients? How might it positively affect the nurse-patient relationship?

When assessing symptom stability of any chronic illness, it is important to evaluate whether daily symptoms are better, about the same, or worse than usual. Some patients with schizophrenia have psychotic symptoms daily yet are able to maintain adaptive responses and carry out activities of daily living. Relapse for these patients is usually indicated by an increase in symptom intensity.

BOX 20-13 A PATIENT'S GUIDE FOR HANDLING POTENTIAL RELAPSE

- Go to a safe environment with someone who can help you if help is needed. This person should be able to monitor behavior that indicates the relapse is getting worse.
- Reduce the stress and demands on yourself. This includes reducing stimuli. Some people find a quiet room where they can be alone, perhaps with soft music. Relaxation techniques or distraction techniques may work for you. A quiet place where you can talk with one person you trust is often helpful.
- Take medications if this is part of your program. Work with your prescriber to determine whether medications may be useful in reducing relapse. Medications are most helpful when used with a safe, quiet environment and stress reduction.
- Talk to a trusted person about what the voices are saying to you or about the thoughts you are having. This person needs to know ahead of time that you will call if you need help.
- Avoid negative people who say things such as, "You are thinking crazy" or "Stop that negative talk."

The nurse conducting discharge teaching or working in an outpatient or residential setting must stress the lengthy adaptation process, with special emphasis on the sedative qualities of the medications that are often used to prevent relapse. When families and residential supervisors who do not understand the length of time needed for recuperation complain that the patient just wants to sit around, smoke, and watch television, the nurse is encouraged to provide information on the postpsychotic adjustment process. The following clinical example illustrates this behavior.

CLINICAL EXAMPLE

A 26-year-old man with a medical diagnosis of schizophrenia who had experienced a lengthy relapse was discharged from an acute care setting and admitted to a residential group home affiliated with a local mental health center. He was later asked to leave both community-based treatment programs because he was not able to actively engage in the required therapies. He was discharged to the care of his parents, who were to motivate him to take his medications and engage him in some type of therapy, eventually leading to a job. The parents were active in the National Alliance on Mental Illness (NAMI).

After months of frustration, the parents attended a program on relapse and learned about the lengthy rehabilitation period required. They were encouraged to make sure their son ate well and kept up daily hygienic practices, to stop trying to force him to go out, and to support his basic needs based on the wellness model. After 6 months, the

BOX 20-14 SYMPTOM MANAGEMENT TECHNIQUES

Category 1: Distraction
- Listen to music
- Concentrate on hobby
- Watch TV
- Read
- Take a walk/go swimming/go for a ride
- Go to the forest, mountains, beach, or park
- Use humor
- Dance
- Go to a party or concert
- Sing/play a musical instrument
- Work
- Write

Category 2: Fighting Back
- Talk to self (self-talk)
- Don't pay attention to the thoughts
- Yell back at the voices
- Try to think positively
- Avoid situations that cause the symptoms to get worse
- Do a rehearsal (problem solve an upsetting incident)

Category 3: Isolation
- Stay home
- Go to bed
- Try to live with symptoms

Category 4: Attempts to Feel Better
- Pray
- Eat
- Take prescription medication
- Use relaxation/meditation
- Take a shower/bath
- Take herbs
- Hug pillow/stuffed animal

Category 5: Help Seeking
- Talk to family members/friends
- Go to a hospital/emergency room
- Go to a mental health center/clinic
- Talk to the doctor/nurse
- Talk to case manager/therapist

patient said that he wanted to play a sport at which he had previously excelled. He was encouraged to practice and then entered competition. After that positive experience, he was able to reenter life within the limits of his neurobiological responses.

Selected Nursing Diagnoses
- Impaired social interaction related to low energy during recovery, as evidenced by resistance to involvement in activities
- Caregiver role strain related to parents' unrealistic expectations for rapid recovery, as evidenced by positive response to education about relapse and recovery

Anxiety and depression are often overlooked as major contributors to poor health-related practices of people with schizophrenia. Common behaviors related to anxiety include pacing, restlessness, irritability, quickness to anger, and withdrawal. The high incidence of suicide among people with schizophrenia mandates the importance of assessing lethality, potential dangerousness toward self, and risk of discontinuing treatment against medical advice. Because of impaired information processing, patients also should be assessed for potential danger to others.

Finally, a variety of **symptom management techniques** have been found useful by patients. Box 20-14 categorizes these techniques. Patients who have found other symptom management techniques should be encouraged to use them as long as the technique is not harmful to self or others.

The following six steps can serve as a guide to the teaching of effective symptom management techniques:

1. **Identify problem symptoms.**
2. **Identify current symptom management techniques.**
3. **Identify specific support systems.**
4. **Discuss additional symptom management techniques.**
5. **Eliminate nonproductive symptom management.**
6. **Develop new symptom management plan.**

Relapse and Medications. **Patients will most likely stop taking their medications sometime in the first year after diagnosis.** They will stop taking them because the medication worked and symptoms are gone or because the medication did not work and symptoms did not go away. The important Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study found that 74% of patients discontinued their medicine within a few months, regardless of the antipsychotic drug they were taking (Lieberman and Stroup, 2011).

QUALITY AND SAFETY ALERT

- The most common causes of relapse relate in some way to medications.
- Engaging the patient in medication decision making is essential.
- Nurses should focus on the patient's unique perspective, level of motivation, life goals, and treatment preferences.
- The patient needs to be taught about the effects and side effects of the medication.
- Nurses must be sensitive to feedback from the patient concerning how the medication makes the patient feel and adjust the treatment plan accordingly.

Patients also stop taking their medication because of side effects or because they believe the medication increases stigma. Patients who have little insight or awareness of their illness are at risk for discontinuing their medication (Velligan et al, 2010; Tranulis et al, 2011).

Unfortunately, one of the first things nurses often do in assessing relapse is to blame the patient for not taking

medications without finding out why the patient stopped. Patients may think nothing is really wrong and may take the medications just to follow orders. The nurse should realize that relapse is likely to occur whether the patient is taking medications or not, particularly if the patient has poor health practices. However, the onset, quality, and length of relapse depend largely on adherence to the treatment regimen.

People with schizophrenia relapse at a rate of 60% to 70% within the first few years after diagnosis. For those who are faithful to the medication regimen, the relapse rate is approximately 40% but drops to 15% with a combination of medications, group education, and support. Even with support, education, and adherence to the treatment regimen, relapse still occurs. This emphasizes the need for ongoing symptom monitoring, patient education, and identification of factors leading to nonadherence (Goff et al, 2010).

Noncompliant patients tend to have a gradual onset of relapse with prominent psychotic features and generally enter treatment through an involuntary hospital commitment. They usually require a longer hospitalization and a change in medication. Typically, they cannot trace the onset of the relapse to any specific trigger.

Patients who adhere to their medication regimen yet still experience relapse tend to have a rapid onset of mood-related symptoms. They typically recover quickly with minimal or no change in their antipsychotic medications. These patients usually volunteer for treatment and are generally able to trace the onset of their relapse to an identifiable stressor.

Cooperative medication management can be fostered if the patient is included as an equal partner in treatment. **Nurses should focus on the patient's unique perspective, level of motivation, and treatment goals and preferences.** Engaging the patient in medication decision making is essential (Hamann et al, 2011). The patient needs to be taught about the effects and side effects of the medication, and the staff and family must be sensitive to feedback from the patient concerning how the medication makes the patient feel.

Predicting the success of any medication is impossible if the patient consumes alcohol or other drugs, particularly caffeine and nicotine (Bobes et al, 2010). Research involving a variety of ethnic groups also has determined that enzyme variations among population groups cause medications to act and metabolize differently in people of different ethnic or racial backgrounds (Chaudhry et al, 2008; Chee et al, 2008).

QUALITY AND SAFETY ALERT

- Caffeine and nicotine can inhibit the action of psychotropic medications.

Interventions in the Health Promotion Phase

Teaching in the health promotion phase focuses on prevention of relapse and symptom management through engaging the patient in a healthy lifestyle. Patient teaching methods that involve simple, clear, and concrete instructions, including repetition and return demonstrations, are the most helpful. **One of the keys to preventing relapse is identifying symptom triggers and strategies for managing them.** Box 20-15 summarizes nursing interventions intended to prevent relapse.

BOX 20-15 NURSING INTERVENTIONS TO PREVENT RELAPSE

- Identify symptoms that signal relapse.
- Identify symptom triggers.
- Select symptom management techniques.
- Identify coping strategies for symptom triggers.
- Identify support system for future relapse.
- Document action plan in writing, and file with key support people.
- Facilitate integration into family and community.

Family members often do not know how to react to more autonomous functioning and need as much teaching and support as the patient. Psychotherapy also may be helpful in this phase of recovery as patients deal with the neurobiological deficits that often become apparent. The focus of the psychotherapy is usually supportive and nonconfrontational.

Many families make comments such as, "When we learned our son's diagnosis was schizophrenia, it was like he had died." Therefore it is understandable that schizophrenia remains a closely held secret in many households. Such attitudes often prevent families from effectively coping with schizophrenia.

The situation may be complicated by incorrect advice from health professionals who tell or imply to families that they have caused or perpetuated the illness. Parental guilt stemming from self-blame further blocks communication within the family. Parents often do not know how to talk with their ill child and perhaps even fear their child. Clearly this situation does not help parents face the many problems they encounter in their additional roles of case manager, residential supervisor, and legal guardian.

Parents also must act as negotiators among the assigned case manager, guardian, and adult child. No one knows a patient better than the family, but it can be emotionally painful and draining to be a loving, nurturing, advocating parent in one situation, a treatment-enforcing case manager in another, and a residential supervisor to an outside case manager in yet another.

Simultaneous patient/family teaching about symptom management and medication compliance is useful at this stage. Patient and family education also may dispel myths and provide suggestions for improving communication with the treatment team.

Research shows that structured recovery-oriented programs and specialized first-episode psychosis early intervention programs provide significant improvement in function and coping skills. Four programs with structured curricula

and participant manuals have been developed that have as their main goal either to rehabilitate the patient or to help the family cope more effectively with chronic mental illness:

1. The **Three Rs Psychiatric Rehabilitation Program** is for patients with chronic mental illness and their families (Moller and Murphy, 1997, Moller and Rice, 2006). The three Rs are **relapse, recovery,** and **rehabilitation.** The aim of the program is to teach patients to use a wellness model to manage their illness and integrate back into the community. Developed by advanced practice psychiatric nurses, this program has resulted in a significant decrease in hospitalization among its participants.
2. Liberman's **Skill Training Program** has as its aim the rehabilitation of patients by teaching life skills (Liberman et al, 1994). The patient is taken through a structured set of modules that teach coping strategies to effect life changes.
3. McFarlane's **Family Education Program** is aimed at teaching families about schizophrenia and helping them cope with the illness (McFarlane, 1992). This is the only program that is exclusively for families and uses professionals specifically trained to conduct the program.
4. **Family-to-Family** is a self-help program developed by NAMI for families of people with chronic mental illness. It is a scripted program that uses family members who are trained to facilitate the program. It is further described in Chapter 10.

In the health promotion phase, promoting a health lifestyle is an essential nursing intervention. **Physical activity should be encouraged.** Structured group programs can be effective for persons with schizophrenia, including individual or group walking programs and dietary control (Beebe and Smith, 2010; Beebe et al, 2010; Weber, 2010). **Patients also should be helped to stop smoking and to eat a healthy diet** (Cabassa et al, 2010).

A Nursing Treatment Plan Summary for the patient with maladaptive neurobiological responses is presented in Table 20-9.

QUALITY AND SAFETY ALERT

- The physical health needs of this population are often neglected or ignored.
- In providing biopsychosocial care, nurses should emphasize the importance of a healthy lifestyle, including regular physical examinations and appropriate preventive care, such as for cancer screening, dental health, and vision.

EVALUATION

Evaluation of the nursing care provided to patients who have maladaptive neurobiological responses includes input from the patient and family. Because these are serious, long-term illnesses, care is often episodic. Relapse should not be interpreted as a failure of the nursing intervention but should be considered in the context of the patient's life situation. To evaluate the nursing intervention, the following questions may be asked:

- Are the core symptom clusters of the disease improved?
- Is the treatment burden reduced, with limited side effects and long-term health risks?
- Has the burden of illness been decreased by enhancing adaptive and functional skills and minimizing family burden?
- Have health and wellness been promoted?
- Is the patient able to describe the behaviors associated with the onset of a relapse?
- Is the patient able to identify and describe the medications prescribed, reason for taking them, frequency of taking them, and possible side effects?
- Does the patient participate in relationships with other people?
- Is the patient's family aware of the characteristics of the illness and supportive of the patient?
- Are the patient and family informed about available community resources, such as rehabilitation programs, mental health providers, educational programs, and support groups, and do they use them?

TABLE 20-9 NURSING TREATMENT PLAN SUMMARY

Maladaptive Neurobiological Responses

Nursing Diagnosis: Risk for disturbed personal identity

Expected Outcome: The patient will live, learn, and work at a maximum possible level of success, as defined by the individual.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will participate in brief, regularly scheduled meetings with the nurse.	Initiate a nurse-patient relationship contract mutually agreed on by nurse and patient. Schedule brief (5- to 10-minute), frequent contacts with the patient. Consistently approach the patient at the scheduled time. Extend length of sessions gradually based on patient's agreement.	Establishment of a trusting relationship is fundamental to developing open communication. A patient with disturbed thought processes cannot tolerate extended, intrusive interactions and functions best in a structured environment.

Continued

TABLE 20-10 NURSING TREATMENT PLAN SUMMARY—cont'd

Maladaptive Neurobiological Responses—cont'd

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will describe delusions and other disturbed thought processes.	Demonstrate attitude of caring and concern. Validate the meaning of communications with the patient. Help the patient identify the difference between reality and internal thought processes.	Patients are very sensitive to others' responses to their symptoms. A respectful, interested approach enables the patient to discuss unusual and frightening thoughts. Identification of reality by a trusted person is helpful.
The patient will identify and describe the effect of brain disease on thought processes.	Provide information about causes of psychoses. Discuss the relationship between the patient's behaviors and brain function. Involve significant others in educational sessions.	Understanding the physiological basis for disturbed thought processes helps the patient recognize symptoms and feel in control of the illness. Significant others can provide support and experience less stigma if they are informed about the illness.
The patient will identify signs of impending relapse and describe actions to take to prevent relapse.	Help patient and significant others identify behaviors related to disturbed thought processes that indicate threatened relapse. Identify community resources, and mutually plan actions directed toward prevention of relapse.	Relapse can be predicted if the patient and family are alert to warning signs. Early intervention allows the patient to control the course of the illness. Family members can help the patient identify symptoms and provide support for seeking assistance.
The patient will describe symptom management techniques that are helpful in living with the illness.	Describe symptom management techniques that other patients have used. Ask the patient to describe techniques used to manage symptoms. Encourage the patient to take control of the illness by using symptom management techniques. Discuss the advantages of engaging in a wellness lifestyle.	Many patients with psychoses continue to have delusions after the acute phase of the illness has passed. Patients can function better if they learn ways to manage symptoms. Symptom self-management promotes personal empowerment. Elimination of substances that interfere with healthy CNS function improves cognition and perception.
The patient will engage in a trusting relationship with the nurse.	Initiate a nurse-patient relationship contract mutually agreed on by nurse and patient. Establish mutual goals related to social interaction. Establish trust by consistently meeting the elements of the plan and engaging in open and honest communication.	Patients who have maladaptive neurobiological responses often have difficulty trusting others. Difficulty with information processing causes problems with interpreting the communication of others.
The patient will discuss personal goals related to social interaction.	Encourage the patient to describe current relationship patterns. Discuss past relationship experiences. Identify problems associated with social interaction. Explore goals.	The patient may be unaware of the characteristics of mutually satisfying interpersonal relationships. Honest feedback from the nurse can help the patient identify the reasons for past problems. Knowledge of the patient's relationship goals leads to the development of realistic behavioral change.
The patient will identify behaviors that interfere with social relationships.	Share observations about the patient's behavior in social situations.	Identification of problematic behavior helps the patient and nurse target changes.
The patient will practice alternative social behaviors with the nurse.	Discuss possible behavioral changes that will facilitate the establishment of social relationships. Role play alternative behaviors. Provide feedback.	Practice will help the patient gain comfort with new behaviors. Feedback provides reinforcement for successful behavioral change.
The patient will select one person and practice social interaction skills.	Discuss experience of practicing new behavior with another person. Discuss ways of maintaining a relationship.	The patient will need ongoing feedback and support related to maintaining behavioral change.

CNS, Central nervous system.

LEARNING FROM A CLINICAL CASE OUTCOME

1. What positive and negative symptoms of schizophrenia did he exhibit?

He exhibited a paranoid delusion that he was being spied upon. His speech patterns at times were bizarre. He experienced auditory hallucinations. These were positive symptoms. His negative symptoms were at times alogia, avolition, and anhedonia.

2. How did his illness affect his social and occupational functioning?

He had previously been ambitious, imagining himself participating on the global stage. He was concerned about water purification and its impact in Third World countries. However, when he became mentally ill, he was no longer able to think abstractly. He had been near the top of his college graduating class, but with this disease he could no longer function independently.

3. What problems in cognitive functioning did he exhibit?

He exhibited behavior consistent with a smaller prefrontal cortex of the brain through loss of executive functioning. It appears that the ventricles in his brain were enlarged, as is typical with this diagnosis, and he was unable to think at a complex level or coordinate his previously utilized mental abilities. Therefore, his cognitive functioning was significantly compromised.

4. What impact did his illness have on his family?

The illness had a major impact. They loved their son and had cheered for him weekly at sports events; he had been the center of their world. The loss of the promise of his life was devastating. They lost their sense of purpose and had to grieve for the son they had known and loved. He no longer seemed like the person they knew.

5. How was his physical health affected?

With his medication, an atypical antipsychotic, he experienced significant weight gain. Although previously very athletic, he spent his time watching television (avolition and anhedonia). The result was onset of type 2 diabetes and heart disease. He also began using substances. This is very common (50% comorbidity with psychotic disorders).

6. What behavioral strategies would help this patient and his family?

Family education could contribute significantly to medication and treatment compliance. This family is very engaged; therefore, teaching them about his illness, alleviating any guilt they may have associated with the illness, and offering reassurance is critical. Medication compliance is critical to treatment of his symptoms. However, not all patients are symptom free even when compliant. Therefore, helping the patient to differentiate between the auditory hallucinations and reality can be very helpful. Job placement has been important in helping this young man and his family. Community-based programs for vocational training and job placement have supported his highest level of functioning. Side effect monitoring regarding medications on a regular basis also would be critical for his health.

7. Make a plan for each treatment phase of the Stuart Stress Adaptation Model

- **Crisis phase:** During the initial stage of treatment, safety is the primary concern. Suicide risk for psychotic individuals must be carefully evaluated, and the patient must be protected. Family education is critical, and assessing means is important. Patients' risk for accidental suicide, such as jumping off a building thinking they can fly or wandering into traffic while distracted, has to be considered during their crisis state.
- **Acute phase:** While a patient with a psychotic illness has active symptoms, a carefully planned and multifaceted treatment regimen must be followed. This involves medication compliance, referral to community agencies that can offer services and support, and in-depth education of the family. Modeling appropriate social behavior and assisting the patient to relate to others is part of a comprehensive treatment plan.
- **Maintenance phase:** Once the patient's symptoms are managed and are in partial remission, the patient's functional status must be evaluated and vocational training initiated. Some individuals with this illness have significant improvement and continue with their life plan and career. However, many require continuous monitoring and support.
- **Health promotion phase:** The negative symptoms of this disease and the side effects of medications put the patient at risk for weight gain and chronic illnesses. Co-morbid substance abuse, noncompliance with medications, and use of cigarettes can produce other risks for chronic illness. Therefore health promotion means supporting recovery as well as promoting positive physical health through prevention and health promotion activities.

Case Outcome

Eventually, he stopped taking drugs and started working at the local grocery store. They had a program to employ people with disabilities, and he became a good worker. He lived in an apartment near his parents, and they made sure he made his appointments and took better care of himself. His nieces and nephews liked playing board games with him in the evenings at their grandparents' house. They knew he was different but loved him. His mother worried about who would look after him after she was gone and hoped he would continue on his road to recovery.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Rebecca Clough, MSN, ARNP, BC

I first met K, diagnosed with paranoid schizophrenia, while working in the medication clinic at a local community mental health center. Ten years after her first psychotic break, she remained stable on a first-generation depot antipsychotic and anticholinergic side effect medication. She was one of my easier patients, since she came faithfully every 3 weeks for her injection. Although her illness had resulted in the loss of her job as a professional artist and a divorce, she was living independently in the community with supportive family members in the local area. She had not required another hospitalization since diagnosis.

Several years after I began working with K, she secured part-time employment with the help of a job coach through the mental health center. Working greatly increased her self-esteem, and she began to discuss her life in terms of future plans. She was insightful about the role psychotropic medication played in her ability to remain stable and continue functioning without another hospitalization.

After attending psychoeducation groups at the mental health center and learning more about recovery and the new atypical antipsychotics, she expressed a desire to do more with her life. Despite being well controlled without positive symptoms, she did have some cognitive slowing and affective blunting and became concerned about continuing long-term treatment with her current medications. After several sessions of discussing the risk-benefit potential for relapse, we decided to begin the switch to an atypical drug. She had natural fears about making the change but ultimately decided she couldn't lose the chance to improve her quality of life, and we began the process of switching.

K quickly became excited at the prospect of recovering some of her lost creativity. Giving up her art work had been a painful loss, and she had long dreamed of returning to her painting. I offered cautious encouragement during the switch, and she placed her trust in me, always remaining positive. Her anxiety became palpable, and it often seemed like paranoia. Her sleep pattern became disrupted, and for a time she required more medicine than ever. Our appointments became more frequent, and phone contact was often daily for many months. Angry and challenging phone calls came from her employer, job coach, and family members. She was no longer "easy" to treat. The majority of her support network demanded that I put her back on her previous medication regimen and abandon the change. Several intense treatment team meetings occurred with multiple family members and her employer. But no matter how difficult it became, K never lost her resolve to make it through the switch.

The course of her life did change. She met a man at church and began a serious dating relationship, bringing many insecurities and adding to her anxiety. She decided to leave her job and enroll in graduate school to pursue art therapy part-time. As I supported her through these changes, I wondered whether her life really was better. But she was firm in stating that having an intimate relationship and resuming her love of painting were exactly what she wanted from life.

I realized that everything happening in her life represented the dynamics of normal life. She was recovering her life, not just managing symptoms. She taught me that it requires more work to support patients who want more than symptom control and stability out of life. I learned that I had to face insecurities as a treatment provider, just as she had to face them in her life. The value of a trusting relationship was immeasurable for both of us during the process. When I last saw her, she was studying in graduate school part-time and working at the mental health center as a consumer provider in the psychosocial rehabilitation program. Both her psychiatric recovery and her life recovery continue.

CHAPTER IN REVIEW

- The range of neurobiological responses includes a continuum from adaptive responses, such as logical thought and accurate perceptions, to maladaptive responses, such as thought distortions, hallucinations, and psychosis.
- Schizophrenia is a serious and persistent neurobiological brain disease. It is one of a group of psychotic disorders.
- Psychosis is sometimes present in other disorders, such as depression with psychotic features, manic episodes of bipolar disorder, posttraumatic stress disorder, delirium, and organic mental disorders.
- About 50% of patients with schizophrenia have a co-occurring substance use disorder, most frequently alcohol or cannabis.
- A common system for categorizing the symptoms of schizophrenia lists them as "positive symptoms" (exaggerated behaviors) and "negative symptoms" (loss of behaviors).
- Symptoms related to problems in information processing associated with schizophrenia include problems in cognitive functioning in all aspects of memory, attention, form and organization of speech, decision making, and thought content.
- Memory problems associated with schizophrenia can include forgetfulness, disinterest, difficulty learning, and lack of compliance.
- Disturbances in attention are common in schizophrenia and include difficulty completing tasks, difficulty concentrating on work, and easy distractibility.
- Problems with form and organization of speech (formal thought disorders) may include loose associations, word salad, tangentiality, illogicality, circumstantiality, pressured speech, poverty of speech, distractible speech, and clanging.
- Problems with decision making include difficulties with insight, judgment, logic, decisiveness, planning, ability to carry out decisions, and abstract thought.

CHAPTER IN REVIEW—cont'd

- The inability of the brain to process data accurately can result in paranoid, grandiose, religious, nihilistic, and somatic delusions.
- Hallucinations are false perceptual distortions that can arise from any of the five senses.
- Problems with sensory integration include pain recognition, soft neurological signs, right/left recognition, and recognition and perception of faces.
- Terms related to affect include broad, restricted, blunted, flat, and inappropriate.
- Problems of emotion usually seen in schizophrenia include alexithymia, apathy, and anhedonia.
- Maladaptive behaviors in schizophrenia include deteriorated appearance, lack of persistence at work or school, avolition, repetitive or stereotyped behavior, aggression and agitation, and negativism.
- Maladaptive movements associated with schizophrenia include catatonia, abnormal eye movements, grimacing, apraxia/echopraxia, abnormal gait, mannerisms, and extrapyramidal side effects of psychotropic medications.
- Symptoms may prevent the person from socializing within accepted sociocultural norms, resulting in social withdrawal and isolation from life's activities. Specific problems in the development of relationships include social inappropriateness, disinterest in recreational activities, inappropriate sexual behavior, and stigma-related withdrawal by friends, families, and peers.
- Individuals with schizophrenia have higher morbidity and mortality because of physical illness and a shortening of the average life span by about 20 years.
- Evidence shows that maladaptive neurobiological responses are complex illnesses that include genetics, dysregulated neurochemistry, and abnormal structure and function of the brain.
- Schizophrenia has genetic causes, because the most significant risk factor is having a first-degree relative with schizophrenia. But it is caused by the interaction of a variety of mechanisms that are biological, environmental, and experiential.
- The two most consistent neurobiological research findings in schizophrenia are decreased brain volume and alterations of many neurotransmitter systems, particularly those involving dopamine and serotonin.
- Precipitating stressors include biological characteristics, environmental stress, and symptom triggers.
- The Stress Diathesis Model proposes that schizophrenic symptoms develop based on the relationship between the amount of stress that a person experiences and an internal stress tolerance threshold.
- Coping resources are individualized and depend on the nature and extent of the neurobiological disruption. Family resources are very important.
- Coping mechanisms may include regression, projection, withdrawal, and denial and represent the person's attempt to control the illness.
- Individuals with schizophrenia go through a lengthy process of adjustment to having had a psychotic break and becoming diagnosed with schizophrenia.
- Primary NANDA-I diagnoses are impaired verbal communication, disturbed sensory perception, impaired social interaction, and disturbed thought processes.
- Medical diagnoses are the schizophrenias, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, and shared psychotic disorder.
- The expected outcome of nursing care is that the patient will live, learn, and work at a maximum possible level of success as defined by the individual.
- The nursing care plan must be based on which phase of postpsychotic adjustment the patient is in and on understanding of the patient's disabilities, strengths, and preferences. Patient and family education about symptom management and relapse prevention is a critical element of the plan.
- Nursing interventions for patients in the crisis and acute phases of illness include providing for patient safety, managing delusions and hallucinations, medication management, cognitive behavioral therapy (CBT), and patient and family education about symptom management and relapse.
- Nursing interventions in the maintenance phase focus on teaching self-management of symptoms and early identification of symptoms indicating relapse.
- Nursing interventions in the health promotion phase help the patient maintain a healthy physical and psychological lifestyle.
- Evaluation is based on the patient's satisfaction with the level of functioning and ability to communicate improvement or impending relapse.

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CHAPTER

21

Social Responses and Personality Disorders

Gail W. Stuart

The quality of your life is the quality of your relationships.

Anthony Robbins

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive social responses.
2. Identify behaviors associated with social responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to social responses.
4. Describe coping resources and coping mechanisms related to social responses.
5. Formulate nursing diagnoses related to social responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to social responses.
7. Identify expected outcomes and short-term nursing goals related to social responses.
8. Develop a patient education plan to promote adaptive social responses.
9. Analyze nursing interventions related to social responses.
10. Evaluate nursing care related to social responses.

To find satisfaction in life, people must have healthy interpersonal relationships, experiencing closeness with others while keeping their own separate identities. **This closeness or intimacy includes sensitivity to the other person's needs, open communication of feelings, acceptance of the other person as valued and separate, and empathic understanding.**

To become intimately involved with another person, an individual must risk revealing private thoughts and feelings. This can be frightening, especially if one has had past difficulty sharing feelings with other people. People who have extreme difficulty in relating intimately to others may have behaviors that are characteristic of a personality disorder.

CONTINUUM OF SOCIAL RESPONSES

The levels of relationships range from intimacy to casual contact. Intimate and interdependent relationships provide security and instill the self-confidence necessary to cope with the demands of daily life. A lack of intimacy with family members and friends leaves only superficial encounters and can exclude many of life's most meaningful experiences.

A person's relationships with others can be analyzed based on the degree of involvement, comfort, and well-being (Figure 21-1):

- **Connectedness** indicates that the person is actively involved in satisfying relationships. It involves high levels of belonging, mutuality, reciprocity, and interdependence.
- **Disconnectedness** relates to a lack of involvement that is not satisfactory to the person.
- **Parallelism** is a lack of involvement that is comfortable and acceptable to the individual.
- **Enmeshment** occurs when the person is involved in relationships but is unable to maintain a unique sense of self and ego boundaries.

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

They were so happy to have found each other. While he was 10 years younger and not very experienced in love, she had much experience and the charm he had been wanting. She had struggled to raise two children alone. Her children were now adults, and she had hoped to find someone to share her life, someone stable and successful, which he certainly was. Her first husband had been a gambler and an alcoholic and just could not be depended upon.

But he was anxious and she was depressed. They had each been struggling with issues related to these symptoms for years but now wanted treatment to make this partnership work. They came in individually and were assessed, diagnosed, and treated with antidepressants. The treatment was successful, and he began to feel more relaxed and confident; her mood was improved, and she became more active in solving problems in her life and more engaged in her work.

He was an accountant, and she ran a nonprofit service for abused children. She poured her creativity into her work. He had the perfect house that needed a family. He was lonely. And she had the family and no house. She needed his stability. They thought they were a match and suddenly announced that they were getting married right away. They had known each other for 6 months.

Soon after they married, her daughter broke up with her boyfriend and needed a place to stay while she got back on her feet. Almost simultaneously, her grant was not refunded because of administrative irregularities, and she found herself without a job. She was delighted her daughter was there and began throwing dinner parties. She loved a house full of life of which she was the center.

But he became very upset. He didn't want all of these people in his house. He was very particular. People scuffed up his floor and left water rings on his coffee table. Her daughter left her curlers out in the bathroom and didn't hang up her towel right. She said if she sat down a glass of water she was drinking, he grabbed it, poured out the water, and put the glass in the dishwasher when she hadn't even finished drinking the water.

They called for an emergency appointment and came in getting in a heated debate about how to put decorative pillows on the bed. He had always put them vertically in front of the other pillows and she said, everyone knows you put them horizontally on the bed. "How could he be so stupid." He had found out, much to her distress, that she was hopelessly in debt. They were at an impasse. It became obvious that they each had a personality disorder.

Case Critical Reasoning Questions

1. What are the features of his and her personality disorders?
2. What would each diagnosis be?
3. What are the predisposing factors of personality, temperament, and character that make their personalities problematic in this relationship?
4. What were the precipitating stressors that created the conflict?
5. What maladaptive coping made it difficult for them to communicate and accept each other's needs?

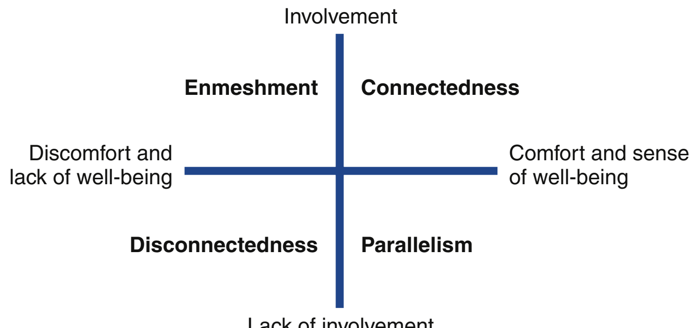

FIG 21-1 States of relatedness. (From Hagerty BMK et al: *Image J Nurs Sch* 25:291, 1993.)

Adaptive and Maladaptive Responses

Within a relationship people usually develop a **balance of dependent and independent behavior, described as interdependence.** The interdependent person can decide when to rely on others and when to be independent. An interdependent person can let another be dependent or independent without needing to control that person's behavior.

All people are responsible for controlling their own behavior while receiving support and help from significant others as needed. **Adaptive social responses include the ability to tolerate solitude and the expression of autonomy, mutuality, and interdependence.** Establishing strong affective bonds with others is crucial to the development of a mature personality.

Interpersonal relationship behaviors may be represented on a continuum that ranges from healthy interdependent interactions to those involving no real contact with other people (Figure 21-2). **At the midpoint of the continuum, a person experiences loneliness, withdrawal, and dependence. The maladaptive end of the continuum includes the behaviors of manipulation, impulsiveness, and narcissism.** People with these responses often have a history of problematic relationships in the family, on the job, and in the social arena.

> **Critical Reasoning** Compare the relationships you have had with family, friends, and patients. How are they alike and different?

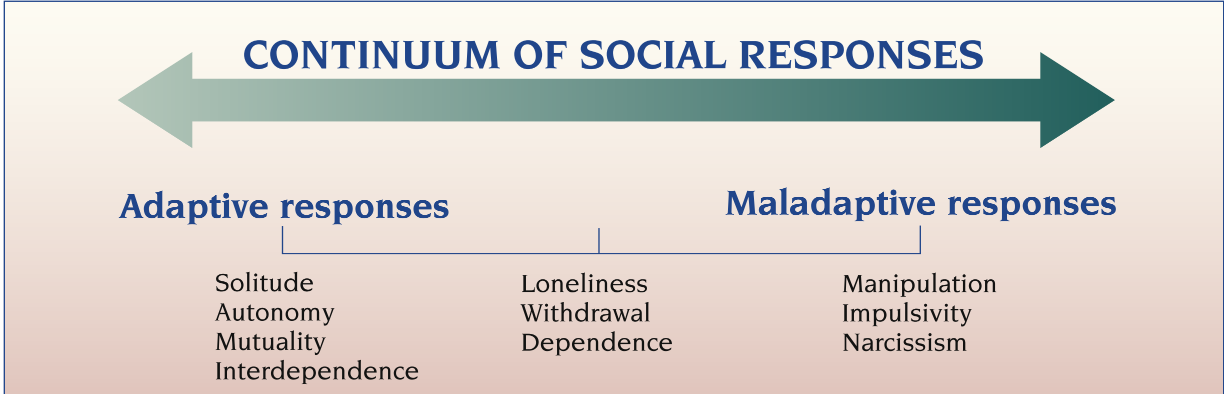

FIG 21-2 Continuum of social responses.

Development Through the Life Cycle

Personality is shaped by biology and social learning. The seed of personality is temperament, which is a set of hereditary biological dispositions, evident almost from birth. Temperament affects mood and activity level, attention span, and responsiveness to stimulation.

Infancy. From birth until 3 months of age the infant does not perceive physical separation between self and mother. Although physical differentiation begins at about 3 months, psychological differentiation does not begin until 18 months. **The period between 3 and 18 months is the symbiotic stage of development.** The infant is completely dependent on others.

Trust develops as needs are met consistently and predictably. The infant experiences the environment as unconditionally loving, nurturing, and accepting. Feelings of positive self-worth result from the infant's complete dependence on an environment that is good and loving. This creates a capacity for empathic understanding in future relationships.

Preschool Years. The period between 18 months and 3 years of age is the separation-individuation stage of development. Separation includes all the experiences and events that promote a sense of being separate and unique. **Individuation** is the development of the child's internal psychological structure and growing sense of separateness, wholeness, and capability.

In this developmental stage the toddler ventures away from the mother to explore the environment and a sense of object constancy develops. This means that the child knows that a valued person or object continues to exist even when it cannot be seen. Games such as peek-a-boo teach object constancy. The child seeks the parents' reassurance, support, and encouragement. If the response is positive and reinforcing, it helps build a solid sense of self and a capacity for interpersonal growth.

Childhood. The development of morality and empathic feelings occurs between the ages of 6 and 10 years. During this time a supportive environment that encourages the budding sense of self fosters development of a positive, adaptive self-concept. Conflict occurs as adults set limits on behavior, often frustrating the child's efforts toward independence. However, loving, consistent limit setting communicates caring and helps the child develop interdependence.

The older child adopts the parents' guidelines for behavior, and a value system begins to emerge. In school the child begins to learn cooperation, competition, and compromise. Peer relationships and approval of adults from outside the family, such as teachers, community leaders, and friends' parents, become important.

Preadolescence. By preadolescence the person becomes involved in an intimate relationship with a friend of the same gender, a best friend. This relationship involves sharing. It offers another chance to clarify values and recognize differences in people. This is usually a very dependent relationship, and it often excludes others.

Adolescence. As adolescence develops, the dependence on a close friend of the same gender is often accompanied by a dependent heterosexual relationship. **While young people are involved in these dependent relationships with peers, they are asserting independence from their parents.** Friends support each other in this struggle. Parents can help the adolescent grow by providing consistent limits. Another step toward mature interdependence is taken as the person learns to balance parental demands and peer group pressures.

Young Adulthood. Adolescence ends when the person is self-sufficient and maintains interdependent relationships with parents and peers. Decision making is independent, taking the advice and opinions of others into account. The person may marry and begin a new family. Occupational plans are made, and a career is begun.

The mature person demonstrates self-awareness by balancing dependent and independent behavior. Others are allowed to be dependent or independent as appropriate. Being sensitive to and accepting the feelings and needs of oneself and others is critical to this level of mature functioning. Interpersonal relationships are characterized by mutuality.

Middle Adulthood. Parenting and adult friendships test the person's ability to foster independence in others.

Children gradually separate from parents, and friends may move away or drift apart. The mature person must be self-reliant and find new supports. Pleasure can be found in the development of an interdependent relationship with children as they grow. Decreased dependent demands by children create freedom that can be used for new activities.

Late Adulthood. Change continues during late adulthood. Losses occur, such as the physical changes of aging, the death of parents, loss of occupation through retirement, and later the deaths of friends and one's spouse. This can result in loneliness or eccentric behavior (Magoteaux and Bonnivier, 2009; Theeke, 2009). The need for relatedness still must be satisfied. The mature person grieves over these losses and recognizes that the support of others can help resolve the grief.

However, new possibilities arise, even with a loss. Old friends and relatives cannot be replaced, but new relationships can be developed. Grandchildren may become important to the grandparent, who may delight in spending time with them. The aging person also may find a sense of relatedness to society as a whole. Life has deeper meaning as one reviews personal accomplishments and contributions.

The mature elderly person can accept whatever increase in dependence is necessary but also strives to retain as much independence as possible. Even loss of physical health does not necessarily force the person to give up all independence. The ability to maintain mature relatedness throughout life enhances one's self-esteem.

ASSESSMENT

Behaviors

Personality is a set of deeply ingrained, enduring patterns of thinking, feeling, and behaving. A **personality disorder** is a set of patterns or traits that hinder a person's ability to maintain meaningful relationships, feel fulfilled, and enjoy life (Newton-Howes et al, 2008). It begins in adolescence or early adulthood, is stable over time, and leads to distress or impairment (Oldham, 2005).

Personality disorders are attitudes toward self, others, and the world expressed in everything a person thinks, feels, and does. They often decrease in severity as a person ages, mainly because of corrective life experiences. Personality disorders are continuous across a wide range of circumstances in the individual's life, although the appearance and severity of a particular symptom can vary over time.

The concept of personality "disorder" suggests that one knows what a normal personality is even though it is very difficult to define. A healthy individual is able to adjust and adapt to the demands or expectations of different people and different situations. **Individuals with personality disorders have a significant and persistent impairment in their interpersonal relationships and other aspects of functioning.**

The following are three key features of personality disorders:

1. **The individual has an inflexible and maladaptive approach to relationships and the environment.**
2. **The individual's needs, perceptions, and behavior tend to foster cycles that promote unhelpful patterns and provoke negative reactions from others.**
3. **The individual's coping skills are unstable and fragile, and there is a lack of resilience when faced with stressful situations.**

It is estimated that about 4% of the general population and as many as 20% in clinical populations have personality disorders, often with significant morbidity (Kernberg and Michels, 2009). Some of these disorders are associated with a high mortality rate because of suicide. Suicide victims with personality disorders almost always also have a depressive illness, substance use disorder, or both.

Many individuals with a current alcohol use disorder have at least one personality disorder, and the association is even stronger with a current drug use disorder. A comorbid personality disorder also prolongs the course of major depression (Skodol et al, 2011).

An essential element of the diagnosis is that the symptoms of personality disorders are fixed and long lasting. Even with treatment, it is not possible to completely change someone's personality. However, it is possible to help people with personality disorders improve the quality of their lives. Treatment can lead to significant improvement in the symptoms, distress, and general functioning of patients with personality disorders.

Personality disorders are characterized by chronic, maladaptive social responses. The *DSM-IV-TR* (American Psychiatric Association, 2000) has grouped personality disorders into three clusters:

1. **Cluster A includes personality disorders of an odd or eccentric nature (paranoid, schizoid, and schizotypal personality disorders).**
2. **Cluster B disorders are of an erratic, dramatic, or emotional nature (antisocial, borderline, histrionic, and narcissistic personality disorders).**
3. **Cluster C includes disorders of an anxious or fearful nature (avoidant, dependent, and obsessive-compulsive personality disorders).**

QUALITY AND SAFETY ALERT

- Patients with borderline and antisocial personality disorders are more likely to attempt suicide.

The nursing assessment and implementation of care for people with antisocial, borderline, and narcissistic personality disorders are emphasized in this chapter. Common maladaptive responses of people with cluster B personality disorders include manipulation, narcissism, and the impulsivity that often overlaps both.

Manipulation. People who use manipulative behaviors present a particularly difficult nursing problem. **Manipulation** is a behavior in which people treat others as objects and form

relationships that center around control issues. Their behavior is easily misunderstood, as illustrated in the following clinical example.

CLINICAL EXAMPLE

Mr. Y was a 20-year-old single man who was committed to an inpatient psychiatric unit by a judge for a psychiatric evaluation. He had been charged with the sale of illicit drugs, statutory rape of his 15-year-old pregnant girlfriend, and contributing to the delinquency of a minor. He had been arrested on the grounds of a junior high school, where he was selling PCP and barbiturates to a group of young teenagers.

In jail Mr. Y had been observed to be "crazy" by the guards. He paced his cell, chanted, and threw his food on the floor. Because of this behavior, the judge agreed to order a psychiatric evaluation. On arrival at the psychiatric unit, Mr. Y continued to behave in the same manner. However, his behavior did not seem typical of psychosis. There was no evidence of hallucinations or disorders of thought or affect. When unaware that he was being observed, Mr. Y seemed relaxed and was noted at one time to be talking with another patient.

By the day after admission he seemed to be free of his symptoms. At this point the staff began to describe him as a "nice guy." He complimented female staff members and behaved toward them in a pleasant but slightly seductive manner. He was respectful to the physicians and agreed to abide by all rules. He was helpful with other patients. In group meetings he admitted that he had behaved badly in the past and described how his friends had led him astray. He said he became involved in drugs because he wanted to be "one of the gang" and he needed money so he "had to" start selling drugs even though he knew better. He began to receive the sympathy of the other patients and the staff.

Four days after admission, after visiting hours, it was noted that Mr. Y and two other patients looked lethargic. Their speech was slurred and their gaits ataxic. The nursing staff immediately collected urine and blood specimens for toxicological analysis. The unit was searched for hidden drugs, but none were found. The results of the toxicology screening tests were positive for barbiturates.

Suspicion was immediately focused on Mr. Y, because the other patients involved were young adolescents with no history of drug abuse. When confronted, Mr. Y seemed amazed and hurt that he could be suspected and pointed out his past behavior as a model patient. He admitted that he had behaved strangely and wondered whether someone had "slipped" him some drugs. He was convincing but was warned that if he was involved in any way with drugs, he would be sent directly back to jail.

Mr. Y convinced his parents of his good intentions, and they agreed to allow him to move into their house. On the basis of his positive behavioral change, Mr. Y received a recommendation for probation, which was carried out by the judge.

Three months after discharge from the hospital, Mr. Y and a friend were arrested for operating a PCP manufacturing laboratory in a friend's garage.

Selected Nursing Diagnoses

- Defensive coping related to need for control, as evidenced by illegal behavior and treating people like objects
- Impaired social interactions related to inability to identify relationship problems, as evidenced by manipulation of others

Manipulative patients usually have little motivation to change because manipulative behavior often has rewards for them; they are getting what they want. **Manipulators are goal oriented or self oriented, not other oriented.** However, they are skilled at giving the impression that they care about others. In this clinical example, Mr. Y was able to gain the confidence of the staff in order to escape a jail sentence. This is typical of a person with an antisocial personality disorder.

The manipulative person is unaware of a lack of relatedness and assumes that **interpersonal relationships are formed to take advantage of others.** This person cannot imagine an intimate, sharing relationship. The manipulator believes in maintaining control at all times to avoid being controlled.

Antisocial personality disorder is a complex disorder that is difficult to diagnose and treat. To meet *DSM-IV-TR* criteria, an individual must be at least 18 years old but must demonstrate a pattern of breaking rules since the age of 15 (American Psychiatric Association, 2000). **The diagnosis is applied when an individual consistently ignores social rules; is manipulative, exploitative, or dishonest; lacks remorse for actions; and is involved in criminal activity.** Although this diagnosis occurs in only 3% of men and 1% of women, these individuals are responsible for a large proportion of crime, violence, and social distress.

Patients with borderline and antisocial personality disorders are often manipulative. This results in their inability to participate in mature interpersonal relationships, as illustrated in the next clinical example.

CLINICAL EXAMPLE

Ms. S was a 23-year-old woman who was admitted to a general hospital psychiatric unit. She had cut her wrists superficially three times during the week before admission. Each time she cut herself, she telephoned her therapist, a psychiatric advanced practice nurse. Because the therapist was about to leave for vacation and was concerned for the safety of Ms. S, she decided to hospitalize her.

On admission Ms. S appeared mildly depressed. She gave the impression of a guilty child who had been punished. She denied any current self-destructive thoughts. During the physical assessment the nurse noted that there were many scars on the patient's body. When asked about these, she claimed she was abused as a child. Her therapist's records described the scars as the result of much self-mutilation since the age of 16 years. This had been her main reason for seeking therapy. There was also a history of sexual promiscuity.

Ms. S described herself as a failure, stating that she had "the best parents in the world, but they did not get the daughter they deserve." She said she was a drifter who had never been able to settle on a career, a lifestyle, or any consistent friends. She didn't know who or what she was. When asked how she felt, she responded, "Most of the time, I don't feel anything, just empty." She had no signs of psychosis.

Ms. S was placed on constant observation to prevent further cutting. All sharp objects were removed from the room. At first she was very cooperative and superficially friendly to other patients. Because of her smooth adjustment, constant observation was discontinued after 2 days. She was also given a schedule of activities and informed that she was responsible for following it. The next day, an X-Acto knife was missing from the activities therapy room. Ms. S was found in the bathroom, bleeding from several small cuts on her ankles. This sequence was repeated several times. Each time the constant observation was discontinued, she found a sharp object and cut herself.

Ms. S was also very labile emotionally. She had unpredictable outbursts of anger, similar to temper tantrums. However, these outbursts passed as quickly as they came, never lasting more than a few minutes. She also began to categorize the staff as "good guys and bad guys." When she was with staff members she liked, she was pleasant, complimenting them on their kind and understanding attitudes toward her. With staff she disliked, she was sullen and uncooperative, comparing them unfavorably with the others. Eventually the staff began to bicker about her care, some believing she was spoiled and others that she was neglected.

Ms. S remained in the hospital during her therapist's absence. When the therapist returned, Ms. S refused to see her. The frequency of angry outbursts increased dramatically. However, after frequent visits from her therapist, Ms. S began to request discharge. Behavioral criteria for discharge were set, including no self-mutilation and no temper tantrums. She met the criteria and was discharged back to outpatient treatment.

Selected Nursing Diagnoses

- Risk for self-mutilation related to anxiety about therapist's vacation, as evidenced by cutting
- Chronic low self-esteem related to unclear goals and expectations, as evidenced by describing herself as a failure
- Impaired social interaction related to inability to tolerate close relationships, as evidenced by splitting staff into "good guys" and "bad guys"

The diagnosis of **borderline personality disorder** occurs in 1% to 6% of the general population and is the most prevalent personality disorder (15% to 25%) in mental health settings (Gunderson, 2009). The diagnosis is made more often in women than in men. Developmental theory suggests that the borderline person does not achieve object constancy during the separation-individuation stage of psychosocial development. People who fail to complete separation from the mother (or primary caretaker) and develop autonomy in childhood often repeat this developmental crisis at adolescence. Behaviors characteristic of this phase include the following:

- Clinging
- Depression accompanied by rage and defended by acting out
- Detachment and withdrawal

Many of these behaviors can be seen in the preceding clinical example. Borderline personality disorder has one of the highest suicide rates of all the personality disorders. **Impulsive aggression is the hallmark of borderline personality disorder, and it is seen in the borderline person's self-mutilation, unstable relationships, violence, and completed suicides.**

These patients can be frustrating for nursing staff to interact with and treat because they are manipulative and unable to become involved in reciprocal interpersonal relationships. However, nurses must remember that this behavior is not consciously planned but is a defense against a fear of loneliness.

> **Critical Reasoning** Do you know someone who is manipulative in relating to you? If so, how do you respond to them?

Narcissism. The term **narcissism** comes from the Greek myth of Narcissus, who fell in love with his own reflection in the water and died. The flower that bears his name sprang up at the site of his death.

Many successful people are narcissistic. Acting, modeling, professional sports, and politics are usually attractive occupations to people with this personality trait. However, problems occur when people do not gain the status they think is deserved or lose status. The frustration caused by lack or loss of recognition may be expressed as anger, depression, substance abuse, or other maladaptive behaviors.

People with **narcissistic personality disorders** have **fragile self-esteem,** driving them to search constantly for praise, appreciation, and admiration (Kay, 2008; Ronningstam, 2011). The following clinical example demonstrates narcissistic entitlement, which describes an egocentric attitude, envy, and rage when others are seen as critical or not supportive.

CLINICAL EXAMPLE

The psychiatric nurse was called to the emergency department to see a new patient, Mr. F, who was accompanied by his wife. The nurse knew from the intake form that Mr. F was a 44-year-old man with no psychiatric history. His chief complaint was that he had gone into a "blind rage" when he had an argument with his wife earlier in the evening and had punched her on the arm. He was frightened by his loss of control and said that he felt like a failure. Both Mr. and Mrs. F denied any history of violence, although Mr. F said that his first marriage ended "because of my anger."

Mr. F appeared quite anxious; he was tapping his foot and wringing his hands, and he avoided eye contact with the nurse. After a short time, however, he became more verbal, and he willingly explained what had led to the "blowup." He had been self-employed for the past 10 years and had been "highly successful," expanding his company nationally. He told the nurse that his father was a "multimillionaire" and that he had been on his way to exceeding his father's wealth. It seemed important to impress the nurse by dropping the names of well-known people, whom he described as his friends.

Mrs. F angrily interrupted him, saying, "That's what's important to you—who you know and how it looks." Mrs. F then explained that business began slipping 2 years ago. Despite several profitable years, he had never invested or

saved money. When sales fell, instead of cutting expenses and downsizing the company, he continued to live lavishly, making extravagant purchases. It was this situation that led to their argument. When Mrs. F accused her husband of taking them to the brink of financial collapse, he went into a rage and punched her.

Mrs. F began sobbing, and Mr. F seemed not to notice. He said he felt like his life was falling apart and that he must be the failure his father always said he was. He angrily referred to his "rich brother," who, in his father's eyes, was the perfect son. He became tearful, and Mrs. F then turned to her husband, attempting to provide support and reassurance.

Selected Nursing Diagnoses

- Impaired social interaction related to the need for approval by others, as evidenced by attempts to impress others and inability to respond to wife's distress
- Risk for other-directed violence related to impulsivity, as evidenced by acts engaged in during "blind rage"
- Interrupted family processes related to inconsistency between goals of husband and wife, as evidenced by wife's reaction to patient's description of his problem
- Defensive coping related to fear of failure, as evidenced by bragging and name dropping
- Chronic low self-esteem related to perceived lack of caring and approval from father, as evidenced by stated need to exceed his father's success and description of himself as "a failure" in his father's eyes

Mr. F's impulsiveness was seen in his extravagance, inability to establish and follow a life plan, failure to learn by experience, poor judgment, and unreliability.

The behaviors related to maladaptive social responses are summarized in Table 21-1. Patients often exhibit combinations of these behaviors. The nurse should be able to identify the complex behaviors associated with high levels of stress and anxiety. In some cases a usual mode of behavior, such as manipulation, may be exaggerated or combined with a change in behavior.

For instance, manipulative people may withdraw when confronted about their manipulations and may be rejected by those they have been trying to manipulate. In other instances, the behavior resulting from stress may be different from the person's usual style of relatedness. A person who is usually agreeable may become critical and defensive when under great stress. It is therefore helpful to include a description of the patient's usual relationships in the nursing assessment. This provides a baseline of behavior for that person against which the nurse measures the patient's progress.

Predisposing Factors

Personality is composed of temperament, which is inherited, and character, which is learned. Personality disorders develop from a variety of predisposing neurobiological, early developmental, and sociocultural factors. The nurse should explore all relevant areas during the nursing assessment.

> **Critical Reasoning** Describe one of your own personality traits that is due to temperament and one that is due to character. How has each affected your life?

TABLE 21-1 BEHAVIORS RELATED TO MALADAPTIVE SOCIAL RESPONSES

BEHAVIOR	CHARACTERISTICS
Manipulation	Others are treated as objects Relationships center around control issues Person is self oriented or goal oriented, not other oriented
Narcissism	Fragile self-esteem Constant seeking of praise and admiration Egocentric attitude Envy Rage when others are not supportive
Impulsivity	Inability to plan Inability to learn from experience Poor judgment Unreliability

Biological Factors. Many researchers believe that there is a strong **inherited biological vulnerability or a genetic susceptibility for these disorders, which sets the stage for environmental influences.** Studies suggest a genetic link for antisocial personality disorder and a biological hypothesis that impulsive and violent behavior may be caused by brain dysfunction, a low threshold of excitability in the limbic system, low levels of serotonin, or toxic chemical substances.

Other studies have found that people with antisocial personality disorder have reduced prefrontal gray matter volume and lower than average activity in the frontal lobes of their brain. This results in low arousal, poor fear conditioning, lack of conscience, and decision-making deficits.

Personality disorders also have been linked to **alcohol and drug abuse**. Findings reveal that first-degree relatives of people with personality disorders have a higher than normal rate of substance abuse; therefore, they are considered to have a probable genetic link. Borderline personality disorder and antisocial personality disorder in particular are associated with a wide variety of substance use disorders, and the combination results in severe impairment.

Researchers are looking for the biological basis of very early infant and childhood characteristics. For instance, about 20% of children are inhibited from an early age and can be upset easily by the age of 4½ months. Evidence shows that these children have an accelerated heart rate, even in the womb, and that their amygdalas (the brain region that governs learned fear and emotion) may be more excitable than average.

In contrast, antisocial personality appears to be correlated with abnormal brain processing of emotionally charged words, an unusually low heart rate, and slow responses to experimental rewards and punishments from an early age. Further research is needed to clarify the role of inheritance and that of brain structure and function in the development of personality disorders.

Developmental Factors. Patients with borderline personality disorder are more likely to report having been **emotionally, physically, or sexually abused.** However, abuse by itself

does not cause borderline personality disorder; other predisposing factors also must be involved.

About 25% of patients with borderline personality disorder are also given a diagnosis of **posttraumatic stress disorder (PTSD),** a condition that results from an overwhelming psychological assault (see Chapter 15). Similarly, childhood histories of people with antisocial personality disorder often reveal abuse, neglect, and the absence of an early emotional attachment.

Based on these findings, it has been proposed that lack of parental caring is internalized, and the individual becomes incapable of bonding with others. People with antisocial personality disorder thus do not develop a sense of trust or a capacity for guilt or remorse.

In a study of childhood behaviors that preceded diagnosis of a personality disorder in adolescence, four childhood conditions were found: conduct problems, depressive symptoms, anxiety or fear, and immaturity. Antecedents of adolescent personality disorder may be identifiable in childhood through an accurate assessment of emotional and behavioral problems. Cluster A and cluster B personality disorders and paranoid, narcissistic, and passive-aggressive personality disorder symptoms during adolescence also may increase risk for violent behavior that persists into early adulthood.

Theories of family impact on personality are controversial. Some research supports the fact that, apart from genetic similarity, children raised in the same family do not resemble one another more closely than strangers. Influences outside the family (e.g., peer groups) are greater than parental influences during childrearing. Others believe that many people with maladaptive social responses are enmeshed in a family system that blocks further development and makes change difficult and hazardous.

Families of borderline and narcissistic people often operate with the unspoken ground rule that independence and separation from the family imply rejection of family values. The parents often reenact their own developmental conflicts through their children, and role reversals (e.g., parent as child) are common.

Features of these families include some restriction from the outside world, absence of clearcut lines of authority, confusion of parental executive and nurturing roles, blurred generational boundaries, generations of family patterns in which people are labeled as good or bad, and the generational transmission of irrational forms of thinking and relating.

Therefore the nurse should assess the nature of family interactions and gather information related to early childhood behaviors, child abuse, and alcohol abuse as part of a comprehensive data collection.

Critical Reasoning Identify ways in which families can both protect and place at risk a child's ability to form healthy relationships with others.

Sociocultural Factors. **Sociocultural factors influence the person's ability to establish and maintain relatedness** (Box 21-1). Many forces in U.S. culture make people feel isolated and lonely. Friendships are often short term because of the mobility involved in many occupations. Family relationships may be more distant as adult children move away and see their parents only occasionally. Friends are often closer than siblings.

BOX 21-1 SOCIOCULTURAL CONTEXT OF CARE

Social Sensitivity

Mental illnesses manifest with different symptoms in different cultures, and some are seen only in specific social settings. Personality disorders must be considered in the context of a patient's cultural reference group. Behaviors such as passivity, emotionality, and emphasis on success are all influenced by culture.

Certain sociocultural contexts may lead to behaviors that are mistaken for personality disorders. For example, members of minority groups, immigrants, or refugees may appear overly guarded, mistrustful, avoidant, or hostile in response to an experience of discrimination or language barriers.

Personality disorders, in particular, are "socially sensitive" because their symptoms reflect behaviors and feelings that are significantly shaped and molded by culture. Only when one's behaviors are in excess or not in accordance with the standards of one's cultural milieu should the diagnosis of a personality disorder be considered.

Involuntary social isolation affects disabled and chronically ill persons of any age. People with chronic or terminal illnesses or disfiguring disorders are often stigmatized and avoided by others. This also is true for people with long-term psychiatric problems.

Although an effort has been made to decrease long-term institutionalization, many people continue to resist integrating disabled people into "their" community. This involuntary isolation may result in a variety of maladaptive social responses as the person tries to cope with loneliness.

Immigration continues to be an active cultural force in the United States and many other parts of the world. As people move into entirely different cultures, they may feel alienated and frightened about customs they do not understand. Sometimes immigrants form separate communities to preserve their traditions. These close-knit communities help meet relationship needs but create barriers to broader community participation and integration. Unfortunately, they also focus attention on the group, often attracting discriminatory behavior by others.

Closeness is the ideal in U.S. culture. At the same time, people are given the message that they need to be careful in deciding whom to trust. This can cause confusion and a feeling of insecurity. Rising crime rates cause fear and reluctance to risk closeness or contact with strangers. Some urban residents, particularly elderly people, often become lonely prisoners in their own homes.

Precipitating Stressors

Maladaptive social responses are the result of experiences that have had a negative influence on the person's emotional growth. Often, a series of life events predisposes a person to have relationship problems. Many people cope with their interpersonal problems and say they are reasonably satisfied

with their relationships. However, additional stress can cause a somewhat satisfying interpersonal life to become dissatisfying.

Response to stressors is highly individual, and the nurse should remember that the person experiences an increase in anxiety as a result of the stressor, and this is often the cause of the maladaptive behavior. Precipitating stressors may be sociocultural or psychological.

Sociocultural Stressors. One sociocultural stressor is **instability in the family.** Divorces are common. Mobility has broken up the extended family, depriving people of all ages of an important support system. Less contact occurs between the generations. Tradition, which provides a powerful link with the past and a sense of identity, is less often maintained when the family is fragmented.

Interest in ethnicity and "roots" may reflect the efforts of isolated people to associate themselves with a specific identity. The many stresses on the family have made it more difficult for family members to accomplish the developmental tasks related to intimacy.

Nurses who work in general hospitals often encounter patients with maladaptive social responses. Even a reasonably well-adjusted person may have difficulty maintaining a satisfying level of intimacy while hospitalized. The impersonal hospital environment enhances the patient's feeling of isolation. Sometimes patients need to be isolated because of infection or, in the psychiatric setting, to control behavior. They are then susceptible to the effects of sensory deprivation. Creative nursing care is needed to minimize this problem.

For instance, a patient who is in isolation for infection control could be given a schedule of times when staff will be present. This should include time to talk. Family members should be encouraged to visit, telephone, and share current activities. On the other hand, sensory overload may be a problem for patients in critical care units. This also can lead to loneliness and separation from others.

Psychological Stressors. Many psychological theories have been proposed to explain problems in establishing and maintaining satisfying relationships. **High anxiety levels result in impaired ability to relate to others.** A combination of prolonged or intense anxiety with limited coping ability can cause severe relationship problems.

The person with borderline personality disorder is likely to experience an incapacitating level of anxiety in response to life events that represent increased autonomy and separation (e.g., high school or college graduation, going away to camp, marriage, birth of a child, employment, job promotion). The person who has narcissistic personality disorder tends to experience high anxiety, causing relationship difficulties, when the significant other no longer adequately nourishes the person's fragile self-esteem. These relationships often move through predictable stages:

1. Idealization and overvaluation
2. Disappointment when unrealistic needs for maintaining self-esteem are not met
3. Rationalization and devaluation
4. Rejection of the other person based on "narcissistic injury"

Typically, these people go through life repeating this pattern on the job, in marriages, and in friendships.

Appraisal of Stressors

The mature person who can participate in healthy relationships is still vulnerable to the effects of psychological stress. Therefore a person's appraisal of stressors is critically important. A series of losses or a single significant loss may lead to problems in establishing future intimate relationships. The pain of a loss can be so great that the person avoids future involvements rather than risk more pain. This response is more likely if the person had difficulty with developmental tasks pertinent to relatedness.

Losses of significant others may cause difficulty with future relationships, but other types of losses may do the same. For example, the loss of a job decreases a person's self-esteem. This can also result in future withdrawal and emotional problems unless the person has a well-established support system.

> **Critical Reasoning** Identify a novel, a popular song, or a work of art that would have meaning for a person who is trying to cope with an interpersonal loss. How do such things help you?

Coping Resources

When a person is having problems with relationships, it is important for the nurse to assess the person's coping resources. For many people, when one relationship is troublesome or lost, others are available to offer support and reassurance. Those who have broad networks of family and friends have many resources to draw upon. Sometimes they need encouragement to reach out for help.

Some people do not have readily available human supports but have other ways of managing interpersonal problems. Pets can be an important way of expressing relatedness. Isolated elderly people often focus their need to give and receive affection on a dog or cat.

Sometimes a person who is troubled about a relationship will use creative ways to express feelings. Use of expressive media such as art, music, or writing allows the person to explore and resolve an upsetting experience. Others are helped by reading, exercise, looking at art, dancing, or listening to music.

Coping Mechanisms

Coping mechanisms associated with maladaptive social responses are attempts to cope with anxiety related to threatened or actual loneliness. However, they are not healthy and often have the unintended effect of driving people away. Thus the person is always caught in the approach-avoidance conflict of the need-fear dilemma, searching for some degree of human contact on the one hand and pushing people away on the other.

Manipulative people view other people as objects. Their defenses protect them from potential psychological pain related to the loss of a significant other. People with antisocial personality disorder often use the defenses of projection and splitting.

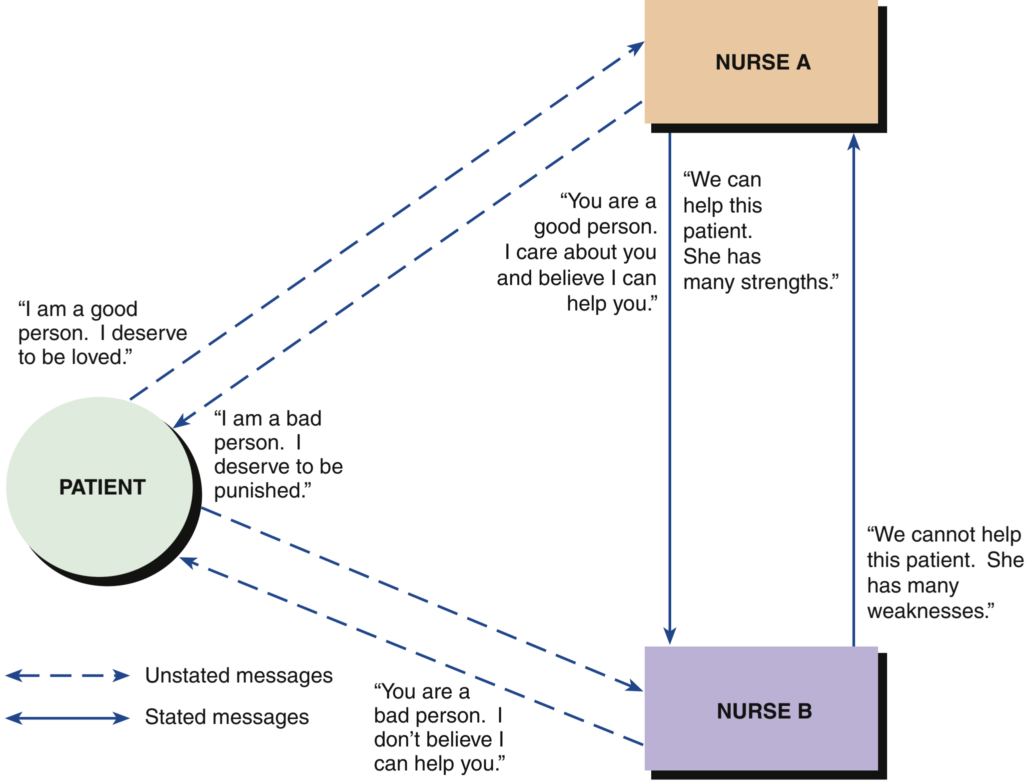

FIG 21-3 Projective identification and splitting affect patient-to-nurse and nurse-to-nurse communication.

Projection places responsibility for antisocial behavior outside oneself. For instance, a patient may rationalize using drugs by saying, "Everybody I know uses cocaine. Why shouldn't I?"

Splitting is characteristic of people with borderline and narcissistic personality disorders as well. It is the inability to integrate the good and bad aspects of oneself and objects. An object is anything outside the self, animate or inanimate, to which the person has an attachment. An object could be a parent, a friend, or a teddy bear. The process of splitting by a borderline patient results in different staff members' seeing the borderline patient in very different ways.

Projective identification is a complex defense mechanism. Borderline patients project parts of themselves onto others, who are often not aware of this. However, they may begin to behave like the projected parts. For example, a patient projects onto a nurse the cruel, punishing parts of himself. The projection connects with something in the nurse, and the nurse begins to react to the patient in a cruel, punishing way. Likewise, staff members who have received idealized projected parts of the patient may tend to respond in an overly involved, protective, indulgent manner. An example of projective identification is demonstrated by Ms. T in the following clinical example.

CLINICAL EXAMPLE

A nurse was talking to her supervisor about her relationship with a borderline patient, Ms. T. She explained that Ms. T had become negativistic and increasingly demanding to the point that her demands had no bounds. Ms. T began calling her "Nurse Ratchet." If that was not difficult enough, Ms. T was also telling new patients on the unit about what a tyrant she was and how wonderful all the other nurses were.

In supervision, the nurse realized that soon after Ms. T had cast her as "Nurse Ratchet," she started to react to the patient far more rigidly than was typical for her. Indeed, most of her interactions with Ms. T were now focused on policy adherence and strict limit setting. With this realization she was able to change the nature of her interactions with Ms. T.

Selected Nursing Diagnosis

- Chronic low self-esteem related to the use of the defense mechanism of splitting, as evidenced by relationships with the nursing staff

The defense mechanisms of splitting and projective identification help explain why different staff members often see the same patient in very different ways, as illustrated in Figure 21-3.

Critical Reasoning Compare the processes of empathic understanding and projective identification. Give some examples of each from your experience.

DIAGNOSIS

Nursing Diagnoses

When diagnosing maladaptive social responses, the nurse should consider the extent and nature of maladaptive behaviors, coping mechanisms, and the predisposing factors and precipitating stressors leading to the behaviors. The nurse

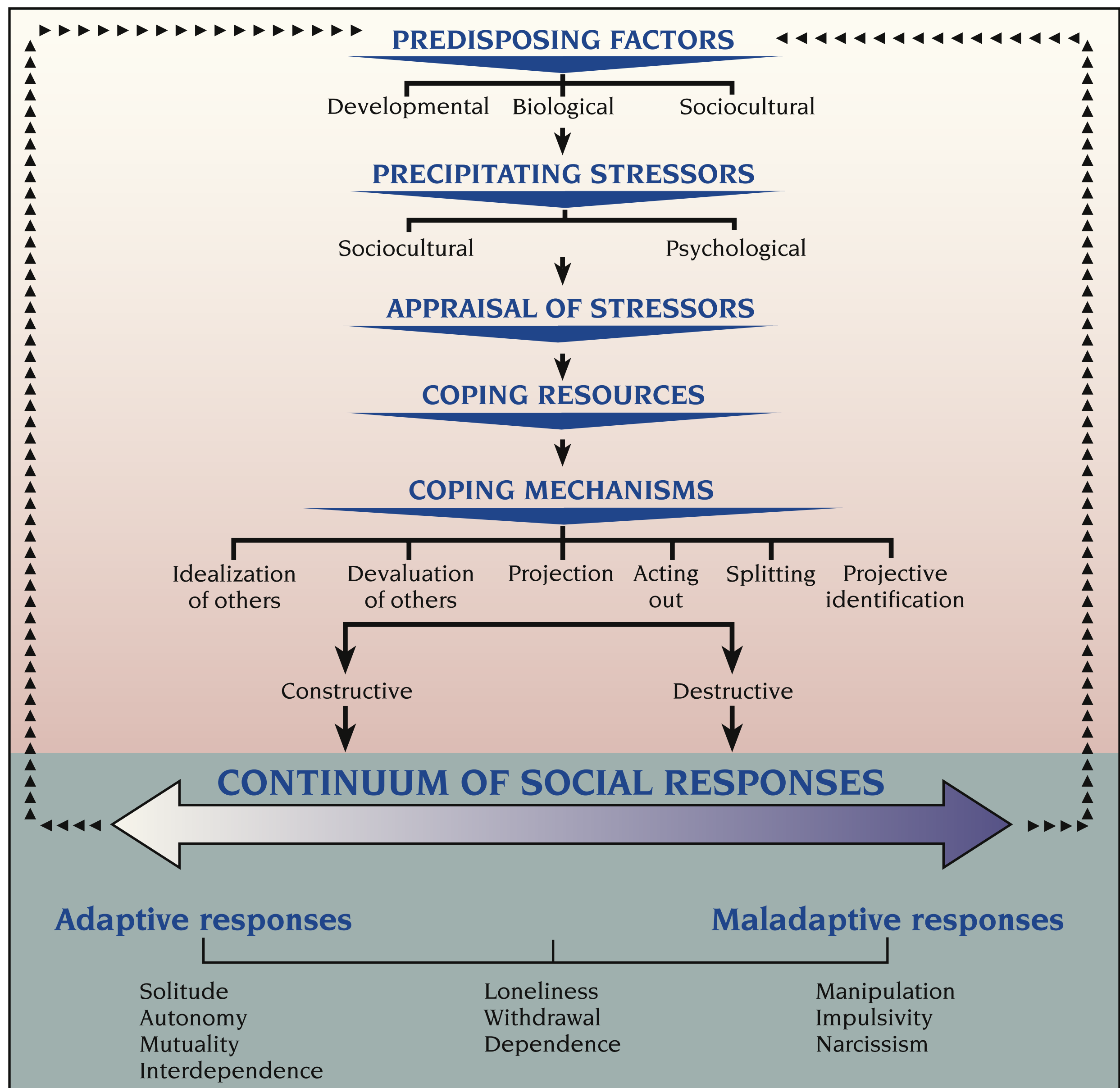

FIG 21-4 The Stuart Stress Adaptation Model as related to social responses.

may formulate a nursing diagnosis by using the Stuart Stress Adaptation Model (Figure 21-4) as a guide.

Nursing diagnoses associated with maladaptive social responses are presented in the Table 21-2. **Primary NANDA International (NANDA-I) diagnoses include defensive coping, chronic low self-esteem, risk for self-mutilation, impaired social interaction, and risk for violence (self-directed or other-directed).**

Medical Diagnoses

In general, distinguishing elements of personality disorders include the following:

- Chronic and long-standing condition
- Not based on a sound personality structure
- Difficult to change

Medical diagnoses related to maladaptive social responses include paranoid, schizoid, schizotypal, histrionic, antisocial, narcissistic, borderline, obsessive-compulsive, dependent, and avoidant personality disorders. Selected medical terms and their definitions are described in Table 21-2.

OUTCOMES IDENTIFICATION

The **expected outcome** for nursing care of the patient with maladaptive social responses is as follows: ***The patient will obtain maximum interpersonal satisfaction by establishing and maintaining self-enhancing relationships with others.***

Short-term goals are more specific to the patient's problems. They may progress from simpler to more complex changes in behavior. It can be difficult to set mutual nursing care goals with a patient who has problems with relatedness. This is partly because mutuality must be based on a strong nurse-patient relationship. It is difficult

TABLE 21-2 NURSING DIAGNOSES AND MEDICAL TERMS RELATED TO *Maladaptive Social Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Defensive coping	Defensive coping related to early traumatic losses, as evidenced by grandiosity and superior attitudes toward others
Chronic low self-esteem	Chronic low self-esteem related to physical abuse during childhood, as evidenced by verbalized unhappiness with personal accomplishments
Risk for self-mutilation	Risk for self-mutilation related to fear of rejection, as evidenced by cutting self after visits from parents
Impaired social interaction	Impaired social interaction related to rejection of sociocultural values, as evidenced by stated belief that rules do not pertain to self
Risk for self-directed violence	Risk for self-directed violence related to need to punish self, as evidenced by repeated burning of hands and feet when criticized
Risk for other-directed violence	Risk for other-directed violence related to use of projection, as evidenced by blaming, argumentativeness, and recent purchase of a handgun
MEDICAL TERM	**DEFINITION***
Paranoid personality disorder	A psychiatric condition in which a person has a long-term distrust and suspicion of others, but does not have a full-blown psychotic disorder such as schizophrenia
Schizoid personality disorder	A psychiatric condition in which a person has a lifelong pattern of indifference to others and social isolation
Schizotypal personality disorder	A mental health condition in which a person has trouble with relationships and disturbances in thought patterns, appearance, and behavior
Antisocial personality disorder	A mental health condition in which a person has a long-term pattern of manipulating, exploiting, or violating the rights of others. This behavior is often criminal.
Borderline personality disorder	A condition in which people have long-term patterns of unstable or turbulent emotions, such as feelings about themselves and others. These inner experiences often cause them to take impulsive actions and have chaotic relationships.
Histrionic personality disorder	A condition in which people act in a very emotional and dramatic way that draws attention to themselves
Narcissistic personality disorder	A condition in which people have an inflated sense of self-importance and an extreme preoccupation with themselves
Avoidant personality disorder	A mental health condition in which a person has a lifelong pattern of feeling very shy, inadequate, and sensitive to rejection
Dependent personality disorder	A long-term (chronic) condition in which people depend too much on others to meet their emotional and physical needs
Obsessive-compulsive personality disorder	A condition in which a person is preoccupied with rules, orderliness, and control

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to develop a strong relationship with a patient who fears intimacy.

In addition, setting a goal implies a commitment to change. Many patients who have maladaptive social responses are reluctant to commit themselves to change. Because most of these behavioral problems also serve as coping mechanisms, **resistance to change can be very strong.**

For these reasons, even though it is desirable to have the patient's full participation, it may be necessary for the nurse to set more immediate initial goals that will eventually lead to mutual care goals. To overcome a problem with relatedness, the person must be involved with others. At first the other person may be the nurse, but eventually others will take the nurse's place.

Short-term goals for these patients may focus on reducing acting-out behaviors and modifying specific communication patterns. Examples include the following:

- The patient will use verbal communication as an alternative to acting out.
- The patient will verbally identify angry feelings when they occur during a one-to-one interaction.

These goals should be developed with the patient's active participation.

Learning to relate more directly and openly causes anxiety. Therefore the patient's ability to tolerate anxiety must be considered when setting goals. Increasing the anxiety level before the patient has increased coping ability and environmental supports may reinforce use of maladaptive coping behaviors.

Outcome indicators related to social interaction skills from the Nursing Outcomes Classification (NOC) project are presented in Box 21-2 (Moorhead et al, 2008).

PLANNING

The nursing treatment plan provides a guide for intervention and promotes consistency among the treatment staff members who provide care to the patient. This is particularly important when working with patients with maladaptive social responses. Planning also includes attending to the patient's educational needs.

A Patient Education Plan for modifying impulsive behavior is presented in Table 21-3. It is an important and challenging part of the nurse's responsibility to help patients and their families understand the nature and treatment of any disorders that cause maladaptive social responses.

BOX 21-2 NOC OUTCOME INDICATORS FOR SOCIAL INTERACTION SKILLS

Uses disclosure as appropriate
Exhibits receptiveness
Cooperates with others
Exhibits sensitivity to others
Uses assertive behaviors as appropriate
Uses confrontation as appropriate
Exhibits consideration
Exhibits genuineness
Exhibits warmth
Exhibits poise
Appears relaxed
Engages others
Exhibits trust
Uses compromise
Uses conflict resolution methods

From Moorhead S et al, editors: *Nursing outcomes classification (NOC),* ed 4, St Louis, 2008, Mosby.

IMPLEMENTATION

Patients with personality disorders come to treatment for help with depression, anxiety, alcoholism, or difficulties in work or personal relationships, not to have their personalities changed. In fact, they often regard any attempt to change their personality as unnecessary and intrusive. The focus of therapy, therefore, is to help patients change the maladaptive thinking and behavior that result from personality traits and to treat any comorbid conditions.

Personality disorders are often seen as difficult to treat and poorly understood. Recovery with both symptom remission and good psychosocial functioning is difficult for many patients to attain (Zanarini et al, 2010).

In addition, there often is professional bias or stigma against the diagnosis and those who suffer from it (Kealy and Ogrodniczuk, 2010). Education and clinical supervision is required to address negative clinician attitudes (Purves and Sands, 2009; Treloar, 2009).

TABLE 21-3 PATIENT EDUCATION PLAN

Modifying Impulsive Behavior

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Describe characteristics and consequences of impulsive behavior.	Select a situation in which impulsive behavior occurred. Ask the patient to describe what happened. Provide the patient with paper and a pen. Instruct the patient to keep a diary of impulsive actions, including a description of events before and after the incident.	The patient will identify and describe an impulsive incident. The patient will maintain a diary of impulsive behaviors. The patient will explore the causes and consequences of impulsive behavior.
Describe behaviors characteristic of interpersonal anxiety, and relate anxiety to impulsive behavior.	Discuss the diary with the patient. Help the patient to identify interpersonal anxiety related to impulsive behavior.	The patient will connect feelings of interpersonal anxiety with impulsive behavior.
Explain stress-reduction techniques.	Describe the stress response (see Chapter 15). Demonstrate relaxation exercises (see Chapter 29). Help the patient to return the demonstration.	The patient will perform relaxation exercises when signs of anxiety appear.
Identify alternative responses to anxiety-producing situations.	Using situations from the diary and knowledge of relaxation exercises, help the patient to list possible alternative responses.	The patient will identify at least two alternative responses to each anxiety-producing situation. Practice using alternative responses to anxiety-producing situations.
Role play each of the identified alternative behaviors.	Discuss the feelings associated with impulsive behavior and the alternatives.	The patient will describe the relationship between behavior and feelings. The patient will select and perform anxiety-reducing behaviors.

The full spectrum of treatment includes psychotherapy, engaging patients as collaborators in a strong treatment alliance, the need for a primary clinician to care for the patient, psychoeducation, family involvement, and limited use of medications (Gunderson, 2009; Lamont and Brunero, 2009). Borderline personality disorder is the only major psychiatric disorder for which psychosocial interventions are the primary treatment. **Empirically validated treatments for borderline personality disorder are summarized in Table 21-4** (Nathan and Gorman, 2007).

Protection from Self-Harm

The deliberate self-destructive, self-mutilating, or suicidal behavior of the borderline patient may be difficult to treat (see Chapter 19). The suicidal ideation of these patients should be taken seriously and addressed by safe management, psychotherapy, and pharmacotherapy (Berk et al, 2009).

Patients with borderline personality disorder are often hospitalized because of impulsive attempts at self-mutilation or suicide. **Often the inpatient nursing staff must observe the patient constantly to prevent physical harm.** The nursing intervention of constant close observation is usually initiated to protect the patient from impulsive behavior. This intervention activates the patient's conflicts about close relationships.

At the same time, these patients can have intense dependency needs. This makes it difficult to wean them from constant staff attention, and contact must be decreased gradually. Observation may need to be increased again if the patient seems out of control.

Splitting may become evident as the patient establishes preferences for the staff assigned to observation. The patient is challenged to outwit the staff and find opportunities to act out. When efforts are made to decrease the level of observation, the patient's attachment conflicts emerge. Behavior intended to maintain the undivided attention of staff by renewed self-harming behavior is often exhibited.

Patient involvement in planning for decreased observation may be helpful. The patient must be reassured that less contact does not equal no contact. Consistent, scheduled time with a staff member is recommended. Primary nursing is particularly effective with a patient who needs to work through these separation issues.

Identification of cues and triggers allows the patient to request assistance, thereby becoming an active participant in the therapeutic process. Nurses are less judgmental about the patient if they understand the source of the behaviors and if they are in touch with the patient's feelings.

TABLE 21-4 SUMMARIZING EVIDENCE-BASED TREATMENTS FOR *Borderline Personality Disorder*

DISORDER	TREATMENT
Borderline personality disorder	Dialectical behavioral therapy (DBT) has been found to reduce rates of suicide attempt, hospitalizations for suicidal ideation, and overall medical risk. Patients treated with DBT were less likely to drop out of treatment and had fewer psychiatric emergency room visits and psychiatric hospitalizations. Strong evidence supports the efficacy of the atypical antipsychotic medication olanzapine in reducing anger, impulsivity-aggression, possibly depression, and interpersonal sensitivity in borderline personality disorder.

From Nathan PE, Gorman JM, editors: *A guide to treatments that work,* ed 3, New York, 2007, Oxford University Press.

QUALITY AND SAFETY ALERT

- The nurses must maintain the patient's safety, facilitate the patient's participation in care, select the least restrictive intervention, support behavior change, and help the patient assume responsibility for his own actions.

Establishing a Therapeutic Relationship

No matter what type of maladaptive social response the patient is experiencing, nursing care is based on accessibility. **The nurse must be *physically present* with the patient on a regular basis to foster an opportunity for interaction.**

***Psychological accessibility* also must be a part of this regular interaction.** This means that the nurse shows genuine interest in the patient and tries to understand the patient by clarifying meanings and validating perceptions. The nurse is also empathic and strives for a strong therapeutic alliance (Warwar et al, 2008).

In working with patients with personality disorders, the nurse must closely focus on monitoring appropriate levels of concern and the boundaries of the relationship. If the nurse-patient relationship is a healthy one, the patient can learn how to find satisfaction in other human relationships (Box 21-3).

Family Involvement

Because intimate relationships are always affected by maladaptive social responses, significant others must be involved in the plan of care (Box 21-4). This is especially important for manipulative patients, who often shift attention away from themselves by creating conflict between the family and the staff.

For instance, the patient may complain to family members about poor nursing care. At the same time, the patient may tell the staff about mistreatment by the family. Staff and family are then in conflict. Attention is distracted from the patient, who then can avoid the discomfort of self-examination. When the staff finally realize what is happening, the result is usually anger directed toward the patient. Nurses should be aware of this and avoid a punitive response. When manipulative patients are hospitalized, this behavior can occur many times.

BOX 21-3 **A PATIENT SPEAKS**

When I was hospitalized, the nurses were my link to the outside world. They were with me more than anyone else. They were also my link to the treatment that was prescribed by my psychiatrist. The doctor left *prn* (as needed) orders because he thought I was a mature woman who could decide when I needed medication. I often felt a loss of dignity when the nurse questioned my need for the prn medication. Because the medicine decreased my anxiety, I think I was the best judge of when I needed it. Because the doctor made me responsible for requesting the medication, it was not the nurse's job to question my need for it unless I asked for more than was prescribed.

Even if someone is in the hospital, a person needs to be treated with dignity and respect. A patient is sick, not a child and not stupid. Nothing hurts more than being treated like a second-class citizen by people who are in a more powerful position. It is much easier to get well when a nurse is kind, supportive, and understanding.

QUALITY AND SAFETY ALERT

- Family involvement is important in promoting and maintaining positive change for the patient and family.

Critical Reasoning How would you help family members participate in the treatment of a person with a personality disorder?

Milieu Therapy

Because it is difficult and takes a long time to change maladaptive social responses, most patients are treated in the community rather than in an inpatient setting. However, sometimes hospitalization is needed. For instance, the person with a borderline personality disorder may be self-destructive, or the antisocial person may require a structured environment with limit setting. Day treatment or partial hospitalization programs can help in treating patients with borderline personality disorder; they offer an acceptable level of intensiveness and containment, resulting in less regressive dependency and acting-out behavior.

The milieu, as found in hospitals, residential treatment, or outpatient programs, provides patients with an opportunity to gain insight into their behavior. Aside from staff limit setting, patients with maladaptive social responses learn from other patients about how much acting out will be tolerated. The best therapeutic milieu is one in which mature, responsible behavior is expected.

Nursing functions when working with patients with personality disorders in milieu therapy are intended to do the following:

- **Provide a structured environment.**
- **Serve as an emotional sounding board.**
- **Clarify and diagnose conflicts and consequences of actions.**
- **Facilitate adaptive change in behavior.**

BOX 21-4 **A FAMILY SPEAKS**

It seems like my brother was always a problem. When we were growing up, he got us both into trouble all the time. Finally I learned to ignore his schemes and stay away from him. As he got older, the situation got worse. Our parents kicked him out of the house, but he would come back and promise to change, and they would let him back in. Then it would start all over again. He began to get into trouble with the law. First there was vandalism for spray-painting graffiti on a building; then he was with a gang of kids who stole a car. He said he was just along for the ride, but I didn't really believe him.

The rest of the family was pretty embarrassed about his behavior. I thought about telling people I was adopted so they wouldn't think I was like him. I didn't do that because I knew it would hurt my parents and they had enough trouble already.

I'll never forget the night when the phone rang at 4 AM, and it was my brother saying he was in jail. He had been caught with drugs in a stolen car and also had resisted arrest. My parents refused to bail him out, and he didn't have any money. The next day he called again to say that he was at the local psychiatric hospital. He had threatened to kill himself in jail, so they sent him to the hospital to see whether he was really mentally ill. My parents were really upset about this.

I think it was actually a good thing, because the doctors and nurses at the hospital explained to us that he has a personality disorder. It did help to know that there might be a reason for his behavior, although he hasn't really changed much. I think my parents are beginning to accept this, but I know it's really hard for them. We like to think that everyone can change. But maybe not.

Consistent clinical supervision is also very important, because **transference** (intense emotional attachment or rejection derived from feelings about earlier personal relationships) and **countertransference** (the nurse's strong reaction to the patient, such as feelings of excessive sympathy, impatience, anger, or contempt) are often an issue when caring for these patients (see Chapter 2).

Positive countertransference by some staff members and negative countertransference by others leads to splitting and staff conflict. Whenever these behavioral patterns emerge while a manipulative patient is on the psychiatric unit, staff members must examine their level of involvement with the patient.

The principles of milieu treatment for patients with cluster B personality disorders include the following:

- **Establish control with no option to escape involvement.**
- **Provide an experienced, consistent staff.**
- **Implement a clear structure with rules that are fair, firm, and consistently enforced.**
- **Provide support while the patient learns to experience painful feelings and try out new behavioral responses.**

QUALITY AND SAFETY ALERT

- Milieu work with patients with personality disorders is most effective if it focuses on realistic expectations and decision-making and social behaviors in the here and now.

Limit Setting and Structure

The way the nurse approaches limit setting can make the difference between a productive and a nonproductive hospital experience. Angry, punitive limit setting confirms the patient's negative expectations. Suppressive and rigid limits create obstacles to self-exploration and therapeutic change. This approach also confirms the patient's belief that he or she has little or no control over life situations. It is essential that the nurse not view limits as a way of controlling the patient.

Limit setting must occur in the context of the patient and nurse working together toward the process of change. For example, a patient with antisocial personality structure engages in physically aggressive acting-out behavior. One way of dealing with this might be to emphasize the need for medications and to tighten restrictions. The treatment team also might issue an ultimatum, such as, "One more similar episode, and we're going to have to transfer you to another hospital."

A more positive way of approaching the situation could be worded as follows: "You seem to want to put the treatment team in the position of having to reassess your staying in this hospital. Have you changed your mind about wanting to help yourself?" The difference in the latter approach is emphasis on the idea that the patient has responsibility for life situations and that the control and the decisions belong to the patient. It also communicates an attitude of respect, which could boost the patient's self-esteem. The more the nurse is able to align with the nonregressive aspects of the patient's ego, the better are the chances for improved functioning.

Manipulative patients should be held responsible for their behavior. They are skilled at placing responsibility on others. Staff members should communicate with each other so that consistent messages are given. These patients recognize any inconsistency and use it to focus attention on others. They usually resist rules. Staff and family members should collaborate in enforcing clear limits. When manipulative patients lie, it is important to confront them with the lie.

These patients need staff attention combined with structured discipline. There must be an expectation that the patient will meet standards of healthy behavior. Failure to meet the standard should be identified and acting out confronted. Loss of control may be dealt with by room restriction, with the patient instructed to think about the episode so that it may be discussed in therapy. The length of the restriction should be based on the seriousness of the behavior.

These approaches may lead to depression. The depressed feelings should be dealt with in psychotherapy sessions; but the staff also can act as role models for appropriate behavior. A school program, occupational therapy, and the milieu may be used to teach age-appropriate social skills and achievement skills. Reality orientation also may be necessary.

Critical Reasoning You believe that a manipulative adolescent patient is exploiting another patient by "borrowing" money, clothing, and snacks. When confronted, the first patient claims that the items were gifts, "because we're friends." Do you think that limit setting is needed? If so, how would you set appropriate limits?

Focusing on Strengths

A useful nursing approach is to encourage these individuals to identify and use their strengths. **Nursing interventions should focus on mobilizing strengths to enhance self-esteem and using adaptive defenses and positive coping skills.**

Patients with maladaptive social responses often are effective leaders within the patient group. On an inpatient unit, they may be given responsibilities and can be helpful to other patients. They are often intelligent and can participate actively in planning their own care. However, they may be resistant to recognizing or dealing with feelings and need consistent encouragement to verbalize emotions.

Nurses may become frustrated with these patients because they seem to be so aware of what is happening and so in control of most situations, yet so unaware of others' needs. Nurses should remember that these patients have little tolerance for intimacy. Their maneuvering of others is a way to keep them at a safe distance.

These patients are often charming, and it is easy to become involved with them. However, as soon as other people make demands or show signs of emotional closeness, the patients dilute the relationship by withdrawing, frustrating others, or distracting attention from themselves.

Journal writing is a nursing intervention that can be helpful to patients who have difficulty with close relationships. Keeping a diary of their thoughts and feelings helps them identify the various aspects of their interpersonal experiences and review them over time. It gives them an opportunity to see continuity of people and relationships. Interpersonal strengths can be identified and reinforced. The nurse also can note behavioral strengths that the patient has not yet identified and help the patient in recognizing these as well.

Behavioral Strategies

Various behavioral strategies can help decrease antisocial behavior. These can include **social skills training** and **anger management,** among others (see Chapters 27 and 28). The patient is usually impatient with delays in gratification. Material rather than emotional rewards are preferred. Therefore reinforcers used in a behavior modification program should be concrete and readily available.

Ignoring undesirable behavior is the least reinforcing response but is not always possible. If behavior is disruptive and there must be a response, it should be matter-of-fact and one not desired by the patient. For instance, removal from contact with others for a specific period of time may discourage undesirable behavior, whereas a lecture that attracts attention may be a reinforcer.

TABLE 21-5 NURSING TREATMENT PLAN SUMMARY

Maladaptive Social Responses

Nursing Diagnosis: Impaired social interaction
Expected Outcome: The patient will obtain maximum interpersonal satisfaction by establishing and maintaining self-enhancing relationships with others.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will participate in a therapeutic nurse-patient relationship.	Initiate a nurse-patient relationship contract mutually agreed on by patient and nurse. Develop mutual behavioral goals. Maintain consistent behavior by all nursing staff. Communicate honest responses to the patient's behavior. Provide honest, immediate feedback about behavioral change. Maintain confidentiality. Demonstrate accessibility.	An atmosphere of trust facilitates open expression of thoughts and feelings. A trusting relationship enables the patient to risk sharing feelings. Honest responses reinforce openness. Staff consistency creates a predictable environment that creates trust.
The patient will describe interpersonal strengths and weaknesses.	Provide opportunities to demonstrate strengths, such as helping other patients, assuming leadership roles. Help to analyze experiences that are perceived as failures. Communicate acceptance of the patient as a person while not accepting maladaptive social behavior.	Patients with maladaptive social responses are unable to identify accurately their interpersonal strengths and weaknesses, leading to fear of closeness and fear of failure. It is important to help the patient separate behavioral incidents from total self-worth and recognize that one can be liked even if imperfect.
The patient will establish or reestablish one interpersonal relationship that is mutually satisfying and adaptive.	Provide consistent feedback about adaptive and maladaptive social behavior. Encourage patient to describe successful and unsuccessful relationship experiences orally or in a written journal. Help patient in initiating or resuming a relationship with one other person. Review aspects of this relationship with the patient. Reinforce the patient's adaptive social responses. Evaluate with the patient alternatives to maladaptive social responses.	Describing and evaluating one's behavior requires taking responsibility for the behavior and its consequences. Patient needs to go beyond understanding or insight to engaging in actual behavioral change. It is important for the nurse to help the patient evaluate whether his responses are adaptive or maladaptive. Alternatives can then be identified to further the patient's goal achievement.

The most effective treatment involves some form of cognitive behavioral therapy. **A specific type of cognitive behavioral therapy called dialectical behavior therapy (DBT) is an empirically validated treatment approach for patients with borderline personality disorder** (Chapman, 2008; Black et al, 2009; McMain et al, 2009; Yen et al, 2009).

DBT uses behavioral and cognitive techniques that include psychological education, problem solving, training in social skills, exercises in monitoring moods, modeling by the therapist, homework assignments, and meditation. It is based on the assumption that temperament and an unresponsive environment have made patients unable to trust their own emotional responses or soothe themselves.

Medications

Medications have a limited role in the treatment of personality disorders. They are used primarily to relieve symptoms such as anxiety, mood swings, and impulsive aggression (Lieb et al, 2010; Silk, 2011).

- Patients with cluster A personality disorders who show subtle psychotic symptoms may respond to antipsychotic medications.
- Patients with cluster B disorders who show subtle signs of bipolar disorder may benefit from mood-stabilizing medication or atypical antipsychotic drugs, either alone or in combination with antidepressant medication.
- Patients with cluster C anxiety-related personality disorders may benefit from the use of serotonergic antidepressants.

A Nursing Treatment Plan Summary for the patient with impaired social interaction is presented in Table 21-5. A Nursing Treatment Plan Summary for the patient at risk for self-mutilation is presented in Table 21-6.

EVALUATION

Evaluating the success of nursing interventions is difficult when the focus is on the quality of the therapeutic

TABLE 21-6 NURSING TREATMENT PLAN SUMMARY

Maladaptive Social Responses

Nursing Diagnosis: Risk for self-mutilation
Expected Outcome: The patient will select constructive rather than self-destructive ways of coping with interpersonal anxiety.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will not engage in self-mutilation.	Develop a contract with the patient to notify staff when anxiety is increasing. Provide close 1:1 observation of the patient when necessary to maintain safety. Remove all potentially dangerous objects from the patient and the environment. Provide prescribed medications.	When the patient is unable to cope with anxiety, safety is the nurse's highest priority. A contract helps the patient assume responsibility and explore healthier coping responses.
The patient will describe self-mutilating episodes.	Help the patient review these events. Identify cues and triggers that precede self-mutilating behavior. Help the patient explore feelings related to these episodes.	Self-mutilation is often a way of relieving extreme anxiety. Structured interpersonal support can help the patient review these events.
The patient will describe alternatives to self-mutilation.	Suggest alternative behaviors, such as seeking interpersonal support or engaging in an adaptive anxiety-reducing activity.	The nurse can help the patient review the full range of adaptive responses. Supportive but critical evaluation is necessary for behavioral change.
The patient will implement one new adaptive response when experiencing high interpersonal anxiety.	Help the patient select new adaptive responses. Reinforce the patient's adaptive behavior. Identify positive consequences of the adaptive responses. Discuss ways these may be generalized to other situations.	The nurses should take an active role in setting limits, examining patient behaviors, and reinforcing adaptive actions. These new learned responses also can be reviewed for their applicability to other life events.

relationship. Because the relationship is central to effective nursing care, it is threatening for many nurses to examine their ability to relate to others.

This type of evaluation must take place on two levels. One level of evaluation focuses on the nurse and the nurse's participation in the relationship. Self-examination may be useful in accomplishing this, especially if the nurse reviews an interaction immediately. Blind spots about one's own feelings that may be present while involved with the patient may become clearer in retrospect.

However, self-evaluation is colored by self-perceptions. Supervision by an experienced nurse therapist can be very helpful in identifying aspects of the nurse-patient relationship that may be less obvious to the nurse. Constructive supervision can help nurses identify the dynamics of the relationship. It also can help them deal with patients' resistance to change. Regardless of the experience of nurses, their perceptions of their participation in a relationship are affected by their self-concept. **The need for supervision continues throughout a nurse's career.**

The second level of evaluation focuses on the patient's behavior and the behavioral changes that the nurse works to facilitate. The patient is the primary source of input about these changes. Perceived changes in behavior should be validated with the patient to see whether the patient is also aware of change. Sharing feelings and intimate thoughts denotes increased trust and a willingness to risk self-revelation.

The patient also reveals responses to the therapeutic relationship nonverbally. Accessibility to the nurse for scheduled meetings indicates trust and involvement in the relationship. Eye contact usually occurs more often when one person is comfortable with another. Initiation of activities with others indicates more openness to relatedness. Increased decision making and assumption of leadership roles imply improved self-esteem and increasing self-confidence. Such behaviors can be observed, documented, and validated with other staff members. Therefore these are useful evaluation criteria.

Significant others also may contribute to the evaluation. They can provide valuable information about the patient's baseline behaviors. It also helps them understand new, more adaptive behaviors learned by the patient, and it gives them an idea of reasonable expectations.

Several questions may help the nurse evaluate the outcomes of interventions with the patient who has maladaptive social responses:

- Has the patient become less impulsive, manipulative, or narcissistic?
- Does the patient express satisfaction with the quality of relationships?
- Can the patient participate in close relationships?
- Does the patient express recognition of positive behavioral change?

LEARNING FROM A CLINICAL CASE OUTCOME

1. What are the features of his and her personality disorders?

She had a very emotional personality. She was very animated and self-expressive. He initially found this very attractive. In the beginning of the relationship, he was willing to put energy into making her the center of his world but thought that after they married, they could settle into a comfortable quiet routine. But it seemed like more and more problems began to surface and no matter how hard he tried, nothing he did was quite enough to satisfy her needs for attention.

He was a rather shy man and not very demonstrative of his affection. She initially found this endearing but later found him to be cold and rigid and found it frustrating to try and share her deepest feelings. He became easily irritated and critical of her habits. He found her daughter was messy. He felt she was ungrateful and therefore unwelcome. He thought they didn't respect him or his "things." He wanted a very predictable, orderly life.

2. What would each diagnosis be?

She had a histrionic personality disorder. He had an obsessive-compulsive personality disorder.

3. What are the predisposing factors of personality, temperament, and character that make their personalities problematic in this relationship?

She was passionate with an effusive personality. She felt deeply about her work and had struggled to raise her children. She thought she should be rewarded by his attention. His achievement was an object for her to manipulate. She needed structure in her life. He provided it. He was rigid and cold. His life lacked excitement and she could provide it. But the rigidity of his personality meant that his need for orderliness and his need to control his environment exceeded his concern for her well-being. They were each self oriented, not other oriented.

4. What were the precipitating stressors that created the conflict?

The precipitating stressors were changes in the relationship. Her grant was no longer funded, and her debts were revealed. Her daughter needed a home and mother, and there was little nurturing available for her.

5. What maladaptive coping made it difficult for them to communicate and accept each other's needs?

The maladaptive coping was that they each projected blame onto the other for their unhappiness. Their unrealistic idealization of each other quickly turned into devaluation of the other.

Case Outcome

This marriage ended in divorce. She moved out soon after and struggled to support herself. She continued in therapy and slowly began to put together part-time jobs, school and retraining; the last time she called, she was struggling to keep putting it together. She and her daughter became roommates and helped each other until her daughter became involved with another man and moved out. He never returned, but his ex-wife said he was dating someone and seemed anxious to get their divorce completed. It was assumed he wanted to get married as soon as possible.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Reatha L. Ryan, PMHNP, CS, CHTRN

A patient with the diagnosis of borderline personality disorder is often branded and labeled with the letter "B" by the treatment staff. This diagnosis may be inappropriately assigned to an inpatient because staff members are irritated and judgmental about the patient's behavior. Some psychiatric nurses apply this "diagnosis" without ever consulting the *DSM-IV-TR* to see whether the criteria are actually met. Perhaps the frustrated nurse is stuck in her own projections and countertransference. The nurse also may be reacting to defensive, immature, or regressive behavior displayed by the patient. This less than adequate functioning by the patient is often part of the very reason for the patient's admission for care.

I saw the many dimensions of this problem in my first job as a nurse on the adult unit of a private psychiatric hospital. I was practicing active listening, validation, reflection, and many other newly learned communication skills when the head nurse got a call from admissions advising her that "Jane Don't" would be brought to the ward in 30 minutes. As word spread among the staff nurses, there were many groans, heads shaking, and negative comments such as, "She's a sickie." "Look out, she's a manipulator." "She's stuck in the revolving door, and she'll never get better." My stomach turned and twisted inside as I heard such negative comments and expectations for this yet-to-be admitted patient. Did she stand a chance of getting better if the staff expected her to fail? I made a mental note to myself to bring this up in a staff meeting. I wanted to talk about the power of our words, thoughts, and expectations. I wanted to talk about how I felt when I heard that kind of talk.

I closed my ears to the negative comments, as I heard myself volunteering to admit this patient. As I went through the process of admission with "Jane Don't," I was warm and empathetic, listening and professional. When she barked at me, "I don't want anyone touching me," I was surprised. Yet soon I was able to shift to a neutral space internally, with the help of a deep breath and the determination to ground my energy squarely over my feet. "I will not take this personally," I said to myself.

I calmly continued, letting Jane know that I would not touch her without her permission. I let her know that I respected her but that there were times when certain tasks required touching. I explained that checking her blood pressure and pulse would require some touching. I let her choose when that would happen. "Would you like to have your blood pressure checked now, or after lunch, in about an hour?" Jane responded, "You may as well go ahead." By giving her two acceptable choices, she could make a decision and feel empowered, and I could

COMPETENT CARING—cont'd

A Clinical Exemplar of a Psychiatric Nurse

Reatha L. Ryan, PMHNP, CS, CHTRN

still get done what I needed to do. I explained each thing I was going to do before I touched her. She cooperated. This cooperation increased as she learned to trust me. Although she would still have her outbursts, by maintaining my professionalism and shifting to neutral I was able to accept her and work with her as she was, without being emotionally reactive to her. I kept my expectations for her positive and pointed out places of improvement, no matter how small.

What I learned from this patient was that the social and interactive functioning of the hospitalized patient might not meet the norm. The patient is ill, and behavioral functioning is often compromised. The nurse does well to maintain professionalism in working with this type of patient. The nurse can choose to "shift into neutral" in regard to her own judgments, reactions, and personal projections. Only by consciously making this shift can the nurse truly function professionally. Instead of joining in with the negative comments of other staff members, the professional nurse can be therapeutic, functioning with respect, clarity, and positive regard for all patients, including those with borderline traits or a borderline personality disorder.

CHAPTER IN REVIEW

- In a healthy relationship, people experience intimacy with each other while maintaining their own separate identities. Adaptive social responses include the capacity for solitude, autonomy, mutuality, and interdependence. Maladaptive responses include manipulation, impulsivity, and narcissism.
- Personality is shaped by biology and social learning, including hereditary biological dispositions and the influence of affective bonds with important others.
- A personality disorder is a set of patterns or traits that hinder a person's ability to maintain meaningful relationships, feel fulfilled, and enjoy life. The fixed, enduring quality of specific personality disorder symptoms is an essential element of the diagnosis.
- Three features of personality disorders are the following: (1) the individual has an inflexible and maladaptive approach to relationships and the environment; (2) the individual's needs, perceptions, and behavior tend to foster cycles that continue unhelpful patterns and provoke negative reactions from others; and (3) the individual's adaptation is characterized by tenuous stability, fragility, and lack of resilience when faced with stressful situations.
- An essential element of the diagnosis is that the symptoms are fixed and long lasting.
- Cluster A includes personality disorders of an odd or eccentric nature (paranoid, schizoid, and schizotypal personality disorders). Cluster B disorders are of an erratic, dramatic, or emotional nature (antisocial, borderline, histrionic, and narcissistic personality disorders). Cluster C includes disorders of an anxious or fearful nature (avoidant, dependent, and obsessive-compulsive personality disorders).
- Manipulation is when people treat others as objects and form relationships centered around control issues.
- Antisocial personality disorder is when an individual consistently ignores social rules; is manipulative, exploitative, or dishonest; lacks remorse for actions; and is frequently involved in criminal activity.
- Impulsive aggression is the hallmark of borderline personality disorder, and it plays a pivotal role in the borderline person's self-mutilation, unstable relationships, violence, and completed suicides.
- People with narcissistic personality disorders have fragile self-esteem, driving them to search constantly for praise, appreciation, and admiration.
- It is helpful to include a description of the patient's usual relationships in the nursing assessment.
- Personality is composed of temperament, which is inherited, and character, which is learned. Personality disorders derive from a variety of predisposing neurobiological, early developmental, and sociocultural factors. Many believe there is a strong genetic basis for them.
- Precipitating stressors that affect social responses include sociocultural values and norms and psychological pressures.
- A wide array of relationships and interests provide coping resources.
- Coping mechanisms associated with maladaptive social responses are attempts to cope with anxiety related to threatened or actual loneliness and may include idealization of others, devaluation of others, projection, acting out, splitting, and projective identification.
- Primary NANDA-I nursing diagnoses are defensive coping, chronic low self-esteem, risk for self-mutilation, impaired social interaction, and risk for violence (self-directed or directed at others).
- Medical diagnoses are paranoid, schizoid, schizotypal, histrionic, antisocial, narcissistic, borderline, obsessive-compulsive, dependent, and avoidant personality disorders.
- The expected outcome of nursing care is that the patient will obtain maximum satisfaction by establishing and maintaining self-enhancing relationships with others.
- The plan of nursing care must be realistic, considering the patient's ability to tolerate anxiety, and must promote consistency of interventions.

CHAPTER IN REVIEW—cont'd

- There often is professional bias or stigma against the diagnosis and those who suffer from it, requiring education and clinical supervision to address negative clinician attitudes.
- The full spectrum of treatment includes psychotherapy, engaging patients as collaborators, the need for a primary clinician to care for the patient, psychoeducation, family involvement, and limited use of medications. Borderline personality disorder is the only major psychiatric disorder for which psychosocial interventions are the primary treatment.
- Primary nursing interventions for patients with maladaptive social responses include protection from self-harm, establishing a therapeutic relationship, family involvement, milieu therapy, limit setting and structure, focusing on strengths, and behavioral interventions, particularly dialectical behavior therapy (DBT).
- One level of evaluation focuses on the nurse and the nurse's participation in the relationship. Another level is based on the patient's recognition of improvement in the quality and quantity of interpersonal relationships.

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CHAPTER

22

Cognitive Responses and Organic Mental Disorders

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I think, therefore I am.

Descartes

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive cognitive responses.
2. Identify behaviors associated with cognitive responses.
3. Analyze predisposing factors, precipitating stressors, and the appraisal of stressors related to cognitive responses.
4. Describe coping resources and coping mechanisms related to cognitive responses.
5. Formulate nursing diagnoses related to cognitive responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to cognitive responses.
7. Identify expected outcomes and short-term nursing goals related to cognitive responses.
8. Develop a family education plan to help caregivers cope with maladaptive cognitive responses.
9. Analyze nursing interventions related to cognitive responses.
10. Evaluate nursing care related to cognitive responses.

The ability to think and reason is unique to human beings. Most people fear the possibility of losing their cognitive abilities of reasoning, remembering, and deciding. These functions allow a person to make sense of experience and interact productively with the environment.

Maladaptive cognitive responses leave the affected person in a state of confusion—unable to understand and learn from experience and unable to relate current to past events or to interact reasonably with the people in one's life. Maladaptive cognitive responses change the way in which individuals think of themselves and the world in which they find themselves, as well as how the world thinks of and relates to them in return.

CONTINUUM OF COGNITIVE RESPONSES

Adaptive coping responses include decisiveness, intact memory, complete orientation, accurate perception, focused attention, and coherent, logical thought. Learning is any relatively permanent change in behavior that results from experience. Learning involves biological changes in the brain that are affected by external environments (the experience of the world in which one is raised) and internal environments (genetic characteristics, developmental events, neurotransmission).

Memory is the storage and retrieval of past experience. Like learning, it is a neurochemical process mediated by the brain. To exercise judgment, make decisions, or even be oriented to time and place, a person must remember past experiences. Therefore, loss of memory is a particularly frightening symptom.

In some people with brain dysfunction, cognitive responses either do not develop fully or deteriorate once they have developed. In general, maladaptive cognitive responses that occur during childhood are called *developmental disabilities* or *mental retardation*. This chapter considers maladaptive

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

His wife was very worried and needed somewhere confidential where she could sort everything out. Her husband was a legislator and a very popular politician. He had helped the county get money for a big highway project and brought industry to their small town when everyone needed jobs. People believed in him and sought his counsel.

But lately she had noticed a change. It was subtle, but she had lived with the man for 40 years. She noticed it over a period of 9 months or even longer. At times she found him standing in one place in the den like he didn't quite know what to do next. Previously, he really looked forward to his golfing outings and knew his tee-off times by heart. Everything else was scheduled around those commitments. But lately he seemed to get confused about the times and dates. He made other plans and often had scheduling conflicts. That had never happened before. Last night as he drove home, he hit a curb and blew out a tire. He called her on his cell phone to help him decide what to do. He was very agitated. That had certainly never happened before.

When she approached his doctor, he made light of her concerns. She had always been an anxious, hovering wife, and his doctor said he was sure it was nothing. But she felt very protective. Her husband had had an unblemished political record, and she didn't want anything to happen to tarnish it this late in his life.

Finally she convinced his doctor to refer him to a neurologist. He was sent to a memory disorders clinic and tested. He returned several months later for a follow-up test and scans. The results showed he had Alzheimer disease, a mild form.

Case Critical Reasoning Questions

1. How was his dementia different from depression or delirium?
2. Which neurotransmitters would be affecting his dementia as evidenced by what specific behaviors?
3. What would be the nursing diagnoses?
4. What interventions would be helpful for this patient?

CONTINUUM OF COGNITIVE RESPONSES

Adaptive responses		Maladaptive responses
Decisiveness	Periodic indecisiveness	Inability to make decisions
Intact memory	Forgetfulness	Impaired memory and judgment
Complete orientation	Mild transient confusion	Disorientation
Accurate perception	Occasional misperceptions	Serious misperceptions
Focused attention	Distractibility	Inability to focus attention
Coherent, logical thought	Occasional unclear thinking	Difficulties with logical reasoning

FIG 22-1 Continuum of cognitive responses.

cognitive responses in the adult. Although maladaptive cognitive responses may occur at any age, they are most common in the elderly.

Maladaptive cognitive responses include an inability to make decisions, impaired memory and judgment, disorientation, misperceptions, decreased attention span, and difficulties with logical reasoning. They may be episodic or continuous. Depending on the stressor, the condition may be reversible or it may be a progressive deterioration in functioning. Figure 22-1 presents the continuum of cognitive responses.

ASSESSMENT

Behaviors

Maladaptive cognitive responses are seen in people who have the psychiatric diagnoses of delirium, dementia, and amnestic and other cognitive disorders. This chapter focuses primarily on delirium and dementia, because these are the psychiatric categories related to cognitive impairment that nurses encounter most often. Assessment relies heavily on biological findings (see Chapter 5) and on the results of the mental status examination (see Chapter 6). Standardized assessment tools also may be useful.

Cognitive activity depends on intelligence, education, life experience, and culture. These can affect cognitive test scores, but not all rating scales or raters of cognitive function take them into account. The nurse should consider that some measures may have these shortcomings when assessing patients with varied abilities and from varied sociocultural backgrounds.

Behaviors Associated With Delirium. Delirium is the behavioral response to widespread disturbances in cerebral metabolism. It should be considered any time there is an acute change in mental status. Although delirium can occur at any age, advanced age is probably the greatest risk factor. It

often occurs in hospitalized patients but also can occur after hospitalization and in many cases may result from medications or medical procedures.

QUALITY AND SAFETY ALERT

- Delirium manifests as a sudden decline from a previous level of functioning.
- It is often considered a medical emergency that can lead to death or permanent cognitive decline if not treated.

Delirium results in disturbances in the following areas:

- **Consciousness—**reduced clarity or awareness of the environment
- **Attention—**impaired ability to direct and maintain mental focus, resulting in problems with processing stimuli into information
- **Cognition—**recent memory impairment, disorientation to time and person, or language disturbance
- **Perception—**misinterpretations, illusions, or hallucinations
- **Motor ability—**poor balance, ambulation, or coordination

The patient experiences a reduced awareness of the environment that involves sensory misperceptions and disordered thought (disturbed attention, memory, thinking, orientation) and also disturbances of psychomotor activity and the sleep-wake cycle. These disturbances develop rapidly (over hours to days) and tend to fluctuate over the course of the day, with occasional periods of mental clarity. The disturbances usually worsen at night.

The clinical example that follows illustrates the behavior typical of a patient who is delirious.

CLINICAL EXAMPLE

Ms. S was brought to the emergency department of a general hospital by her parents. This 22-year-old single woman was described as having been in good health until 2 days before admission, when she complained of malaise and a sore throat and stayed home from work. She worked as a secretary in a small office and had a stable employment record. According to her parents, she had an active social life, and there were no significant conflicts at home.

On admission, Ms. S was extremely restless and had a frightened facial expression. Her speech was garbled and incoherent. When approached by an unfamiliar person, she would become agitated, try to climb out of bed, and strike out aimlessly. Occasionally she would slip into a restless sleep. Her temperature on admission was 104° F (40° C), her pulse was 108 beats per minute, and her respirations were 28 per minute. Her skin was hot, dry, and flushed. According to her mother, Ms. S had only a few sips of water in the last 24 hours and had not urinated at all, but she had experienced several episodes of profuse diaphoresis.

Ms. S's ability to cooperate with a mental status examination was limited. She would respond to her own name by turning her head. When her mother asked her where she was, she said "home," but she could not say where her home was. She would give only the month when asked for the date and said it was January (the actual date was February 19). She also refused to give the day of the week. A neurological examination was negative for signs of increased intracranial pressure and for localized signs of central nervous system (CNS) disease.

The tentative medical diagnosis was delirium secondary to fever of unknown origin. Symptomatic treatment of the fever, including intravenous fluids, an aspirin suppository, and a cool water mattress, was begun immediately while further diagnostic studies were performed. Nurses caring for Ms. S noticed that she continued to be restless and disoriented and that her speech was still incoherent. They also noticed that she was picking at the bed clothing. Suddenly she became extremely agitated and tried to get out of bed while crying out, "Bugs, get away, get bugs away!" She was brushing and slapping at herself and the bed. As her mother and the nurse talked with her and held her, she gradually became calmer but periodically continued to slap at "the bugs" and needed reassurance and reorientation.

Additional laboratory results became available later in the day. A lumbar puncture was performed, as was magnetic resonance imaging (MRI) of the head; results were normal. Results of a toxicological screening of the blood also were negative. However, the electroencephalogram (EEG) revealed diffuse slowing. In addition, the elevated white blood count and electrolyte imbalance were consistent with severe dehydration. Cultures of Ms. S's throat and blood were both positive for β-hemolytic streptococci, and intravenous antibiotic therapy was begun at once while other supportive measures were continued.

Ms. S's mental state improved as the infection gradually came under control and the fever decreased. Her cognitive functioning was completely normal when she was discharged from the hospital, with the exception of amnesia for the time during which she was delirious.

Selected Nursing Diagnoses

- Hyperthermia related to infection, as evidenced by elevated temperature; hot, dry, flushed skin; and diaphoresis
- Deficient fluid volume related to decreased fluid intake, as evidenced by anuria for 24 hours and hot, dry, flushed skin
- Risk for injury related to fear and disorientation, as evidenced by agitated behavior and hallucination of bugs
- Impaired verbal communication related to altered brain chemistry, as evidenced by garbled and incoherent speech

Ms. S demonstrated many behaviors often seen in patients with delirium. These behaviors have a sudden onset and are related to alterations in neurochemical and electrical responses in the brain as a result of the stressor that causes the maladaptive response. Disorientation is generally present and sometimes in all three aspects of time, place, and person. Thought processes are usually disorganized. Judgment is poor, and there is a lack of sound decision-making.

Stimuli may be misinterpreted, resulting in illusions or distortions of reality. An example of such an illusion is the perception that a polka-dot drape is actually covered with cockroaches. Delirious patients may **hallucinate.** These hallucinations are usually visual and often take the form of

animals, reptiles, or insects. They are real to the person experiencing them and are very frightening. Assaultive or destructive behavior may be the patient's attempt to strike back at a hallucinated image.

At times, patients with delirium also exhibit a **labile affect,** changing abruptly from laughter to tearfulness and vice versa for no apparent reason. A loss of usual social behavior also may be noted and may result in acts such as undressing, playing with food, and grabbing at others. **Delirious patients tend to act on impulse.**

Other behaviors may be specifically related to the cause of the behavioral syndrome. For example, Ms. S's brain syndrome and the fever and dehydration she experienced were a result of her systemic streptococcal infection. It is very important that observations of behavior be described carefully, because this helps identify the stressor.

Treatment is usually conservative until a specific stressor has been isolated. Although most patients recover, it is possible for the person to develop long-term disabilities or to die as a result of the severity of the stressor.

Delirium is commonly found in hospitalized patients, particularly in intensive care units (ICUs), geriatric psychiatry units, emergency departments, alcohol treatment units, and oncology units (Fricchione et al, 2008; Uguz et al, 2010). In addition, a diagnosis of delirium can be missed because the symptoms are assumed to be caused by depression. If adequate intervention does not take place, delirium may become chronic and irreversible.

Behaviors Associated With Dementia. Dementia **is a loss of intellectual abilities that interferes with the patient's usual social or occupational activities.** The loss of intellectual ability includes impairment of memory, judgment, and abstract thought. The patient with dementia does not have the clouding of awareness or the rapid onset that is seen with delirium.

The onset of dementia is usually gradual. It may result in progressive deterioration, or the condition may become stable. **Personality changes often occur.** They may appear either as a change or as an intensifying of the person's usual character traits.

In some cases the process of dementia can be reversed, and the person's intellectual functioning improves if the underlying stressors are identified and treated. However, in many cases dementia involves a continual and irreversible decline in mental function and behavior. Reversible causes of dementia are listed in Box 22-1.

Dementia may occur at any age but most often affects the elderly. This condition results from structural and neurochemical changes in the brain resulting from trauma, infection, cerebrovascular disruptions, substance use, or an unknown cause. The various types of dementia are listed in Table 22-1.

Alzheimer disease (AD) **is the most common type of dementia and accounts for approximately 70% of cases of the disease.** However, AD is not a normal part of aging.

In the United States, early-onset dementia affects more than one-half million people younger than 65 years of age. In younger adults, early symptoms may be mistaken as stress or depression (Hunt, 2011). Dementia forces individuals to assume dependent roles within their families at a time when they may be primary caretakers themselves. Facts and figures about AD are presented in Box 22-2.

BOX 22-1 REVERSIBLE CAUSES OF DEMENTIA

- Subdural hematoma
- Tumor (especially meningioma)
- Cerebral vasculitis
- Hydrocephalus

TABLE 22-1 TYPES AND OCCURRENCE RATES OF DEMENTIA

TYPE OF DEMENTIA	RATE (%)
Alzheimer disease	**60-80**
Vascular dementias with Alzheimer disease	10
Supranuclear palsy	8
Parkinsonian dementia	7
Vascular dementias (multiinfarct dementia)	5
Alzheimer disease plus dementia with Lewy bodies	5
Dementia with Lewy bodies	
AIDS dementia complex	
Frontal lobe dementia	

AIDS, Acquired immunodeficiency syndrome.

QUALITY AND SAFETY ALERT

- Early-onset AD is associated with a more rapid course and genetic predisposition compared with late-onset AD.

The following clinical example demonstrates the behaviors associated with dementia.

CLINICAL EXAMPLE

Mr. B is a 73-year-old widower who has resided in a retirement home for 3 years. He chose to move to the retirement home after his wife's death even though his son encouraged him to live with him and his family. Mr. B stated that he did not want to burden his family and would be happier with others of his same age. He did well for the first 18 months. He was an active participant in social groups both in the home and in his church, which he continued to attend regularly. He also visited his son weekly and enjoyed seeing his grandchildren.

About 18 months ago, Mr. B began to seem forgetful. He would ask the same question several times and on occasion prepared for church on a Friday or Saturday. He also became irritable and accused his son of not caring about him and of abandoning him in "that place." Mr. B spent many hours taking papers from his desk and studying them. When asked what he was doing, he would say, "Attending to my business."

He began to withdraw from activities and make flimsy excuses to avoid playing his favorite card game, gin rummy. When persuaded to play, he usually quit in frustration because he could not remember which cards had been played. Mr. B was quite anxious at times. He seemed well oriented at times and expressed great concern about the changes he was experiencing, wondering if he was "going crazy."

Because of the concern of the retirement home staff, Mr. B was scheduled for a complete physical examination by his family physician and for a psychiatric evaluation by the geriatric psychiatric nurse consultant who came to the retirement home each week. The physical examination found Mr. B to be in generally good health for a man his age. He had a mild hearing loss and slight prostatic hypertrophy. Hypertension had been diagnosed 10 years before this examination but was well controlled by diuretics. A neurological examination revealed normal reflexes, normal muscle strength, a slight intention tremor, normal responses to sensation, normal cranial nerves, and no disturbance of gait. The results of electroencephalography (EEG) were normal, as were those of laboratory studies of blood and urine. Computed tomography (CT) studies of the brain revealed some atrophy of the cerebral cortex.

The mental status examination confirmed the deficits in cognitive functioning observed by the nursing home staff and Mr. B's son. Mr. B was oriented to person and place but stated the date as April 6, 1958 (the real date was January 21, 2010). He also thought the day of the week was Friday, and it was actually Wednesday. He correctly identified the season of the year as winter. Mr. B was able to state correctly his birth date, the date of his son's birth, and the year he began to work at his first job.

He spoke at length and with great detail about his exploits as a young man. His vocabulary was excellent, as was his fund of general information. However, he could not repeat the names of three objects after 5 minutes and could not remember what he had eaten for lunch or the last name of the man who shared his room. He became distressed while trying to answer these questions. He was unable to remember the names of the two most recent presidents but could recite the names of the eight presidents before them.

Mr. B's judgment was somewhat impaired. When asked what he would do if he found a stamped, addressed, sealed envelope, he said he would "read it, then mail it." His abstract thinking was concrete, as was seen in his difficulty in interpreting proverbs. His attention span and ability to concentrate were normal. His eye-hand coordination was disrupted, as demonstrated by difficulty in copying simple figures. A hand tremor was evident both when he was drawing and when he was signing his name.

Mr. B's affect was appropriate to the content of the discussion both in quality and in quantity. He appeared depressed when talking about his memory loss but cheerful and proud when describing his grandchildren. No abrupt mood swings were noted. His flow of speech was of a normal rate and volume. The content of his speech was logical and coherent but became somewhat disjointed when he tried to remember and describe recent events.

As a result of the data gathered in the physical and mental status examinations, Mr. B was diagnosed as having dementia not otherwise specified. Over the next several months his condition continued to deteriorate gradually. He became increasingly forgetful and began to confabulate and fabricate stories. He was less conforming to social norms and needed to be reminded about hygiene and appropriate dress. He also became seductive with female residents and staff, making suggestive remarks and occasionally fondling someone.

Visits to his son's home became impossible as his behavior deteriorated. His memory of the identity of family members was sometimes confused. He would misidentify his daughter-in-law as his wife and his grandson as his son. His conversation increasingly consisted of rambling reminiscences about his life in his youth. His son and health care providers began to discuss plans to move him to the assisted living program associated with his retirement home. Because he was surrounded by caring people, Mr. B continued to live with dignity and respect despite his progressively limited ability to communicate and to take care of himself.

Selected Nursing Diagnoses

- Impaired verbal communication related to cognitive impairment, as evidenced by recent memory loss, confabulation and disorientation
- Impaired social interaction related to altered thought processes, as evidenced by a loss of conformity to social norms
- Bathing self-care deficit related to cognitive impairment, as evidenced by a failure to perform personal hygiene activities without reminders
- Dressing self-care deficit related to cognitive impairment, as evidenced by a need for assistance in selecting appropriate clothing

The behaviors associated with dementia reflect the brain tissue alterations that are taking place (Table 22-2). **Behavioral change occurs slowly in the early and late stages of AD and rapidly in the middle stage.** The three stages of AD are listed in Box 22-3.

Cognitive changes are related to the stressors that interfere with the functioning of the cerebral cortex and the hippocampus. Other areas of the brain also are affected, which is one reason for performing a complete medical and neurological examination.

Another reason is that although dementia is often irreversible, progression may sometimes be stopped or slowed by identifying the stressor and treating the underlying dysfunction. For example, the treatment of hypertension may prevent a further occurrence of one large or many small brain hemorrhages, which are possible causes of vascular dementia.

Depression in the elderly is often misinterpreted as dementia and therefore is not treated appropriately. **Pseudodementia** is a cognitive impairment that occurs secondary to a functional psychiatric disorder such as depression and is characterized by lapses in memory and judgment, poor concentration, and seemingly diminished intellectual capacity. This condition is reversible with appropriate treatment of the depression.

BOX 22-2 ALZHEIMER DISEASE FACTS AND FIGURES

- AD is not just memory loss. AD kills.
- AD is the sixth leading cause of death in the United States and the fifth leading cause of death for those aged 65 and older.
- AD is the only cause of death among the top 10 in the United States without a known prevention or cure.
- Deaths from AD increased 66% between 2000 and 2008, whereas deaths from other major diseases, including the number 1 cause of death (heart disease), decreased.
- Today, 5.4 million Americans are living with AD. By 2050, as many as 16 million Americans will have the disease.
- Two thirds of those with AD are women.
- One in eight Americans aged 65 years and older has AD, and almost half of those aged 85 and older have the disease.
- Most people survive 4 to 8 years after being diagnosed with AD, but some live as long as 20 years with the disease.
- Four percent of the general population will be admitted to a nursing home by age 80. But 75% of those with AD will be admitted to a nursing home by age 80.
- In 2010, 14.9 million family members and friends provided 17 billion hours of unpaid care for people with AD and other dementias.
- More than 60% of caregivers for people with AD or dementia rate the emotional stress of caregiving as high or very high; one third report symptoms of depression.

Adapted from http://www.alz.org/alzheimers_disease_facts_and_figures.asp. Accessed October 2011.

TABLE 22-2 ASSOCIATION OF AREAS OF BRAIN PATHOLOGY WITH BEHAVIORAL CHANGES IN DEMENTIA

ANATOMICAL STRUCTURE	FUNCTION	DYSFUNCTION
Occipital lobe	Visual processing	Blindness, loss of depth perception, color agnosia (lack of recognition), persistent after-images
Frontal lobe	Organization of words into fluent speech	Difficulty using "little words" (e.g., in, on, he, she, or); changes in personality, judgment, and behavior
Parietal lobe	Association area for integrating sensory input	Alexia (inability to read), agraphia (inability to write), neglect syndrome, inability to perceive pain, agnosia, apraxia, aphasia, visual-spatial disturbances, loss of executive functions, psychosis
Temporal lobe	Recognition and comprehension of sensory input; hearing; memory consolidation; association of memory, thought, perception, and emotion	Agnosia, apraxia, aphasia, visual-spatial disturbances, loss of executive functions, disorientation in space and time, psychosis, memory loss, misinterpretation of emotional events, misinterpretation of relationships
Limbic system	Emotions, storage of short-term memory, mood	Memory dysfunction, no affective dimension to memory, apathy, unstable affect, personality changes, poor learning ability, memory loss

BOX 22-3 THREE STAGES OF ALZHEIMER DISEASE

Stage I: Mild—2 to 4 average years duration

- Repeats words or action
- Has trouble remembering names and common objects
- Gets lost easily
- Loses things
- Beginning problems in activities of daily living (ADLs)
- Subtle personality changes
- Shows lack of interest in usual activities

Stage II: Moderate—2 to 10 average years duration

- Obvious memory problems
- Gets confused about recent events
- Decreased ability to perform ADLs
- Argues easily
- Seems anxious and depressed
- Paces
- Noticeable behavioral difficulties
- Close supervision needed

Stage III: Severe—1 to 3 average years duration

- Fragmented memory
- No recognition of familiar people
- No recognition of self in mirror
- Uses words improperly
- Depends on others for basic ADLs
- Reduced mobility

TABLE 22-3 **COMPARISON OF DELIRIUM, DEPRESSION, AND DEMENTIA**

PARAMETER	DELIRIUM	DEPRESSION	DEMENTIA
Onset	Rapid (hours to days)	Rapid (weeks to months)	Gradual (years)
Course	Wide fluctuations; may continue for weeks if cause is not found	May be self-limited or may become chronic without treatment	Chronic; slow but continuous decline
Level of consciousness	Fluctuates from hyperalert to difficult to arouse	Normal	Normal
Orientation	Patient is disoriented, confused	Patient may seem disoriented	Patient is disoriented, confused
Affect	Fluctuating	Sad, depressed, worried, guilty	Labile; apathetic in later stages
Attention	Always impaired	Difficulty concentrating; patient may check and recheck all actions	May be intact; patient may focus on one thing for long periods
Sleep	Always disturbed	Disturbed; excess sleeping or insomnia, especially early-morning waking	Usually normal
Behavior	Agitated, restless	Patient may be fatigued, apathetic; may occasionally be agitated	Patient may be agitated or apathetic; may wander
Speech	Sparse or rapid; patient may be incoherent	Flat, sparse, may have outbursts; understandable	Sparse or rapid; repetitive; patient may be incoherent
Memory	Impaired, especially for recent events	Varies day to day; slow recall; often short-term deficit	Impaired, especially for recent events
Cognition	Disordered reasoning	May seem impaired	Disordered reasoning and calculation
Thought content	Incoherent, confused, delusional, stereotyped	Negative, hypochondriac, thoughts of death, paranoid	Disorganized, rich in content, delusional, paranoid
Perception	Misinterpretations, illusions, hallucinations	Distorted; patient may have auditory hallucinations; negative interpretation of people and events	No change
Judgment	Poor	Poor	Poor; socially inappropriate behavior
Insight	May be present in lucid moments	May be impaired	Absent
Performance on mental status examinations	Poor but variable; improves during lucid moments and with recovery	Memory impaired; calculation, drawing, and following directions usually not impaired; frequent "I don't know" answers	Consistently poor; progressively worsens; patient attempts to answer all questions

Depression associated with AD is among the most common mood disorders of older adults. Aggression in patients with dementia is strongly linked to the presence of depressive symptoms. Appropriate treatment of the depression may be a way of preventing and managing the physically aggressive behavior. AD behaviors related to delirium, dementia, and depression are compared in Table 22-3.

Critical Reasoning Elderly adults with depression are often misdiagnosed as having dementia; the diagnosis of delirium is often missed too. What nursing observations help determine whether a patient's mental disorder is primarily affective or cognitive, and how would this affect treatment?

A common behavior related to dementia is **disorientation.** Time orientation is usually affected first, then place, and finally person. This can be distressing to the patient, who may be aware of this difficulty and embarrassed or frightened by it. This is particularly true if the person's mental acuity fluctuates. In these instances the person is aware, during clear periods, of the confusion and disorientation experienced at other times.

Memory loss is another prominent characteristic of dementia. Those with declining memory are often not fully aware of their deficits in activities of daily living (ADLs). A mathematically based memory assessment, the MCI Screen, detects early signs of memory impairment caused by AD and related disorders. The MCI Screen helps justify the importance of regular memory assessments in people older than 65 years of age who have no previous diagnosis of memory disorders.

Memory includes several aspects:

- **Remote memory:** recall of events, information, and people from the distant past
- **Recent memory:** recall of events, information, and people from the past week or so
- **Immediate memory:** recall of information or data to which a person was just exposed

All of these are evaluated during a mental status examination (see Chapter 6).

In the last clinical example, Mr. B had trouble remembering the three objects he had heard named 5 minutes before and what he had eaten for lunch, but he gave accurate dates for significant events earlier in his life. Most aging people dwell on the past, but people with recent memory loss have difficulty shifting to the present and at advanced stages may seem to live in the past. This was demonstrated by Mr. B's misidentification of his grandson and his daughter-in-law.

Another behavior related to memory loss is confabulation. **Confabulation is a confused person's tendency to make up a response to a question when unable to remember the answer.** For instance, when Mr. B was asked whether he knew one of the female residents of the home, he replied, "Of course I know her. I used to play gin with her husband." Actually, the woman's husband had been dead for many years, and Mr. B had never met him.

Confabulation should not be viewed as lying or as an attempt to deceive but rather as a way of trying to save face in an embarrassing situation. Mr. B is aware that he should know the answer to the question and gives an answer that seems reasonable, not entirely disbelieving it himself.

It is not unlike the situation in which a person meets an acquaintance and cannot recall the other's name or where they met. The person acts as if these facts are remembered, hoping that the other will offer clues about their identity. Denial of memory loss also may be related to the effect of dementia on the cognitive abilities needed for awareness of the problem.

As AD progresses, patients often develop aphasia, apraxia, agnosia, and amnesia:

- **Aphasia** is difficulty finding the right word.
- **Apraxia** is the inability to perform familiar skilled activities.
- **Agnosia** is difficulty in recognizing well-known objects, including people.
- **Amnesia** is significant memory loss in the absence of clouded consciousness or other cognitive symptoms.

These behaviors are related to the effect of the illness on the temporal-parietal-occipital association cortex.

Vocabulary and general information may be less affected by dementia until its late stages, and recall depends on when the information was learned. Facts learned early in life may be recalled well, whereas those learned recently may be quickly forgotten, as seen by Mr. B's performance in listing the last 10 presidents.

Patients with dementia may have **disturbed sleep,** which can worsen memory complaints. They can have **labile mood swings,** particularly if the limbic system has been affected by the disease process. Some **deterioration in social skills** may be present as well.

Impulsive sexual advances may occur, reflecting decreased inhibition and impaired judgment as well as deterioration in the limbic system. Often this behavior is an attempt to establish interpersonal contact and is a way of asking for caring from others. It is also a way of reinforcing an important part of the person's identity—a part that becomes less secure as mental functioning declines.

Alterations in sexual functioning associated with AD cause great concern for patients and their partners. Loss of erection ability is a common problem among men with AD, and it is uncertain whether this is physiological or psychological in origin. However, often both the patient and the sexual partner can benefit from continued sexual intimacy.

Restlessness and **agitation** are other behaviors that occur with dementia. Extreme agitation may occur at night, a phenomenon known as **sundowning syndrome.** Sundowning syndrome probably results from tiredness at the end of the day combined with fewer orienting stimuli at night, such as planned activities, meals, and contact with people.

Critical Reasoning Based on your understanding of sundowning syndrome, describe nursing interventions that would decrease the severity of this problem in patients with dementia at home, in the hospital, or in the nursing home.

QUALITY AND SAFETY ALERT

- Behavior that becomes extremely agitated is called a **catastrophic reaction** and is a medical emergency.

Agitation can be caused by physical and medical problems, environmental stresses, sleep problems, and psychiatric disorders. Each should be carefully evaluated and treated. Disorientation can result in fear and agitation in individuals with cognitive impairment.

The following are precipitating factors related to catastrophic reactions:

- A change in cognitive status that results in difficulty organizing and interpreting information, sensory or cognitive overload, or misinterpretation of sensory stimuli
- Side effects of medications
- Psychosocial factors that result in increased demands to remember, such as fatigue, changes in routines or caregivers, and disorienting stimuli
- Environmental factors, including environmental changes, noise, and decreased light

The term **confusion** is often used when referring to a person with cognitive impairment. Although widely accepted as nursing and medical jargon, this term has not been specifically defined. It is better to use specific terms when describing a patient's behavior. Five types of disturbing behaviors characteristic of dementia are summarized in Table 22-4.

Some people with maladaptive cognitive responses function at a level that is lower than would be expected on the basis of objective measurements of their impairment. This functional deficit is called **excess disability.**

TABLE 22-4 **DISTURBING BEHAVIORS CHARACTERISTIC OF DEMENTIA**

BEHAVIOR	DESCRIPTION	EXAMPLES
Aggressive psychomotor behavior	An increase in gross motor movement that has the effect of harming or repelling another	Hitting, kicking, pushing, scratching, assaultiveness
Nonaggressive psychomotor behavior	An increase in gross motor movement that does not have an apparent negative effect on others but draws attention because of its repetitive nature	Restlessness, pacing, wandering
Verbally aggressive behavior	Vocalizations that have the effect of repelling others	Demanding, disruptive, manipulative behaviors; screaming; complaining; negativism
Passive behavior	A diminution of behavior—that is, a decrease in gross motor movement accompanied by apathy and a lack of interaction with the environment	Decreased activity, loss of interest, apathy, withdrawal
Functionally impaired behavior	Loss of ability to perform self-care, the expression of which may be aversive and burdensome	Vegetative behaviors, incontinence, poor personal hygiene

This problem adds to the frustration of the patient and to the burden placed on caregivers. Caregivers may contribute to the development of excess disability by performing activities for the patient rather than coaching and assisting when needed. Functional abilities are lost more rapidly as the patient becomes more passive in self-care routines.

Patients with a cognitive impairment are often referred to a clinical psychologist for psychological testing. This referral should be made only for a specific purpose, because the testing is time-consuming, expensive, and tiring for the patient. Reasons for psychological testing include measuring the extent of the disability, identifying the stressors causing the disruption, understanding the dynamics of the problem, developing guidelines for therapeutic intervention, and obtaining a prognosis for recovery.

Behaviors Associated with Traumatic Brain Injury. Traumatic brain injury, **often referred to as TBI, is a disruption of normal brain function that occurs when the skull is struck, suddenly thrust out of position, or penetrated.** Most often it is an acute event similar to other injuries. But it differs in important ways from other injuries. Brain injury can affect all aspects of a person's life, including personality (U.S. Dept. VA/DoD 2009; SAMHSA, 2010; Reeves and Panguluri, 2011).

No two brain injuries are alike, and each injury manifests in a different way. **Symptoms may appear right away, or they may not be present until days, weeks, or months after the injury.** The person may not even realize that a TBI has occurred.

The initial trauma tears, shears, or destroys brain tissue. These effects cause secondary injury in the brain including internal bleeding, swelling, oxygen deprivation, and neurochemical changes leading to cell death. A TBI can affect a single, specific region of the brain (**focal injury**), be distributed throughout the brain (**diffuse injury**), or both.

On average, an estimated 1.7 million TBIs occur each year in the United States; 52,000 of those experiencing TBI die, 275,000 are hospitalized, and 1.365 million—almost 80%—are treated and released from emergency departments. In every age group, TBI rates are higher for males than for females. Among the age groups that have the highest proportions of TBI are adolescents (aged 15-19 years) and older adults (≥75 years). Sports-related TBIs alone are estimated at between 1.6 million and 3.8 million each year.

For service members in Iraq or Afghanistan, the main TBI risk has been from an improvised explosive device (IED) such as a roadside bomb. Helmets and body armor provide some protection against penetrating head injury and, to a lesser extent, against head-impact events. However, the brain remains vulnerable to the effects of blast waves from IEDs. Gunshot wounds as well as combat- or training-related falls and motor vehicle crashes are other causes of service-related TBI (Snell and Halter, 2010). See Chapter 39 for a discussion of the mental health needs of the military and their families.

TBI is classified into three categories: mild, moderate and severe.

- **Mild**—A brain injury can be classified as mild if loss of consciousness and/or confusion and disorientation lasts **less than 30 minutes.** About 75% of all TBIs are mild. Concussion **is often used interchangeably with mild TBI.** Whereas magnetic resonance imaging (MRI) and computed tomography (CT) scans are often normal, the individual has cognitive problems such as headache, difficulty thinking, memory problems, attention deficits, mood swings, and frustration. These injuries are often overlooked and can be difficult to diagnose.
- **Moderate**—Moderate brain injury is related to loss of consciousness for **more than 30 minutes and less than 24 hours.** There may be amnesia for 1 to 7 days related to the injury. Brain imaging may or may not reveal abnormalities.

BOX 22-4 COMMON EFFECTS OF TRAUMATIC BRAIN INJURY (TBI)

Physical Problems
- Dizziness, lightheadedness
- Fatigue or lethargy
- Trouble walking
- Headaches and other pain symptoms
- Nausea
- Sensory impairments (blurred vision, sensitivity to light or sound, ringing in the ears, persistent noxious smell or taste in mouth, itching)
- Sleep disturbances
- Weakness
- Posttraumatic epilepsy

Cognitive Problems
- Posttraumatic amnesia
- Executive function problems affecting ability to organize thoughts and plans, follow through on actions, do abstract reasoning, problem-solve, make judgments
- Impaired attention and concentration
- Language and communication impairments
- Aphasia
- Difficulty multitasking
- Worsened memory
- Dementia

Affective Problems
- Anxiety
- Apathy
- Lack of initiative, motivation
- Difficulty regulating emotions
- Lability
- Lack of self-awareness (including lack of awareness of cognitive deficits)
- Personality changes

Behavioral Problems
- Aggressive
- Irritable
- Disruptive
- Socially inappropriate
- Agitated

- **Severe—**Severe brain injury is associated with loss of consciousness for **longer than 24 hours.** There is often objective evidence of brain injury on brain scans and neurological examinations. The deficits range from impairment of higher-level cognitive functions to comatose states. Survivors may have limited function of arms or legs, abnormal speech or language, loss of thinking ability, and emotional problems.

The common effects of TBI are listed in Box 22-4. The level and duration of the effects vary from person to person. These effects can be confused with symptoms of other psychiatric disorders.

After TBI, a person is at risk for a range of psychiatric disorders, including depression, generalized anxiety disorder, panic disorder, agoraphobia, and posttraumatic stress disorder (Bryant et al, 2010). About half of all people with TBI also experience chronic pain. **These comorbid psychiatric illnesses predict poorer health outcomes and poorer quality of life** (Bombardier et al, 2010; Reeves and Panguluri, 2011).

QUALITY AND SAFETY ALERT
- Risk for suicide is two to four times greater for individuals with TBI.
- Even mild brain injury increases suicide risk.

Many people with TBI make a full recovery, but others have long-lasting cognitive and behavioral changes that limit their ability to work and live a functional and productive life. It is estimated that 2% of the population have chronic disabilities resulting from TBI. Multiple TBIs are cumulative in the damage that can occur, so mild cases can become severe.

Predisposing Factors

Maladaptive cognitive responses are usually caused by a biological disruption in the functioning of the central nervous system (CNS). The CNS requires a continuous supply of nutrients, including oxygen, in order to function. Any interference with the provision of supplies to the brain or with the removal of waste products will cause functional disruptions in cognition.

Aging. In 2030, almost one in five U.S. residents, including all of the so-called baby boomers, will be 65 years of age and older. This age group is projected to increase to 88.5 million in 2050, more than doubling the number in 2008. Similarly, the 85 and older population is expected to more than triple, from 5.4 million to 19 million between 2008 and 2050 (U.S. Census Bureau, 2008).

Although aging itself predisposes a person to maladaptive cognitive responses, the loss of mental abilities is not automatically associated with aging. Although a cumulative degeneration of brain tissue *is* associated with aging, it is not extensive enough to be particularly noticeable in most people.

As people age normally, their cognitive functions slow down but remain intact. If other stressors are added, the person may experience difficulty. Exposure to a toxic chemical or heavy metal, disease, or injury may result in maladaptive cognitive responses, which disrupt normal cognitive responses at any age. **However, advanced age is one of the risk factors for dementia associated with AD.**

Neurobiological. **AD is the most prevalent cause of maladaptive cognitive responses.** Intensive research has focused on identifying its causes, characteristics, and treatment

TABLE 22-5 **RELATIONSHIPS BETWEEN NEUROTRANSMITTERS AND BEHAVIOR IN DEMENTIA**

NEUROTRANSMITTER SYSTEM/ NEUROTRANSMITTER	ANATOMICAL ORIGIN	FUNCTION	DYSFUNCTION AND BEHAVIOR
Cholinergic system/ acetylcholine (ACh)	Synthesized by an enzyme, choline acetyltransferase, in the nucleus basalis of Meynert in the basal forebrain	Promotes hippocampal and cerebral cortex function; necessary for selective attention, learning, memory, and the sleep-wake cycle	Diminished levels of ACh lead to amnesia, agitation, and psychotic symptoms Possible direct relationship to severity of disease Imbalance in the dopamine (DA) system
Noradrenergic system/ norepinephrine (NE)	Locus ceruleus in the rostral pons of the brainstem	Modulates mood and stress response; produces psychotic symptoms	Increased NE: hypervigilance, decreased appetite, insomnia, anxiety, agitation, psychosis Decreased NE: depressed mood Imbalance in the serotonin (5-HT) system
Serotonergic system/ serotonin (5-HT)	Raphe nuclei in the brainstem	Regulates body temperature, cardiovascular system, respiratory system, sleep/alertness, mood, aggression, sensory perception, sexual behavior, and feeding behavior	Decreased 5-HT: anxiety, agitation, psychomotor activity, insomnia, psychosis, depressed mood, possibly suicidal behavior Imbalance in the NE system
Dopaminergic system/ dopamine (DA)	Substantia nigra in the brainstem, with projections directly communicating with the frontal lobe, limbic system, and motor areas	Regulates emotional responses (limbic system), executive functions (frontal lobes), and complex movements (motor striatum)	Decreased DA: difficulty initiating movement, rigidity, postural abnormalities, parkinsonian tremor (akinesia or bradykinesia), blunted affect, apathy Imbalance in the ACh system

(Holcomb, 2008). Investigators have found that characteristic alterations occur in brain tissue of people with AD:

- **Neuritic plaques,** which consist of amyloid-β (a starch-like protein) and remains of dying nerve cells. Plaques also contain altered glial cells.
- **Neurofibrillary tangles,** which are twisted clumps of protein fibers. Tangles contain a substance called *tau protein*, which seems to interfere with internal transport in neurons.

It is not known how excessive amyloid and tau protein deposits lead to the plaques and tangles that cause extensive structural and biochemical changes in axons, dendrites, and neuronal cell bodies. These changes reduce synaptic function by as much as 40% in affected regions and reduce protein synthesis and cellular processes. However, there is no doubt that this buildup of amyloid protein, combined with the formation of neurofibrillary tangles and other structural changes in neurons, contributes to a progressive breakdown of neuronal circuits necessary for communication in the brain.

It is as if the limbic system, particularly the hippocampus, amygdala, and the association cortices (which are affected early in the AD process and are necessary to the organization of mental processes), becomes isolated and out of touch with other brain regions; hence, the gradual impairment of memory, judgment, abstraction, and language. Eventually, motor and sensory regions also are affected, and the patient with AD becomes totally disabled.

These phenomena are found in the cortex (cognition, judgment), the amygdala (emotion), and the hippocampus (consolidation of short-term memory), consistent with the emotional changes and short-term memory loss characteristic of AD. In addition, atrophy of the associational areas of the cortex is noted.

Alterations also have been seen in the neurotransmitter systems, in particular, a significant **deficiency of the neurotransmitter acetylcholine (ACh).** The cholinergic system originates in the basal forebrain, which is positioned at the interface between the limbic system and the cerebral cortex, where it plays a role in emotion and memory.

ACh is produced in a region of the basal forebrain that is selectively devastated by AD. It is thought that too little ACh may allow a buildup of amyloid protein, which is implicated in the pathophysiology of AD.

Although correlations can be drawn between neurotransmitter deficits and the pathology and clinical symptoms of AD, they seem to reflect damage that is specific to affected regions and structures rather than entire neurotransmitter systems throughout the brain. Table 22-5 lists the

TABLE 22-6 HIV SYMPTOMS RELATED TO BRAIN STRUCTURES AND FUNCTIONS

BRAIN STRUCTURE	CLINICAL SYMPTOMS
Frontal lobes	Apathy, trouble concentrating and planning, loss of organizational skills, depression
Basal ganglia	Impaired movement, tremor
Limbic system	Emotional lability, memory loss, language impairment
Brainstem	Disturbances of gait, vision, and eye movement
Demyelination	Impaired fine motor skills, delayed information processing, impaired response time, incontinence

HIV, Human immunodeficiency virus.

relationships between neurotransmitters and behavior in dementia.

There are a number of brain syndromes that affect cognition.

- **Acquired immunodeficiency syndrome (AIDS) dementia complex,** usually in the late stages of the disease, affects several brain structures. Up to one third of people who are infected with human immunodeficiency virus (HIV) develop this brain syndrome (Table 22-6). Symptoms include very slowed thinking and severe forgetfulness, difficulty performing multistage complex tasks (e.g., dressing and other ADLs), muscle control problems, and eventually, social withdrawal, apathy, and depression.
- **Vascular dementia** is caused by disruptions in the cerebral blood supply. Causes include hemorrhage, hypoperfusion (e.g., cardiac arrest, hypotension), ischemic stroke, postsurgical complications, and vasculitis resulting from autoimmune diseases (e.g., lupus) and infectious diseases (e.g., neurosyphilis, Lyme disease). Patients with hypertensive vascular disease may experience this type of dementia as a result of the sudden closure of the lumen of arterioles related to pressure changes. Atherosclerosis may lead to the formation of thrombi or emboli. In either case the outcome is infarction of the brain tissue in the area supplied by the affected blood vessels. The resulting cognitive problems are related to the area of the brain involved.
- **Dementia with Lewy bodies (DLB)** is the second most common form of degenerative dementia. Lewy bodies are neurofilament material found in the brainstem, thalamus, and basal ganglia of patients with dementia associated with atypical Parkinson disease and in the cerebral cortex of patients with DLB. In AD, 50% to 75% of patients also have Lewy bodies present in their brains.
- **Frontotemporal dementia (FTD),** previously called *Pick disease*, is the accumulation of cytoplasmic collections in the brain, which leads to a progressive loss of judgment, disinhibition, social misconduct, apathy, and loss of expressive language and comprehension. It is the third most common cause of cortical dementia affecting the frontal and/or temporal lobes of the brain.
- **Huntington disease** is an inherited, progressive disorder that causes irregular movements of the arms, legs, and facial muscles, personality changes, and a decline in the ability to think clearly.
- **Parkinson disease** affects control of movement, resulting in tremors, stiffness, and impaired speech. Many individuals with Parkinson disease also develop dementia in later stages of the disease. Drugs for Parkinson disease can help steadiness and muscle control but have no effect on dementia symptoms.

Brain imaging. Positron emission tomography (PET) scans and performance tests indicate that the brains of healthy people in their 80s are almost as active and function almost as well, although more slowly, on tests of memory, perception, and language as the brains of people in early adulthood.

Patients with early-onset AD may show cortical atrophy, ventricular enlargement, and loss of temporal lobe volume (particularly the hippocampus) with CT or MRI, as well as a marked loss in brain weight. Patients with late-onset AD who develop the disease after the age of 75 years usually show only age-related changes. PET scans in patients with either kind of AD show a typical pattern of frontal, association, and temporal hypometabolism (Figure 22-2).

CT scans can detect skull fractures and intracranial lesions. **MRI is recommended for patients with acute TBI** (Duckworth and Stevens, 2010).

Genetic. Genetic predisposition also may be a cause of maladaptive cognitive responses. Progress has been made in identifying the genetic markers that indicate a potential for developing AD. The risk for development of AD is greater for relatives of people with the illness than it is for those with no family history of AD. An individual who has one parent with early-onset AD has a 50% chance of developing AD before the age of 55 years.

QUALITY AND SAFETY ALERT

- The risk of AD is greatest for relatives of people who developed AD before age 55 years (early-onset AD).

Those offspring who do not inherit early-onset AD do not pass it on to their own children and presumably have the same risk of developing AD much later in life as does the general population. Early-onset AD also occurs more often in people with Down syndrome (who have three rather than two copies of chromosome 21), another genetic brain disorder that affects normal growth and development and cognitive abilities.

Chromosomes 1 and 14 are involved in activities that prevent amyloid precursor protein (β-APP) from elongating and accumulating in the brain. Chromosome 21 is the gene that forms β-APP, the substance from which the protein

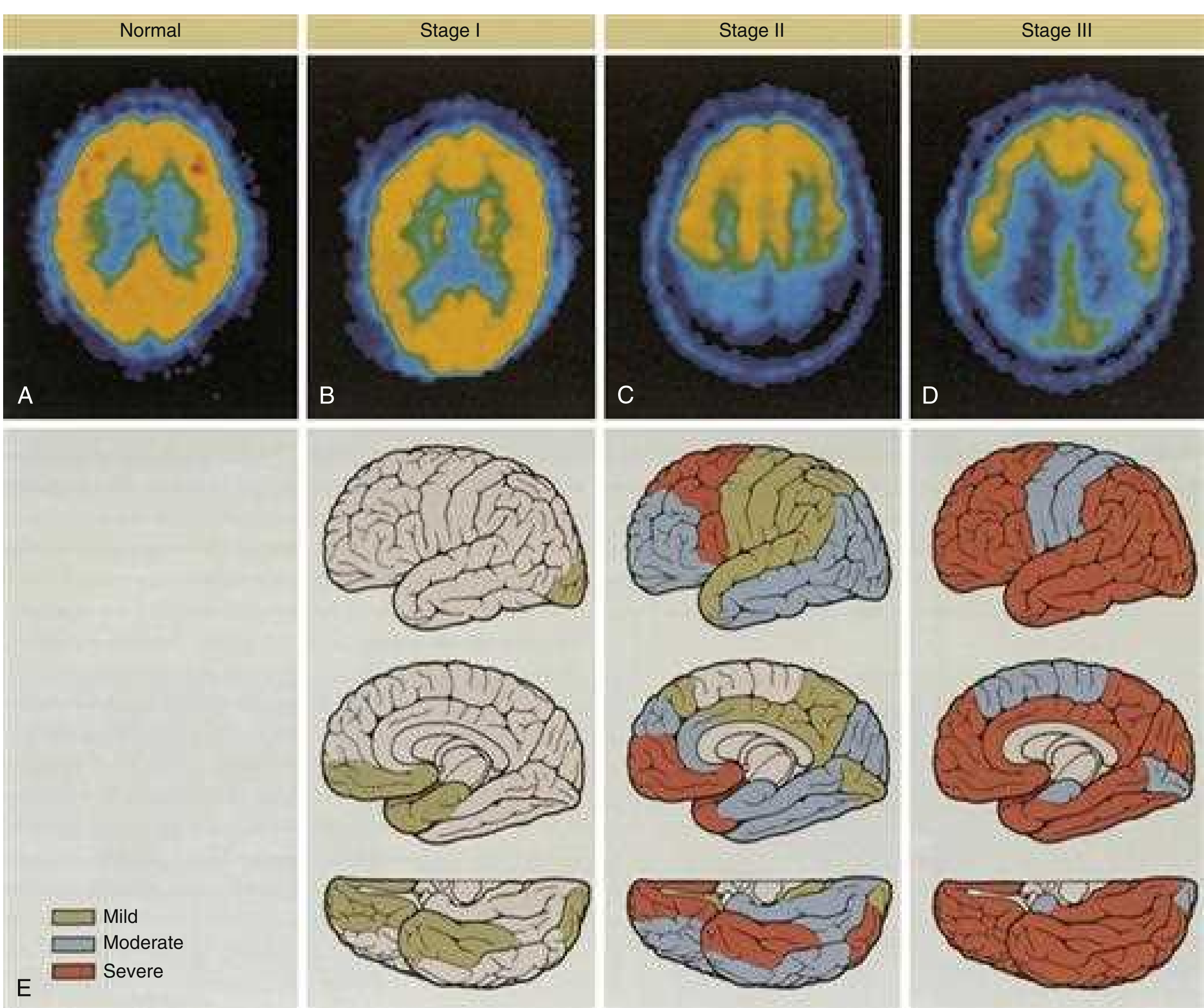

FIG 22-2 Pathological spread of Alzheimer disease (AD) as shown by positron emission tomography scans. **A,** Normal brain. **B,** Brain in stage I AD. **C,** Brain in stage II AD. **D,** Brain in stage III AD. **E,** Diagrams show the spread of the pathology in AD. (From Roberts GS et al: *Neuropsychiatric disorders*, London, 1993, Mosby-Wolfe.)

β-amyloid is formed. Although the function of β-amyloid is not fully understood, its production is accelerated in AD.

Excessive deposits form the senile plaques that cluster outside each affected neuron, and the amyloid is deposited in the walls of cerebral blood vessels. It is also probably related to the production of the neurofibrillary tangles seen within the neurons of patients with AD.

In **early-onset AD,** which accounts for only 10% of the incidence of AD, the relevant genes are located on the following chromosomes (Health Centre for Genetics Education, 2011):

- Chromosome 14: the *presenilin-1* gene, a mutation that is thought to be implicated in more than 50% of these relatively rare familial cases
- Chromosome 1: the *presenilin-2* gene, a mutation implicated in a group of families from an ethnic group known as the Volga Germans, who now live mostly in the United States and Canada
- Chromosome 21: the *APP* gene, known to be implicated in about 20 families in the world
- Chromosome 17: the *progranulin* gene, a mutation reported to result in dementia affecting the brain at the front of the skull

In cases where a strong family history of early-onset AD is noted and a mutation on one of these genes is identified as causing AD in the family, genetic testing may be available. Such testing is called *presymptomatic testing* because the test is usually done before the onset of any symptoms of the condition. Counseling that examines the implications of the testing is essential.

AD that occurs in later life is associated with several genes:

- The first gene to be identified that is associated with AD in later life, called *APOE*, is located on chromosome 19. Everyone has two copies, one from each parent. The *APOE* gene tells the cell to produce apolipoprotein E,

which guides cholesterol through the bloodstream. It is thought that the e4 form of the *APOE* gene increases the risk for AD (perhaps by making people more susceptible to some other influence, which then causes the disease). The e2 form appears to be somewhat protective against developing AD; e4 is the chief known genetic risk factor for later-life AD.
- The *K variant* gene is located on chromosome 3, and its interaction with e4 is thought to increase the risk of developing late-onset AD.
- About 10% to 15% of cases of late-onset AD are thought to be related to mutations in a gene called *a2m* (α_2-macroglobulin), located on chromosome 12. This mutation is thought to break down β-amyloid protein. Although the function of this protein is not fully understood, its production is accelerated in AD.

The search for other genes associated with AD is continuing, as is the search for risk and protective factors in the development of AD. Studies of identical (monozygotic) twins have found that when one twin develops AD, the other twin often remains unaffected, suggesting that nongenetic factors for AD also must be involved.

Underlying Psychiatric and Medical Disorders. A degree of cognitive impairment may be found along with other psychiatric problems. For instance, people with delusions may seem disoriented because they misidentify their location. People with affective disorders may have short attention spans. Depression also may result in memory disorders, although it is often difficult to determine whether the problem is related to memory loss or to a lack of motivation.

Patients with mental disorders resulting from a general medical condition also can exhibit symptoms of cognitive impairment. Such medical conditions include thyroid disease, adrenal dysfunction, hypoglycemia, brain lesions, and degenerative disorders. The predisposing factors associated with maladaptive cognitive responses caused by psychiatric and medical disorders are related to the underlying primary problem.

Precipitating Stressors

Precipitating Stressors Associated With Delirium. Any major dysregulation in the balance of body functions can disrupt cognitive functioning. **The most commonly recognized risk factor for the evolution of delirium is drug or substance use.** Medications associated with delirium can be found in Box 22-5.

Delirium related to alcohol or sedative-hypnotic withdrawal is most commonly recognized by an agitated, hyperactive/hyperalert motoric state. The use of polypharmacy and the frequent addition of over-the-counter drugs to prescribed drug regimens, particularly in the elderly, have received much attention, as has the mixing of drugs with alcohol in various populations.

The underlying medical conditions most commonly associated with delirium can be categorized into five major groups: **CNS disorders, metabolic disorders, cardiopulmonary disorders, systemic illnesses,** and **sensory deprivation** or **stimulation** (Box 22-6). The psychiatric nurse should be alert for possible causes of delirium when evaluating each patient with maladaptive cognitive responses and when assessing a change of cognitive status from a previous level of functioning.

Central nervous system disorder. Any major assault on the brain is likely to disrupt cognitive functioning. Severe head trauma and other brain diseases and infections such as meningitis and encephalitis cause changes in the normal function of the brain. When these disorders occur in areas of the brain responsible for cognitive function, the patient exhibits symptoms that indicate maladaptive cognitive responses.

Metabolic disorder. Metabolic disorders often affect mental functioning, especially when they are severe or of long duration. **Endocrine malfunctioning,** whether it involves underproduction or overproduction of hormones, can adversely affect cognition.

For example, thyroid hormone greatly influences mental alertness. People with hypothyroidism are sluggish and dysfunctional in their thinking. Those with severe hypothyroidism (myxedema) may develop psychotic behavior characterized by delusional thinking. Other endocrine disorders that may cause cognitive disruptions include hypoglycemia, hypopituitarism, and adrenal disease.

Hypoxia can result in cognitive dysfunction because the brain is not getting its normal oxygen supplies. Hypoxia resulting from anemia may be insidious in onset. Possible stressors include aspirin ingestion that results in occult bleeding, other occult blood loss, and deficiencies of iron, folic acid, or vitamin B_{12}. Other causes of hypoxia include dehydration, hyperthermia, hypothermia, and increased

BOX 22-5 MEDICATIONS ASSOCIATED WITH DELIRIUM

Narcotic
Meperidine

Sedative-Hypnotics
Benzodiazepines
Barbiturates

Cardiac Medications
Antiarrhythmics
Antihypertensives

Anticholinergics
Antihistamines
Antiparkinsonian agents
Antispasmodics
Tricyclic antidepressants

Miscellaneous
Anticonvulsants
Steroids
Nonsteroidal antiinflammatory drugs
Caffeine
Cold and sinus preparations

BOX 22-6 UNDERLYING CONDITIONS COMMONLY ASSOCIATED WITH DELIRIUM

Central Nervous System Disorders
Head trauma, seizures, postictal state, vascular disease (e.g., hypertensive encephalopathy), degenerative disease, tumor, brain abscess, meningitis, encephalitis

Metabolic Disorders
Renal failure, hepatic failure, anemia, hypoxia, hypoglycemia, vitamin deficiency (thiamine, folate, B_{12}, nicotinic acid), endocrinopathy, fluid or electrolyte imbalance, acid-base imbalance, low albumin, malnutrition

Cardiopulmonary Disorders
Myocardial infarction, congestive heart failure, cardiac arrhythmia, shock, respiratory failure, severe hypertension

Systemic Illnesses
Substance intoxication or withdrawal (e.g., alcohol, antidepressants, antipsychotics, anesthetics, benzodiazepines, opiates, anticholinergics, nonsteroidal antiinflammatory drugs [NSAIDs], corticosteroids), toxins (insecticides, carbon monoxide, fuel, paint), infections (urinary tract, pneumonia, human immunodeficiency virus [HIV], septicemia), neoplasm (primary and metastatic tumors), severe trauma (burns, surgery, fractures [especially hip]), temperature dysregulation, postoperative state

Sensory Deprivation or Stimulation
Sensory deprivation (underload), sensory stimulation (overload)

intracranial pressure resulting from a tumor, subdural hematoma, or normal-pressure hydrocephalus.

Nutrition in general can affect cognitive functioning. Malnutrition increases a person's risk of organic brain disease and is often a problem in the elderly, who may lack the physical or financial resources needed for an adequate diet.

Young people with anorexia nervosa or bulimia nervosa are also at risk for cognitive impairment. Vitamin B–complex deficiency, particularly thiamine deficiency, is believed to cause the Wernicke-Korsakoff syndrome found in some persons with chronic alcoholism. A prominent feature of this syndrome is a severe deficit in cognitive functioning.

> Critical Reasoning Based on a review of neurophysiology, compare the effects of hypoxia, hypothyroidism, and hypoglycemia on cerebral functioning.

Cardiopulmonary disorder. Heart disease that compromises the flow of blood to the brain or the exchange of carbon dioxide for oxygen in the lungs is likely to cause maladaptive cognitive responses. Respiratory illnesses, such as chronic obstructive lung disease and acute respiratory infection, and cardiac conditions, such as congestive heart failure, atherosclerosis, hypotension, and hypertension, are common problems and may be underlying causes of changes in cognitive function.

Systemic illness. Substances such as **alcohol** and **drugs,** and even many drugs commonly used in the treatment of psychiatric disorders, can cause changes in cognition. Some substances may cause these changes during withdrawal. Prescription and over-the-counter drugs can be potential toxic stressors.

A thorough assessment of drug use is critical with all patients. It is especially critical with elderly patients because of the increased sensitivity to drugs associated with normal aging and because confusion can lead to difficulty in following the directions for taking drugs. Interactions between drugs or between drugs and other substances, particularly alcohol, also may lead to disruptions in cognitive functioning.

Toxic and **infectious agents** also may result in the behavior typical of maladaptive cognitive responses. Toxins may originate within the patient or in the external environment. An example of an internally generated toxin is the elevated blood level of urea found in a patient with renal failure. Environmental toxins include various poisonous substances, such as toxic wastes and animal venoms. Infections in any body system also may impair the CNS if body temperature is extremely elevated.

Sensory deprivation or stimulation. Sensory deprivation or sensory overload can result in cognitive dysfunction. People who are placed in environments with minimal stimuli seem to develop internally produced stimuli in the form of hallucinations. In contrast, the constant light and activity in ICUs can lead to confusion, delusions, and hallucinations; this is sometimes called **ICU psychosis.**

It is difficult to determine the extent to which the cognitive impairment results from the sensory experience as opposed to other concurrent stressors, such as the introduction of multiple drugs into the system, massive assaults on physical integrity, immobilization from the use of physical restraints, and changes in the normal sleep cycle of ICU patients.

> **Critical Reasoning** Sensory overload or sensory deprivation may lead to maladaptive cognitive responses. How would this information affect your nursing care of a patient who is in cardiac intensive care or in a seclusion room on a psychiatric unit?

Precipitating Stressors Associated with Dementia. In addition to age, family history of AD, and Down syndrome, the most common underlying conditions associated with dementia across the life span are listed in Box 22-7. Other factors that have a positive impact on cognitive functioning include physical activity, education, social interaction, intellectual pursuits, and cognitive remediation. Factors that have a negative impact include poor health, poor sleep habits, poor nutrition, substance abuse, depression, and anxiety (Vance et al, 2010).

Factors that may precede AD are depression, mild cognitive impairment, hippocampal atrophy, and delayed paragraph recall on neurocognitive testing (Goveas et al, 2008). Box 22-8 lists the risk factors and proposed protective factors for AD.

BOX 22-7 UNDERLYING CONDITIONS COMMONLY ASSOCIATED WITH DEMENTIA ACROSS THE LIFE SPAN

Children
Head trauma (including child abuse)
Subacute sclerosing panencephalitis
AIDS

Adolescents
Head trauma
Huntington disease (juvenile type)
Wilson disease (hepatolenticular degeneration)
Subacute sclerosing panencephalitis
AIDS
Substance abuse (especially inhalants)

Adults/Elderly
Degenerative Brain Disorders
Alzheimer disease
Vascular dementia
Dementia with Lewy bodies
Frontotemporal dementia
Huntington disease
Parkinson disease
Late-onset extrapyramidal symptoms

Toxic-Metabolic Disturbances
Iatrogenic drug-induced dementia
Alcoholism
Poisons
Inhalants
Heavy metals
Cardiopulmonary disease
B_{12} deficiency
Hypothyroidism

Central Nervous System Infections
Chronic meningitis
Neurosyphilis
AIDS
Subacute sclerosing panencephalitis

Miscellaneous
Traumatic brain injury
Cerebral hemorrhage
Brain tumors
Hydrocephalus
Depression
Thyroid disease

AIDS, Acquired immunodeficiency syndrome.

BOX 22-8 RISK FACTORS AND PROPOSED PROTECTIVE FACTORS FOR ALZHEIMER DISEASE

Risk Factors
Definite
Age
Family history
APOE e4 genotype
Down syndrome
Specific mutations on chromosomes 1, 14, and 21

Possible
Female gender
Low level of education
Head injury with loss of consciousness
Vascular brain lesions
Aluminum exposure
Insulin-dependent diabetes mellitus
Solvent exposure
Electromagnetic exposure
Elevated thyrotropin
Hypertension
Myocardial infarction
Obesity

Proposed Protective Factors
Estrogen
Gene *APOE* e2 and e3 genotypes
Higher education
Antiinflammatory medications
Vitamin E
Social and intellectual activity
Regular physical exercise
Omega-3 fatty acids

Modified from American Psychiatric Association: *Am J Psychiatry* 164(Suppl):1, 2007; Geldmacher D: *Contemporary diagnosis and management of Alzheimer's dementia*, Newton, Pa, 2003, Handbooks in Health Care Co.

Precipitating Stressors Associated with Traumatic Brain Injury. There are three major stressors that lead to TBI.

- **Open head injury**—This can occur as a result of bullet wounds or any injury that penetrates the skull. It results in largely focal damage.
- **Closed head injury**—This can occur as the result of a fall, motor vehicle accident, explosions, or contact sports activity. There is diffuse damage to the brain and no penetration of the skull.
- **Deceleration injury**—The skull is hard and inflexible. The brain is soft and pliable and is encased inside the skull. In an automobile accident or in playing football, for example, the movement of the skull through space (acceleration) and the rapid discontinuation of this action when the skull meets a stationary object (deceleration) cause the brain to move inside the skull. The brain moves at a different rate than the skull because it is soft. Different parts of the brain

move at different speeds because of their relative lightness or heaviness. The differential movement of the skull and the brain when the head is struck results in direct brain injury, diffuse axonal shearing, contusion, and brain swelling.

QUALITY AND SAFETY ALERT

- A history of substance abuse is a risk factor for TBI.
- Alcohol use at the time of injury is common.
- Substance abuse results in worse outcomes from TBI.
- Substance abuse is linked to recurrent TBI.

Critical Reasoning A neighbor asks your advice as a nurse. His son wants to play high school football but he is concerned about potential head injury. How would you respond?

Appraisal of Stressors

Unless there is a discrete injury, the specific stressor related to cognitive impairment often cannot be identified. Understanding the biochemical process of the brain and the response of the brain and nervous tissue to stressors is the subject of much research.

For example, severe deficiency in the neurotransmitter ACh has been observed in patients with AD. It is not known whether this is a cause or an effect of the illness, but psychopharmacological treatment approaches include drugs such as cholinesterase inhibitors, which are designed to preserve this neurotransmitter in the brain.

In general, when assessing maladaptive cognitive responses, physiological causes are ruled out first, and then psychosocial stressors are considered. Even when physiological factors are present, psychosocial stress may further compromise the person's thought process; therefore appraisal of this stressor is critically important (Peavy et al, 2009). Each patient should receive a complete assessment so that nursing care can be planned in a competent and thorough manner.

Coping Resources

Individual and interpersonal resources are important to the person who is attempting to cope with maladaptive cognitive responses. A person who has many skills may be able to substitute for functional losses (Huntley et al, 2011). For example, people with AD who have higher levels of education and who have remained active and involved in their lives deteriorate less rapidly than those who have less education and have been inactive and socially isolated.

Interpersonal resources are extremely important to the person with a cognitive impairment. Family members and friends often have a calming influence on the agitated person. They can provide the nurse with information about the person's usual lifestyle and ensure that the environment contains familiar objects.

Caregivers also need coping resources, which often can be found by attending self-help groups such as those offered by the Alzheimer's Association. The importance of family involvement is seen in Box 22-9.

BOX 22-9 A FAMILY SPEAKS

My mother, Margaret, is 78 years old and has been in a nursing home for the past 3 years. She is diagnosed with dementia. There are days when she does not recognize me, and there are some days when she does, but even then her mood may not be very pleasant. Many days she just sits in her chair and responds to nothing. Often she cannot feed herself or express her needs. I visit her nearly every day.

The nurses in the home are my only link to my mother. The doctor visits weekly but rarely communicates with me unless there is an emergency. The nurses give me information about my mother's condition and listen to me when I have concerns about her. In the beginning, the nurses were indifferent to me, and I worried that they were the same with my mother. I brought pictures of the family to the nursing home and shared them with the nurses. These pictures allowed the nurses to see a person instead of a patient. They began to see that her past life had been very different, and this helped them treat her with more respect and dignity. Now I really depend on the nurses to let me know how my mother is doing from day to day.

Coping Mechanisms

How a person copes with maladaptive cognitive responses is greatly influenced by past experience. A person who has developed many effective coping mechanisms is better able to handle the onset of a cognitive problem than one who has not.

Coping Mechanisms Associated With Delirium. Because the basic behavioral disruption in those with delirium is altered awareness (which reflects the severe biological disturbance in the brain), psychological coping mechanisms are not generally used. **The nurse must protect the patient from harm and provide a substitute for the patient's previous coping mechanisms by constantly reorienting the patient and reinforcing reality during the treatment process.**

Coping Mechanisms Associated With Dementia. The patient's response to the onset of dementia often mirrors the patient's basic personality. For instance, a person who usually reacted to stress with anger toward other people and the environment before developing dementia will probably react similarly after limitations in intellectual abilities have occurred. Likewise, a person who is more apt to direct anger inward and become depressed will be likely to respond with depressive behaviors. A person who has relied on a mechanism such as intellectualization will be even more threatened by the loss of intellectual ability than one who has used a mechanism such as reaction formation.

One characteristic of early dementia is the mechanism of **denial.** Those with dementia try to continue their usual daily routine and make light of memory lapses. They may be able to use some environmental resources to help them cope. For instance, a businessman who is experiencing difficulty with recent memory might ask his secretary to remind him of all

his appointments and to provide him with the names of the people with whom he is meeting and the meeting's purpose.

As the impairment worsens, the person may become very resistant to any limitations on independence. For example, the family of a woman with AD might become concerned about her ability to continue to drive a car safely. However, she may be very reluctant to give up her driver's license and may deny having any problem driving.

Regression is often used to cope with advanced dementia and may be caused in part by deterioration in mental function. It probably also results from the behavioral signs of dementia, which cause the patient to become more dependent on others for the fulfillment of basic needs, such as nutrition and hygiene. **Encouraging patients to perform self-care also supports their use of healthier coping mechanisms.**

As cognitive ability decreases, efforts to cope become more obvious. For instance, a family member may complain that a relative has "always been irritable but is now belligerent when he doesn't get his way." In other cases, the person's behavior may be perceived as a personality change.

Behaviors that may be attempts to cope with a loss of cognitive ability include suspiciousness, hostility, joking, depression, seductiveness, and withdrawal. Because it is threatening to admit that a close relative has dementia, family members may focus on the coping mechanism instead of on the real problem, thus participating in the denial of the underlying cognitive impairment.

Coping Mechanisms Associated With Traumatic Brain Injury. Patients with TBI should be asked about the impact of their symptoms on their daily functioning. Those with a concussion or mild TBI may be able to go about their life with minimal disruption. Others may experience significant problems doing everyday tasks such as driving, childcare, managing money, or working outside the home. Patients' understanding about the cause of their problems is important to assessing how they are coping with it.

DIAGNOSIS

Nursing Diagnoses

The nursing diagnosis of the patient with cognitive impairment should consider both the possible underlying stressors and the patient's behaviors. Figure 22-3 summarizes the Stuart Stress Adaptation Model as related to maladaptive cognitive responses.

Most cognitive impairment disorders are physiological in origin. Therefore the nurse should consider both the patient's physical needs and the psychosocial behavioral problems. For example, a delirious patient may be reacting to an infection, a drug overdose, or a drug reaction. The identified problem and all its effects should be reflected in an expanded nursing diagnosis.

Many people with dementia are elderly. They experience the effects of the aging process along with impaired cognitive functioning. A thorough nursing diagnosis reflects all these influences on the patient's behavior.

In addition, the nature of a cognitive impairment may inhibit the patient's ability to participate in the care-planning process. The nurse should rely on observational skills and on the input of significant others to arrive at an accurate, relevant diagnosis. If the nursing diagnosis cannot be validated with the patient, a family member familiar with the patient's behavioral patterns should be involved.

The primary NANDA International (NANDA-I) nursing diagnoses related to maladaptive cognitive responses are acute or chronic confusion and impaired social interaction. The primary NANDA-I diagnoses and examples of expanded nursing diagnoses are presented in Table 22-7.

Medical Diagnoses

Medical diagnoses related to maladaptive cognitive responses are most apparent in people who have a psychiatric diagnosis of delirium, dementia, or an amnestic disorder (American Psychiatric Association, 2000). Some medical terms and their definitions are described in Table 22-7.

OUTCOMES IDENTIFICATION

The **expected outcome** related to the patient who has maladaptive cognitive responses is as follows: ***The patient will achieve optimum cognitive functioning.***

Goals may be directed toward an improved ability to process information (if this is realistic) or toward optimal use of the abilities the patient retains (if the impairment is irreversible). For example, a goal for a patient who is disoriented because of drug withdrawal might be that the patient will be oriented to person, place, and time within 3 days.

In contrast, a goal for a patient who is disoriented because of chronic alcoholism and is not in withdrawal might be that the patient will find his or her own bed every night without assistance after 1 month.This patient may never be able to remember the exact date but may not need that information if functioning in a protected setting. However, the first patient will need that information. In addition, the nurse can use the assessment of the patient's orientation to time to assess the current status of mental functioning.

Goals should be realistic to avoid discouragement. If the second patient is required to learn the date, frequent confrontation with deteriorated cognitive skills might lead to frustration, higher anxiety, and possibly less effective coping.

If an identified stressor is causing the patient's behavioral disruption, goals that focus on that stressor also should be developed. For instance, if a person is delirious because of a fever, a goal might state that the patient's temperature will be maintained below 100° F (37.8° C).

After the cause of the elevated temperature has been identified, appropriate goals are written to address that problem. For example, dehydration may be a stressor that contributes to an elevated temperature. A related nursing goal might be that the patient's fluid intake is at least 3000 mL in each 24-hour period. As the various elements of the patient's behavior are explored and documented, nursing goals must

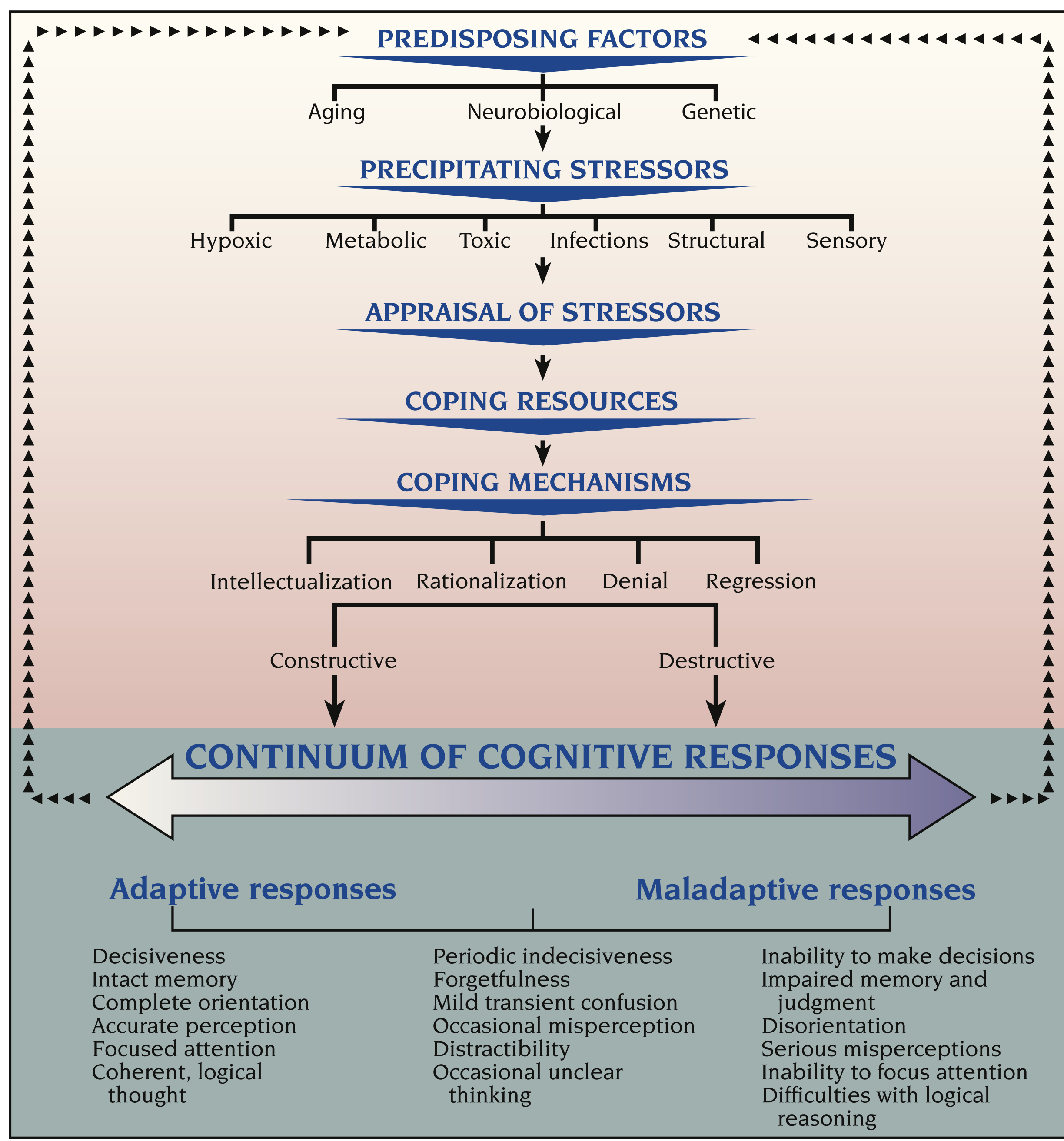

FIG 22-3 The Stuart Stress Adaptation Model as related to cognitive responses.

be updated and modified, new goals must be added, and accomplished goals must be deleted.

PLANNING

The nursing care plan for a patient with maladaptive cognitive responses must address all of the patient's biopsychosocial needs. In most cases the patient either has or is at risk for physiological problems in addition to the psychosocial disruption.

Life-threatening problems always receive the highest priority for nursing intervention. Protection of safety is almost always a concern with these patients.

Mental health education related to patients with impaired cognition should be directed toward the family, who often are the caregivers for these patients. The nurse can help caregivers cope with this difficult and demanding responsibility by providing them with information about problematic behaviors and problem solving. A Family Education Plan for the families of cognitively impaired people is presented in Table 22-8.

IMPLEMENTATION

Practice guidelines have been developed to treat delirium and dementia and are excellent references for comprehensive clinical care.

TABLE 22-7 NURSING DIAGNOSES AND MEDICAL TERMS RELATED TO *Maladaptive Cognitive Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Acute confusion	Acute confusion related to severe dehydration, as evidenced by hypervigilance, distractibility, visual hallucinations, and disorientation to time, place, and person
Chronic confusion	Chronic confusion related to brain disorder, as evidenced by inaccurate interpretation of environment, deficit in recent memory, impaired ability to reason, and confabulation
Impaired social interaction	Impaired social interaction related to traumatic brain injury, as evidenced by irritability, agitation, and aggressiveness when with others
MEDICAL TERM	**DEFINITION***
Delirium	Sudden severe confusion and rapid changes in brain function that occur with physical or mental illness
Delirium due to a general medical condition	Sudden severe confusion and rapid changes in brain function that occur as a direct result of a general medical condition
Substance-induced delirium	Sudden severe confusion and rapid changes in brain function that occur as a result of substance intoxication or withdrawal, medication side effects, or toxin exposure
Dementia	A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior.
Dementia of the Alzheimer type	One form of dementia that gradually gets worse over time. It affects memory, thinking, and behavior. Memory impairment, as well as problems with language, decision-making ability, judgment, and personality, are necessary features for the diagnosis.
Vascular dementia	The second most common form of dementia after Alzheimer disease (AD). The condition is not a single disease; it is a group of syndromes relating to different vascular mechanisms. Vascular dementia is preventable; therefore, early detection and an accurate diagnosis are important. Patients who have had a stroke are at increased risk for vascular dementia.
Dementia due to other general medical conditions	Dementia due to a general medical condition such as HIV, TBI, Parkinson disease, Huntington disease, Pick disease (FTD), Creutzfeldt-Jakob disease, normal-pressure hydrocephalus, hypothyroidism, brain tumor, vitamin B_{12} deficiency
Substance-induced persisting dementia	A specific subtype of Amnestic Disorders in which memory and learning are impaired as a direct result of a medical condition or the effects of a substance. These disorders are characterized by an individual's impairment in the ability to recall past events and previously known information and impairment in the ability to create new memories and learn new information.
Amnestic disorder	Mental conditions defined by loss of memory or inability to recall past information or retain new information in the memory. They are characterized by disorientation to time and space, personality change, display of inappropriate emotions and possible confabulation.

FTD, frontotemporal dementia; *HIV,* human immunodeficiency virus; *NANDA-I,* NANDA International; *TBI,* traumatic brain disorder.

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*Sources: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001749/; http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001748/; http://emedicine.medscape.com/article/292105-overview; http://www.drugrehabwiki.com/wiki/Substance-Induced_Persisting_Amnestic_Disorder; http://www.mental-health-disorders.org/personality-disorders/amnestic-disorders-overview-symptoms-and-treatments/.

Intervening in Delirium

Physiological Needs. Highest priority is given to nursing interventions that will maintain life. If the patient is too disoriented or agitated to attend to basic physiological needs, nursing care should be planned to meet those needs. **Nutrition** and **fluid balance** may be maintained by intravenous therapy. If the patient is very agitated or restless, restraint may be necessary to keep the intravenous line open. However, restraints can increase agitation and anxiety and therefore should be used only when absolutely necessary.

> **QUALITY AND SAFETY ALERT**
>
> - A disoriented patient should never be restrained and left alone.

Sleep deprivation may be another problem. Intervention is important, because a lack of sleep can add to an already existing cognitive dysfunction. Because sedative medications may complicate attempts to identify the original stressor, the physician or advanced practice nurse may be reluctant to prescribe a sedative.

TABLE 22-8 FAMILY EDUCATION PLAN

Helping a Family with a Cognitively Impaired Member

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Explain possible causes of maladaptive cognitive responses.	Describe predisposing factors and precipitating stressors that may lead to impaired cognition. Provide printed reference materials.	The family identifies possible causes of the patient's disorder.
Define and describe orientation to time, place, and person.	Define the three spheres of orientation. Role play interpersonal responses to disorientation.	The family identifies disorientation and provides reorientation.
Relate level of cognitive functioning to ability to communicate.	Describe the impact of maladaptive cognitive responses on communication. Demonstrate effective communication techniques. Videotape and discuss return demonstration.	The family adjusts communication approaches to the patient's ability to interact.
Describe effect of maladaptive cognitive responses on self-care behaviors.	Describe the usual progression of the gain or loss of self-care ability related to the nature of the disorder. Encourage the family to help in providing care to patient. Provide written instructional materials.	The family helps with ADLs as required by the patient's level of biopsychosocial functioning.
Refer to community resources.	Provide a list of community resources. Arrange to meet with staff members of selected community programs. Visit meetings of selected programs and self-help groups.	The family describes various programs that provide services relevant to the patient's and family's needs and contacts appropriate programs or self-help groups when needed.

ADLs, Activities of daily living.

Creating a **calm, comfortable environment** is important. Nursing measures such as a back rub, a glass of warm milk, and gentle but persistent orientation so that patients are continually reminded of their surroundings are low-tech interventions that decrease the incidence of delirium in elderly patients.

The **presence of a family member** is also reassuring to the patient. Disoriented patients need to be in a **lighted room.** Shadows may be misinterpreted and add to the patient's fear. Environmental objects also help the patient orient to place and person.

> **Critical Reasoning** Do you think it is safer and more effective to use physical (mechanical) restraints or chemical (medication) restraints with an agitated, delirious patient?

Hallucinations. Disoriented patients may need to be protected from hurting themselves or others, particularly when they are having hallucinations. Visual hallucinations of delirium are often very frightening. Patients may try to run away or even jump from a window. Patients' rooms must be safe, with security screens and a minimum of extra furniture or other objects that might cause harm. **These patients often require one-on-one nursing observation and repetitive verbal reorientation.**

It is tempting to help a frightened patient eliminate the hallucinated object. For instance, the patient might request help in brushing the bugs off the sheets. Agreeing to do this is not usually therapeutic. By participating in this activity, the nurse is nonverbally communicating to the patient that the hallucinated objects are real. This can make the patient even more frightened.

In reality, the hallucinations will continue until the underlying stressor is eliminated. A more appropriate response is to orient the patient continually to the reality of being sick and hospitalized. In addition, the patient can be assured that the nursing and medical staff members are there to help and to keep the patient safe. Family members also should be helped to respond in a supportive way. Nursing interventions for hallucinations are further discussed in Chapter 20.

Antipsychotics—including haloperidol and atypical agents—have been shown to effectively manage a wide range of delirium symptoms, but they are not approved by the U.S. Food and Drug Administration (FDA) for treatment of delirium. Further research is needed to fully assess the efficacy of antipsychotics in the treatment of delirium.

Communication. **Patients with maladaptive cognitive responses need clear messages and instructions, with choices kept to a minimum.** Independent decision-making can be introduced into the plan of nursing care as the patient improves. Decisions related to orientation may be especially difficult for the patient. Responding appropriately to the question, "What time would you like to take your bath?" requires knowledge of the present time and some idea of the usual routine.

TABLE 22-9 CHOLINESTERASE INHIBITOR THERAPY FOR ALZHEIMER DISEASE

PARAMETER	DONEPEZIL (ARICEPT)	GALANTAMINE (RAZADYNE)	RIVASTIGMINE (EXELON)
Dosage (mg/day)	5-10	16-32	6-12
Mechanism of action	Selective AChE inhibition	AChE inhibition nicotinic modulatory receptor effect	Butyryl ChE, AChE inhibition
Plasma half-life (hours)	5-7	5-7	0.6-2.0
Elimination pathway	Hepatic	Renal, hepatic	Renal
Metabolism	CYP 2D6 CYP 3A4	CYP 2D6 CYP 3A4	ChE-mediated hydrolysis
Protein binding	96%	18%	40%
Doses per day	1	2	2
Net proportion of subjects improved relative to placebo in clinical trials at 6 months	23%-24%	20%-25%	10%-29%

Data from Geldmacher D: *Contemporary diagnosis and management of Alzheimer's dementia*, Newton, Pa, 2003, Handbooks in Health Care Co.
AChE, Acetylcholinesterase; *ChE*, cholinesterase; *CYP,* cytochrome P450.

Simple, direct statements are reassuring and are most likely to result in an appropriate response. Orienting phrases, such as "here at the hospital" or "now that it's June," can be woven into a conversation.

Patients who have difficulty dressing or feeding themselves need matter-of-fact, specific directions. Confused patients need to be fed or dressed in a way that allows them to maintain their dignity. Families often can help with this. Helping the patient can lessen the family's anxiety, and the patient may be reassured by the family's physical closeness and concern.

Patient Education. While recovering, patients may be concerned about what has happened to them. The health care team needs to discuss this issue and arrive at a conclusion about the disruption in functioning that occurred. This should then be explained to the patient and family. The nurse should assess the patient's understanding of the nature of the problem, the stressors that were involved, any ongoing therapy that is required, and preventive measures that will decrease the probability of a recurrence.

Teaching may need to be repeated several times before the patient can cope with personal feelings and understand the information. Written materials can be helpful to patients who are having problems processing information. The teaching should include at least one responsible family member so that the information will be reinforced when the patient goes home.

A community health nursing referral may be helpful if the patient is discharged from the hospital with a residual deficit in cognitive functioning. The community health nurse can then continue to implement the nursing care plan and validate the patient's compliance with the treatment plan.

Intervening in Dementia

Nursing care of the patient with dementia is similar to that of the patient with delirium. However, with dementia, the stressors involved usually do not present an immediate threat to life. **Therefore, the highest priority is given to nursing care that will help the patient maintain an optimal level of functioning.** This will differ for each patient and must include a range of biopsychosocial nursing interventions.

Principles of care include the following:

- **Adjusting daily routines to focus on the person, not the task**
- **Adjusting interaction and communication strategies to ensure that the person receives the message**
- **Changing reactions and responses to the person's behavior**
- **Monitoring and adjusting the environment**

An attitude of hopelessness is sometimes seen in those who work with chronically ill people. This can lead to stereotyping and a decreased ability to see and appreciate the uniqueness of each person. It is challenging to search for this uniqueness and rewarding to find it. Individualized nursing care is most important for those who will be institutionalized for a long time.

Pharmacological Approaches. **Once AD begins, there is no cure.** The goal of AD research is to identify agents that prevent the occurrence, delay the onset, slow the progression, or improve the symptoms of disease. Pharmacological approaches to the treatment of dementia are related to theories about the cause of the disorder. Cholinesterase inhibitors improve cognitive symptoms or temporarily reduce the rate of cognitive decline.

The acetylcholinesterase (AChE) inhibitor class of drugs has proven efficacy in the treatment of some of the symptoms of AD. The three approved agents most often used are donepezil (**Aricept**), galantamine (**Razadyne**), and rivastigmine (**Exelon**). They are described in Table 22-9. Tacrine (**Cognex**), a fourth AChE inhibitor, was the first cholinesterase inhibitor to receive approval as a specific treatment for the cognitive symptoms of AD. **It is used only occasionally now because of liver toxicity problems.**

TABLE 22-10 ANTIPSYCHOTIC AGENTS USED IN ELDERLY PATIENTS WITH BEHAVIORAL DISTURBANCES AND DEMENTIA

AGENT	INITIAL DOSE (mg/day)	AVERAGE TARGET DOSE (mg)	HIGHEST RECOMMENDED DOSE (mg)
Risperidone*	0.25-0.5	0.5-1.5	2-6
Olanzapine*	2.25-5.0	5.0-7.5	12.5-15
Quetiapine*†	12.5-25	50-100	150-300
Haloperidol‡	0.5-1.0	1.5-2.0	2-7

Data from Geldmacher D: *Contemporary diagnosis and management of Alzheimer's dementia*, Newton, Pa, 2003, Handbooks in Health Care Co.
*Atypical antipsychotic agent.
†Quetiapine usually requires at least twice-daily dosing.
‡Typical antipsychotic agent.

The Exelon Patch (rivastigmine transdermal system), the only skin patch available for the treatment of AD, delivers medication to individuals with mild to moderate forms of AD or parkinsonian dementia. When applied to the back, chest, or upper arm it maintains steady drug levels in the bloodstream, improving tolerability and allowing a higher proportion of patients to receive therapeutic dosages.

This class of drugs maximizes the function of cholinergic neurons by inhibiting the enzyme AChE. AChE has been found to be lower than normal in people with AD. Inhibition of AChE prevents the metabolism of ACh, the neurotransmitter that is associated with memory and learning. Therefore, these drugs allow a greater concentration of ACh in the brain, thereby improving cholinergic function. Because AChE is the primary gastrointestinal motility–enhancing transmitter, nausea, anorexia, and diarrhea are common, and these are the primary limiting factors when using these drugs.

Memantine (Namenda), the first *N*-methyl-D-aspartate (NMDA) receptor antagonist, is approved for use in moderate to severe dementia. It may be combined with a cholinesterase inhibitor for severe dementia.

QUALITY AND SAFETY ALERT

- Atypical antipsychotics carry a "black-box" warning for increased risk of death and cerebral vascular accidents in dementia. They also worsen cognitive functioning.
- Typical antipsychotics are not any safer.
- Drugs with anticholinergic effects and benzodiazepines (which interfere with learning) should be avoided.

Antipsychotic medications taken by patients with dementia (Table 22-10) are associated with higher mortality rates. In the Clinical Antipsychotic Trial of Intervention Effectiveness—Alzheimer's Disease (CATIE-AD) study, atypical antipsychotics were associated with worsening of cognitive functioning (Vigen et al, 2011). Other medications, such as benzodiazipines, also have adverse cognitive effects. Nevertheless, antipsychotic use is frequent, with a report that 29% of nursing home patients receive at least one antipsychotic medication (Chen et al, 2010).

Table 22-11 lists the many categories of pharmacological treatments used for AD based on the targeted symptom (Howland, 2010). However, each of these medications has unintended consequences, including increased cognitive disability. Therefore, a risk-benefit analysis is always part of the decision process when considering the use of psychotropic medication (Meeks and Jeste, 2008; Devanand and Schultz, 2011).

TABLE 22-11 PHARMACOLOGICAL TREATMENTS USED IN ALZHEIMER DISEASE

CATEGORY	TARGET SYMPTOMS
Cholinesterase inhibitors	Apathy, psychosis (delusions, hallucinations), agitation, anxiety, nighttime behavior; positive effects have been shown on cognition, ADLs, and global functioning
NMDA antagonists	Severe dementia
Antipsychotics	Psychosis (delusions, hallucinations), hostility, aggression, agitation, violent behavior
Antidepressants	Depressive symptoms, anxiety disorders, insomnia
β-Blockers	Agitation
Benzodiazepines	Anxiety, agitation
Estrogen	Agitation
Anticonvulsants	Agitation, aggression, mood swings
Serotonergic agents	Psychosis, agitation

ADLs, Activities of daily living; *NMDA, N*-methyl-D-aspartate.

There is no evidence that other drug therapies, including vitamin E, vitamin B, selegiline, NSAIDs and other antiinflammatory drugs, ω-3 fatty acids, and estrogen or progestin therapy, are either safe or effective for use in dementia (Howland, 2011). Most importantly, nurses need to remember that medications must be used with care when treating persons with dementia (Sherrod et al, 2010). Elderly people, especially, are very sensitive to medications and combinations of medications.

Orientation. Because disorientation is a common problem of people with cognitive impairment, nursing interventions should help the patient best function in the environment. In an institution, it is helpful to mark patient rooms with large, clearly printed signs indicating the occupant's name. This also reminds forgetful people of others' names. Everyone

needs a personal space. A favorite rocking chair, a handmade afghan, or a family picture gives the patient a sense of identity and helps to identify a personal area of the institution. Personal possessions also can be orienting devices.

A light in the room at night helps the patient remain oriented and decreases nighttime agitation. Clocks with large faces help with orientation to time. Calendars with large writing and a separate page for each day also help with time orientation. Newspapers provide other orienting stimuli and help to stimulate interest in current events. An institutional newspaper provides a creative outlet that focuses on patient strengths and helps patients maintain an awareness of their environment.

Reality orientation is helpful to patients with cognitive impairments. It includes attention to the dimensions of time, place, and person. This approach often takes place in a group and is most effective if the group meets daily and at a consistent time. A pattern of group activity should be established.

For instance, the group might begin with each person introducing himself or herself, after which everyone is informed of the date and time. A review of the schedule for the day is often helpful. A brief time is allowed for questions. In general, this type of group meeting should last only 15 to 20 minutes. If the members become fatigued, their cognitive ability will deteriorate.

Communication. Recent memory loss is another common problem. Patients may be frustrated when constantly confronted with evidence of failing memory. Conversational focus can be directed toward topics that the patient initiates. Most patients feel more comfortable talking about remote memories and may derive pleasure from discussing past experiences. Misperceptions of the present can be dealt with gently and diplomatically.

For example, if an elderly woman who has been widowed for 10 years says that she expects her husband to come home soon, the nurse might reply, "You must have loved your husband very much. Sometimes it seems to you that he's still here." Explicitly or implicitly agreeing that her husband will "come home" fosters false hope, perhaps leading to disappointment and distrust. Abrupt confrontation with the reality of her husband's death is cruel and will increase her anxiety.

Nurses should introduce themselves at each interaction with the patient. The nurse's attitude should reflect unconditional positive regard. Empathy, warmth, and caring are important, and verbal communication should be clear, concise, and unhurried. A pleasant, calm, supportive tone of voice should be used, with the voice modulated in relationship to the patient's ability to hear. Shouting may be interpreted as anger by a person who hears well.

Questions that require yes-or-no answers are best. Behavior should be requested one step at a time; if repetition is required, the request should be stated in exactly the same way as the first time. Nonverbal communication skills are also important, and verbal and nonverbal communication must be congruent. Nonverbal techniques, especially touch, are sometimes reassuring to the patient.

The nurse should try to understand who the patient was in the past. This can be accomplished by encouraging reminiscence and talking with family members. Pictures or music may help the patient remember past experiences. The patient's daily schedule should be predictable and unhurried. Distraction or diversion, along with decreased stimulation, should be used if a patient appears to become agitated. An appropriate use of humor and flexibility by the nurse helps the patient function in the environment.

Socialization and Structured Activities. Nursing approaches should address the patient's need for social interaction and structured activities. Interventions that may be helpful include discussion groups with set agendas, exercise groups to promote physical activity, reality orientation groups, sensory stimulation, and parties that are appropriate to the time of year or that recognize important events, such as birthdays.

Other structured activities may be recreational, such as drawing, or physical, such as walking. Social interaction should be carefully monitored, however. Although lack of interaction may lead to functional decline, high social interaction can lead to increased agitation in those with severe cognitive impairment.

Arranging for visits from community volunteer groups provides stimulation as well as an opportunity to socialize. Referral to other members of the treatment team, especially occupational, recreational, art, music, and dance therapists, may be indicated. Other interventions that can decrease sensory deprivation and increase social interactions include contact with pets, use of videos that contain remote memories of favorite experiences, and reminiscence through memory cues such as photograph albums.

Sensory Enhancement. Interventions also may focus on stimulating the senses. Soothing music based on personal preference can have a calming effect and reduce agitation. Aromas of essential oils derived from plants or flowers can have a positive effect on mood, sleep, and stress in people with dementia. Massage or touch therapy may be comforting.

The *Snoezelen* intervention is a multisensory, environmental strategy designed to relax the patient and enhance trust. Snoezelen rooms usually have a variety of objects to stimulate the senses, such as textured objects, colored lights, and music. This intervention has been suggested to be helpful to some people with dementia.

Reinforcement of Adaptive Coping Mechanisms. Previous coping mechanisms are used by patients with maladaptive cognitive responses. Sometimes these attempts to cope may be helpful; at other times they may create more problems. They can be hard to understand unless placed in the appropriate context.

For example, an older man who pats and strokes nurses and makes lewd remarks may have had past success dealing with his anxiety by behaving seductively. An elderly woman who hoards food in her room may equate food with security.

An aging person who has been suspicious of others in the past may become more suspicious over time.

These behaviors have a protective nature and therefore should not be actively confronted. Instead, the nurse should try to discover the source of the patient's anxiety and either attempt to alleviate it or suggest more positive coping strategies.

Wandering. Wandering is a behavior that causes great concern to caregivers. It often leads to institutionalization or to the use of restraints. **Nurses should observe patients carefully in order to understand such behavior, identify the situations that contribute to it, and plan appropriate interventions.**

In some cases, medications can cause agitation and restlessness. Some patients are extremely sensitive to stress and tension in the environment, and their wandering may be an attempt to get away. Similarly, patients who are aware that an activity they dislike is about to occur (e.g., bathing, medication administration) may try to avoid it. If wandering meets a patient's need for attention, efforts to control the behavior may actually reinforce it.

The nurse should decrease stress in the patient's environment, especially at night, when many people have decreased stress tolerance. Eliminating distracting background noise or shadows may help. Safe areas should be provided where patients can move about freely. If possible, this should include an outside area with adequate staff supervision to ensure safety.

Environmental design can be used to camouflage doorways or to incorporate distractions. Any method of increasing orientation also can decrease the need to wander. However, it is important to base nursing interventions on observations and an analysis of the motivation for the patient's behavior.

Decreasing Agitation. Patients may become agitated when pushed to do something unfamiliar or unclear. Expectations should be explained simply and completely. If the patient is able to make choices, the appropriate choices should be offered.

A daily schedule of activities can help the person prepare for and plan the day. If a patient refuses to participate in an activity, continued insistence usually leads to increased agitation and sometimes to a loss of behavioral control, resulting in a catastrophic response. The best approach may be to wait a few minutes and then return to see if the patient will agree to the request.

Meanwhile, the approach to the patient can be examined to determine whether the nurse might have contributed to the problem. Perhaps the patient thought the nurse was too controlling and a power struggle developed, or perhaps the nurse initiated the request abruptly and did not allow the patient a time for transition.

Family and Community Interventions. Many people with dementia live in the community with their families. It is important to support the caregivers, because the patient can benefit from being with them. When hospitalization occurs, careful discharge planning is needed to help the family prepare to receive the patient back home. Box 22-10 provides practical recommendations that may be helpful to caregivers.

Families of patients with AD need support in identifying and coping with feelings such as denial, anger, and guilt—feelings much like those experienced by individuals who are

BOX 22-10 PRACTICAL RECOMMENDATIONS FOR CAREGIVERS OF AGITATED AND AGGRESSIVE PATIENTS WITH DEMENTIA

Decrease Escalation

Decrease environmental stimuli, and modify the environment.
Approach in a calm manner.
Use distraction: food, drink, music.
Maintain eye contact and a comfortable posture with arms/hands relaxed.
Use more than one sensory modality to send a calm message.
Match verbal and nonverbal signals.
Identify the affect observed in the patient; verbalize this for the patient.
Do not add more demands at this time.
Slow down pace, and simplify your actions.
Maintain physical comfort.
Identify what is fueling the fire (e.g., triggers, reactions).
Maintain safety.

Communicate Effectively

Capture the patient's attention; stay in view.
Use simple, direct statements.
Limit choices.
Use gestures to assist with verbal directions.
Use one-step commands.
Speak clearly and slowly; allow time for response.
Use lower tone if voice needs to be raised because of hearing deficit.
Communicate your desire to help.

Review the Basics

Behavior is symptomatic of the illness; separate the behavior from the person.
A damaged mind gets stuck in one activity and has trouble shifting gears; what worked an hour ago may not work now.
The caregiver is the only security in a shrinking world.
Persons with dementia lose the ability to plan.
Know the person, and structure the environment accordingly.
Having a daily pattern of repetitive behaviors at predictable times and by familiar persons helps those with memory impairment to help themselves.
A loving voice, attentiveness, touch, and consistency are enormously important.
Remember, a caregiver is not always an angel; there are times when frustration and anger are expressed; no one is perfect.
The caregiver's needs also must be recognized and respected.
Maintain the patient's religious/spiritual identity.
Humor can help.

grieving over a dying loved one. Loneliness and depression were found to be significantly higher in the caregiving wives of husbands with AD than in caregiving husbands of wives with AD and in the general spousal population.

It is important for nurses to be aware of the mental health needs of family members, particularly of the caregiver, who often is the spouse, in-law, or grown child of the afflicted person. Research suggests that spouses who are inexperienced caregivers may be most vulnerable to negative outcomes (Williams, 2011). Families may need assistance in providing 24-hour care for the patient. Home care agencies may provide nursing and homemaking services to enable patients to remain in their own homes.

If family members are not available to provide care during the day, adult day care centers are available in some communities. These programs provide help with ADLs, recreation, health supervision, rehabilitation, exercise, and nutrition. Families also receive support and assistance, particularly during the first few weeks of attendance, when the patient may be resistant because of difficulty adapting to a new experience.

A model for helping families with AD is presented in Table 22-12. This model identifies critical issues and helpful nursing interventions to implement with families at each phase of the illness.

Intervening in Traumatic Brain Injury

Brain injuries do not heal like other injuries. Recovery is functional, involving many aspects of cognition. Treatment of patients with TBI can be difficult and complex because many aspects of a patient's life are affected by this illness. **A collaborative, interprofessional team approach that includes the family is required.** Family members should be considered an essential part of the treatment team.

Rehabilitation should begin as soon as possible after the injury. Interventions can include exercises to improve memory, problem-solving ability, attention span, speech, reading, and physical functioning. Patients can be helped to learn adaptive coping and compensatory strategies, new skills, and vocational retraining if needed. **Lifestyle changes** can be discussed including exercise, diet, sleep hygiene, stress reduction, relaxation training, and engaging in pleasurable activities.

The patient and family should be **educated** about the causes and symptoms of TBI, how to prevent further injury,

TABLE 22-12 SIX-PHASE MODEL FOR HELPING FAMILIES WITH ALZHEIMER DISEASE

PHASE	DESCRIPTION	NURSING INTERVENTIONS
1: Prediagnostic	There is a growing awareness in the family that something is wrong.	Provide information and educational materials to help families understand their situation.
2: Diagnostic	Families must deal with the fear, emotions, and lost dreams related to the diagnosis.	Provide a one-session family consultation meeting to help family process the information and facilitate communication.
3: Role change	The person with dementia needs increasing care; the family must learn the person's abilities and adapt situations to maximize participation; family tasks must be reassigned; the entire family deals with issues of loss.	Provide family educational programs, support groups, counseling; also, provide services to the person with dementia to maintain a sense of self and morale.
4: Chronic caregiving	With increasing needs of the person with dementia, the family must stave off the exhaustion, burnout, and depression associated with caregiving. Respite must be provided; appropriate community services must be accessed. Normal family life is crowded out by the disease.	Provide psychoeducational programs to minimize caregiver stress; connect family with services such as day care and caregiver skills training programs to provide concrete guidance in caring for the person with dementia, the caregiver, and the family.
5: Transition to alternative care	The person with dementia often must eventually be placed in a nursing home or other care facility. The family needs help to identify this time and find a placement. This marks the end of personal caregiving and a shift into collaborative caregiving with appropriate role expectations.	Provide services that address the demoralization families experience with placement; facilitate the development of collaborative care relations between family and facility staff.
6: End of life	Ethical dilemmas faced in making end-of-life decisions must be resolved. The family must be helped to develop an image of a "good death," including rituals and legacies, to bring closure and meaning at the point of death.	Provide a bridge to the primary medical provider to educate the family on treatment options and offer support as the family anticipates death and faces repeated discussions involving decision making.

Modified from Educational Support Advisory Group: *Tools for the assessment and treatment of dementia in managed care settings,* 2001, Chronic Care Networks for Alzheimer's Disease Initiative.

self-monitoring of symptoms, and recovery patterns. No medication has been approved for TBI. However, medications can be used to assist with such symptoms as sleep problems, depression, and pain. Complementary and alternative therapies such as acupuncture and biofeedback also may be helpful.

Throughout the course of treatment, the nurse should communicate caring and empathy, honesty and openness, and expectations for a positive recovery. **Instilling a sense of hope empowers the TBI patient to move forward with his or her own recovery.**

A Nursing Treatment Plan Summary for patients who have maladaptive cognitive responses is presented in Table 22-13.

EVALUATION

Expectations of the patient who has cognitive difficulty must be realistic but not pessimistic. One evaluation criterion is the appropriateness of the nursing goal to the patient. The nurse should assess whether the expectation is too high or too low. Levels of expectation can be increased until the patient is clearly unable to function and then lowered to the realistic level.

The evaluation of the nursing care of the patient who has maladaptive cognitive responses is based on achievement of the identified nursing care goals. If these goals are not met, the nurse should ask the following questions:

- Was the assessment complete enough to correctly identify the problem?
- Were the goals individualized for the patient?
- Was enough time allowed for goal achievement?
- Did I have the skills needed to carry out the identified interventions?
- Were there environmental factors that affected goal achievement?

TABLE 22-13 NURSING TREATMENT PLAN SUMMARY

Maladaptive Cognitive Responses

Nursing Diagnosis: Chronic confusion

Expected Outcome: The patient will achieve optimum cognitive functioning.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will have basic biological needs met.	Maintain adequate nutrition, monitor fluid intake and output, and monitor vital signs. Provide opportunities for rest and stimulation. Help with ambulation if necessary. Help with hygiene activities as needed.	Basic biological integrity is necessary for survival. Interventions related to survival are given high priority for nursing intervention.
The patient will be safe from injury.	Assess sensory and perceptual functioning. Provide access to items such as eyeglasses, hearing aids, canes, and walkers. Observe and remove safety hazards (e.g., obstacles, slippery floors, open flames, inadequate lighting). Supervise medications if necessary. Protect from injury during periods of agitation with one-to-one nursing care; use restraints only if absolutely necessary.	Maladaptive cognitive responses usually involve sensory and perceptual disorders that can endanger the patient's safety.
The patient will experience an optimal level of self-worth and dignity.	Communicate respect and dignity for the patient. Provide reality orientation. Establish a trusting relationship. Encourage independence. Identify interests and skills; provide opportunities to use them. Give honest praise for accomplishments. Use therapeutic communication techniques to help patient communicate thoughts and feelings.	All patients are deserving of respect when receiving nursing care. Cognitive impairment is a threat to one's self-worth. A positive nurse-patient relationship can help the patient express fears and feel secure in the environment. The recognition of accomplishments also raises self-esteem.
The patient will maintain positive interpersonal relationships.	Initiate contact with significant others. Encourage patient to interact with others; involve patient in group and other structured activities. Teach family and patient about the nature of the problem and the recommended health care plan. Allow significant others to help with patient care if they wish. Meet with significant others regularly and provide them with an opportunity to talk. Involve patient and family in discharge planning.	Caring relationships with others promote a positive self-concept. Communication from significant others often can be understood more easily than communication from strangers. Family and friends can provide help in knowing the patient's habits and preferences. Involvement of significant others in caregiving often helps them cope with the stress of the patient's health problems.

- Did additional stressors affect the patient's ability to cope?
- Was the goal achievable for this patient?
- What alternative approaches could be tried?

Colleagues are helpful in evaluating the nursing care plan. They may suggest alternative interventions or provide feedback about transference and countertransference issues. For instance, nurses who work with aging patients with dementia may respond to concerns about their own aging or that of their parents and have difficulty seeing patients as unique persons.

Hallucinating patients often arouse anxiety in nurses, who may then respond with their own defense mechanisms. Regular supervision can help nurses develop enhanced self-awareness and determine when a anxiety-provoking situation has particularly bothered them and why.

The population of individuals with altered cognitive responses is growing. By providing biopsychosocial care for these patients, nurses convey competence, respect, and understanding and build a positive relationship with patients and their families. This includes the understanding of links among cognitive, behavioral, and functional abilities of the patient; the effects of their decline over time; and the emotional, psychological, physical, and social needs of patients and families.

LEARNING FROM A CLINICAL CASE OUTCOME

1. How was his dementia different from depression or delirium?

The pace of onset is an important difference. Dementia is a disease that has a very gradual onset taking months to years. Depression has an onset of weeks to months. Delirium has a sudden onset and progresses rapidly in a few hours.

2. Which neurotransmitters would be affecting his dementia as evidenced by what specific behaviors?

ACh promotes cerebral cortex functioning. Its loss is associated with amnesia, psychotic symptoms, and agitation. Norepinephrine modulates mood and response to stress. If it is increased, the patient becomes hypervigilant, agitated, and anxious. If it is decreased, the patient becomes depressed but responds to treatment. Serotonin regulates body systems including temperature, mood, sleep, and aggression. Decreased serotonin produces depression, insomnia, and possibly suicidal behavior,

3. What would be the nursing diagnoses?

The appropriate nursing diagnoses are acute and chronic confusion and disturbed thought processes. Role strain for the caregiver is another possible nursing diagnosis that must receive a focused assessment.

4. What interventions would be helpful for this patient?

Interventions center on adjusting the daily routine to focus on the needs of the patient. Golf outings should be viewed more as opportunities to be with friends and to relieve the caregiver for a few hours and less as a competitive game. Communication strategies can be modified. For example, when he became more impaired, his wife gave him a doodle cell phone because he had lost the ability to manage a regular cell phone. With this phone, he could reach his wife at any time, because hers was the only phone number in it. His wife also needed help in changing her responses to his behavior. She no longer had the same expectations for his participation in her life. However, the patient often thanked his wife for her care and spoke to his physician about his concern for his wife's well-being.

Case Outcome

Gradually, he told close friends and relatives about his illness. An election was imminent, and he announced he would not run for re-election. As the legislative session ended, he told his fellow senators that he had AD and would be retiring to the privacy of his life with his family. People grieved, but his illness began to progress very rapidly. He returned to his community, and people continued to drop by his home and take him out to eat. He made several public service announcements about the illness. His contributions were deeply appreciated, and he helped dispel many myths about the illness. He educated his community one last time.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Alison Meeks, RN, MS

I worked on a unit that was set up to care for patients with behavioral problems that develop as a result of their dementia. I vividly remember one call we received about Ms. S, a patient who was described as violent, explosive, confused, and in need of total care in regard to ADLs. When Ms. S arrived on the unit, I discovered that she weighed 90 pounds, had long beautiful hair arranged in a bun-style hairdo, and was ambulatory. She thought she was going to a hotel, so we took her bags and served her lunch while we interviewed her husband, who was her primary caregiver.

His was a very sad story. Tearfully he reported that his wife no longer loved him, that she was very malicious, and that she became physically violent at least once daily. He wanted to go on vacation while she was in the hospital, which some of the staff felt was probably the reason for this admission. However, he had been caring for his wife for 5 years with little or no help from the community or family members, and it was clear that he needed a break. It would be hard on him, however, because this would be the first time they had been apart from each other in their 58 years of marriage.

Ms. S had a Mini-Mental State Examination score of 12 and great difficulty in visually interpreting her environment. For

Continued

COMPETENT CARING—cont'd

A Clinical Exemplar of a Psychiatric Nurse

Alison Meeks, RN, MS

example, she thought a comb was a knife and the garbage can was her purse. She was also very sensitive to her environment. If the unit was loud and a lot of people were walking around, she became more active and often had the potential for getting hurt or hurting someone else. During periods of activity on the unit, such as a shift change, we escorted Ms. S to her room, where she would fold clothes or go through one of four pocketbooks we put together for her. We needed four pocketbooks because she would misplace one and we would not be able to find it. This symptom presented great problems at home for the caregiver, because anything left out would be moved and often never found. Our solution was to set up several baskets of safe items for Ms. S to rummage through.

Ms. S became physically violent three times during her 8-day hospitalization. Each incident occurred when staff members entered her room and she accused them of breaking into her home. We started to knock on her door before entering and would have something for her such as a pocketbook, a book, or her stockings in our hands. That seemed to solve that problem. Another intervention that worked for Ms. S was music. She always liked ballet and now thought she was a retired dancer. We never challenged this and listened to her wonderful stories about dance and other dancers.

Ms. S did not recognize her husband when he came back from vacation. He was hurt and said we had done nothing to help her. We worked extensively with her husband by having him come and observe our interventions with Ms. S. Our goal was to help him realize the level of her impairment. He soon realized that her actions were not malicious. We diagnosed a urinary tract infection during her admission, which we treated, and we prescribed 0.5 mg of haloperidol each morning, which helped to decrease her explosive episodes. We also enlisted the help of family members, friends, and a home health provider to care for Ms. S. I made one home visit after discharge and gave suggestions on how to make the home safe for Ms. S.

Four weeks after discharge, Mr. S mailed the nurses a letter thanking us for giving him his life back. He explained that he felt he should have been better able to care for his wife on his own before her hospitalization and that he had even contemplated suicide because of the overwhelming burden of caring for his wife. It seemed to us that in this case we had touched the lives of two rather than one.

CHAPTER IN REVIEW

- The continuum of cognitive responses is related to behavioral and biological models of learning and memory. Cognitive activity depends on intelligence, education, life experience, and culture.
- Behaviors related to cognitive responses vary depending on whether the maladaptive response is acute and likely to resolve (as in delirium) or progressive and chronic (as in dementia).
- Maladaptive cognitive responses include an inability to make decisions, impaired memory and judgment, disorientation, misperceptions, decreased attention span, and difficulties with logical reasoning.
- Delirium is the behavioral response to widespread disturbances in cerebral metabolism; it represents a sudden decline from a previous level of functioning and is usually considered a medical emergency.
- Delirium results in disturbances in consciousness, attention, cognition, perception, and motor ability.
- Dementia is a loss of intellectual abilities that interferes with the patient's usual social or occupational activities. The onset is gradual, and changes in personality usually occur.
- Alzheimer disease (AD) is the most common type of dementia and accounts for approximately 70% of cases of dementia.
- Pseudodementia is a cognitive impairment that occurs secondary to a functional psychiatric disorder. Depression associated with AD may be among the most common mood disorders of older adults.
- Memory loss is a major feature of dementia. Confabulation is a confused person's tendency to make up a response to a question when unable to remember the answer.
- Aphasia is difficulty finding the right word. Apraxia is an inability to perform familiar skilled activities. Agnosia is difficulty in recognizing well-known objects, including people.
- Amnesia is significant memory loss occurring in the absence of clouded consciousness or other cognitive symptoms.
- Traumatic brain injury (TBI) is a disruption of normal brain function that occurs when the skull is struck, suddenly thrust out of position, or penetrated.
- Symptoms may appear right away or may not be present until days, weeks, or months after the injury.
- A TBI can affect a single, specific region of the brain (focal injury), or effects can be distributed throughout the brain (diffuse injury), or both.
- TBI is classified into three categories—mild, moderate, and severe—based on the duration of lost consciousness. The term "concussion" is often used interchangeably with mild TBI.
- Common effects of TBI are physical, cognitive, affective, and behavioral. After a TBI, a person is at risk for a range of psychiatric disorders including depression, generalized anxiety disorder, panic disorder, agoraphobia, and post-traumatic stress disorder.
- The rate of suicide is two to four times greater among people with TBI.
- Predisposing factors related to impaired cognition are aging, neurobiological functioning, changes in brain structures, genetic factors, and underlying psychiatric and medical conditions.

CHAPTER IN REVIEW—cont'd

- Precipitating stressors related to delirium are categorized as CNS disorders, metabolic disorders, cardiopulmonary disorders, systemic illness, and sensory deprivation or stimulation.
- Precipitating stressors related to dementia are categorized as degenerative brain disorders, cerebrovascular causes, toxic-metabolic disturbances, CNS infections, and miscellaneous causes.
- Precipitating stressors related to TBI include open head injury, closed head injury, and deceleration injury. A history of substance abuse is a risk factor for TBI.
- Coping resources are largely based on individual and interpersonal supports.
- Coping mechanisms include intellectualization, rationalization, denial, and regression.
- The primary NANDA-I nursing diagnoses are acute or chronic confusion and disturbed thought processes.
- Medical diagnoses are categorized as delirium, dementia, and amnestic disorders.
- The expected outcome of nursing care is that the patient will achieve the optimal level of cognitive functioning.
- Interventions related to delirium include caring for physiological needs, responding to hallucinations, therapeutic communication, and patient education.
- Interventions related to dementia include pharmacological approaches, orientation, therapeutic communication, socialization and structured activities, sensory enhancement, reinforcement of coping mechanisms, responding to wandering, decreasing agitation, and family and community approaches.
- Interventions related to TBI include patient and family education; life style changes; exercises to improve memory, problem-solving ability, attention span, speech, reading, and physical functioning; and learning adaptive coping skills.
- Evaluation of nursing care is based on goal accomplishment and involves feedback from the patient, significant others, peers, and supervisors.

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CHAPTER

23

Chemically Mediated Responses and Substance-Related Disorders

Donald L. Taylor and Gail W. Stuart

In the course of history, many more people have died for their drink and their dope than have died for their religion or their country.

Aldous Huxley

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive chemically mediated responses.
2. Identify behaviors associated with chemically mediated responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to chemically mediated responses.
4. Describe coping resources and coping mechanisms related to chemically mediated responses.
5. Formulate nursing diagnoses related to chemically mediated responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to chemically mediated responses.
7. Identify expected outcomes and short-term nursing goals related to chemically mediated responses.
8. Develop a patient education plan to promote patients' adaptive chemically mediated responses.
9. Analyze nursing interventions related to chemically mediated responses.
10. Evaluate nursing care related to chemically mediated responses.

Drugs have been used by people in almost all cultures since early times. Psychoactive substances alter the mind, the way reality is perceived, and the way a person feels. People use drugs for relief of negative emotional states such as depression, fear, and anxiety; for relief from fatigue or boredom; and as a break from daily routines because the drugs produce altered states of consciousness.

Moderate use for any of these purposes is not likely to result in major social or individual harm. However, all cultures have recognized the negative effects of alcohol and drug use. **Excessive use of these substances has contributed to profound individual and social problems.**

Any drug that affects the pleasure centers of the brain and produces pleasurable changes in mental or emotional states has the potential for abuse. Drugs that cause the most marked and immediate desirable effects have the greatest abuse potential. Alcohol and cocaine are very popular because they produce effects in the brain within minutes. Drugs of potential abuse include legal drugs such as alcohol and prescription medications; illegal drugs such as heroin, cocaine, and methamphetamine; and household products such as inhalants.

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

On the phone she said she needed help. Her life was chaotic, and she felt out of control. An aspiring fashion designer, she clearly had talent but could never break out of a moment-to-moment existence. When she came in for treatment, she was thin, athletic, androgynous in appearance, and serious in her demeanor. She looked around the room nervously.

She had grown up in a small rural town, moved to a larger city, and distanced herself from her family because she assumed they would not accept her sexual orientation. She began getting jobs in the food and beverage sector, usually getting off work around midnight. She had developed a pattern of drinking heavily with friends and had experimented with cocaine. Her parents had both an anxiety disorder and depression.

She was surprised to learn that anxiety and depression had a genetic basis and that the amount she was drinking might lead to alcoholism. She thought she just drank like most people because the people she worked and partied with all drank that same amount. Occasionally when drinking, she briefly had thoughts of suicide, but they quickly went away. She said she would think about all of these things but wanted an antidepressant. She thought it would make her feel better and therefore make her life better.

She continued drinking, smoking, and coming to therapy intermittently during crises for 2 years. Then one morning she called saying she was ready to quit drinking. She had awakened at home from a blackout. Her car had been wrecked during the night with bumpers smashed and paint scraped off doors, but she had no recollection of the event. She was terrified.

After coming to the office, she went to her first Alcoholics Anonymous meeting. She took the program seriously and chose a sponsor. Soon she began the 12-step program, and her life started to change.

Case Critical Reasoning Questions

1. What is the prevalence of substance abuse, and could she be at risk for suicide?
2. Could her sexual orientation and distancing herself from her family be stressors?
3. What are some of her external and internal triggers?
4. What model of change did she use in her substance abuse treatment?

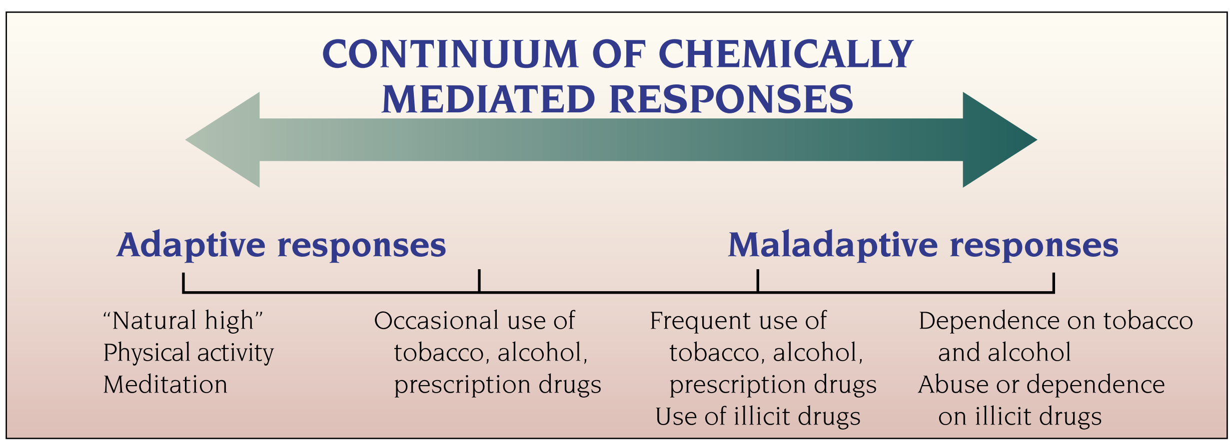

FIG 23-1 Continuum of chemically mediated responses.

CONTINUUM OF CHEMICALLY MEDIATED RESPONSES

Definition of Terms

A person may achieve a state of relaxation, euphoria, stimulation, or altered awareness in several ways. The range of these chemically mediated responses is shown in Figure 23-1. **Although there is a continuum from occasional drug use to frequent drug use to abuse and dependence, not everyone who uses drugs becomes an abuser, nor does every abuser become dependent.**

The definitions of the terms *use, abuse*, and *dependence* have changed through the years. The nurse needs to understand that what one person or health care professional means by addiction is not necessarily what is meant by another.

- **Substance abuse** refers to continued use despite related problems.
- **Substance dependence** indicates a severe condition, usually considered a disease. There may be physical problems and serious disruptions in the person's work, family, and social life.
- **Addiction** refers to the psychosocial behaviors related to substance dependence. The terms *dependence* and *addiction* are often used interchangeably.
- **Dual diagnosis** is the co-existence of substance abuse and one or more psychiatric disorders in the same person.
- **Withdrawal symptoms** result from a biological need that develops when the body becomes adapted to having the drug in the system. Characteristic symptoms occur when the level of the substance in the system decreases.

TABLE 23-1 PROFILING COMMON ADDICTIONS IN THE UNITED STATES

ADDICTION	STATISTIC
Alcohol	About 18.7 million people, or about 7% of the U.S. population, are dependent on or abuse alcohol. Only about 10% of them belong to Alcoholics Anonymous. Every day, 12,500 people try alcohol for the first time.
Caffeine	The most widely used mood-altering drug in the world, caffeine, is regularly ingested by up to 90% of people in the United States. About 100 mg (one cup of coffee) per day can lead to physical dependence and withdrawal symptoms on quitting. Caffeine can alter behavior and affect sleeping habits.
Drugs	It is estimated that 3.6 million people are dependent on drugs, and 700,000 of them are in treatment for their addiction at any one time. Every day, 8000 people try drugs of abuse for the first time. Marijuana, cocaine, and pain relievers are the leading drugs of abuse.
Food addiction	Food addiction affects 4 million adults and a quickly growing number of children; binge eating is the most common eating disorder. An estimated 15% of mildly obese people are compulsive eaters.
Gambling	About 3% of adults experience a serious problem with gambling that results in significant debt, family disruption, job losses, criminal activity, or suicide.
Internet	Between 5% and 10% of the population suffer from Internet addiction, which is defined as any online-related, compulsive behavior that interferes with normal living and causes severe stress on family, friends, loved ones, and the work environment.
Sex	Sex addiction affects more than 16 million people in the United States. Addicts become dependent on the neurological changes in the brain that occur during sex. They are consumed by sexual thoughts, making it difficult to work or engage in healthy personal relationships.
Shopping	At least 1 in 20 people in the United States is a compulsive shopper, with men and women affected equally. Cultural factors, such as those emphasizing happiness associated with purchasing products, are thought to fuel shopping addictions.
Tobacco	In the United States, 69.7 million people use tobacco products. The highest rate of use is among 18 to 25 year olds and among people living in the Midwest. Approximately 25% of men and 21% of women are cigarette smokers.

Data from Department of Health and Human Services, SAMHSA Office of Applied Studies 2009 National Survey on Drug Use and Health, www.mayoclinic.com/health/caffeine/NU00600; Center for Translational Neuroimaging, http://www.bnl.gov/medical/RCIBI/addiction.asp; Illinois Institute for Addiction Recovery, www.addictionrecov.org; Center for Internet Addiction Recovery, www.netaddiction.com; and MedicineNet.com, www.medicinenet.com/sexual_addiction. All accessed October 2011.

- **Tolerance** means that with continued use, more of the substance is needed to produce the same effect.

Many people progress from use to abuse at some time in their lives. However, only about 1 in 10 people progresses from use to abuse to dependence. After use has begun, the risk of becoming dependent is influenced by many biological, psychological, and sociocultural factors.

Attitudes About Substance Abuse

Substance abuse is viewed differently depending on the substance used, the person using it, and the setting in which it is used. Nurses should be aware of these social and cultural attitudes and recognize their impact on individual users and people close to them.

> **Critical Reasoning** Can you describe examples of sociocultural mixed messages regarding the use of tobacco, caffeine, alcohol, or marijuana? How would you, as a health care professional, change these attitudes?

Changing laws related to the consumption, sale, and serving of alcohol and drugs may reflect changing attitudes about their use. **Driving while intoxicated (DWI)** or **driving under the influence (DUI)** laws are becoming tougher. When groups of friends go out, it is common for one person to be chosen as the designated driver who will not drink alcohol. Places where alcoholic beverages are served can be held liable if a customer overindulges and then causes an accident. Mandatory sentencing for certain drug offenses is intended to show an unaccepting attitude about drug abuse.

All nurses need to be educated about the signs of substance use, ways to screen for them, and brief interventions that they can use regardless of clinical setting (Tran et al, 2009; Mollica et al, 2011). Nurses often see substance abusers at their worst, during a medical or psychiatric crisis. They may see these patients returning repeatedly for alcohol- or drug-related health problems.

Nurses have less contact with people with alcoholism and drug addiction who have recovered from their addiction, because after they have recovered, they are usually ill less often. When they do seek health care, these patients may not reveal their substance abuse history. The best way for nurses to understand these individuals is to attend open meetings of self-help groups, where they will meet people recovering from alcoholism and addiction who have overcome tremendous odds to remain sober and lead healthy, productive lives.

Prevalence

The United States has one of the highest levels of substance use and addiction in the world (Table 23-1). Approximately 30% of people in the United States report having some form of alcohol use disorder at some point in their lives.

Substance use is involved in many medical illnesses, hospitalizations, emergency room visits, and deaths. Substance use is a chronic, relapsing health problem that consumes a significant amount of health care resources. Substance users may be in treatment many times or make repeated attempts to quit before they are successful. Key facts about alcohol use and drug abuse are presented in Box 23-1.

Adolescence is the most common period for the first experience with drugs. Although teenagers who use psychoactive substances tend to progress from nicotine to alcohol to marijuana and then to drugs that are perceived to be more dangerous, drug use patterns seem to be most related to availability.

According to the National Institute on Drug Abuse, about 71% of high school seniors in the United States have used alcohol sometime in their lives. Among eighth graders, 36% have had at least one drink of alcohol, 5% report having been drunk, 20% have smoked cigarettes, and 17% have used marijuana. Among twelfth graders, 41% had consumed alcohol in the past 30 days; about 23% reported heavy alcohol consumption, called *binge drinking* (at least five or more drinks on one occasion within the past 2 weeks); and 3% said they consumed alcohol daily (Johnson et al, 2011; NIAAA, 2011).

QUALITY AND SAFETY ALERT

- Apart from being illegal, underage drinking poses a high risk for injury and social consequences, such as increased motor vehicle accidents, suicide, sexual assault, and high-risk sexual behavior.
- Underage alcohol use is more likely to kill young people than are all illegal drugs combined.

In 2009 an estimated 21.8 million, or 8.7%, of people in the United States age 12 years or older used an illicit drug, compared with 8.0% in 2008. **The largest increase in regular drug use was for "psychotherapeutics"—inappropriately used prescription drugs—most of which were pain relievers.**

When examined by age groups, in 2009, 10.0% of youths ages 12 to 17 years were current drug users, compared with 9.3% in 2008. Among adults between the ages of 18 and 25 years, current drug use increased from 19.6%in 2008 to 21.2% in 2009. The rate of drug use among adults age 26 years or older increased from 5.9% in 2008 to 6.3% in 2009 (Substance Abuse and Mental Health Services Administration, 2010).

Overall use of alcohol and illicit drugs increases with age until the mid-20s, levels off, and then decreases. However at-risk and binge drinking are frequently reported by middle-aged and elderly adults (Blazer and Wu, 2009). **If regular use begins before age 17 years, the individual is more likely to have alcohol and illicit drug abuse and dependence problems as an adult.** The lifetime prevalence and the intensity of alcohol use are greater among males.

At least one half of adults arrested for major crimes, including homicide, theft, and assault, test positive for drugs at the time of their arrest. Among those convicted of violent crimes, approximately 50% of state prison inmates and 40% of federal prisoners had been drinking or taking drugs at the time of their offense.

BOX 23-1 KEY FACTS ABOUT SUBSTANCE USE AND ABUSE

Excessive Alcohol Use

- Excessive alcohol use is a leading cause of preventable death in the United States among all adult age groups, contributing to more than 79,000 deaths per year. The alcohol-related death rate for American Indians and Alaska Natives is six times the national average.
- Alcohol use alone is estimated to cost up to 25% of the overall health care budget.
- More than one half of the alcohol consumed by adults and 90% of the alcohol consumed by youths occurs while binge drinking.
- Every day, almost 30 people in the United States die in motor vehicle crashes that involve an alcohol-impaired driver—one death every 48 minutes.

Drug Abuse

- Prescription drug abuse is the fastest growing drug problem in the United States.
- Chronic drug use, crime, and incarceration are closely connected.
- Six million children (9%) live with at least one parent who abuses alcohol or other drugs. These children are more likely to experience abuse (physical, sexual, or emotional) or neglect and are more likely to be placed in foster care.
- Illicit, prescription, or over-the-counter drugs are detected in about 18% of motor vehicle drivers' deaths.
- Injection drug use accounts for approximately 16% of new human immunodeficiency virus (HIV) infections in the United States. Injection and noninjection drug use is associated with sexual transmission of HIV and other sexually transmitted infections.
- Rates of marijuana use by youth and young adults are on the rise, and fewer youth than adults perceive great risk from smoking marijuana once or twice per week.

One of the most troubling effects of alcohol is its effect on marriage, which is reflected in the relationship between heavy drinking and marital violence**. Illicit drugs and alcohol play a role in domestic violence, affecting married and unmarried couples.** Another consequence of alcohol is self-injury.

QUALITY AND SAFETY ALERT

- Alcohol use and intoxication substantially increases the risk for self- and other-inflicted injury or suicide.

Most people with alcohol use disorders do not seek treatment (Substance Abuse and Mental Health Services Administration, 2010). **It is estimated that only 11% of people in the United States who need alcohol treatment receive it.** The most frequently cited reasons for not seeking alcohol treatment are cost, not wanting to stop using the substance, and not seeing the need for treatment (Edlund et al, 2009; Oleski

et al, 2010). Unmet need for treatment is highest among the elderly, persons from racial-ethnic minority groups, those with low income, those without insurance, and those living in rural areas (Grella et al, 2009).

Substance abuse receives relatively little medical and public health attention compared with other medical conditions. Reasons include stigma, tolerance of personal choices, acceptance of youthful experimentation, pessimism about treatment efficacy, powerful tobacco and alcohol industries, and patient resistance.

Multiple Substance Use. Simultaneous or sequential use of more than one substance is common. People do this to enhance, lessen, or otherwise change the level of their intoxication or to relieve withdrawal symptoms. Use of alcohol with cocaine or use of alcohol with heroin, also known as **speed balling,** is especially common. Heroin users often combine alcohol, marijuana, and benzodiazepines with heroin.

Multiple drug use is particularly dangerous if synergistic drugs, such as barbiturates and alcohol, are used. It also complicates substance use assessment and intervention because the patient may be showing the effects of or withdrawal from several drugs at the same time.

Dual Diagnosis. In the addicted population, prevalence of psychiatric illness is no greater than in the general population. However, **up to 50% of individuals with a serious mental illness are also dependent on or addicted to alcohol or illicit drugs.** They are referred to as having a *dual diagnosis*.

For example, people with schizophrenia are more than four times as likely to have a substance use disorder during their lifetimes, and those with bipolar disorder are more than five times as likely to have such a diagnosis as people in the general population. Many individuals who have experienced trauma and are diagnosed with posttraumatic stress disorder (PTSD) also have a substance use disorder. **Almost 60% of male and 70% of female alcohol abusers are thought to have at least one other psychiatric disorder.** This is challenging for clinicians because these patients can be more difficult to diagnose and are often treatment resistant with high relapse rates.

Failure to detect substance abuse disorders results in misdiagnosis of the psychiatric disorder and failure to provide appropriate treatment and referral. Underdetection can be caused by the following:

- Clinicians' lack of awareness of the symptoms or the high rates of substance disorders in psychiatric populations
- Difficulty in differentiating substance disorders from psychiatric disorders
- Patients' denial, minimization, and reluctance to talk about their substance-related problems
- Patients' cognitive, psychotic, and other impairments related to their psychiatric illness

Studies show that despite the high rate of dual disorders in various populations, such as those with severe and persistent mental illness, the chronically homeless, and those incarcerated in prison, the facilities and programs designed to treat both disorders are underused (Brunette et al, 2008).

Substance-Related Disorders in Nurses. Disciplinary records from state boards of nursing provide information about impaired nurses. Unfortunately, it is still a common practice to deal with a nurse who has a drug problem by ignoring the problem, firing the nurse, or asking for the nurse's resignation rather than reporting it to the state licensing board and facilitating treatment for the nurse. Data reported by each state board may reflect only a small segment of the problem.

As it is in the general population, alcohol is the drug of choice for nurses, and nurses' choice of substance is influenced by availability and exposure. Of all health care professionals, physicians and nurses use parenteral narcotics the most in their practices, and they are more likely to choose these drugs for their own use.

Among narcotics, the drug of choice for nurses is meperidine (Demerol). Anesthesiologists and nurse anesthetists who abuse substances tend to favor fentanyl, a potent, short-acting narcotic. Health care professionals tend to abuse prescription drugs rather than "street drugs," whether they acquire them by prescription or diversion.

ASSESSMENT

Accurate assessment of a patient's pattern of drug and alcohol use is essential, but it is sometimes difficult to accomplish. People with alcohol and drug addictions may use many defense mechanisms when discussing their chemical use. They may deny how much they use and its relationship to problems in their lives. They often rationalize their substance use. Patients should not be criticized for these unconscious mechanisms. They are often not aware of the extent or effects of their use.

It is also true that some patients purposely distort the truth about drug use to avoid feared consequences. The nurse should be aware of these behaviors and take them into account. The nurse also should be aware that only about 1 in 10 people who drink develops substance dependence at some point in their lifetime, and should not jump to the conclusion that a person is in denial if he or she claims to have no alcohol-related problems.

Screening for Substance Abuse

Screening for substance use problems is essential in the primary care setting where most people seek health care (Neushotz and Fitzpatrick, 2008; Savage, 2008; Baird, 2009; Oleski et al, 2010).

QUALITY AND SAFETY ALERT

- Despite their prevalence, substance-related disorders are frequently underdetected and underdiagnosed in primary care settings, as well as in acute-care psychiatric and medical settings, particularly in hospital emergency services.
- Nurses caring for patients in all clinical settings must be able to assess for substance use disorders.

To screen effectively, the nurse must ask the right questions in the right way. People who drink, take drugs, or do both tend to be around others who drink and use drugs as they do. They do not have a good idea of what normal use patterns are. However, even people who deny drug and drinking problems are likely to answer certain questions truthfully. These questions are included in screening tools, which are the first level of assessment for alcohol and drug dependence.

Simple screening tools are available that are useful in identifying people who may have problems with substance use. Because screening tools are only suggestive, findings from them should be followed by a full diagnostic assessment.

AUDIT-C. **The Alcohol Use Disorders Identification Test-C (AUDIT-C) is a 3-item screening tool used to identify individuals who are hazardous drinkers or have active alcohol use disorders** (Box 23-2).

> **Critical Reasoning** Given that AUDIT-C is such a simple screening tool, why do you think it is not used more often in routine nursing assessments?

B-DAST. **The Brief Drug Abuse Screening Test (B-DAST) is the quickest drug abuse screening tool** (Box 23-3). Each item has a 1-point value. Scores of 6 or more suggest significant drug abuse problems. Patients who score above established cutoff scores are considered to be addicted.

SBIRT. **Screen, Brief Intervention, Refer to Treatment (SBIRT)** is a public health approach to delivering early intervention to anyone who uses alcohol or drugs in unhealthy ways (Madras et al, 2009; Robinson, 2010; Kazemi et al, 2011). **The goal of SBIRT is to improve early identification of people who are overusing, abusing, or dependent on alcohol or other substances** (Table 23-2). Initial screening is completed for all patients annually. When indicated by the initial screening, further evaluation using a standardized instrument such as AUDIT-C or B-DAST is done followed by a brief intervention.

Motivational interviewing skills (Chapter 2) are used as the intervention to increase insight about substance use and motivation to change. Referral to an addiction specialist or treatment facility is indicated for patients who are identified as being at risk for dependency or when use places them or others at risk for harm. **SBIRT should be an essential practice skill of all nurses.**

Breathalyzer. **The simplest biological measure to obtain is blood alcohol content (BAC) by use of a Breathalyzer.** Alcohol in any amount has an effect on the central nervous system (CNS). The behaviors that can be expected from a nontolerant person at different concentrations of alcohol in the blood are shown in Table 23-3. In the United States, the legal limit as of 2011 is 0.08% blood alcohol content as measured by a breath device, urinalysis, or blood test.

BOX 23-2 AUDIT-C: ALCOHOL USE DISORDERS IDENTIFICATION TEST

1. How often do you have a drink containing alcohol?
   ____ a. Never
   ____ b. Monthly or less
   ____ c. 2 to 4 times a month
   ____ d. 2 to 3 times a week
   ____ e. 4 or more a week
2. How many standard drinks containing alcohol do you have on a typical day?
   ____ a. 1 or 2
   ____ b. 3 or 4
   ____ c. 5 or 6
   ____ d. 7 to 9
   ____ e. 10 or more
3. How often do you have six or more drinks on one occasion?
   ____ a. Never
   ____ b. Less than monthly
   ____ c. Monthly
   ____ d. Weekly
   ____ e. Daily or almost daily

Scoring

The Audit-C is scored on a scale of 0-12.

Each Audit-C question has 5 answer choices. Points allotted are:

- In men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- In women, a score of 3 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- However when the points are all from Question 1 alone (#2 and 3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.
- Generally the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

A person who has developed tolerance to alcohol would not demonstrate these behaviors and could have a high BAC without showing any signs of impairment. A level greater than 0.10% without associated behavioral symptoms indicates the presence of tolerance. **The higher the level without symptoms, the more severe the tolerance. High tolerance is usually a sign of physical dependence.**

Blood and Urine Screening. **Blood and urine are the body fluids most often tested for drug content, although methods of analyzing saliva, hair, breath, and sweat have been developed.** Identification and measurement of drug levels in the blood are useful for treating drug overdoses or complications in emergency room and other medical settings. Otherwise, urine drug screening is the method of choice because it is noninvasive.

Urine drug screening is used to test prospective employees and athletes for evidence of drug use. Drug treatment

BOX 23-3 B-DAST: BRIEF DRUG ABUSE SCREENING TEST

Instructions: The following questions concern information about your involvement and abuse of drugs. Drug abuse refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions and (2) any nonmedical use of drugs. Carefully read each statement and decide whether your answer is yes or no. Then circle the appropriate response.

YES NO 1. Have you used drugs other than those required for medical reasons?
YES NO 2. Have you abused prescription drugs?
YES NO 3. Do you abuse more than one drug at a time?
YES NO 4. Can you get through the week without using drugs (other than those required for medical reasons)?
YES NO 5. Are you always able to stop using drugs when you want to?
YES NO 6. Have you had blackouts or flashbacks as a result of drug use?
YES NO 7. Do you ever feel bad about your drug abuse?
YES NO 8. Does your spouse (or parents) ever complain about your involvement with drugs?
YES NO 9. Has drug abuse ever created problems between you and your spouse?
YES NO 10. Have you ever lost friends because of your use of drugs?
YES NO 11. Have you ever neglected your family or missed work because of your use of drugs?
YES NO 12. Have you ever been in trouble at work because of drug abuse?
YES NO 13. Have you ever lost a job because of drug abuse?
YES NO 14. Have you gotten into fights when under the influence of drugs?
YES NO 15. Have you engaged in illegal activities in order to obtain drugs?
YES NO 16. Have you ever been arrested for possession of illegal drugs?
YES NO 17. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?
YES NO 18. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?
YES NO 19. Have you ever gone to anyone for help for a drug problem?
YES NO 20. Have you ever been involved in a treatment program specifically related to drug use?

Items 4 and 5 are scored in the NO, or false, direction. Each item is 1 point. A score of 6 or more points suggests significant problems.

From Skinner HA: *Addict Behav,* 7:363, 1982; Center for Substance Abuse Treatment: *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992, Rockville, Md, 2005, Substance Abuse and Mental Health Services Administration.

TABLE 23-2 SBIRT: SCREEN, BRIEF INTERVENTION, REFER TO TREATMENT

SCREENING	FOCUS	EXAMPLE
Annual (initial) screen	Screening can quickly assess the presence and severity of substance use and may be completed with an interview and self-report; important to always use supportive and nonjudgmental communication skills	How many times in the last year have you had 5 or more drinks in a day? Or How many days per week do you drink alcohol? When you drink, how many drinks do you have?
Full (secondary) screen	More focused assessment	AUDIT-C, (see Box 23-2) or other screening tool
Brief intervention	Emphasis on increasing awareness of substance use, understanding the impact on health status, and encouraging behavioral change	Motivational Interviewing (see Chapter 2) What do you enjoy about drinking/using? What don't you like when you drink? From 1 to 10, how ready are you to change your drinking habits? What change would you be able to make?
Refer to treatment	If the assessment indicates substance use placing the patient or others at risk for harm, a screening score identifying a need for specialist care, or if patient requests, provide a referral to a local treatment center	http://findtreatment.samhsa.gov/

TABLE 23-3 COMPARISON OF BLOOD ALCOHOL CONCENTRATIONS WITH BEHAVIORAL MANIFESTATIONS OF INTOXICATION

BLOOD ALCOHOL LEVEL	BEHAVIORS
0.05-0.14 g/dL	Euphoria, labile mood, cognitive disturbances (decreased concentration, impaired judgment, loss of sexual inhibitions)
0.15-0.19 g/dL	Slurred speech, staggering gait, diplopia, drowsiness, labile mood with outbursts
0.20-0.29 g/dL	Stupor, aggressive behavior, incoherent speech, labored breathing, vomiting
0.30-0.39 g/dL	Coma
0.40-0.50 g/dL	Severe respiratory depression, death

personnel also use it to determine whether patients have used drugs while in treatment. Urine drug screening is often used in court to validate a person's drug use related to criminal activity.

The person being tested may try to alter the sample to hide drug use. The most common ways to do this are diluting the specimen with water from the toilet or substituting a "clean" specimen donated by a friend for the "dirty" specimen. To help prevent these practices, the specimen is often collected on random days under direct observation of a same-gender staff member. Another way is to have the person leave jackets, sweaters, purses, and other items outside the stall, place drops of dye in the toilet water to alter its color, and test the specimen for temperature. Fresh, undiluted urine should feel warm through the cup and should be approximately 98.6° F (37° C).

The length of time that drugs can be found in blood and urine varies according to dosage and the metabolic properties of the drug. All traces of the drug may disappear within 24 hours or may still be detectable several weeks later.

Behaviors of Abuse and Dependence

Using alcohol and drugs can have many serious consequences. Lifestyles associated with substance abuse carry risks. Accidents are frequent, and violence is common. Self-neglect is the norm, contributing to physical and mental illnesses. Substances of abuse and their associated lifestyle can lead to complications during pregnancy and the risk of fetal abnormalities and fetal substance dependence.

Intravenous drug users and their sexual partners are at high risk for infection with blood-borne pathogens, particularly hepatitis B virus (HBV) and the human immunodeficiency virus (HIV), which causes the acquired immunodeficiency syndrome (AIDS). More recently, hepatitis C virus (HCV) has become recognized in the drug abuse population and has become one of the leading causes of chronic hepatitis in the United States (Centers for Disease Control and Prevention, 2011).

It is common for people with addictions to share needles when they are using drugs in a group. Because the needles are not cleaned, blood is transferred from one person to the others. This is an ideal situation for the transmission of HIV or hepatitis.

Central Nervous System Depressants. The term *CNS depressant* is used for any drug that depresses excitable tissues at all levels of the brain. These drugs are also called *sedative-hypnotics*. Their primary effects are to reduce anxiety (the calming, antianxiety, or sedative effect), induce sleep (the hypnotic effect), or both. Included in this class are alcohol, barbiturates, and benzodiazepines. The signs and symptoms of the use of, overdose by, and withdrawal from CNS depressants are listed in Table 23-4.

Cross-tolerance develops among most drugs in this category. This means that as tolerance develops to one drug, it also develops to other drugs in this category. For example, a person with chronic alcoholism will need very high doses of benzodiazepines to control signs of withdrawal.

Alcohol. Alcohol misuse includes risky, hazardous, or harmful drinking that places a person at risk for problems.

- ***Risky or hazardous drinking*** is defined as more than 7 drinks per week or more than 3 drinks per occasion for women and more than 14 drinks per week or more than 4 drinks per occasion for men.
- ***Harmful drinking*** occurs if a person is experiencing physical, social, or psychological harm from alcohol use but does not meet the criteria for dependence.

Although alcohol is a sedative, it creates an initial feeling of euphoria. This is probably related to decreased inhibitions. Symptoms of sedation of different CNS structures increase as the amount of alcohol ingested increases.

Approximately 15% of drinkers progress to alcoholism. One person's drinking may begin like any other's pattern, or a person may be able to drink more alcohol than others before feeling intoxicated. In either case, the person likes the feeling of intoxication and continues to drink whenever possible. Gradually, drinking occurs more often and in larger quantities. As this happens, drinking begins to cause problems in the person's life, which the person may explain away. The problems increase, the drinking increases, **physical and psychological dependence** develops, and the person begins to drink to avoid withdrawal symptoms; or the person drinks in binges.

Not everyone progresses in the same way or displays all these characteristics, and the time over which the progression occurs varies widely. The next clinical example illustrates many of the behaviors described. Mr. H has the medical diagnoses of alcohol dependence and alcohol withdrawal delirium.

CLINICAL EXAMPLE

Mr. H was admitted to the detoxification center of a large metropolitan hospital because of acute alcohol withdrawal. He was delirious and having visual hallucinations of bugs in his bed. He was extremely frightened, thrashing around in bed, and mumbling incoherently. Because he had a long and well-documented history of alcohol abuse, family members were contacted and confirmed that he had recently stopped drinking after a 2-week binge.

The patient had been a successful lawyer with a large practice. He specialized in corporate law and conducted much business over lunch or dinner. He also kept a well-stocked bar in his office to offer clients a drink. Without being aware of it, Mr. H's drinking had gradually increased. After a few years, he was drinking almost nonstop from lunchtime to bedtime. He then began to have a Bloody Mary with breakfast "just to get myself going."

His wife reported that he had become irritable, particularly when she questioned his drinking. On two occasions, he had hit her during their arguments. She was seriously considering divorce. He also had become alienated from his children, who appeared frightened of him. Infrequently, he felt guilty about neglecting his family and planned a special outing. Most of the time, however, he was too drunk to carry out his plans. The family also had become less involved in activities with friends. Ms. H and the children felt embarrassed about his behavior and did not invite

Text continued on p. 446

SUBSTANCE	SUBSTANCE ROUTE (MOST COMMON FIRST)	SUBSTANCE COMMON STREET NAMES	SUBSTANCE DEPENDENCE: PHYSICAL/ PSYCHOLOGICAL	SUBSTANCE USE SIGNS AND SYMPTOMS OF CLASS	SUBSTANCE OVERDOSE SIGNS AND SYMPTOMS OF CLASS	SUBSTANCE WITHDRAWAL SIGNS AND SYMPTOMS OF CLASS	SUBSTANCE SPECIAL CONSIDERATIONS/ CONSEQUENCES OF USE OF CLASS
Depressants							
Alcohol	Ingestion	Booze, brew, juice, spirits	Yes/yes	Depression of major brain functions, such as mood, cognition, attention, concentration, insight, judgment, memory, affect, and emotional rapport in interpersonal relationships; extent of depression is dose dependent and ranges from lethargy through anesthesia and death Psychomotor impairment, increased reaction time, interruption of hand-eye coordination, motor ataxia, nystagmus Decreased REM sleep leading to more dreams and sometimes nightmares	Unconsciousness, coma, respiratory depression, death	*General depressant withdrawal syndrome:* tremors, agitation, anxiety, diaphoresis, increased pulse and blood pressure, sleep disturbance, hallucinosis, seizures, delusions, delirium tremens (DTs) *High-dose sedative-hypnotic withdrawal:* for short-acting sedative-hypnotics (including alcohol), symptoms begin between several hours to 1 day after the last dose and peak after 24-36 hours; for long-acting sedative-hypnotics, symptoms peak after 5-8 days *Low-dose sedative-hypnotic withdrawal:* usually transient symptom rebound effects (anxiety, insomnia) for 1-2 weeks; may have more severe symptoms including perceptual hyperacusis, psychosis, cerebellar dysfunction, seizures *Postacute (protracted) withdrawal:* irritability, anxiety, insomnia, mood instability may occur for months	Chronic alcohol use leads to serious disruptions in most organ systems, including malnutrition and dehydration; vitamin deficiency leading to Wernicke encephalopathy and alcoholic amnestic syndrome; impaired liver function, including hepatitis and cirrhosis; esophagitis, gastritis, pancreatitis; osteoporosis; anemia; peripheral neuropathy; impaired pulmonary function; cardiomyopathy; myopathy; disrupted immune system; brain damage High susceptibility to other dependencies Dependence on barbiturates and benzodiazepines may develop insidiously; users may underreport the actual amount taken because of guilt about multiple prescriptions and abuse

Continued

TABLE 23-4 **CHARACTERISTICS OF SUBSTANCES OF ABUSE—cont'd**

SUBSTANCE	SUBSTANCE ROUTE (MOST COMMON FIRST)	SUBSTANCE COMMON STREET NAMES	SUBSTANCE DEPENDENCE: PHYSICAL/ PSYCHOLOGICAL	SUBSTANCE USE SIGNS AND SYMPTOMS OF CLASS	SUBSTANCE OVERDOSE SIGNS AND SYMPTOMS OF CLASS	SUBSTANCE WITHDRAWAL SIGNS AND SYMPTOMS OF CLASS	SUBSTANCE SPECIAL CONSIDERATIONS/ CONSEQUENCES OF USE OF CLASS
Barbiturates	Ingestion, injection	Barbs, beans, black beauties, blue angels, candy, downers, goof balls, G.B., nebbies, reds, sleepers, yellow jackets, yellows	Yes/yes				
Benzodiazepines	Ingestion, injection	Downers	Yes/yes				
Stimulants							
Amphetamines	Ingestion, injection, smoking, inhalation	A, AMT, bam, bennies, crystal, diet pills, dolls, eye-openers, ice, lid poppers, meth, pep pills, purple hearts, speed, uppers, wake-ups	Yes/yes	Sudden rush of euphoria, abrupt awakening, increased energy, talkativeness, elation Agitation, hyperactivity, irritability, grandiosity, pressured speech Diaphoresis, anorexia, weight loss, insomnia Increased temperature, blood pressure, pulse Tachycardia, ectopic heartbeats, chest pain Urinary retention, constipation, dry mouth *High dose:* slurred, rapid, incoherent speech Stereotypic movements, ataxic gait, teeth grinding, illogical thought processes, headache, nausea, vomiting *Toxic psychosis:* paranoid delusions in clear sensorium; auditory, visual, or tactile hallucinations; very labile mood Unprovoked violence	Seizures, cardiac arrhythmias, coronary artery spasms, myocardial infarctions, marked increase in blood pressure and temperature that can lead to cardiovascular shock and death	*Acute withdrawal (after periods of frequent high-dose use):* intense and unpleasant feelings of depression and fatigue and sometimes suicidal ideation *Otherwise:* milder symptoms of depression, anxiety, anhedonia, sleep disturbance, increased appetite, and psychomotor retardation, which decrease steadily over several weeks Sometimes a user stops stimulants purposely to decrease tolerance, decreasing amount needed to get high	Certain amphetamines prescribed for ADHD in children because of a paradoxical depressant action; sometimes these medications are stolen and abused; may be used alternately with depressants
Cocaine	Inhalation, smoking, injection, topical	Bernice, bernies, big C, blow, C, charlie, coke, dust, girl, heaven, jay, lady, nose candy, nose powder, snow, sugar, white lady Crack = conan, freebase, rock, toke, white cloud, white tornado	Yes/yes				Cocaine use may lead to multiple physical problems, including destruction of nasal septum related to snorting, coronary artery vasoconstriction, seizures, cerebrovascular accidents, transient ischemic episodes, sudden death related to respiratory arrest, myocardial infarction Intravenous use of stimulants may lead to serious physical consequences described under Opiates

Opiates							
Heroin	Injection, ingestion, inhalation	H, horse, harry, boy, scag, shit, smack, stuff, white junk, white stuff	Yes/yes	Euphoria, relaxation, relief from pain, "nodding out" (apathy, detachment from reality, impaired judgment, drowsiness), constricted pupils, nausea, constipation, slurred speech, respiratory depression	Unconsciousness, coma, respiratory depression, circulatory depression, respiratory arrest, death; anoxia can lead to brain abscess	*Initially:* drug craving, lacrimation, rhinorrhea, yawning, diaphoresis *In 12-72 hours:* sleep disturbance, mydriasis, anorexia, piloerection, irritability, tremor, weakness, nausea, vomiting, diarrhea, chills, fever, muscle spasms, flushing, spontaneous ejaculation, abdominal pain, hypertension, increased rate and depth of respirations *Protracted withdrawal:* hypersensitivity to sensory stimuli, paresthesias, perceptual distortions, muscle pains, twitching, tremors, headache, sleep disturbances; tension, irritability, lack of energy, impaired concentration, derealization, depersonalization May last for several months	Intravenous use leads to risk for infection with blood-borne pathogens, such as HIV or hepatitis B; other infections (skin abscesses, phlebitis, cellulitis, and septic emboli causing pneumonia, pulmonary abscess, or subacute bacterial endocarditis) may occur as result of lack of asepsis or contaminated substances Chronic use leads to lack of concern about physical well-being, resulting in malnutrition and dehydration; criminal behavior may occur as means of acquiring money for drugs
Morphine	Injection		Yes/yes				
Meperidine	Injection, ingestion		Yes/yes				
Codeine	Injection, ingestion		Yes/yes				
Opium	Smoking, ingestion		Yes/yes				
Methadone	Ingestion		Yes/yes				
Marijuana							
Marijuana	Smoking, ingestion	Acapulco gold, aunt mary, broccoli, dope, grass, grunt, hay, hemp, herb, J, joint, joy stick, killer weed, maryjane, pot, ragweed, reefer, smoke, weed	No/yes	Altered state of awareness, relaxation, mild euphoria, reduced inhibition, red eyes, dry mouth, increased appetite, increased pulse, decreased reflexes, panic reaction	Toxic psychosis	No acute symptoms, but irritability and difficulty sleeping may last for a couple of days	Pulmonary problems; interference with reproductive hormones; may cause fetal abnormalities

Continued

TABLE 23-4 **CHARACTERISTICS OF SUBSTANCES OF ABUSE—cont'd**

SUBSTANCE	SUBSTANCE ROUTE (MOST COMMON FIRST)	SUBSTANCE COMMON STREET NAMES	SUBSTANCE DEPENDENCE: PHYSICAL/ PSYCHOLOGICAL	SUBSTANCE USE SIGNS AND SYMPTOMS OF CLASS	SUBSTANCE OVERDOSE SIGNS AND SYMPTOMS OF CLASS	SUBSTANCE WITHDRAWAL SIGNS AND SYMPTOMS OF CLASS	SUBSTANCE SPECIAL CONSIDERATIONS/ CONSEQUENCES OF USE OF CLASS
Hallucinogens							
LSD	Ingestion, smoking	Acid, big D, blotter, blue heaven, cap, D, deeda, flash, L, mellow yellows, microdots, paper acid, sugar, ticket, yello	No/no	Distorted perceptions and hallucinations in the presence of a clear sensorium Distortions of time and space, illusions, depersonalization, mystical experiences, heightened sense of awareness Extreme mood lability	Rare with LSD: convulsions, hyperthermia, death	None	Flashbacks may last for several months; permanent psychosis may occur
DMT			No/no	Tremor, dizziness, piloerection, paresthesias, synesthesia, nausea, vomiting			
Mescaline			No/no				
MDMA		Ecstasy	No/no	Increased temperature, pulse, blood pressure, and salivation Panic reaction, "bad trip"			
Phencyclidine (PCP)	Smoking, ingestion	Angel dust, DOA, dust, elephant, hog, peace pill, super-grass, tic tac	No/no	Intensely psychotic experience characterized by bizarre perceptions, confusion, disorientation, euphoria, hallucinations, paranoia, grandiosity, agitation Anesthesia Apparent enhancement of strength and endurance Rage reactions May be agitated and hyperactive with tendency for violence or catatonic and withdrawn or vacillate between the two conditions Red, dry skin; dilated pupils, nystagmus, ataxia, hypertension, rigidity, seizures	Seizures, coma, death	None	If flashbacks occur, they are mild and usually not disturbing

Inhalants							
Gasoline, glue, aerosol sprays, felt tip markers, paint thinner	Inhalation	Bagging, bolt, huffing, rush, sniffing, spray	Yes/yes	*Psychological:* belligerence, assaultiveness, apathy, impaired judgment *Physical:* dizziness, nystagmus, incoordination, slurred speech, unsteady gait, depressed reflexes, tremor, blurred vision, euphoria, anorexia	Lethargy, stupor/coma, respiratory arrest, cardiac arrhythmia	Symptoms similar to alcohol withdrawal	Death from inhalants can occur in different ways: sudden death is caused by cardiac arrhythmia—sometimes this happens the first time the inhalant is used; suicide may be a result of impaired judgment *Injury:* under the influence of inhalants, a person feel invulnerable Burns and frostbite also can be caused by these chemicals Permanent cognitive impairment may require an individual to reside in a structured setting
Nicotine							
Nicotine	Smoking, chewing, buccal	Bidis, chewing tobacco, cigarettes, cigars, kreteks, pipe tobacco, snuff	Yes/yes	Feelings of pleasure, increased alertness, enhanced mental performance, increased heart rate, increased blood pressure, restricts blood flow to heart muscle	Not applicable	Anger, anxiety, depressed mood, difficulty concentrating—all of which subside within 3-4 weeks; increased appetite and craving for nicotine, which may persist for months	Smoking by pregnant women contributes to low birth weight, increased incidence of stillborn and premature babies

ADHD, Attention deficit hyperactivity disorder; *DMT, N,N*-dimethyl-tryptamine; *HIV,* human immunodeficiency virus; *LSD,* lysergic acid diethylamide; *MDMA,* 3,4-methylenedioxymethamphetamine; *REM,* rapid eye movement.

anyone to their home. On two occasions, Mr. H had tried to stop drinking. The first time, he went to a private hospital, where he was detoxified. He abstained from drinking for about 1 month after discharge.

He then lost an important case and decided to have "just one drink" to carry him through the crisis. His drinking soon was again out of control. His second hospitalization was at a general hospital with an active alcoholism rehabilitation program. He was introduced to Alcoholics Anonymous (AA) and started taking disulfiram (Antabuse). This program worked until he decided that he could manage without medication. A couple of weeks later, his coworkers persuaded him to help celebrate at an office party. This was the start of a binge that ended when he had an automobile accident on the way home from a bar. A passenger in the other car was killed, and Mr. H was charged with vehicular homicide and driving under the influence of alcohol. He stopped drinking abruptly, which resulted 3 days later in his current hospital admission.

Selected Nursing Diagnoses

- Ineffective coping related to repeated drinking, as evidenced by work and family problems and denial of drinking problems
- Risk for injury related to drinking and driving, as evidenced by a recent automobile accident
- Risk for other-directed violence related to lack of control of behavior when drunk, as evidenced by the past pattern of violent behavior

Barbiturates. Barbiturates include barbital, amobarbital (Amytal), phenobarbital, pentobarbital (Nembutal), secobarbital (Seconal), and butabarbital. These drugs were once widely prescribed for their sedative and hypnotic effects. However, many problems were associated with their use. **They have been a major cause of deaths by overdose from accidental poisonings and suicide.** They produce excessive drowsiness, even at therapeutic doses. **Tolerance to them develops rapidly.** Like alcohol, barbiturates are depressants that cause an initial response of euphoria. Although they remain popular street drugs, their use as sedative-hypnotics has decreased.

Barbiturate use leads to physical and psychological dependence. The combination of **alcohol and barbiturates produces a synergistic effect,** meaning that either drug potentiates the effects of the other. Despite these issues, barbiturates are useful for the treatment of epilepsy and general depressant withdrawal syndromes.

QUALITY AND SAFETY ALERT

- Combinations of barbiturates and alcohol are particularly dangerous and can lead to accidental overdose and death.

Benzodiazepines. **Benzodiazepines have replaced barbiturates as the preferred treatment for anxiety and related disorders.** They are as effective as barbiturates but are safer to use. Benzodiazepines cause decreased anxiety and drowsiness, although less than barbiturates. **They also can be addictive, causing physical and psychological dependence. They lead to the same withdrawal symptoms as alcohol.**

Because benzodiazepines are longer acting than barbiturates, the symptoms are less intense and continue over a longer period. They are less harmful in cases of overdose. They are commonly prescribed in the United States, usually with few resulting problems if used as directed. The clinical uses of benzodiazepines are described in Chapter 26.

Stimulants. Stimulant drugs excite the CNS at many levels. The most common drugs are the amphetamines and cocaine. People use these drugs to produce feelings of euphoria, relief from fatigue, added energy, and alertness. The signs and symptoms of use, overdose, and withdrawal are similar for all drugs in this class (see Table 23-4).

Amphetamines. The amphetamine drugs include amphetamine, methamphetamine, dextroamphetamine, and benzphetamine. Amphetamines act by releasing norepinephrine and dopamine from neuronal storage vesicles into the synapse. Increased levels of these catecholamines at the receptors cause increased stimulation.

Methamphetamine (meth) use is a large problem in the United States (Box 23-4). When people with addictions use it repeatedly, the drug changes their brain chemistry, destroying the wiring in the brain's pleasure centers. Methamphetamine abuse damages dopamine receptors and neurons, decreasing the ability to experience pleasure without using the drug. This destruction can be repaired with continued sobriety lasting longer than 1 year, but cognitive deficits remain, including severe impairment in memory, judgment, and motor coordination, which are similar to symptoms seen in individuals with Parkinson disease. Although studies have shown that these tissues can regrow over time, the process can take years, and the repair may never be complete. **The chemical changes from methamphetamine use can lead to hyperactive, obsessive, and violent behavior.**

Methamphetamine use causes changes in physical appearance. Because methamphetamine causes the blood vessels to constrict, it cuts off the steady flow of blood to all parts of the body. Heavy use causes tissue damage, and it inhibits the body's ability to repair itself. Acne develops, sores take longer to heal, and the skin loses its luster and elasticity. Poor diet, teeth grinding, and lack of oral hygiene result in tooth decay and loss. Some users are covered in small sores, the result of obsessive skin picking brought on by the hallucination of bugs crawling beneath the skin.

Clear patterns of tolerance and withdrawal have been described for the amphetamines. Tolerance develops to the euphoria and the pleasant effects of these drugs but not to the wakefulness effects.

QUALITY AND SAFETY ALERT

- Prolonged or excessive use of amphetamines can lead to psychosis, which is almost identical to paranoid schizophrenia.

The legal use of amphetamines is limited to three types of conditions: narcolepsy, attention deficit hyperactivity

BOX 23-4 METHAMPHETAMINE

- Methamphetamine causes a flood of dopamine release, creating an intense rush of pleasure and a longer lasting euphoric feeling.
- The amount of dopamine released into the synapse by methamphetamine is up to 12 times that of food or sex. Sex releases 100 to 200 units of dopamine; cocaine releases 350 units; and methamphetamine releases 1250 units.
- Methamphetamine induces a stronger and longer-lasting high than cocaine. A cocaine high lasts 20 to 30 minutes, whereas a methamphetamine high lasts 6 to 24 hours. Methamphetamine users often use repeatedly in "runs" lasting days or longer.
- Chronic methamphetamine use can cause the following:
  - Permanent brain damage affecting reasoning, judgment, and motor skills
  - Psychosis with auditory or visual hallucinations, delusions, and paranoia
  - Increased potential for aggressive and violent behaviors
- Methamphetamine abuse has many physical effects, including tachycardia, liver damage, stroke, seizure, and significant risk of death.
- Tooth decay is common (also known as *meth mouth*), caused by decreased saliva, binging on sugary food and drink, neglecting oral hygiene, and grinding teeth (a symptom similar to the extrapyramidal side effects seen with use of some antipsychotic medications).
- Chronic users develop sores on their bodies from scratching imaginary bugs crawling on or under the skin. They develop shadows under their eyes and acne-type skin lesions on their face.
- Methamphetamine increases libido and impairs judgment, potentially leading to risky sexual behavior. Combined with intravenous drug use, this heightens the potential for exposure to human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS), hepatitis viruses, and other sexually transmitted infections.

disorder (ADHD) in children and adults, and short-term weight reduction programs. The abuse potential of amphetamines outweighs the benefit of their medical use except for certain conditions (e.g., ADHD, refractory depression). Safer treatments for these conditions usually are preferred when effective; however, amphetamines may be the only effective treatment option. Extended-release formulations and medication patches decrease the abuse potential by administering a steady amount of drug over a longer period.

Cocaine. Cocaine can be inhaled as a powder, injected intravenously, or smoked. The form of cocaine that is smoked is produced by a process called ***freebasing.*** The *crack* form of freebase cocaine is produced by heating ("cooking") street-grade cocaine in a baking soda solution. Its name is derived from the cracking sound it makes when it is smoked.

The euphoria caused by cocaine is short acting, starting with a 10- to 20-second rush and followed by 15 to 20 minutes of less intense euphoria. A person who is high on cocaine feels euphoric, energetic, self-confident, and sociable.

Biochemically, cocaine blocks the reuptake of norepinephrine and dopamine. Because more neurotransmitter is present at the synapse, the receptors are continuously activated. It is believed that this causes the euphoria. At the same time, presynaptic supplies of dopamine and norepinephrine are depleted. This causes the *crash* that happens when the effect of the drug wears off.

Cocaine produces physical dependence and withdrawal symptoms very similar to those seen in amphetamine users, beginning with intense craving and drug-seeking behavior. **The relapse rate for patients who try to discontinue cocaine use is very high.**

QUALITY AND SAFETY ALERT

- Cocaine use can result in sudden death.

Cocaine use has been glamorized by the publicity given to it by movie stars, sports figures, and other well-known people. This makes it inviting to adolescents who regard famous people as role models.

Addiction to barbiturates ("downers") and stimulants ("uppers"), particularly the amphetamines, often occurs simultaneously. A patient who has been using downers sometimes develops a need for uppers to provide enough energy to function. The next clinical example illustrates this pattern. Ms. W's pattern is not uncommon. Aside from street use, many people slip into drug abuse without being aware of the consequences of their behavior.

CLINICAL EXAMPLE

Ms. W was a 34-year-old woman who was moderately overweight. She had tried various diets on her own with little success. A friend told her about a "diet doctor" who had a reputation for helping his patients lose weight with minimal deprivation. Ms. W decided to see the physician and was accepted for treatment. She was given a diuretic and appetite-suppression medication, which contained amphetamines. She began to lose weight as soon as she started the prescribed regimen and was delighted. She also liked the additional burst of energy she felt every time she took her medication. She completed projects that she had been planning to work on for months. However, her family began to complain because she was irritable and very restless. She developed insomnia and roamed about the house at night.

At the urging of her husband, she went to her family physician. Because she felt guilty about seeing another physician for her weight problem, she did not tell her regular physician about this. With the history of insomnia, irritability, and recent weight loss, her physician thought she might be depressed. He ordered an antidepressant medication and a barbiturate sedative. Ms. W soon found that she was able to sleep well with her sedative. However, she felt slightly hung over in the morning, and still wanting to lose more weight, she continued with her diet pills. For a while, she was able to function well. Gradually, however, she found that she needed two sedatives, and then she began to use extra stimulants. Her husband questioned her drug use.

Ms. W had read about drug abuse, and with her husband's help, she identified her problem. She decided to see her family physician again, and this time told him the whole story. He then advised a brief hospitalization so that she could be withdrawn from both drugs under medical supervision. Ms. W was very embarrassed by her addiction. While in the hospital, she needed a great deal of nursing support to integrate this experience.

Selected Nursing Diagnoses

- Ineffective coping related to dependence on stimulants and depressants, as evidenced by inability to function without the drugs and the development of tolerance
- Ineffective role performance related to drug dependence, as evidenced by family concern about her behavior
- Imbalanced nutrition: more than body requirements related to repeated dieting failures, as evidenced by seeking a doctor who would help her lose weight with minimal deprivation

Opiates. The opiates include opium, heroin, meperidine, morphine, codeine, and methadone. Meperidine, morphine, and codeine are commonly used **analgesics.** Methadone is used to treat addiction to other opiates. It can be used to aid withdrawal or to provide maintenance at a stable dose. It is useful because it does not interfere with the ability to function productively, as other narcotics do. **Patients taking a maintenance dose of methadone may work and live normally, although they are still addicted to narcotics.**

Although opiate use is less widespread than some other substances, prescription opiate abuse is receiving increasing attention (Box 23-5). **The epidemic of overdoses of opioid pain relievers in the United States has continued to worsen** (Centers for Disease Control and Prevention, 2011). Although some people use opiates for years with few problems, people with opiate addiction often deteriorate mentally and physically until they are unable to function productively.

One characteristic of narcotic addiction is the development of tolerance, which also increases the expense of the habit. Physiological effects of narcotics are included in Table 23-4. Illegal behavior, such as stealing or prostitution to acquire money for drugs, may result from addiction. Obtaining and using drugs become an all-consuming passion.

The most important psychological response to opiate use is euphoria, or feeling high. This powerful, pleasurable response causes the person to use the drug repeatedly, leading to addiction. Other psychological effects of narcotics include apathy, detachment from reality, and impaired judgment. The phrase *nodding out* describes this group of behaviors combined with drowsiness. The next clinical example demonstrates the behaviors associated with opiate abuse.

CLINICAL EXAMPLE

Mr. C was a 45-year-old man who had been jailed for automobile theft. He was believed to be a member of a large ring of car thieves in a major metropolitan area. His arrest record included several episodes of armed robbery and breaking and entering. A few hours after he had been jailed, Mr. C complained of abdominal cramps and appeared very anxious. His nose and eyes were running, there were beads of perspiration on his brow, and he was rocking back and forth on his bunk. The guard called the correctional health nurse.

The nurse observed Mr. C and performed a brief physical assessment. She observed that his pupils were dilated, his blood pressure was elevated, and he had gooseflesh. There were multiple needle tracks on his arms. She asked him directly about drug use, and he admitted that he had been addicted to heroin. He stated that his addiction began while he was stationed with the army in Vietnam. When he returned to the United States, he remained in the army for 18 months and was able to stop using drugs altogether. He planned to get a job and attend school after leaving the service. He related that he was disturbed by the attitude of people about Vietnam veterans. While he was still in the service, he was able to use peer support to cope with his feelings. However, after his discharge, he was reluctant to talk about his military experience. Others seemed disinterested, embarrassed, or hostile when he talked about it.

Mr. C had difficulty finding a civilian job. He was an artillery specialist in the army and found that it was difficult to apply this experience to civilian life. He began to have nightmares and flashbacks of his combat experiences. Because of the associated anxiety, he returned to drugs. Without a job, he used illegal means to finance his habit and therefore was repeatedly sent to jail.

The nurse discussed Mr. C's problem with the physician in the prison health department. They decided to assess Mr. C's eligibility for a methadone drug treatment program and to request consultation from a counselor at the local veterans counseling center.

Selected Nursing Diagnoses

- Ineffective coping related to inability to obey the law, as evidenced by repeated arrests
- Ineffective role performance related to difficulty adjusting to civilian life, as evidenced by inability to find a job or seek out peer support
- Social isolation related to unresolved stressful military experiences, as evidenced by reliance on drugs rather than people
- Risk for other-directed violence related to compelling need for drugs, as evidenced by history of armed robbery

BOX 23-5 MISUSE OF PRESCRIPTION DRUGS

- Accidental overdose of prescription opioids caused 11,499 deaths in 2007, which is more than caused by heroin and cocaine overdoses combined.
- Emergency room visits related to opioid abuse doubled between 2004 and 2008.
- Prescription analgesic abuse is the second leading reason for admission to substance treatment programs.
- Many patients consider prescription medications both legal and safe because a health care provider gave them the prescription, not understanding the dangers associated with such medications.

Modified from Okie S: A flood of opioids, a rising tide of deaths, *N Engl J Med,* 363:21, 2010.

Withdrawal from narcotics is extremely uncomfortable but is not usually life threatening. In contrast, **an overdose of narcotics is very dangerous, and it can rapidly lead to coma, respiratory depression, and death.** Accidental overdoses among people with narcotic addictions sometimes occur, particularly because the users are uncertain of the drug's strength. Drugs are usually cut with inert (and sometimes toxic) substances before they are sold, resulting in the availability of varied strengths on the streets.

Natural opiates. Natural substances that act like morphine in the brain are known as **endorphins** and **enkephalins.** These neurotransmitters bond with opiate receptors in the brain and pituitary gland. Release of these natural opiates results in a feeling of euphoria.

This understanding has led to a **theory of drug cravings:** When large amounts of artificial opiates are taken over a long period, the brain responds by cutting off production of endorphins in an attempt to restore homeostasis. As the artificial opiates leave the system, there are no natural opiates to take their place. This deprivation is experienced as craving.

Marijuana. Marijuana (cannabis) is one of the most commonly used illicit drugs. **It may serve as a gateway drug for more serious drug use.** It is sometimes classified as a hallucinogenic drug, but it rarely causes hallucinations. It can, however, increase the risk for psychotic disorders (Zammit et al, 2011). It causes sedation but is not primarily a CNS depressant. The active ingredient in marijuana is tetrahydrocannabinol (THC).

The marijuana cigarette can be smoked as it is or through a water pipe ("bong") to cool the hot vapors. Marijuana usually produces an altered state of awareness accompanied by a feeling of relaxation and mild euphoria. Effects depend on the potency of the drug and on the setting and the experience of the user. Strength can vary from 1% to 30% THC content.

Prolonged use may lead to apathy, lack of energy, loss of desire to work or be productive, diminished concentration, poor personal hygiene, and preoccupation with marijuana. This cluster of symptoms is known as the **amotivational syndrome.** Although study findings are controversial, there seems to be general support for the existence of such a syndrome.

Rates of marijuana use are higher among young people experiencing a first episode of psychosis, with evidence that use of the drug often predates the psychosis by several years. Use of very large doses can lead to a toxic psychosis that clears as the substance is eliminated from the body. Marijuana also may precipitate psychosis when used by people with schizophrenia whose symptoms are otherwise controlled with antipsychotic drugs. It does not appear to lead to psychosis in people without schizophrenia.

The main physiological effects of marijuana are mild (see Table 23-4). **Tolerance develops in heavy users, but no clear withdrawal pattern has been documented.** Marijuana has been reported to have medicinal benefits in alleviating glaucoma and the nausea and vomiting associated with chemotherapy used in cancer treatment. **Sixteen states and Washington, DC, have enacted laws legalizing medical marijuana.**

> **Critical Reasoning** Supporters of legalization of marijuana use say that the penalties for using it are too severe and that marijuana has medicinal effects. What is your position on the legalization of marijuana?

Hallucinogens. Drugs that create experiences very similar to those typical of a psychotic state have been called **hallucinogens,** although they usually produce **perceptual distortions,** not true hallucinations. They also have been called psychedelic or mind-revealing drugs. Lysergic acid diethylamide (LSD), peyote, mescaline, and psilocybin are commonly used hallucinogens.

LSD is usually swallowed. It is colorless and tasteless and is often added to a drink or food, such as a sugar cube. It may be given to a person without that person knowing. Pleasurable effects of hallucinogen use include intensification of sensory experiences. Colors are described as more brilliant, and sounds, smells, and tastes are heightened. Users of these drugs sometimes report synesthesia, or a crossover of sensory experiences during which music may be seen or colors may be heard. Space and time are distorted.

Hallucinogens do not appear to cause physical dependence, but tolerance develops if they are used regularly. Hallucinogens also can lead to self-destructive behavior because they cause impaired judgment. Vulnerable people who take these drugs may experience "bad trips," sometimes resulting in psychotic episodes. They may experience paranoid, grandiose, or somatic delusions, usually accompanied by vivid hallucinations. The hallucinatory experience may be pleasant or frightening.

Patients who are psychotic are not in contact with reality and often misinterpret environmental events. They may be unable to attend to any of their biological needs and may inadvertently hurt themselves or others in response to hallucinations or while trying to escape from the frightening experience.

Because no physical dependence develops, withdrawal symptoms do not occur. Usually, psychotic behavior decreases gradually, although the patient may have **flashbacks** for several months. These brief recurrences of the hallucinogenic experience can be frightening. Patients may express the fear that they are crazy and will never be free of the aftereffects of the drug.

> **Critical Reasoning** A college classmate who is not a nursing major tells you that she overheard her 12-year-old brother talking with a friend about "doing microdots." You suspect that he was talking about LSD. What would you advise her to do?

MDMA (Ecstasy). Ecstasy, which is taken in tablets or capsules, can induce euphoria, a sense of intimacy with others, and diminished anxiety. It is one of the most widely used recreational drugs in the world, commonly associated with dance

parties ("raves") and electronic dance music. Users usually report feeling the effects within 30 to 60 minutes after consumption, hitting a peak at approximately 1 to 1.5 hours, and reaching a plateau that lasts about 2 to 3 hours. In a few hours, the effects wear off and fatigue can result. Some studies have found that repeated recreational users of MDMA have increased rates of depression and anxiety, even after quitting the drug.

Phencyclidine (PCP). As a street drug, phencyclidine (PCP) may be ingested, but it is often smoked in a mixture with another substance, such as marijuana. Severity of symptoms is dose dependent. At low doses (less than 5 mg), the user experiences a euphoric, floating feeling, along with heightened emotionality and incoordination. Distorted perceptions, such as objects floating or growing in size, inability to judge distance, or feelings of being outside one's body, are common. At higher doses, PCP use may precipitate an intensely **psychotic experience** characterized by extreme agitation.

QUALITY AND SAFETY ALERT

- PCP users may become violent toward themselves or others.

Because the drug is an anesthetic, PCP-intoxicated people feel little or no pain. They may pound their heads into a wall or strike out violently, causing serious injury to themselves or others. Physical manifestations of PCP intoxication are listed in Table 23-4. PCP may cause or exacerbate a previously controlled psychosis. The unpredictability of the reaction to PCP makes it an extremely dangerous drug.

Inhalants. Approximately 1400 products are known that can be inhaled. The most common inhalants include butane (lighter fluid), gas, air fresheners, rubber cement, correction fluid, and nitrous oxide (whippets). **Children who abuse inhalants early in life are more likely to use illicit drugs later.** Children and adolescents choose inhalants as a means of obtaining a euphoric effect because of the quality of the high, the rapid onset of the effect, the low cost, and the ease of availability.

The nurse should be alert to the physical indicators of inhalant abuse when completing an assessment. Signs include residue from paint, glue, or substances observed on the clothes, hands, or face, especially around the nose. Youths may have symptoms of a cold, such as a runny nose, or pimples or sores around the mouth. These symptoms are caused by the abrasive effect of the chemicals on the skin. Nurses must take a leadership role in educating children and adults about the nature of inhalant abuse.

Critical Reasoning You are working as a nurse in a local high school in which a 15-year-old student recently died while inhaling butane. The principal approaches you requesting that students not be told that inhalants were involved in the death because it may "give other students ideas." How do you respond?

Nicotine. Nicotine is the active substance found in cigarettes, cigars, pipe tobacco, snuff, bidis (small brown cigarettes with up to seven times the nicotine of regular cigarettes), and kreteks (clove cigarettes that anesthetize the throat, promoting deeper inhalation). It is both a stimulant and a depressant.

Because smoke is a lung irritant, a person must learn how to inhale and must adjust to the body's natural rejection of this substance. Once inhaled, the nicotine in tobacco is readily absorbed into the bloodstream and has an almost immediate effect on the reward systems in the brain.

Nicotine mimics the neurotransmitter acetylcholine, binding to and activating a subset of receptors called the *nicotinic acetylcholine receptors*. Nicotine affects the brain in much the same way as cocaine, opiates, and amphetamines. It stimulates the release of dopamine and prolongs the actions of dopamine by decreasing the metabolizing enzyme monoamine oxidase and increases the expression of nitric oxide, which inhibits dopamine reuptake, and even more dopamine is available in the synapse.

Because the brain adjusts to the presence of nicotine, the individual who consumes this substance experiences **withdrawal** if the substance is discontinued. Because **smoking is associated with increased morbidity and mortality, it poses a serious public health problem.**

Caffeine. Caffeine is the active ingredient in coffee, tea, chocolate, and many carbonated beverages. Major effects of use are increased alertness and increased blood pressure. Overuse can cause jitteriness. Although caffeine increases alertness, it is not addictive. It does not affect the dopaminergic brain structures related to reward, motivation, and addiction as do the drugs of abuse and nicotine.

Heavy use of caffeine can lead to withdrawal symptoms, a sign of physical dependence. Symptoms include headache, irritability, sleepiness, fatigue, problems in attention and concentration, and decreased vigor. They are usually transient and mild, with relatively little interference in a person's daily life. However, the presence of these withdrawal symptoms may be the main factor for the continued use of the substance.

Date Rape Drugs. Date rape drugs include flunitrazepam (Rohypnol, "roofies"), γ-hydroxybutyric acid (GHB), and ketamine. These drugs are powerful and can be slipped into a drink without being detected because they have no color, smell, or taste. Potential effects include weakness, confusion, loss of consciousness, coma, and death. They are often used to assist in a sexual assault. Rohypnol is not legal in the United States and is brought into the country illegally. Ketamine is legally used in the United States as an anesthetic for humans and animals. GHB is legal in the United States to treat problems from narcolepsy.

Codependence. The term *codependency* originally referred to people who had problems as a result of living in a committed relationship with a person with alcoholism. It was said that the person with alcoholism was addicted to the bottle

and the codependent was addicted to the person with alcoholism. The major focus was on the spouse of the person with alcoholism.

Al-Anon, a support group for friends and family of people with alcoholism, was created specifically to help family members cope with their own problems that stem from living with a person with alcoholism. This includes the lasting effects of growing up in an alcoholic home.

Adult children of alcoholics (ACOA) are believed to share certain characteristics as adults because they all struggled to survive the chaos of growing up with an alcoholic parent, including the following:

- Overinvolvement with a dysfunctional person
- Obsessive attempts to control the dysfunctional person's behavior
- A strong need for approval from others
- Constantly making personal sacrifices to help the dysfunctional person become "cured" of the problem behavior
- Enabling behavior, which inadvertently reinforces the drinking of the alcoholic person

The term *codependency* has broadened to include almost anyone who has had anything to do with a dysfunctional person while growing up or as an adult. However, the concept of codependency is still poorly researched, and the nurse should be cautious before referring to anyone as codependent.

The positive aspect of this movement is that it may allow many people who are unhappy with themselves to reframe their life situation and improve their functioning in very significant ways, with or without formal counseling. Many people who otherwise would never have recognized their own dysfunction identify with the characteristics of codependency and are motivated to seek counseling and self-help groups.

The many ACOA and codependency self-help groups are based on the 12-step recovery program of Alcoholics Anonymous (AA). Dozens of self-help books have been published by people who self-identify with the concept and who offer recommendations about how to recover from it. Clinicians also have developed specific recovery programs for codependents. The negative side of the movement is that some people use the label to blame problems on current or past relationships without taking responsibility for their own part in the process.

Despite the popularity of this movement, no evidence has been found to support the existence of a specific clinical syndrome for ACOA. Several studies have shown that adults raised in alcoholic homes share many characteristics with adults raised in nonalcoholic but otherwise seriously dysfunctional homes. Symptoms of adults raised in dysfunctional alcoholic or nonalcoholic homes vary from none to severe. The environment, family system, and individual must be assessed when working with ACOA.

Whether a clearly identifiable and unique syndrome exists or not, it is easy to understand how children who grow up in alcoholic homes can develop low self-esteem. As an adult, it is often expressed in a preoccupation with the lives, feelings, and problems of others. Although codependents want their loved ones to stop drinking or using drugs, their behavior may have the opposite effect and enable the person to continue drug or alcohol use.

The nurse may observe some of these behaviors in family members of substance-dependent patients, in the patients themselves, or in nurses and other professionals. Simple questions asked of family members about efforts they have made to try to control the addicted person's use may uncover the pattern. Questions asked of patients about their relationships with others may indicate that growing up in an alcoholic home may have contributed to their own substance abuse problem.

Dual Diagnosis

A patient may have a substance use disorder, a psychiatric disorder, or both concurrently. **The co-occurrence of psychiatric and substance use disorders, or *dual diagnosis*, is common** for many reasons (Box 23-6). One disorder can precede and cause the other, such as when the person with alcoholism becomes severely depressed or when the person with depression uses alcohol to treat the depression.

It is often difficult to distinguish between the two disorders, especially early in the assessment process. To complicate matters further, substance abuse may cause psychiatric symptoms, such as hallucinations or paranoia, even though the person has no separate psychiatric diagnosis.

Even though effective treatments are available, patients with a dual diagnosis are not receiving appropriate comprehensive mental health and substance abuse treatments. Because substance use problems are so common among psychiatric patients, mental health clinicians should routinely assess all patients for these problems and use evidence-based treatments for the patient with dual diagnosis.

Detection of substance abuse in patients with psychiatric illness is most effective when multiple types of assessment are used. A combination of interview, screening tools, information from collateral sources, and laboratory tests, including urine drug screens, should be used.

BOX 23-6 RELATIONSHIPS BETWEEN SUBSTANCE USE AND PSYCHIATRIC DISORDERS

- Substances may be used to self-medicate the symptoms of the psychiatric disorder (e.g., alcohol may alleviate the distress associated with social anxiety or panic disorder).
- Substance use may be causing the psychiatric disorder (e.g., alcohol-induced depressive disorders, cocaine-induced psychotic disorders, stimulant-induced anxiety disorders).
- Substances may be used to counter the side effects of prescribed medications (e.g., stimulants or cocaine may counter the lethargy and sedation or the extrapyramidal side effects caused by some antipsychotic drugs).
- The individual may have a genetic predisposition to a substance use disorder and a psychiatric disorder.
- There may be no relationship between the substance use and the psychiatric disorders.

The nurse should be aware that psychiatric patients may be especially vulnerable to small amounts of substances. For example, even small amounts of cocaine may precipitate a psychotic episode in a patient with schizophrenia. The special problems posed by patients who are dually diagnosed can be seen in the next clinical example.

CLINICAL EXAMPLE

Robbie is a 25-year-old, single man who began using alcohol and drugs at age 16 years, around the time he dropped out of school. He continued to live with his mother and spent most of his time in his room, although there were long periods of time when she did not know where he was. His mother reported that he increasingly isolated himself and acted so strangely that others did not feel comfortable around him.

Over the next couple of years, Robbie's behavior became increasingly bizarre until one day his mother observed him pacing, talking to himself, saying strange and threatening things aloud, and pounding his fists together. She obtained an emergency petition, and the police took him to the emergency room for an evaluation. He was diagnosed with schizophrenia, stabilized with medication, and returned to his mother's home with an appointment for outpatient follow-up. However, he did not return to the clinic, stopped taking his medication, and was rehospitalized 1 month later. He was prescribed fluphenazine (Prolixin), and he promised to return to the clinic as scheduled in 2 weeks.

He seemed to do well for a few days until he resumed drinking and smoking marijuana. He disappeared for several weeks and then was found by his mother wandering the city streets, dirty, unkempt, reeking of alcohol, and talking to himself. During the subsequent rehospitalization, he admitted to using cocaine and heroin occasionally. He was referred to AA and assigned to a social worker, who helped him obtain social services.

He began getting a disability check every month, which exacerbated his problems. Every month, he cashed his check as soon as he got it and went on a binge of drug and alcohol use until his money was gone, usually in about 1 week. Unable to afford such heavy use for the remainder of the month, Robbie approached people on the streets and demanded money. Eventually, he was picked up by the police for aggressive panhandling. By the time he was 24 years old, Robbie was well known by the police and emergency rooms in town. He had been hospitalized at least a dozen times and arrested for numerous petty crimes. His mother, doctor, and social worker were totally exasperated by his failure to comply. When the new Dual Diagnosis Clinic opened in the Mental Health Center, Robbie was one of the first referrals.

Predisposing Factors

Several etiological models have been proposed for substance abuse. Belief in a particular model influences the assessment and intervention. Awareness of the differences among these models helps the nurse understand why patients and other professionals hold many different views about substance use treatment. Much research has been conducted concerning the factors that predispose a person to becoming chemically dependent. These factors may be biological, psychological, or sociocultural.

Biological. **A key biological factor is the tendency of substance abuse to run in families.** More than one half of current drinkers have a family history of alcoholism. Most genetic research has focused on alcoholism, but the body of knowledge on the genetics of other drugs of abuse is growing. Much evidence from adoption, twin, and animal studies indicates that heredity is significant in the development of alcoholism.

Research has identified subtypes of alcoholism that differ in heritability. One type of alcoholism is associated with an early onset, inability to abstain, and an antisocial personality. This type appears to be limited to males and is primarily genetic in origin. Another type tends to be associated with onset after age 25 years, inability to stop drinking once started, and a passive-dependent personality. This type seems to be influenced much more by the environment. However, controversy in the field has caused some to question whether these subtypes actually exist and, if so, what the precise nature of their characteristics is.

The discovery that the *A1* allele of the dopamine D_2 receptor *(DRD2)* gene appeared to be associated with alcoholism and other substance abuse disorders gave rise to much genetic research. It is theorized that genetic abnormalities may block feelings of well-being. This results in a tendency to develop anxiety, anger, low self-esteem, and other negative feelings, as well as a craving for a substance that will counter the bad feelings. People with such a disorder need alcohol or some other psychoactive drug just to feel normal.

These genetic findings are still preliminary and are only one of many predisposing factors for substance abuse (Dong et al, 2011). It is important to understand that a larger role appears to be played by environmental factors and still unidentified genes.

Critical Reasoning If genetic factors are clearly identified as major influences on the development of alcoholism in some people, what ethical issues are likely to be debated?

Biological differences in the response to alcohol ingestion also may influence susceptibility. For example, some Asian people experience a physiological response to alcohol, including flushing, tachycardia, and an intense feeling of discomfort. This appears to be related to the tendency for Asians to have a genetically inactive form of the enzyme aldehyde dehydrogenase. This leads to a buildup of the toxic substance acetaldehyde, an alcohol metabolite, which causes the symptoms.

Psychological. Many psychological theories have attempted to explain the factors that predispose people to developing substance abuse. Behavior or learning theories view addictive behaviors as overlearned, maladaptive habits that can be examined and changed in the same way as other habits. Cognitive theories suggest that addiction is based on a distorted way of

thinking about substance use. Family system theory emphasizes the pattern of relationships among family members through the generations as an explanation for substance abuse.

Clinicians have observed a link between substance abuse and several psychological traits, such as depression, anxiety, antisocial personality, and dependent personality. Little evidence has been found to show that these psychological problems existed before or caused substance abuse. It is just as likely that they resulted from drug and alcohol use and dependence. Other studies have tried but failed to find common personality traits among people addicted to alcohol or drugs. Studies show a wide variety of personality types among people with alcoholism.

Another theory of substance abuse focuses on the human tendency to seek pleasure and avoid pain or stress. Drugs create pleasure and reduce physical or psychological pain. Because pain returns when the effect of the drug wears off, the person is powerfully attracted to repeated drug use. It has been suggested that some people are more sensitive to the euphoric effects of drugs and are more likely to repeat their use. This repeated drug use leads to more problems and initiates the downhill spiral of substance use.

Some substance abusers have psychological problems related to adverse childhood experiences and parental alcohol abuse. Many have histories of childhood physical or sexual abuse. Most have low self-esteem and difficulty expressing emotions. These problems may have influenced the initial use of drugs and the progression to dependence.

Sociocultural. Several sociocultural factors influence a person's choice of whether to use drugs, which drugs to use, and how much to use. Attitudes, values, norms, and sanctions differ according to nationality, religion, gender, family background, and social environment. Assessment of these factors is necessary to understand the whole person. Combinations of factors may make a person more susceptible to drug abuse and interfere with recovery.

Nationality and ethnicity influence alcohol use patterns. For example, northern Europeans have higher alcoholism rates than southern Europeans. Values may influence the way in which addiction is viewed. Some believe that addiction results from moral weakness or lack of willpower. Unfortunately, a moralistic approach may cause the person to feel guilty, often resulting in drinking to alleviate the guilt.

Formal religious beliefs also can affect drinking behavior. Members of religions that discourage the use of alcohol have much lower rates of alcohol use and alcoholism than members of those that accept or encourage its use. Of the major religious groups in the United States, Roman Catholics have the highest rate of alcoholism and Jews the lowest. During assessment, however, the nurse should not assume certain use or nonuse patterns related to ethnic or religious factors.

Gender differences are observed in the prevalence of substance abuse. Cultural factors shape substance-using behaviors. Alcoholism in females is much less accepted by society, which is one reason this abuse problem is often hidden, even though it has been increasing. Women tend to deny having a drinking problem even longer than men do. In the United States, more women than men abuse prescription drugs, such as benzodiazepines. This is more socially acceptable and sometimes even encouraged. In contrast, use of antianxiety drugs is viewed as weak and unmasculine behavior in men, whereas the ability to drink large amounts of alcohol is considered manly.

Sociocultural factors also influence drug use, abuse, and treatment. Chronic stress and trauma may predispose or unmask vulnerability to substance use disorders, psychiatric disorders, or both. Multiple social crises can contribute to the risk for drug abuse in poor neighborhoods. Affordable and decent housing and shelter are difficult to find. Job opportunities are limited, and many jobs are low paying. Social programs often inadvertently foster development of single-parent families. The dropout rate in inner-city schools is high, and advanced education is difficult to obtain.

Living in neighborhoods dominated by these problems—along with poor health care access, crime, and violence—creates vulnerability to the escape some people find in drugs and alcohol. However, it is important to recognize that most people living in these circumstances are not addicted to drugs, which supports the belief that many factors influence the development of drug use patterns, not just the social environment.

> **Critical Reasoning** What sociocultural factors have you observed that encourage the use of drugs and alcohol?

Precipitating Stressors

Withdrawal. If a person becomes physically dependent on a substance, substance abuse may continue simply to avoid withdrawal symptoms. The person may no longer get much effect from the substance other than its ability to prevent withdrawal. Symptoms of withdrawal from specific drugs of abuse are listed in Table 23-4. **The emergence of withdrawal symptoms and cravings together serves as powerful precipitating stressors for continued drug use.**

General depressant drug withdrawal. Withdrawal from all depressant drugs (including alcohol) is similar and sometimes is referred to as the **general depressant withdrawal syndrome.** The main differences are as follows:

- ***Time course* of symptoms depends on the half-life of the particular drug.**
- ***Severity* of symptoms depends on the drug dose and length of use.**

For example, substances with short half-lives, such as alcohol and the short-acting benzodiazepines and barbiturates, lead to earlier appearance of withdrawal symptoms and a shorter withdrawal syndrome. The shorter-acting drugs are considered to be more addictive because the effect is felt quicker. However, these drugs also leave the system more quickly, increasing the chance of withdrawal.

Prescribed depressants and sedative-hypnotics withdrawal. The use of depressants at higher-than-therapeutic doses for more than 1 month can produce physical dependence

and can result in a *high-dose withdrawal syndrome*. Symptoms may peak within 24 hours for the short-acting drugs but take as long as 8 days for long-acting ones.

Patients who have taken regular, therapeutic doses of sedative-hypnotics for at least 4 months (or less with higher doses) may experience a *low-dose withdrawal syndrome* when the dosage is decreased or discontinued. These effects may be caused by an intensified return of the symptoms for which the drug was prescribed in the first place, a phenomenon called ***symptom rebound.*** Although many patients have no symptoms or only mild symptoms after cessation of therapeutic doses, a few may experience a more severe syndrome.

Alcohol withdrawal. When a large amount of alcohol is ingested, unpleasant symptoms usually occur. If overindulgence is short lived, symptoms are caused by the direct effect of alcohol on body cells. This results in headache and stomach and intestinal distress—the typical hangover. However, if heavy drinking occurs over a long time, a decrease in blood alcohol level may cause symptoms of withdrawal. Alcohol sedates the CNS. When alcohol is withdrawn, the symptoms resemble a rebound reaction in the CNS. Figure 23-2 presents information on the alcohol withdrawal syndrome.

Neurobiology. Most abused drugs interact with specific nerve cell receptors, imitating or blocking the actions of normally working neurotransmitters in the brain. Heroin and other opiates, for example, activate opioid receptors that normally respond to the brain's natural opioid-like neurotransmitters (e.g., endorphin, enkephalin, dynorphin).

Alcohol activates some receptors (e.g., the neurotransmitter γ-aminobutyric acid [GABA]) and blocks others (e.g., the neurotransmitter glutamate). In contrast, cocaine and other stimulants block the reuptake of various neurotransmitters, including dopamine, serotonin, and norepinephrine, and prolong the action of these brain chemicals on target cells.

Other aspects of neurobiology account for the reinforcing and addicting aspects of drugs of abuse. The mesolimbic dopamine system is a pathway in the brain that originates from dopamine-producing cells in the brainstem and targets higher regions of the brain (see Chapter 5). This brain pathway regulates natural drives, such as the desire for food, drink, and sex. Taking drugs of abuse repeatedly produces long-lasting changes in these areas of the brain, leading to the negative feelings during withdrawal and strong drug cravings. It also produces cognitive changes, making the risk of relapse over many years, even a lifetime, quite high.

Most drugs also inhibit the cyclic adenosine monophosphate (cAMP) pathway, which is an intracellular messenger system. Cyclic AMP is one of the chemicals within target cells that can be activated or inhibited when a neurotransmitter locks onto a receptor. Most drugs of abuse inhibit the cAMP response, and this is thought to contribute to the reinforcing actions of the drugs.

As the person continues to use drugs, the brain cells try to compensate for the lack of cAMP by making more cAMP and other molecules involved with its action. This leads to drug tolerance. Because of changes in gene expression, the brain cells continue to overproduce cAMP, which leads to withdrawal symptoms, such as dysphoria and lack of motivation. These unpleasant feelings are countered by taking more drug, leading to drug dependence.

With chronic drug exposure, certain other nerve cells become more excitable, making the drug user more sensitive to the drugs or to conditioned cues associated with drug

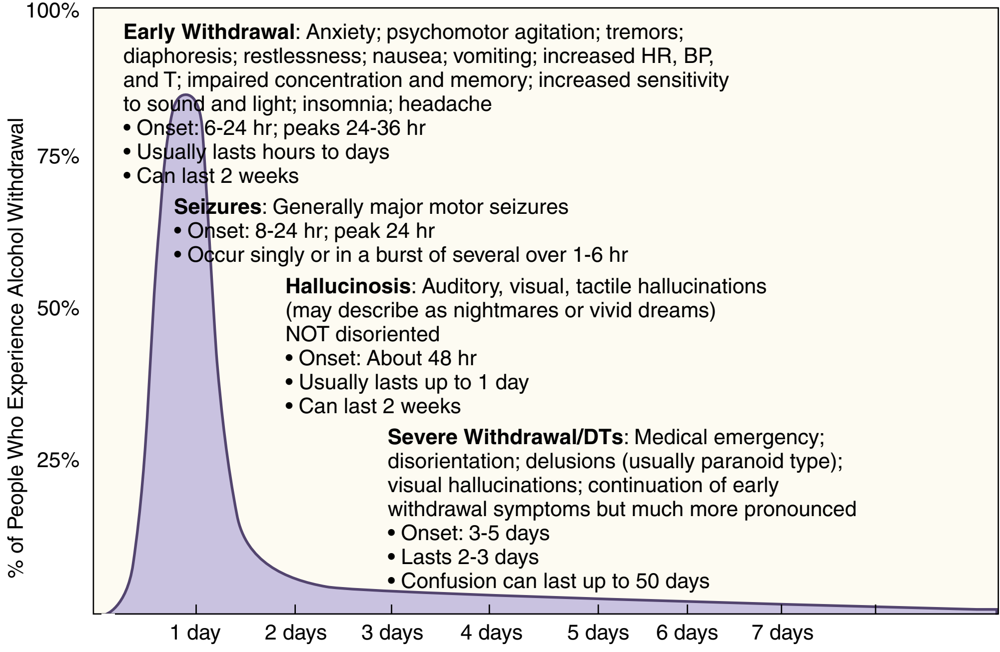

FIG 23-2 Alcohol withdrawal syndrome. *BP,* Blood pressure; *HR,* heart rate; *T,* temperature.

exposure or even to stress. Sensitization is thought to be a powerful factor in drug relapse and a powerful precipitating stressor for the continued use of drugs.

Appraisal of Stressors

The reasons a person initiates use of substances vary widely. Curiosity, peer pressure, and the desires to be grown up, rebel against authority, ease the pains of living, and feel good all are stressors and may apply. If use of the substance brings about the desired effects, use is likely to continue.

As the amount and frequency of substance use increase, so do the perceived stressors, which lead to more use. If substance use becomes associated with relief from emotional and social pain in the person's mind, the stressors will lead to more substance use. Perceiving the substance as the answer to these problems, the person fails to develop healthier coping mechanisms. Gradually, it takes more of the substance to get the same effect.

Coping Resources

Comprehensive assessment of a patient with a substance abuse problem must include assessment of the personal, social, and material assets available to the person. Assessment of motivation and social supports is particularly important.

- **What is the patient's motivation to change the substance use pattern?** The patient may be sick and tired of being sick and tired or may have been ordered to complete a treatment program after receiving a DUI charge.
- **What social supports does the patient have?** Family, friends, and co-workers may be available for support, or the patient may be homeless and have no family or friends.
- **What is the status of the patient's health?** The health status may be perfect, or the patient may have hepatitis, AIDS, or other complications of abuse.
- **What social skills does the patient have?** Some patients are very adept in social interactions, and some are withdrawn, quiet, and isolated.

Patients may not have developed problem-solving skills in other areas of their lives. They may not have other social, material, and economic assets to support recovery. They may not have intellectual skills and personality traits that contribute to positive change.

Coping Mechanisms

Although the patient may have used substances in response to certain stressors, the substance use may have escalated to the point at which it has become an additional stressor. Patients who use problem-focused coping mechanisms will take responsibility for the substance use problem and find ways to change or seek help in doing so. These are constructive coping mechanisms.

Patients also may use destructive coping mechanisms, such as when they change the meaning of the substance abuse problem so that it becomes a nonproblem, saying that there is no problem ("It's just the thing to do.") or devaluing a desired object ("I didn't want that job anyway."). Patients also may try to decrease emotional stress by several means:

- **Minimization** of the extent of use ("I only had a couple of beers.") or the consequences of use ("We don't fight about it too much.")
- **Denial** ("I don't have a problem. I can quit anytime I want.")
- **Projection** ("Tom's the one who can't deal with his family or hold his liquor.")
- **Rationalization** ("If you had the problems I have, you'd drink too.")

It is impossible in the initial assessment to sort out the facts from the distortions caused by these coping mechanisms. This is one reason why assessment is an ongoing process. Information from collateral sources and continued observation of behavior over time are essential.

DIAGNOSIS

Nursing Diagnoses

After completion of the nursing assessment, the nurse synthesizes the data regarding the patient's drinking or drug use behavior. Using the Stuart Stress Adaptation Model (Figure 23-3) and the NANDA International (NANDA-I) classification system, appropriate nursing diagnoses are identified.

Addiction problems are very complex. They affect almost every aspect of the patient's functioning. The nurse should be sure that the nursing diagnoses selected reflect the whole person.

Nursing diagnoses related to chemically mediated responses are listed in Table 23-5. **The primary NANDA-I diagnoses include acute confusion, ineffective coping, and dysfunctional family processes: alcoholism.**

Medical Diagnoses

Disorders that are related to substance abuse are included in *DSM-IV-TR* (American Psychiatric Association, 2000) in two ways. First, **diagnoses that are primarily related to alcohol or drug use are categorized as substance-related disorders.** A patient with a substance-related disorder who is also diagnosed with another Axis I psychiatric disorder is considered to be **dually diagnosed. Medical terms are presented in Table 23-5.**

Second, if substance-induced intoxication or withdrawal is associated with another type of mental disorder, the diagnosis is located in the substance-induced category. For example, if a person were depressed related to alcohol withdrawal, the medical diagnosis would be substance-induced (withdrawal) mood disorder. The categories that include substance-induced diagnoses are delirium, dementia, amnesic, psychotic, mood, anxiety, sex, and sleep.

> **Critical Reasoning** How would you respond to a patient who prefers street drugs to prescribed medication because of the side effects of the medication?

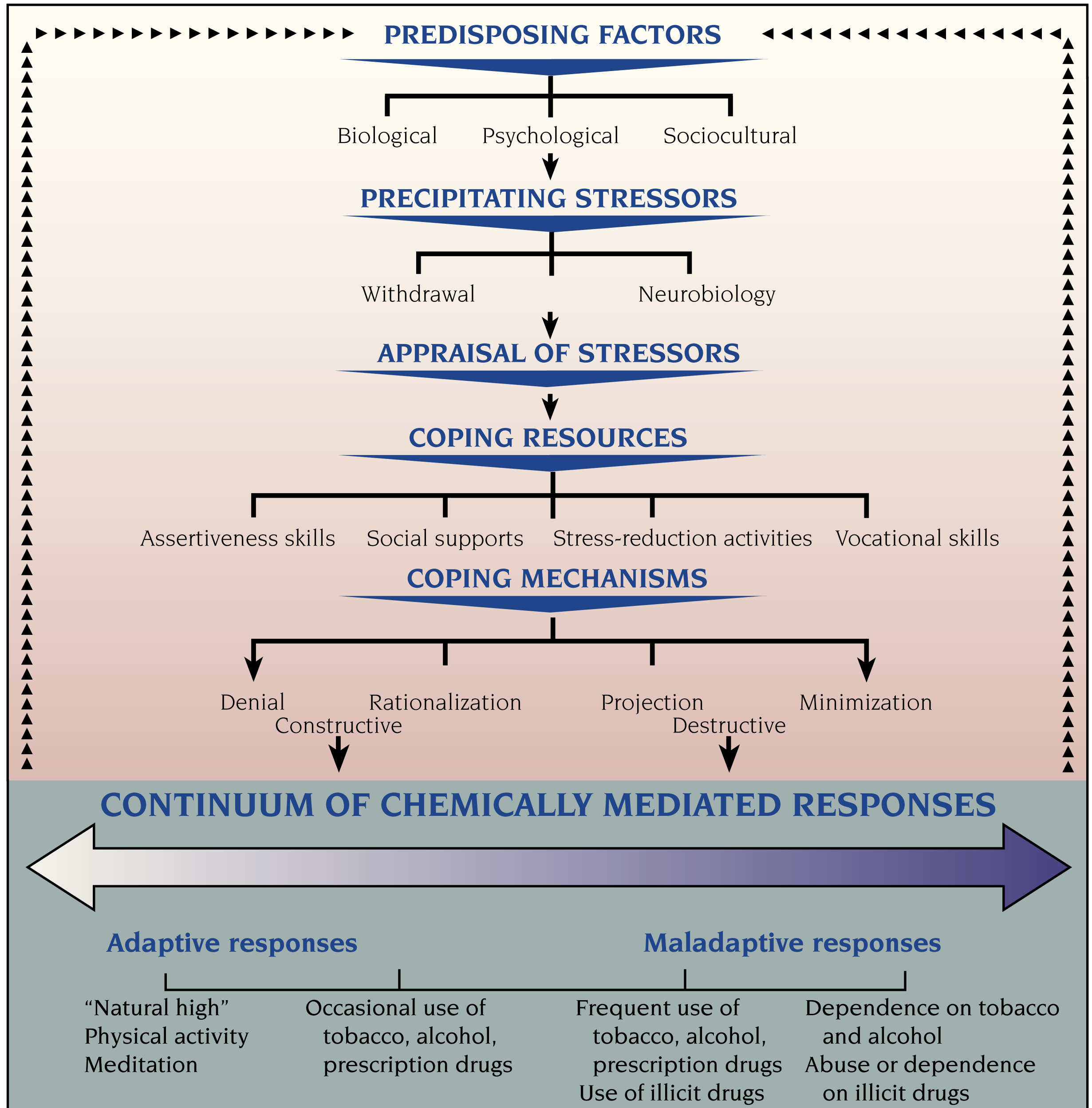

FIG 23-3 The Stuart Stress Adaptation Model as related to substance abuse.

OUTCOMES IDENTIFICATION

The **expected outcome** for patients in **withdrawal from drugs or alcohol** is as follows: ***The patient will overcome withdrawal safely and with minimal discomfort.***

Short-term goals related to this phase of recovery may include the following:

- The patient will withdraw from dependence on the abused substance.
- The patient will be oriented to time, place, person, and situation.
- The patient will report symptoms of withdrawal.
- The patient will correctly interpret environmental stimuli.
- The patient will recognize and talk about hallucinations or delusions.

The **expected outcome** for patients **dependent on drugs or alcohol** is as follows: ***The patient will abstain from all mood-altering chemicals.***

Studies have shown that most people who are dependent on a drug or alcohol cannot safely return to any level of use of any addictive drug. If they do, most eventually return to their old addictive patterns. However, patients often become very anxious at the thought of never again using the substance to which they are addicted, and it may be helpful to focus on short-term goals. Short-term goals related to abstinence may include the following:

- The patient will agree to remain drug and alcohol free for 1 week, with the agreement to be renewed weekly.
- The patient will make a daily commitment to abstain.

TABLE 23-5 NURSING DIAGNOSES AND MEDICAL TERMS RELATED TO *Chemically Mediated Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Acute confusion	Acute confusion related to alcohol withdrawal, as evidenced by disorientation to time, person, and place
Ineffective coping	Ineffective coping related to cocaine abuse of 6 months' duration, as evidenced by loss of job and lack of personal goals
Dysfunctional family processes: alcoholism	Dysfunctional family processes related to alcoholism, as evidenced by marital conflict and avoidance of the family and home by the children
MEDICAL TERM	**DEFINITION***
Substance dependence	A pattern of behavioral, physiologic, and cognitive symptoms that develop due to substance use or abuse; usually indicated by tolerance to the effects of the substance and withdrawal symptoms that develop when use of the substance is terminated.
Substance abuse	The excessive use of a substance, especially alcohol or a drug. A pattern of harmful use of any substance for mood-altering purposes.

Nursing Diagnoses–Definitions and Classification 2012-2014. Copyright © 2012, 1994-2012 by NANDA International. Used by arrangement with Blackwell Publishing Limited, a company of John wiley & Sons,Inc.
*Sources: http://dictionary.webmd.com/terms/substance-dependence; http://www.samhsa.gov/.

- The patient will attend at least two support group meetings weekly.
- The patient will contact a supportive person if experiencing an urge to use an addictive substance.

Development of a support system is an essential aspect of care for drug-dependent patients. After abstinence and support system goals are established, attention can turn to learning about dependence and recovery and to developing alternative coping skills.

Goals related to the person's job, relationships, or education should be deferred until later unless any are roadblocks to recovery. For instance, a person is usually encouraged to focus on self and not on a relationship. However, if the person's spouse abuses alcohol and violence in the home is common, the priority shifts to finding a safe place to live.

Goals should be worded so that it is clear that the patient is responsible for behavior. Addicted patients often want others to do the work for them. Writing the goals and a specific plan of action into a contract and providing the patient with a copy of the contract can reinforce the patient's responsibility. The contract should be signed by both nurse and patient.

PLANNING

Long-range goals of treatment for patients with substance use disorders include the following:

- **Abstinence or reduction in the use and effects of substances**
- **Reduction in the frequency and severity of relapse**
- **Improvement in psychological and social functioning**

Priority must be given to the most immediate needs. Plans must be made in collaboration with the patient, considering the overall assessment and the patient's current life situation and desires. Family members and supportive friends should be included in the planning process. This approach helps them understand the problems that the patient may encounter as recovery continues.

QUALITY AND SAFETY ALERT

- For patients who are experiencing drug withdrawal, the highest priority is given to patient safety.
- This involves stabilizing the patient's physiological status until the crisis of withdrawal has subsided.
- After safety needs are met, abstinence and support system issues must be addressed.

The nurse should be aware that it is rare for an addicted person to suddenly stop substance use forever. Most addicted people try at least once and usually several times to use the substance in a controlled way. It is important for them to know that they should return to treatment after these relapses. They can learn from what they did and try to prevent further relapses. These issues should be addressed openly in the planning process.

The following aspects of care should be included in treatment planning (Department of Veterans Affairs, 2009):

- **Motivating change**
- **Establishing a therapeutic alliance**
- **Assessing safety and clinical status**
- **Managing intoxication**
- **Managing withdrawal**
- **Reducing morbidity and sequelae of substance use disorders**
- **Facilitating adherence to the treatment plan**
- **Maintaining abstinence and preventing relapse**
- **Providing education about substance use disorders and their treatment**
- **Facilitating access to social, medical, mental health, and other needed services**

IMPLEMENTATION

The nurse cares for patients with substance use problems in all health care settings. The types of interventions

recommended depend largely on the setting in which the nurse works. When caring for a patient outside addiction treatment programs, the nurse should refer the person to treatment.

If a patient has a history of seizures or serious withdrawal symptoms or is at risk for developing symptoms because of a heavy, chronic use pattern, the first referral should be to a detoxification program. Otherwise, referral should be to the program that appears to match the patient's level of severity. **It is important for the nurse to know local resources for treatment; one resource for finding treatment options is http://findtreatment.samhsa.gov/.**

Substance abusers often come into contact with the health care system because of a physiological crisis. It may be related to overdose, withdrawal, allergy, or toxicity. The nurse may notice physical deterioration caused by the damaging effects of drugs, including conditions such as malnutrition, dehydration, and infections (e.g., HIV).

When an acute physical condition is present, it takes priority over the other health needs of the patient. It is particularly important to attend to the condition that the patient has identified as the problem. The nurse is then seen as potentially helpful and will have more credibility when other aspects of the addiction are addressed.

Empirically validated treatments for substance use disorders are summarized in Table 23-6 (Nathan and Gorman, 2007).

Intervening in Withdrawal

Interventions depend on the current and potential withdrawal symptoms that the patient may experience:

- Withdrawal from the **general depressants and opiates** is usually treated by substitution with a longer-acting drug in the same class, which is then gradually tapered.
- Withdrawal from **opiates and amphetamines** can be extremely uncomfortable but usually not dangerous, although a patient may become suicidal during the acute phase of cocaine withdrawal.
- Symptom-specific medications may be used to treat symptoms of **stimulant withdrawal.**
- Phenobarbital may be prescribed for **inhalant withdrawal** symptoms.
- No acute withdrawal pattern associated with marijuana, hallucinogens, or PCP has been identified.

QUALITY AND SAFETY ALERT

- Substances with potentially life-threatening courses of withdrawal include alcohol, benzodiazepines, and barbiturates.
- The possibility of seizures should always be anticipated.

Withdrawal symptoms may occur despite efforts to prevent them. People who abuse substances do not always give accurate drug use histories, although it is extremely important to obtain as specific an assessment as possible. If the amount of substance used has been understated or if multiple abuse is undetected, withdrawal symptoms may occur unexpectedly.

Drug abuse should always be considered when unexpected seizures occur. If drug abuse is suspected, the physician should be informed so that blood and urine specimens can be collected for laboratory analysis and an appropriate treatment plan initiated.

The process of helping a person with an addiction safely through withdrawal is called **detoxification.** The liver detoxifies the substance. Medications and nursing actions only help to relieve the symptoms. Detoxification is best accomplished in a setting in which there can be close monitoring of the patient. This can be an inpatient or outpatient medical or psychiatric unit or a crisis stabilization unit.

It is best to provide a quiet, calm environment for patients experiencing the general depressant withdrawal syndrome. This helps the patient relax and decreases nervous system irritability. Reassurance can be given in a calm, quiet tone of voice. To help maintain the patient's orientation, the nurse should place a clock within sight and give frequent, low-key reminders

TABLE 23-6 SUMMARY OF EVIDENCE-BASED TREATMENT FOR *Chemically Mediated Responses*

SUBSTANCE USE DISORDER	TREATMENT
Nicotine	The use of nicotine replacement therapy to induce and maintain smoking cessation significantly increases nicotine abstinence.
Alcohol	The treatment of alcoholism is enhanced by the opiate antagonist naltrexone, which reduces alcohol reward and results in decreased alcohol craving and reduced drinking.
Heroin	Methadone maintenance treatment for heroin dependence is effective. The partial opiate agonist buprenorphine has increased treatment options for heroin dependence.
General	Effective psychosocial treatment for the substance use disorders addresses not only drinking or drug use behavior but also patients' life contexts, sense of self-efficacy, and coping skills. Effective treatments include cognitive behavioral treatments, community reinforcement and contingency management approaches, 12-step facilitation and 12-step treatment, and behavioral couples and family treatment. Motivational interventions focus primarily on enhancing an individual's commitment to behavior change. Therapists who are interpersonally skilled, empathetic, and less confrontational produce better patient outcomes.

From Nathan P, Gorman J: *A guide to treatments that work,* ed 3, New York, 2007, Oxford University Press.

about who the patient is, where the patient is, the nurse's name, and the day of the week. If possible, another patient who is further along in detoxification may be assigned as a buddy so that the patient is not left alone. A family member also may help.

The patient in withdrawal should be treated symptomatically:

- Fluids should be encouraged only if the person is dehydrated.
- Eating should be encouraged, and vitamins are usually ordered.
- Acetaminophen (Tylenol) or attapulgite (Kaopectate), if ordered, may be given for discomfort or diarrhea.
- A small amount of milk may be offered frequently to help manage epigastric distress.
- Seizure precautions should be taken.
- A cool washcloth can be offered for the forehead if the patient is feeling warm or diaphoretic.
- Position changes, assistance with ambulation, and changing damp clothing are also indicated.

Evidence suggests that offering this type of intense, supportive care can reduce withdrawal symptoms rapidly and often dramatically without medications. If the patient is receiving large doses of benzodiazepines, the nurse should monitor for signs of toxicity, such as **ataxia** (difficulty walking) and **nystagmus** (involuntary rhythmic movement of the eyeball). The patient always should be treated with respect and dignity.

Management of Alcohol Withdrawal. The principles of **alcohol detoxification,** according to evidence-based practice guidelines, are as follows:

- The long-acting **benzodiazepines are the drugs of choice** in treating alcohol withdrawal because they effectively reduce signs and symptoms of withdrawal, prevent seizures, and have a better margin of safety than many other drugs. The dosing regimens recommended are listed in Box 23-7.
- A symptom-triggered dosing regimen is preferred over fixed-schedule dosing because it is effective, requires significantly less medication, and appears to prevent seizures as well as fixed schemes.
- The use of a clinically valid and reliable withdrawal assessment tool, such as the Clinical Institute Withdrawal Assessment–Alcohol, Revised (CIWA-AR), is recommended as the basis for medication determinations. This reduces overmedication resulting from patient overreporting of symptoms or fixed regimens and undermedication resulting from staff reluctance to treat.
- A fixed schedule with as-needed (PRN) dosing may be indicated if used on a unit where the staff members have no training in the use of a withdrawal assessment tool.
- Although neither magnesium nor thiamine reduces seizures, administration of thiamine is recommended to prevent Wernicke disease and Wernicke-Korsakoff syndrome.

Symptoms of alcohol withdrawal do not always progress from mild to severe in a predictable manner. A grand mal seizure may be the first sign of acute withdrawal. However, initial assessment and ongoing monitoring with the CIWA-AR may be effective in preventing the onset of more severe symptoms. A score of 9 or less on the CIWA-AR indicates mild withdrawal, 10 to 18 indicates moderate withdrawal, and a score more than 18 indicates severe withdrawal.

The CIWA-AR should be used with caution in patients with co-occurring medical or psychiatric illnesses and in those with concurrent withdrawal from other drugs because it rates signs and symptoms that may be caused by conditions other than alcohol withdrawal. The assessment should be repeated every 1 to 2 hours. Increasing scores signify the need for additional medication according to a predetermined scale, whereas decreasing scores indicate a therapeutic response to the treatment regimen. Scores less than 10 do not usually require use of medication for treatment.

Some evidence indicates that symptom-triggered medication shortens the length of treatment and requires significantly less medication. There is also evidence that the use of the CIWA-AR as a basis for medication need results in significantly less medication being given with no reduction in efficacy.

Management of Benzodiazepines, Barbiturates, and Other Sedative-Hypnotics Withdrawal. Benzodiazepines, barbiturates, and other sedative-hypnotics are usually prescribed for therapeutic purposes, sometimes for long periods. When this occurs, development of physical dependence on the drug is sometimes unavoidable. As long as the drug is taken as prescribed, the physical dependence is not

BOX 23-7 MANAGEMENT OF ALCOHOL WITHDRAWAL

Monitor the patient every 4 to 8 hours with the CIWA-AR until the score has been less than 8 to 10 for 24 hours. Use additional assessments as needed.

Symptom-Triggered Regimen

Administer one of the following every hour when CIWA-AR scores are more than 8 to 10:
- Chlordiazepoxide, 50 to 100 mg
- Diazepam, 10 to 20 mg
- Lorazepam, 2 to 4 mg

Repeat CIWA-AR 1 hour after every dose to assess need for further medication.

Fixed-Schedule Regimen

Chlordiazepoxide, 50 mg every 6 hours for four doses, then 25 mg every 6 hours for eight doses

Diazepam, 10 mg every 6 hours for four doses, then 5 mg every 6 hours for eight doses

Lorazepam, 2 mg every 6 hours for four doses, then 1 mg every 6 hours for eight doses

Provide additional medication as needed when symptoms are not controlled (e.g. CIWA-AR result of more than 8 to 10) with the previous measures.

Other benzodiazepines may be used at equivalent doses.

CIWA-AR, Clinical Institute Withdrawal Assessment–Alcohol, Revised.

considered substance abuse, and the term ***detoxification*** should be replaced by the term ***therapeutic discontinuation.***

Heroin and stimulant users sometimes use these drugs as part of their drug abuse pattern. When individuals use the drug in a way other than prescribed, they obtain the drug by illegitimate means, or its use interferes with their lives, use can lead to dependence, which requires detoxification. Whether these drugs are used therapeutically or abused, abrupt cessation can lead to severe withdrawal and even death. Careful medical management is required.

High-dose withdrawal may be treated by a gradual reduction of the drug being used, or phenobarbital may be substituted during the detoxification process. The dosing regimen starts with the patient's average daily dose (as self-reported) of all sedative-hypnotic drugs, including alcohol. This dose is then converted to phenobarbital equivalents, and the daily amount is divided into three doses.

Before each dose, the nurse checks for signs of phenobarbital toxicity (e.g., sustained nystagmus, slurred speech, ataxia). Because nystagmus is the most reliable sign, if present, the dose is withheld. If all three signs are present, the next two doses of phenobarbital are withheld, and the daily dosage of phenobarbital for the following day is reduced by one half.

If the patient is in acute withdrawal and is at risk for withdrawal seizures, the first dose of phenobarbital is administered intramuscularly (IM). If nystagmus and other signs of intoxication develop 1 to 2 hours after IM dosing, the patient is in no immediate danger from barbiturate withdrawal. In this case, patients continue to receive the initial dosing schedule for 2 days. If the patient displays no signs of withdrawal or toxicity and does not have an unsteady gait, doses are decreased by 30 mg/day.

If toxicity develops, the daily dose is decreased by 50%, and the 30 mg/day withdrawal is continued from the reduced dose. If the patient has objective signs of withdrawal, the daily dose is increased by 50%, and the patient is restabilized before continuing withdrawal.

Low-dose withdrawal depends on the patient's symptoms. Seizures are uncommon unless the patient has an underlying seizure disorder, in which case anticonvulsants should be administered and other medications that lower the seizure threshold should be avoided. If symptoms are severe, 200 mg of phenobarbital is given per day initially and then slowly tapered over several months.

Management of Opiate Withdrawal. All opiates produce similar withdrawal signs and symptoms, but the time of onset and the duration vary. Treatment is aimed at alleviating the acute symptoms. This may be done by substitution with the long-acting opiate methadone or the partial opiate agonist buprenorphine or by management of the withdrawal symptoms with medications such as clonidine.

- **Methadone** substitution involves initial administration of methadone—an opiate agonist—to stabilize symptoms of heroin withdrawal, usually 10 to 40 mg in the first 24 hours. After the patient is stabilized, the dose can be slowly tapered to zero. Tapering by 5 mg/day is common, but slower tapering may be more comfortable for the patient. The detoxification of patients from longer-acting opioids, such as methadone, requires an even longer period of time.
- **Buprenorphine**-aided opiate withdrawal is initiated after the patient begins showing symptoms of withdrawal. This is necessary because buprenorphine is a partial opiate agonist (partially stimulates the receptor) and may induce significant withdrawal symptoms if other full agonist (completely activate the receptor) opiates are present. Buprenorphine is then titrated to meet the individual's symptoms and gradually tapered over 3 to 5 days.
- **Clonidine** is available in oral, sublingual, or transdermal patch preparations. The protocol for clonidine administration usually involves 0.1 to 0.3 mg in three divided doses on the first day (perhaps higher doses for inpatients who can be closely monitored). The dose is then adjusted until withdrawal symptoms are reduced. The blood pressure should initially be checked every 45 minutes, because some patients are extremely sensitive to clonidine and experience profound hypotension, even at low doses. If the blood pressure drops below 90/60 mm Hg, the next dose should be withheld and subsequent doses adjusted according to patient response. Although clonidine effectively relieves several symptoms of opiate withdrawal, it is not helpful for muscle aches, insomnia, and drug craving, which require additional medication.

Just as the CIWA-AR is useful in rating alcohol withdrawal, the Clinical Institute Narcotic Assessment (CINA) rating scale may be helpful in the assessment and monitoring of opiate withdrawal.

Management of Nicotine Withdrawal

Nicotine gum and the nicotine patch. Nicotine gum and the nicotine patch are nicotine replacement strategies. They allow nicotine to be delivered into the body without the carcinogens and carbon monoxide present in cigarettes. They relieve withdrawal symptoms and allow tapering of the dose to zero over time. The optimal length of treatment before tapering is 4 to 6 weeks. Dosing is most effective at 2 to 4 mg/hr for the gum, which comes in 2- and 4-mg sticks. Patches are available in a 21- to 22-mg/24-hr patch and a 15-mg/16-hr patch (for use while awake). Less popular forms of nicotine are nasal sprays and inhalers.

Bupropion. Bupropion (Zyban) is a non-nicotine replacement therapy for treating nicotine dependence. Dosage should include 150 mg every morning for 3 days and then 150 mg twice daily. Treatment should begin 1 to 2 weeks before the initial quit date and should last for 8 to 12 weeks with 6 months of maintenance.

Varenicline. Varenicline (Chantix) is a non-nicotine replacement therapy that has been found to be more effective than bupropion. Dosage starts at 0.5 mg once each day and increases to 0.5 mg twice daily after 3 days and 1 mg twice daily after 7 days.

Management of Caffeine Withdrawal. Although not classified as a drug of abuse, caffeine has a well-defined physical withdrawal syndrome. Symptoms are relieved with caffeine. There is no published regimen of caffeine administration for the purpose of relieving withdrawal. The recommendation is to gradually decrease caffeine intake over as much time as it takes to avoid most withdrawal symptoms.

Intervening in Toxic Psychosis. Users of LSD, PCP, and amphetamines often come to the emergency room in a state of acute toxic psychosis. Their behavior may be quite similar to that of the patient with schizophrenia. However, there may be no history of abnormal behavior.

Careful assessment of an acute psychotic reaction, particularly in an adolescent or young adult, should include exploration of drug use. It may be necessary to interview friends of the patient to obtain this information. An attempt should be made to identify the specific drug used, although LSD and PCP may be taken without the knowledge of the person involved.

The nursing approach to users of PCP and amphetamines has one important difference compared with the approach to those who have an adverse reaction to LSD. Unless the psychiatric symptoms are severe, LSD users experiencing a "bad trip" often respond to reassurance and may be "talked down." Patients should be oriented frequently and discouraged from closing their eyes because this may make the symptoms worse.

People with PCP-induced psychosis do not respond well to attempts at interaction. **Agitated PCP and amphetamine users are more likely to become violent and strike out in response to their misperceptions and panic.** They are potentially harmful to themselves and others. This aggression may be totally unprovoked.

Because PCP is also an anesthetic, users feel little or no pain, and they seem to have enormous strength. They do not feel pain when they exceed the limits of their muscular capability and may continue pushing, pulling, or hitting until they seriously injure themselves or others.

BOX 23-8 A PATIENT SPEAKS

I have abused drugs and alcohol for many years. One thing that has been important is for nurses to spend time with me so I can learn to trust them. It helps when they make sure I schedule treatment appointments and keep them. Substance abuse education is very important, and it has to be repeated over and over.

I have been through detoxification many times. Some of the nurses in those programs have coddled me. This makes it easy for me to dance around issues of sobriety. I have had the best success with the nurse who will hang in there with me and not let me make excuses, get in my face, and cut me no slack. The nurses who have high expectations leave me enough room to help myself but not enough to be dishonest. There needs to be a balance of empathy and toughness. It is not easy, but that is the role for the nurse to establish.

Other aspects of treatment are basically the same for acutely agitated LSD and PCP users. **Both require a safe environment that has minimal stimulation.** Staff should not perform any procedures without a thorough explanation, should not touch the patient without permission, and should avoid rapid movements in the patient's presence. Adequate staff should be present to control impulsive behavior.

Vital signs should be monitored, and other physiological needs should be met. Although restraints may exacerbate muscle damage and agitation, they may be necessary, especially if a seclusion room is not available. **Benzodiazepines are the treatment of choice, followed by high-potency antipsychotic medications if benzodiazepines are ineffective.** Gastric lavage may be necessary for persistent symptoms or if an overdose has been taken, although this is not recommended for PCP users because it increases agitation.

Intervening to Maintain Abstinence

The immediate short-term goal of pharmacological treatment of substance abuse is the safety of the patient because many intoxication and withdrawal syndromes are potentially life threatening. After the individual is through the initial withdrawal phase, interventions to maintain abstinence can begin.

The first months after cessation of substance use represent the highest risk for relapse and the greatest opportunity for pharmacological interventions that can help patients decrease cravings and maintain abstinence. However, a limited number of drugs are available, and patients often stop taking them. The effects are often temporary unless the drugs are used as part of a broader program of psychosocial treatment.

The goals for the pharmacological maintenance of abstinence in substance abuse treatment are as follows (Center for Substance Abuse Treatment, 2009):

- **The individual:** either total abstinence or a reduction in drug consumption that will allow the person to function better in all facets of life, including educational, occupational, and family domains
- **The dually diagnosed person:** reduction of symptoms that are exacerbated by substance abuse and enhanced compliance with medications needed for the management of the psychiatric condition
- **Society:** reduction of crime, violence, family discord, the spread of HIV and other infectious diseases associated with intravenous drug use and other risky behaviors and other health complications associated with substance abuse

Each substance of abuse requires a different pharmacological approach in the maintenance phase of relapse prevention. No medications are approved for treating methamphetamine dependence.

Alcohol

Naltrexone. Naltrexone (ReVia) is an opiate antagonist effective in helping the alcoholic patient maintain abstinence. It diminishes craving during the early stages of abstinence

and works best when accompanied by psychosocial interventions. A long-acting injectable formulation, Vivitrol, is available, which may improve treatment adherence.

Alcohol intake increases the number of endorphins (naturally occurring opioids) in the brain. Naltrexone, in doses of approximately 50 mg/day, appears to block the effects of these endorphins, reducing the reinforcing effects of alcohol. Limitations of this medication include discontinuation from side effects (primarily nausea) and dose-dependent hepatotoxic effects, which are of particular concern because of the damaging effects of alcohol on the liver. Research suggests that the addition of the anticonvulsant gabapentin to naltrexone can be useful in preventing relapse (Anton et al, 2011).

Disulfiram. Disulfiram (Antabuse) interrupts the metabolism of alcohol, causing a buildup of a toxic substance in the body if the person uses alcohol in any form. The physiological response may include a severe headache, nausea and vomiting, flushing, hypotension, tachycardia, dyspnea, diaphoresis, chest pain, palpitations, dizziness, and confusion.

QUALITY AND SAFETY ALERT

- Antabuse taken with alcohol can lead to respiratory and cardiac collapse, unconsciousness, convulsions, and death.
- Antabuse should never be given without the patient's stated willingness to comply.

It is important that the patient agree to take Antabuse only after careful instruction about the potential consequences of drinking while taking the drug. This instruction should include a written list of alcohol-containing preparations to be avoided, including cough medicines, rubbing compounds, vinegar, aftershave lotions, and some mouthwashes.

Drinking must be avoided for 14 days after Antabuse has been discontinued. This medication cannot prevent someone who is determined to drink from drinking. The person can wait until the Antabuse has been excreted. However, it does help prevent impulsive drinking because the person has to wait for the Antabuse to clear the body to be able to drink safely. This treatment should be used in conjunction with other supportive therapies, not by itself.

Critical Reasoning Describe the information that should be provided to a patient who is to be treated with Antabuse. What issues related to informed consent should be considered in the use of this drug?

Nalmefene. Nalmefene (Revex) is an opioid antagonist that is structurally similar to naltrexone but with a number of pharmacological advances for the treatment of alcohol dependence. These include no dose-dependent association with toxic effects to the liver, greater oral bioavailability, longer duration of antagonist action, and more complete binding with opioid receptor subtypes that are thought to reinforce drinking. It has been found to be effective in preventing relapse to heavy drinking and has few side effects.

Acamprosate. Acamprosate (Campral, calcium acetylhomotaurine) is a synthetic compound, similar in chemical structure to GABA. It is used extensively in Europe and exerts agonist activity at the GABA receptors and antagonist (inhibitory) activity at the *N*-methyl-D-aspartate (NMDA) glutamate receptors. It has demonstrated increased abstinence through decreased alcohol craving.

Acamprosate has been shown to positively affect length of total abstinence, time to relapse, total number of nondrinking days, and retention in treatment. It is associated with few side effects (e.g., diarrhea, headache), and organ toxicity does not appear to be a problem. Because the drug is excreted by the kidneys, it must be used with caution in patients with renal insufficiency.

Citalopram. Citalopram (Celexa) is a selective serotonin reuptake inhibitor (SSRI) that augments central serotonergic function approved for the treatment of depression. It has been shown to decrease desire and the sense of liking alcohol.

Ondansetron. Ondansetron (Zofran) is a serotonin (5-HT_3) receptor antagonist that has been shown to reduce alcohol consumption and craving in patients with early-onset alcohol dependence.

Opiates. People with long-term opiate addiction who meet federal criteria for opiate dependence may be eligible for maintenance with methadone or L-α-acetylmethadol (LAAM). Patients in maintenance programs take stable doses of one of these substitute drugs for years—possibly for the remainder of their lives.

Patients must report to the clinic daily (for methadone) or every other day (for LAAM) to have their medication dispensed to them. Because these medications are Schedule II drugs, they can be distributed only in special clinics that are heavily government regulated, and often these clinics are excluded by local zoning laws. The result is a national shortage of treatment facilities.

These medications are controversial because they are narcotics. However, addiction to them does not cause impaired functioning; the person can be productive while being addicted. Those in favor of methadone or LAAM maintenance point out the benefits of avoiding the debilitating effects of heroin addiction and the lifestyle associated with obtaining illegal drugs on the streets.

L-α-Acetylmethadol. LAAM is a long-acting opiate agonist. LAAM has not been approved for take-home dosing, but if patients cannot get through the weekend free of withdrawal symptoms, they may be given a Sunday take-home dose of methadone.

Methadone. Methadone hydrochloride is a μ-opioid receptor agonist used for the treatment of opioid dependence. At adequate doses it can relieve symptoms of opioid withdrawal and craving for opioids and can block the effect of illicitly used opioids. It is well absorbed orally and has a long half-life and duration of action; once-daily dosing is usually sufficient.

> **Critical Reasoning** Methadone maintenance is essentially substituting a legal narcotic for an illegal one. Do you believe that this is a responsible practice? State the reasons for your position.

Buprenorphine. Buprenorphine (Subutex) is a partial rather than full agonist at opioid nerve receptors. It mimics the effects of opioids in some situations but blocks or reverses those effects in other situations by displacing opioids when they are present in excessive amounts.

Buprenorphine has several advantages over methadone and LAAM. It usually produces a less serious withdrawal reaction. Because it is less likely to cause respiratory arrest, the risk of an accidental or intentional overdose is lower. Another advantage is that it may be taken only three times per week instead of daily like methadone. Most important, buprenorphine can be administered in other settings besides formal narcotics treatment programs, allowing more people with addictions to receive treatment.

Cocaine

Vaccine in development. An exciting breakthrough in the field is the development of a cocaine vaccine that is designed to be part of a comprehensive approach to treating cocaine addiction. A therapeutic vaccine that induces anticocaine antibodies and prevents the drug from crossing the blood-brain barrier is being used in experimental animal trials with some success. It may prove to be a powerful tool for inhibiting the reinforcing activity of the drug.

Effects of Drug Use During Pregnancy

Because most of the drugs that are abused cross the placental barrier, women should be counseled about the possible effects of substance use during pregnancy. Congenital abnormalities and other negative outcomes have occurred in infants of mothers who have taken drugs. **Fetal alcohol syndrome** involves a pattern of mental and physical defects in a fetus in association with high levels of alcohol consumption during pregnancy.

> **QUALITY AND SAFETY ALERT**
>
> - Consumption of alcohol and drugs during pregnancy can result in miscarriage, low birth weight, premature labor, placental abruption, fetal death, and even maternal death.
> - Expectant mothers should be advised to avoid alcohol and illegal drugs.

During pregnancy, the use of drugs that cause physical dependence can result in the birth of an addicted baby who must be withdrawn from the drug. **The safest pregnancy is one in which the mother is totally drug and alcohol free.** The one exception is that for pregnant women addicted to heroin, methadone maintenance is safer for the fetus than acute opiate detoxification.

> **Critical Reasoning** Some policymakers have proposed that pregnant women who abuse substances should be jailed, placed under house arrest, or committed to a mental hospital until the baby is born. Do you agree with this? Support your position. Do you have the same opinion about all abused substances, including alcohol and nicotine?

Psychological Interventions

Medications alone are less effective in the treatment of drug and alcohol dependence. Most patients have optimal benefit with a comprehensive treatment program that includes the addition of psychological, behavioral, social, and spiritual treatments.

Before intervening with a substance-abusing patient, the nurse must develop self-awareness of feelings and attitudes about the problem (Box 23-9). It is recommended that a value clarification approach be used, as described in Chapter 2.

Most people have had personal contact with substance abuse through family, friends, or colleagues. This may create negative feelings and attitudes. It is important that the nurse

> **BOX 23-9 A FAMILY SPEAKS**
>
> When I met Jim in 1993, I knew he dabbled in drugs, but I still married him. I had no idea how his growing drug abuse problem would affect my life over the next decade. In 2004 Jim entered treatment for his heroin addiction for the first time. I was impressed with the nurses in that program. They were compassionate, understanding, and knowledgeable about addiction. They taught Jim the first steps in the recovery process and supported him through the difficult changes that he had to make to maintain a drug-free lifestyle.
>
> One nurse was particularly helpful to me as a family member of a newly recovering addict. She stood out because she consistently showed genuine concern for Jim and me. She always asked about Jim by name. She talked like he was an individual, not just one of the patients in the program. This allowed me to open up to her. I was finally able to ask if some of the things he was going through were normal, and I was very relieved to find out that they were! In contrast, another nurse on the staff talked down to all the patients. Neither the patients nor the family members felt they could talk to her.
>
> Despite all the help he received, Jim relapsed after a few months of being clean. I was disappointed, but I had learned about relapse and I refused to give up on him. After 5 more years, Jim entered a methadone maintenance program. By then our marriage was falling apart. A nurse in the program had special training in working with families. We saw her together. With her help, Jim was able to recognize that he, not I, was responsible for his addiction. He became more responsible for himself. I learned about how I had enabled his addiction and how I would have to change for our drug-free marriage to succeed. It seemed like each of us could hear what the nurse said better than we could hear each other. Now, 4 years later, Jim is still taking methadone, and we are still together. I want nurses to know that little kindnesses and bigger interventions can make a positive difference in the lives of drug addicts and their families.

separate feelings associated with past situations from those related to patients and their families. A supervisor, teacher, or senior clinical nurse can help when a nurse is having difficulty sorting out these feelings.

Traditional addiction treatment is based on the concepts of addiction as a disease, total abstinence from all substances, immersion in 12-step recovery programs, direct confrontation of denial and other defense mechanisms (usually in group sessions), and a lifelong recovery process. Groups are usually led by counselors recovering from alcoholism or addiction. Ambivalence, resistance, and denial are viewed as characteristics of the disease of addiction. Confrontation is viewed as being necessary to break through these defenses.

A practice of using very harsh and confrontational counseling techniques has developed over the years. Although some people respond well to these approaches, others do not. **Despite the popularity of such confrontational strategies, clinical outcome studies do not support their use, and many traditional programs have adopted gentler approaches.**

In the past, traditional addiction treatment was offered in specialized programs, whereas psychiatric patients with substance abuse problems were treated in psychiatric and mental health programs. Many psychiatric professionals viewed alcoholism and other drug addictions as being secondary to psychiatric disorders. They believed that the substance abuse would end when the person's primary psychiatric disorder was resolved. Psychiatric patients often were given tranquilizers to treat what was believed to be their underlying pathology.

However, instead of abstaining from their substance of choice, many of these patients also became addicted to the tranquilizers. Psychiatric treatment models operated from a different philosophical base, which was effective in dealing with psychiatric problems but less effective in dealing with addiction. Differences in treatment philosophies and backgrounds of providers contributed to a developing split between psychiatric clinicians and addiction counselors. Dually diagnosed patients often were caught in the middle.

More recently, approaches have been developed for the treatment of addictions that incorporate knowledge of both addictions and mental health strategies. **Addiction counselors now include motivational approaches, family counseling, and cognitive behavioral strategies in their treatments.** Psychiatric clinicians also are better able to understand addiction as a separate disorder. Dual-diagnosis programs have been developed, and mental health approaches have been adapted for the primary treatment of addiction.

These newer approaches involve creating an alliance between the therapist and the patient, including the patient in the setting of treatment goals (even if the patient's goal is not total abstinence), avoidance of confrontation, and brevity of treatment. More than just a series of techniques, they offer a new type of relationship between clinician and patient. Even more important, they have proved to be effective in the treatment of patients with substance abuse disorders.

Motivational Approaches. Motivational counseling is based on the idea that motivation for change is not static but dynamic and that the clinician can influence change by developing a therapeutic relationship that respects and builds on the patient's own intrinsic motivation for change. **The most important element of treatment is the attitude of the clinician.** Five basic principles are used with this approach:

1. **Express empathy through reflective listening.** This communicates respect for and acceptance of patients and their feelings. It also establishes a safe and open environment that helps in examining issues and exploring personal reasons for change.
2. **Develop discrepancy between patients' goals or values and their current behavior.** Focus patients' attention on how current behavior differs from behavior described as ideal or desired.
3. **Avoid argument and direct confrontation.** Trying to convince a patient that a problem exists or that change is needed could lead to even more resistance. Arguments can rapidly turn into a power struggle and do not promote motivation for beneficial change.
4. **Roll with resistance.** Resistance is a signal that the patient views the situation differently. The four types of resistance are arguing, interrupting, denying, or ignoring. The clinician's job is to ask questions in a way that helps the patient understand and work through resistance.
5. **Support self-efficacy.** This requires the clinician to recognize the patient's strengths and bring these to the forefront whenever possible. It involves supporting hope, optimism, and the possibility of change.

Critical aspects of effective motivational counseling are based on the FRAMES approach, decisional balance exercises, and the stages of change model. These factors are described in detail in Chapter 27. All of these motivational approaches are designed to assess a patient's readiness to change and help improve patient participation in the treatment process.

Cognitive Behavioral Strategies. Cognitive behavioral approaches are aimed at improving self-control, self-efficacy, and social skills to reduce drinking.

- **Self-control strategies** include goal setting, self-monitoring, functional analysis of drinking antecedents, and learning alternative coping skills.
- **Social skills training** focuses on learning skills for forming and maintaining interpersonal relationships, assertiveness, and drink refusal.
- **Behavioral contracting** involves creating a written agreement with the patient that specifies targeted patient behavior and consequences.
- **Contingency management** involves patients receiving incentives or rewards for adaptive behavior or meeting specific behavioral goals (e.g., compliance with treatment, clean urine). It is based on principles of operant conditioning, which posit that behavior that is followed by positive consequences is more likely to be

repeated. It supports the view that positive incentives are more effective in producing improved outcomes than negative consequences.

Cognitive behavioral strategies have been shown to be an effective treatment for alcohol and other substance addictions. They appear to be as effective as longer-term therapies. Cognitive behavioral treatment strategies are discussed further in Chapter 27.

> **Critical Reasoning** Discuss the significance of the substance abuser's level of self-esteem to the recovery process. Describe nursing interventions designed to enhance self-esteem.

Working With Codependency. Alcoholism runs in families. People who grew up in an alcoholic home often develop alcohol problems themselves or may marry people with alcoholism. It is clear that both biological and environmental factors contribute to generational transmission of this disorder. It is common for a patient to be alcoholic and have an alcoholic parent. Intervention is most effective if it addresses intergenerational patterns.

Interventions focus on the patient's primary identified problems and may include assertiveness training, challenging cognitive distortions, teaching self-affirmations, and relaxation training. Because physical abuse and sexual abuse are common in alcoholic families, specific assessment and intervention strategies must be implemented to identify and help patients with these types of problems. Referral to specialized programs may be useful. Additional information about appropriate interventions for survivors of abuse and violence is in Chapter 38.

ACOA self-help groups may be useful. The nurse should suggest that the patient try several self-help groups before deciding to be actively involved in any one group. The nurse also should monitor how the patient responds to participation in these groups. Some groups are more positive and forward focused than others.

Relapse Prevention. Behavior change is always difficult, but change related to addiction is even more difficult because of the chemical imbalance in the brain induced by the substance. An addict rarely makes a sudden and drastic behavioral change and maintains it with no return to the old behaviors.

The patient must be assisted to make behavioral and lifestyle changes. This can be difficult due to the powerful chemical forces in the brain luring the patient to return to the substance that would temporarily restore the brain's chemical balance.

Relapse prevention strategies have been widely used in substance abuse recovery programs and have been shown to be effective in assisting patients to stay clean and sober (National Registry, 2011). **However, most people who try to stop using an addictive substance are not successful on the first attempt.**

> **QUALITY AND SAFETY ALERT**
>
> - Relapse is a process, not an event.
> - Effective relapse prevention strategies include identifying and coping with high-risk situations and triggers, enhancing self-efficacy, lapse management, social support, and cognitive restructuring.
> - Help the patient become aware of cognitive, emotional, and behavioral early warning signs to prevent a lapse from escalating into a relapse.

The nurse who has smoked cigarettes usually can identify with this phenomenon. The nurse who has never used an addictive substance but who has tried dieting can understand through this experience the difficulty of making behavioral changes that have strong physiological forces pulling in the opposite direction. Such personal identifications can help the nurse empathize with the patient and reduce negative judgments, which are essential to being a credible counselor.

It may be better to abandon the notion of relapse altogether because it represents dichotomous thinking that does not fit well with the complexities of human behavior (e.g., a person is either abstinent or relapsed, sober or drinking). **Behavior change is a process that occurs over time.** Nurses can help those who are trying to change by helping them learn from whatever works and does not work in their efforts to change behaviors. This seems to have a more positive focus than a focus on failures or relapses.

In these strategies, **relapse,** or the return of symptoms, is seen as a process, not an event. **Rather than being viewed as an indicator of treatment failure, relapse is dealt with as an error from which to learn—a temporary setback on the road to recovery.** Recovery is not an all-or-nothing proposition. Rather, success is measured by improvements, such as increasing lengths of time being clean between relapses and shorter time periods of relapse.

It is important for the nurse to accept the patient without judging and to assist the patient in learning from the relapse. The nurse should help the patient identify external and internal triggers that may precipitate cravings and lead to drug use.

External triggers include the people, places, and things that have been associated with previous drug use. The nurse helps the patient figure out ways to avoid these triggers. Situations that include one or all of these triggers are called *high-risk situations*. Because these cannot always be avoided, the nurse should assist the patient in managing them successfully.

For example, if alcohol will be served at a family wedding and it is important to the patient to attend, the nurse can encourage the patient to attend the wedding with a relative who will support the patient's decision to remain abstinent. Major lifestyle changes, such as making new friends or moving to a different neighborhood, may have to happen to avoid these triggers.

Internal triggers are the thoughts and feelings contributing to past drug use, such as loneliness, boredom, or anger. The nurse can help the patient identify internal triggers and

develop healthy coping skills to deal with these negative emotional states without using substances.

The nurse needs to help patients restructure their time. So much time might have been spent in obtaining and using drugs that patients have no idea what to do with their newfound free time. **The nurse should teach patients how to identify and deal with cravings.** When cravings occur, it sometimes seems that the only way to satisfy them is to use the substance of choice. However, the nurse can help patients see that the cravings will pass if they get involved in some other non–drug-related activity.

Relapse prevention involves promoting healthy behaviors including exercise, relaxation, and good nutrition. It has been estimated that three fourths of people with serious mental illness smoke cigarettes, and the rates are even higher among those who are dually diagnosed (Ferron et al, 2011). Intervention using a holistic approach is most beneficial.

Patients should be taught that the road to relapse has many decision points—before using, after the first use, and so on. This can help patients avoid the abstinence violation effect, in which patients feel so guilty about violating a period of abstinence that they figure they may as well keep using and "start again tomorrow…Monday…next week…after this run." The goal is for the patient to want to avoid the use altogether but, if it happens, to minimize the amount of substance abuse and the length of time involved.

Social Interventions

Couples and Family Counseling.

Reliable support from caring people is very important to the recovery of people with substance abuse. However, the spouse and family are often frustrated with the patient's behavior and find it difficult to be supportive. They may not understand the nature of addiction and may do the wrong things in attempting to help the patient.

The family often tries to protect the patient from consequences. Family members may cover up by making excuses to employers and other family members for the person's erratic behavior. They also tend to blame themselves for the behavior and go to great lengths to avoid confrontation with the user. All these behaviors are called **enabling** behaviors, and family members who have these behaviors are called *enablers*. By shielding the person from the consequences of drug use, the spouse or family enables the person's continued use of the drug.

Addiction is a family problem (see Box 23-9). Everyone in the family suffers, not just the patient. Some problems that families experience include guilt, shame, resentment, insecurity, delinquency, financial troubles, isolation, fear, and violence.

Families think their problems would be solved if their loved one stopped using drugs or alcohol. However, they can get help even if the user refuses to do so. They also should realize that without help, many of the negative patterns of behavior developed over years of dysfunctional family life will continue after sobriety.

The nurse should encourage family members to seek counseling from a professional experienced in addiction treatment. Referral to **Al-Anon,** a support group for friends and family of people with alcoholism, or **Narc-Anon,** a group for friends and family of people with narcotic addictions, is also helpful. These groups are based on the same 12 steps as AA and Narcotics Anonymous (NA) except that they are powerless over their alcoholic or addicted family member instead of the substance itself.

These families must learn to pay attention to their own needs. They should stop covering up for the person with an addiction. They need to be direct in their communication. They also need to know that they are not alone. These issues are evident in the next clinical example.

CLINICAL EXAMPLE

Mr. B was a 45-year-old man admitted to the medical unit of a general hospital with a diagnosis of gastritis. He complained of abdominal pain, nausea, and vomiting. He had a slightly elevated temperature of 100° F (37.7° C). When the admitting nurse who was completing the nursing assessment asked Mr. B about alcohol use, he said he had "a couple of beers" after work every day. He also reported that his wife had left him the day before admission. He said he was not sure why she left, but he was sure she would be back.

Ms. B did come to the hospital to visit her husband. His primary nurse met with them together and asked Ms. B why she left. She said she was tired of putting Mr. B to bed every night after he passed out from drinking and did not want to continue to call his employer saying he was sick when he was really hung over. She had threatened to leave before, but Mr. B had always begged her to stay, and she had relented. She had married him because she felt sorry for him. He had been living alone and was not taking good care of himself. She revealed that her first husband was also an alcoholic and that her father had been one as well. She would agree to try again to make the marriage a success if he would agree to stop drinking and seek counseling. Mr. B said to the nurse, "I'll be good and do what she says. You tell her I'll be good."

Selected Nursing Diagnoses

- Ineffective coping related to reluctance to be responsible for his behavior, as evidenced by denial of the reason his wife left
- Dysfunctional family processes related to alcoholism, as evidenced by cycles of drinking, threats to leave, and promises to change

Mr. B used alcohol to avoid responsibility for his actions and his life. He used his wife in a similar way. When Ms. B confronted him with her expectations, he responded in a childlike way and tried to place the nurse in the parental role. Ms. B appears to be drawn to dependent men. She is probably a very maternal person who likes to take care of others. This increases the possibility that she will assume the role of enabler. The enabler perpetuates the substance abuse problem by not confronting the substance abuser and by helping to cover up the problem. When Ms. B called Mr. B's employer to say he was sick, she was being an enabler. When significant others play an enabling role, family counseling or family support groups help the family accept and support the changing behavior of the patient.

Group Therapy. Group therapy is the usual method of treatment in traditional substance abuse treatment programs. Chapter 31 provides detailed information about therapeutic groups.

History sharing and feedback are important elements of group programs. Patients share their substance abuse histories and talk about their daily efforts to stop drinking or taking drugs. The therapist and group members listen closely and give feedback to patients about their recovery efforts. Feedback is the honest reaction of group members to what the speaker says. It is based on the content of what the person says and on previous experiences with the speaker.

Although feedback from one person, especially the therapist, may be discounted, it is difficult for the person with an addiction to ignore feedback from several group members, especially if they have experienced the same type of behavior at some point. The style of giving feedback varies from person to person. It may be gentle and facilitative or direct and confrontational. The best feedback is that which is focused and shows respect for the person.

In traditional programs, another major group focus is participation in 12-step self-help programs. Patients may be required to attend a certain number of AA or NA meetings each week to remain in the group. Patients share their reactions to the meetings that they have attended and are encouraged to obtain a sponsor, do service work (e.g., set up the chairs, make coffee for meetings), and actively work the steps of the program.

Successes and difficulties with maintaining abstinence during the past week are shared and discussed. Less traditional groups may encourage trials or active involvement with 12-step programs but not require it. Expectations for work done outside the group are more individualized. In all groups, homework may be assigned that emphasizes an important recovery topic.

Critical Reasoning A group member says he has read that studies have found that some people with alcoholism can learn to drink in a controlled way. How do you respond?

Self-help groups. The most common type of self-help group for substance abusers is the 12-step group. **Alcoholics Anonymous (AA) is the model for 12-step support groups.** It is composed entirely of people with alcoholism who have a desire to stop drinking. They believe that mutual support can give them strength to abstain.

AA aims for total abstinence. Members must admit to alcoholism openly and publicly by introducing themselves at meetings: "My name is (John), and I am an alcoholic." At speaker meetings, one or more members share their life histories with the group. This shows that members are more alike than different, removing a common resistance to involvement.

AA members commit themselves to helping each other. Some AA members serve as sponsors, a role that involves availability and accessibility to another member whenever that member feels the need to drink. The sponsor also teaches the person how to work the 12 steps of the program. This reciprocal relationship gives the new member caring support and the sponsor improved self-esteem.

AA also involves a strong spiritual orientation that is experienced as supportive by some people with alcoholism. The 12 steps of AA are listed in Box 23-10. It is easy to see the therapeutic benefit of these steps. For example, admitting the problem, making amends for past behavior, and reaching out to others who need help are sound therapeutic processes.

However, some aspects of 12-step programs do not appeal to everyone. One of these is the powerlessness that must be acknowledged. Many people believe that the power to change lies within oneself. Some people are upset by the need to turn over one's will to a higher power. Members are told that this higher power can be the AA group, the sponsor, or anything else they want. Although the higher power does not have to be God in the religious sense, the meetings usually have a religious overtone and end with the Lord's Prayer. Some members have formed AA groups especially for agnostics.

Other self-help groups have emerged as alternatives to AA. One is Women for Sobriety (WFS) (Kirkpatrick, 1999;

BOX 23-10 THE 12 STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory, and when we were wrong, promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

The 12 Steps are reprinted with permission of Alcoholics Anonymous World Services, Inc. Permission to reprint this material does not mean that Alcoholics Anonymous (AA) has reviewed or approved of the contents of this publication. AA is a program of recovery from alcoholism only; use of the 12 Steps in connection with programs and activities that are patterned after AA, but address other problems, does not imply otherwise.

WFS, 2011). This program shows women how to change their way of life through a change of thinking. The program serves women's needs by teaching them to overcome depression, guilt, and low self-esteem. WFS helps women overcome their drinking problems with the support of other group members who have the same problems and needs. The difference from AA is evident in the first statement of the WFS acceptance program: "I have a drinking problem that once had me." All 13 statements of WFS are worded positively.

Another self-help program is based on the Rational Recovery (RR) movement. This program asserts that alcohol dependence is not biologically determined nor beyond our control. Rather, it is seen as a way of thinking. Irrational thoughts keep the person with alcoholism drinking. Rational thoughts can get and keep the person sober. RR philosophy is one of personal power; no reference is made to a higher power. RR groups have professional advisors who provide occasional rational input and observe members for problems that indicate a need for a higher level of care. Group meetings operate by discussion, also known as *cross-talking*. This is in contrast to AA, which strongly discourages interrupting or responding to others. Group members read rational literature, learn to think rationally, and become rational counselors to themselves and others.

Total abstinence is the goal of each of these programs. Patients who choose to try controlled drinking get no support for this goal from these programs. **Controlled drinking for a person who has experienced the loss of control characteristic of addiction has mixed support in the research literature.**

Experts have been debating about whether people with alcoholism can return to moderate drinking after detoxification. According to AA and many mental health professionals, abstinence is necessary because these people will inevitably lose control when they start to drink again. Advocates of controlled drinking believe that most people with alcoholism are not powerless over the drug and that they can change their drinking behavior without giving up alcohol entirely.

One way to approach the issue is to distinguish among degrees of severity. Perhaps dependent people with alcoholism need to quit cold, but those with milder cases of abuse can possibly handle controlled drinking. Aiming for abstinence also can be a way to achieve moderation, just as a lower speed limit causes people to drive more slowly even if they still break the law.

Community Treatment Programs. A variety of community programs are available for people who abuse drugs. Medical detoxification may be done in hospitals in medical, psychiatric, or special substance abuse units. Length of stay usually is very short—just long enough to stabilize the person medically. Detoxification also can be done safely on an outpatient basis.

For patients not requiring intense medical monitoring but still in need of strict environmental controls, residential, freestanding rehabilitation programs provide services for weeks to months. Some patients receive court orders to enter into these treatment programs after drug-related arrests, with the costs being covered by the state.

The next level of care after inpatient and residential care is a day or evening program. In these programs, the patient spends most of the day in treatment and returns home at night or spends the day at work and several evenings each week in treatment.

Methadone maintenance programs offer methadone maintenance or withdrawal for people with opiate addictions. Patients must attend daily to obtain their methadone. Methadone programs must have special licensure to operate and follow federal guidelines. For the very stable patient on methadone maintenance, a policy change to monthly visits to the provider has been suggested and may be approved in the future.

Regular outpatient programs that are attended once or twice per week are even less intensive. Most programs provide a mix of group, individual, and family therapy; vocational counseling; drug and health education; and involvement with 12-step self-help programs; 12-step programs such as AA may be an adjunct to or substitute for professionally run programs.

Employee Assistance Programs. Another potential resource for the substance-abusing patient is the **employee assistance programs (EAPs)** that may be part of an employee health service. Many businesses have found that it is profitable to help substance-abusing employees. These programs usually offer counseling and health education. Employees with a substance abuse problem are usually required to participate in the program to retain their jobs. Nurses are often key staff members in EAPs.

A Nursing Treatment Plan Summary for ineffective coping related to substance-abusing behaviors is presented in Table 23-7. A Nursing Treatment Plan Summary for a patient with disturbed sensory perception is presented in Table 23-8.

Working With Dually Diagnosed Patients

The dually diagnosed patient needs treatment for the psychiatric disorder and the substance use disorder. The problem is that the substance abuse and mental health fields have developed approaches that appear to conflict with each other. For instance, many substance abuse counselors rely on direct confrontation of behavior. This may be detrimental to a person with severe mental illness. Substance abuse counselors also tend to have a limited understanding of the medications used for psychiatric disorders. People with chronic mental illnesses are often excluded from substance abuse programs.

Mental health clinicians often do not understand substance abuse and may overlook symptoms of continued use. They tend to think that the substance abuse will stop when the person's psychiatric illness is under control. Patients can suffer from these differences in providers by missing out on some important treatments or by getting caught in the middle of two different approaches with two different clinicians (called *parallel treatment*). To avoid this, treatment is sometimes offered in sequence (first psychiatric treatment and then substance abuse treatment or vice versa).

TABLE 23-7 NURSING TREATMENT PLAN SUMMARY

Chemically Mediated Responses

Nursing Diagnosis: Ineffective coping
Expected Outcome: The patient will abstain from using all mood-altering chemicals.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will substitute healthy coping responses for substance-abusing behavior.	Help the patient identify the substance-abusing behavior and its consequences. Help the patient identify the substance abuse problem. Involve the patient in describing situations that lead to substance-abusing behavior. Consistently offer support and the expectation that the patient has the strength to overcome the problem.	Motivation for change is related to recognition of a problem that is upsetting to the patient. Identification of predisposing factors and precipitating stressors must precede planning for more adaptive behavioral responses.
The patient will assume responsibility for behavior.	Encourage the patient to participate in a treatment program. Develop with the patient a written contract for behavioral change that is signed by the patient and nurse. Help the patient identify and adopt healthier coping responses.	Denial and rationalization are dysfunctional coping mechanisms that can interfere with recovery. Personal commitment will enhance the likelihood of successful abstinence.
The patient will identify and use social support systems.	Identify and assess social support systems that are available to the patient. Provide support to significant others. Educate the patient and significant others about the substance abuse problem and available resources. Refer the patient to appropriate resources and provide support until the patient is involved in the program.	Substance abusers are often dependent and socially isolated people who use drugs to gain confidence in social situations. Substance-abusing behavior alienates significant others, thus increasing the person's isolation. It is difficult to manipulate people who have participated in the same behaviors. Social support systems must be readily available over time and acceptable to the patient.

TABLE 23-8 NURSING TREATMENT PLAN SUMMARY

Chemically Mediated Responses

Nursing Diagnosis: Ineffective coping
Expected Outcome: The patient will overcome addiction safely and with a minimum of discomfort.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will withdraw from dependence on the abused substance.	Supportive physical care: vital signs, nutrition, hydration, seizure precautions. Administer medication according to detoxification schedule.	Detoxification of the physically dependent person can be dangerous and is always uncomfortable for the patient. The patient's physical safety must receive high priority for nursing intervention.
The patient will be oriented to time, place, person, and situation.	Assess orientation frequently, orient the patient if needed, and place a clock and calendar where they can be seen by the patient.	Cognitive function is usually affected by addiction; disorientation is frightening.
The patient will report symptoms of withdrawal.	Observe carefully for withdrawal symptoms, and report suspected withdrawal immediately.	Withdrawal symptoms provide powerful motivation for continued substance abuse; judgment may be impaired by substance use.
The patient will correctly interpret environmental stimuli.	Explain all nursing interventions, assign consistent staff, keep soft light on in room, avoid loud noises, and encourage trusted family and friends to stay with the patient.	Sensory and perceptual alterations related to use of drugs or alcohol are frightening; consistency reduces the need to interpret stimuli.
The patient will recognize and talk about hallucinations or delusions.	Observe for response to internal stimuli, encourage patient to describe hallucinations or delusions, and explain the relationship of these experiences to withdrawal from addictive substances.	Helping the patient identify delusional or hallucinatory experiences and relating them to withdrawal are reassuring.

The best possible treatment for substance abuse problems is an integrated one, with services offered by program staff members who are qualified in various specialty areas and with excellent coordination of other community services. People with chronic mental illnesses can benefit greatly from these programs, which tend to be less confrontational and more supportive than traditional substance abuse programs (National Registry, 2011).

They have professional staff members to prescribe and follow medication effectiveness. They often practice assertive case management, in which caseworkers seek out patients when they fail to show up for treatment and help patients meet multiple psychosocial needs, including basic living arrangements.

QUALITY AND SAFETY ALERT

- Integrated treatment for co-occurring mental illness and substance abuse is an evidence-based practice.

Specialized treatment programs offer special treatment groups for the mentally ill, chemically addicted (MICA) patient (also called *mentally ill, substance abusing* [MISA]) and refer patients to community self-help groups developed for such people, called *double-trouble groups*. Nurses who understand both conditions are in an ideal position to work with dually diagnosed patients.

Appropriate treatment is linked to correct assessment of co-existing conditions. If the causative disorder can be isolated, it should be the focus of initial treatment unless the secondary disorder has become life threatening, as when a patient with alcoholism develops a suicidal depression**. The initial emphasis of treatment must be on the most serious problem at the time.**

It should not be assumed that resolution of primary psychiatric problems will automatically resolve associated substance abuse problems. If substances are used chronically, substance abuse can develop into a primary disorder, taking on a life of its own. Although the relative importance of symptoms may vary with time and influence the focus of treatment, both disorders must be treated.

Comprehensive treatment for co-occurring disorders usually requires a combination of pharmacological treatment, psychosocial treatment, and supportive services. Successful psychosocial programs for patients with psychiatric and substance abuse disorders provide behavioral skill-building interventions as the primary ingredient of active treatment. This has been more effective than case management or 12-step intervention alone.

The following five therapeutic tasks or steps serve as guidelines for structuring treatment for dual-diagnosis patients:

1. **Establish a therapeutic alliance with the patient.**
2. **Help the patient evaluate the costs and benefits of continued substance use.**
3. **Individualize goals for change that include harm reduction as an alternative to total abstinence for the patient.**
4. **Help the patient build an environment and lifestyle supportive of abstinence.**
5. **Acknowledge that recovery is a long process, and help the patient cope with crises by anticipating triggers of relapse and coping with setbacks as they occur.**

Because both mental illness and substance abuse are chronic, relapsing conditions, the course of treatment can be expected to take some time and these individuals need many supports (Villena and Chesla, 2010). Stages of treatment have been identified and are used as the basis for treatment planning in many dual-diagnosis treatment programs. Interventions appropriate to each stage are listed along with goals in Table 23-9. Counselors and interdisciplinary teams are also useful, as illustrated in the next clinical example.

TABLE 23-9 TREATMENT STAGES, GOALS, AND INTERVENTIONS FOR DUALLY DIAGNOSED PATIENTS

STAGE OF TREATMENT	GOALS	INTERVENTIONS
Engagement	Development of working relationship between patient and nurse	Intervene in crises, help with practical living problems, establish rapport with family members, demonstrate caring and support, listen actively
Persuasion	Patient acceptance of having a substance abuse problem and the need for active change strategies	Help analyze pros and cons of substance use, educate patient and family, arrange peer group discussions, expose patient to double-trouble self-help groups, adjust medication, persuade patient to comply with medication regimen (motivational interviewing skills are particularly helpful during this stage)
Active treatment	Abstinence from substance use and compliance with medication	Help change thinking patterns, friends, habits, behaviors, and living situations as necessary to support goals; teach social skills; encourage patient to develop positive social supports through double-trouble self-help groups; enlist family support of changes; monitor urine and breath for substances; offer medications
Relapse prevention	Absence or minimization of return to substance abuse	Reinforce abstinence, compliance, and behavioral changes; identify risk factors and help patient practice preventive strategies; encourage continued involvement in double-trouble groups; continue laboratory monitoring

CLINICAL EXAMPLE

Seventeen-year-old Bobby was admitted to the hospital in an acutely psychotic state after recent use of PCP. The emergency room nurse observed scarring of the veins in Bobby's arm and assessed that he might use heroin. Blood and urine testing confirmed this suspicion. Bobby recovered from his psychotic episode in 24 hours but was extremely uncomfortable because of opiate withdrawal. The decision was made to use titrated doses of methadone to help with the withdrawal.

A young nurse established a close relationship with Bobby during this time. Bobby requested the nurse's help in planning for his future but doubted that he had the strength to stay away from drugs. He was advised to take 1 day at a time. The nurse took Bobby on a visit to a drug treatment program, and he agreed to try membership in one of the groups at this center.

Bobby did well in the group and was very helpful to new members, describing his experiences and encouraging them to "take 1 day at a time." Bobby expressed an interest in finishing school and said he would like to become a drug counselor. The staff of the drug treatment program agreed that Bobby seemed to have an aptitude for that role and encouraged him to pursue his goal.

Selected Nursing Diagnoses

- Ineffective coping related to maturational issues, as evidenced by PCP use and uncontrolled behavior in the emergency room
- Situational low self-esteem related to pessimism about ability to stop using drugs, as evidenced by expressed self-doubt

In this example, the nurse used her relationship with Bobby to communicate her belief that Bobby could successfully give up drugs. This message has a core of positive regard for Bobby's potential strength. The staff of the drug treatment program added to his self-esteem by encouraging Bobby to help others in the program and then to aim higher at becoming a counselor himself. This taught Bobby that there were rewards in life other than those attached to drug use. Gradually, he learned to value the interpersonal rewards more than the drug rewards while making positive use of his past difficulties.

Intervening With Impaired Colleagues

It is often difficult for nurses to respond to a colleague who is showing signs of a substance abuse problem. This is true of supervisors and peers. **For the safety of the nurse and the nurse's patients, it is necessary to identify an impaired colleague and take action.** Many states have laws that require health care professionals to report colleagues who show signs of working while impaired. In these states, reporting is an ethical and a legal obligation.

QUALITY AND SAFETY ALERT

- Nurses are at high risk for substance use problems due to high job stress and access to drugs.
- Hospital policies that promote alternatives to discipline programs combine strict accountability provisions to protect patients while providing an avenue that allows employee retention based on improved performance.

It may not be easy to be sure that a nurse's practice is impaired by drug or alcohol use. However, particular patterns of behavior and signs are characteristic of this problem (Box 23-11). **The concerned colleague should report**

BOX 23-11 SIGNS OF IMPAIRED NURSING PRACTICE

Job Performance Changes

Controlled Drug Handling and Records (Potential Drug Diversion)

- Drug counts incorrect
- Excessive errors
- Excessive wastage, often not countersigned
- Medicine signed out to patient who has not been in pain
- Two strengths of drug signed out to same patient, same time
- Packaging appears to be tampered with
- Patient complaints of ineffective pain control
- Volunteers to give controlled drugs
- Comes in early or stays late
- Disappears into the bathroom after handling controlled drugs
- Unexplained absences from the unit

General Performance

- Medication errors
- Poor judgment
- Euphoric recall for involvement in unpleasant situations, or confrontations on the job
- Illogical or sloppy charting
- Absenteeism, especially in conjunction with days off
- Requesting leave time just before the assigned shift
- Tardiness with elaborate excuses
- Job shrinkage (does the minimal amount of work required to get by)
- Missed deadlines

Behavior and Personality Changes

- Sudden changes in mood
- Periods of irritability
- Forgetfulness
- Wears long sleeves, even in hot weather
- Socially isolates from co-workers
- Inappropriate behavior
- Has chronic pain condition
- History of pain treatment with controlled substances

Signs of Use

- Alcohol on the breath
- Constant use of perfumes, mouthwash, and breath mints
- Flushed face, reddened eyes, unsteady gait, slurred speech
- Hyperactivity, accelerated speech
- Increasing family problems that interfere with work

Signs of Withdrawal

- Tremors, restlessness, diaphoresis, pupil changes
- Watery eyes, runny nose, stomach aches, joint pains, gooseflesh

incidents of this nature to the supervisor. It is also important that these incidents be **documented in writing,** with the time, date, place, description of the incident, and the names of others who were present. This documentation will make it easier to intervene and help the nurse seek treatment.

During treatment, the supervisor should maintain contact with the treatment program to see how the nurse is progressing. It is strongly advised that a return-to-work contract be written that clearly describes the nurse's responsibilities on return. If the state has a nurse rehabilitation or peer assistance program, it can assume some responsibility for monitoring the nurse's progress and for developing treatment and return-to-work contracts. This type of intervention makes it possible for the chemically dependent nurse to get the treatment needed but remain employed, a situation in which everyone benefits.

> **Critical Reasoning** An enabler is a person who supports someone in maintaining an addiction. Describe behaviors that would enable a colleague to continue drug or alcohol use that impairs performance of nursing roles. What alternative behaviors would be more helpful?

Preventive Interventions

The best approach to prevention is to begin early to reduce emerging behavioral and emotional problems in youth. Longer-lasting results can be obtained from changing school, community, and family environments that promote and maintain drug problems in youth. Communities need nurses and other health care providers who are knowledgeable about substance abuse prevention and who can advocate for the implementation of prevention programs with proven effectiveness.

Many communities across the United States have taken positive steps to combat the problem of substance abuse. Examples include alcohol- and drug-free school parties, smoke-free buildings and cities, and drug courts. **Reducing access to substances is an important public health strategy.** Raising the minimum drinking age to 21 years was found to decrease alcohol use by 25% in those 18 to 20 years old, along with a reduction in related accidents and problems. In contrast, laws prohibiting cigarette sales to minors have not resulted in decreased use, because youthful smokers get older friends to make purchases for them.

Media campaigns provide needed information and can slowly affect community norms. Efforts spearheaded by citizen groups, such as Mothers Against Drunk Driving (MADD), can have a positive impact.

Primary Prevention. Primary prevention programs aimed at preventing drug use among children are in place in many elementary schools in the United States. School nurses can be involved in education efforts in the schools. Family-strengthening strategies are key to preventing problems, as are social competency programs. Nurses also can support legislation designed to reduce the incidence of use and abuse and serve as public speakers in the community on drug abuse issues.

The following types of preventive interventions have been effective for smoking, alcohol, and substance use problems:

- **Targeted smoking cessation education and counseling**; successful techniques include the following:
  - 15-minute counseling and skill development session, supplemented by patient reinforcement, social support, newsletter, and follow-up phone calls
  - 4 minutes of clinician advice to quit smoking, supplemented by a self-help book and a 1-year follow-up visit
- **Self-care education** addressing substance use and mental health; successful techniques include the following:
  - Group education workshops, supplemented by a self-care guide and videos, a telephone information service, and individual health evaluation and planning conference
  - Computer-based, serial, personal health–risk reports augmented by individualized recommendation letters and written materials
  - Access to a self-care center
  - One-on-one education centers with a clinician
  - Slide shows
- **Brief screening and counseling to reduce alcohol use**—5 to 15 minutes of advice or counseling by a health care provider on reducing alcohol consumption accompanied by supplemental workbooks or self-help materials and follow-up visits or telephone calls

Secondary Prevention. Secondary prevention efforts are aimed at people with mild to moderate drinking problems. For every person with a severe drinking problem, several more people have mild to moderate drinking problems. Several brief therapies have evolved to address their special needs. They range from simple advice to stop drinking to more elaborate programs involving early identification, presentation of assessment findings, education (Table 23-10), advice regarding the need to reduce drinking with an emphasis on personal responsibility, self-help manuals, and periodic follow-up. People with mild to moderate drinking problems are increasingly being referred to treatment programs through the courts after DUI charges.

Tertiary Prevention. Tertiary prevention can decrease the complications of addiction. Medical and psychiatric treatment settings continue to serve a major role, as do more current case management, community outreach, and dual-diagnosis programs.

Policy approaches often include legislation to reduce the negative consequences of using drugs rather than the drug use itself. This approach is called **harm reduction.** It includes efforts to reduce the effects of drunkenness, such as automobile accidents, drowning, and family disputes, on the user and others. It may include providing public education to increase the number of designated drivers, offering rides to incapacitated friends, using seat belts, and arranging sleepovers after parties involving alcohol.

Under development are cars whose ignition locks if the driver cannot pass a quick sobriety test. In Europe

TABLE 23-10 PATIENT EDUCATION PLAN

Promoting Adaptive Chemically Mediated Responses

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Elicit perceptions of substance use.	Lead group discussion regarding knowledge about chemical use and experience with it; correct misperceptions.	The patient will describe accurate information about substance use.
Demonstrate negative effects of substance abuse.	Show films of physical and psychological effects of substance abuse; provide written materials.	The patient will identify and describe physical and psychological effects of substance abuse.
Interact with peer who has abused chemicals.	Small-group discussion with peer group member who has abused substances and quit because of negative experiences.	The patient will compare advantages and disadvantages of using mind-altering substances.
Obtain agreement to abstain from use of mind-altering substances.	Discuss future plans for refusing abused chemicals if offered.	The patient will verbally agree to abstain from using mind-altering substances.

and Australia, the harm associated with drug use has been reduced by developing needle exchanges, offering drug-testing stations, and offering water at raves.

EVALUATION

The evaluation of substance abuse treatment is based on accomplishment of the expected outcomes and short-term goals. The nurse and patient together should evaluate progress toward these goals on a regular basis. If progress is not being made, they should reevaluate the goal and the progress to see where the problem lies and what needs to be done about it.

Relapse does not mean failure. Progress toward a lifelong goal of abstinence from substances of abuse can be measured in many ways. For example, a significant increase in the time that a patient with chronic alcoholism stays sober between binges or relapses can be viewed as improvement. A decrease in the amount of time that the patient with alcoholism remains in relapse before returning to sobriety can likewise indicate improvement.

The patient who returns to treatment after relapse should be commended for previous successes and for the decision to keep trying. The nurse and patient then can analyze what worked and what did not work in the patient's attempts to maintain sobriety. This information should be used to modify the patient's relapse prevention plan.

Several measures of success in meeting abstinence goals should be used, not just patient self-report. Objective measures such as breath analysis and urinalysis should be used along with information from collateral sources, such as spouses and employers (with a signed release of information). Success in achieving goals in other areas of living, such as obtaining or keeping a job, improvements in health, and improvements in family relationships, is interrelated with abstinence goals and important in the total recovery process.

LEARNING FROM A CLINICAL CASE OUTCOME

1. What is the prevalence of substance abuse, and could she be at risk for suicide?

The prevalence of substance abuse is a 30% lifetime risk. Given her family history of anxiety and depression and her own fleeting thoughts of suicide, she should be evaluated for suicidal risk. Alcohol use increases the risk of self-injury.

2. Could her sexual orientation and distancing herself from her family be stressors?

Coming out can be a stressful, anxiety-provoking experience for homosexuals. Exploring this patient's beliefs about her sexual orientation and discussing how she thinks her family will respond is important. Social support is a critical aspect of care, and being known and understood by family members and friends is important to individuals in the gay community.

3. What are some of her external and internal triggers?

External triggers are the people, places, and things or events that have been associated with her drinking. Internal triggers are her thoughts and feelings that have preceded past drug use, such as anger, loneliness, and fear of rejection. She needs to identify these external and internal triggers and find alternatives to drinking in response to the triggers.

4. What model of change did she use in her substance abuse treatment?

Alcoholics Anonymous (AA), the self-help group, has been helpful to many, and she found the AA community to be warm and welcoming. It was an important part of her treatment. It is offered at no cost, and meetings are available at different times so it worked well with her changing shifts and work hours. She began working the 12 steps with her sponsor.

Case Outcome

She has been sober for 5 years. She suffered one brief relapse but quickly returned to AA with the help of the community of people in recovery around her. She is in a long-term relationship with a woman who is also in recovery. She is living in Brooklyn and making forays into the New York fashion scene. She came out to family members shortly after starting the 12-step program, and they let her know that they had known for many years. They assured her that they loved her very much.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

S.W. Jernigan, BS, RN, C

One Sunday morning, I was changing a dressing on a patient in for her third admission. This patient's right knee had been injured during a "bust" for possession of narcotics. Although the dressing change was a simple one, she seemed talkative and jumped at the chance to complete the procedure in the treatment room. She talked at length about her Baltimore neighborhood where she had lived all her life, her deep roots in the community, and her mother's recent death.

At the time I had perhaps the easiest job in the world—saying "mmm-hum" and "uh-huh" to an interesting person who wanted to talk; but it was not long before she got to the subject of her repeated failures to stay off drugs. She then began to speak more slowly and with intense feeling; she obviously was looking for answers—of which I had few. Her facial expression confirmed that she had already heard the old standards: "Keep trying," "Don't give up," "Go to NA." A silence ensued. Quietly she said, "This is going to kill me. What can I do?" After another silence, I said, "I have heard from some who said the only way they could 'stay clean' was to move—to get away from the old neighborhood, leave all the old friends, and start a new life. It is a radical, shocking change, but for some people, it is the only way." Her shoulders straightened. She nodded.

She was discharged several days later and has not reappeared—maybe because she moved to another state and got "clean"—or so we heard. In retrospect, I think this patient knew what she needed to hear. Patients in difficulty often have a sort of homing instinct about what they need to be well, whether it is attention, solitude, or as in this case, permission to take the next step.

CHAPTER IN REVIEW

- Adaptive chemically mediated responses include natural highs, which may be related to physical activity or meditation. Maladaptive responses include dependence on tobacco and alcohol and abuse of or dependence on illicit drugs.
- Substance abuse refers to continued use despite related problems.
- Substance dependence, related to drugs or alcohol, indicates a severe condition, usually considered a disease.
- The psychosocial behaviors related to substance dependence are often called *addiction.*
- Dual diagnosis is the co-existence of substance abuse and psychiatric disorders in the same person.
- Withdrawal symptoms and tolerance are signs that the person has physical dependence on the drug. Withdrawal symptoms result from a biological need that develops when the body becomes adapted to having the drug in the system.
- Tolerance means that with continued use, more of the substance is needed to produce the same effect.
- The United States has one of the highest levels of substance abuse in the world. Most people with substance use disorders do not seek treatment.
- Prescription drug abuse is our nation's fastest growing drug problem.
- All nurses need to be educated about the signs of substance use, ways to screen for them, and the brief interventions that can be used, regardless of clinical setting.
- Despite their prevalence, substance-related disorders are frequently underdetected and underdiagnosed in primary care and acute-care medical settings.
- Screening for substance abuse can involve the use of the AUDIT-C or B-DAST questionnaires, a breath analysis, or blood and urine testing.
- SBIRT should be an essential practice skill of all nurses.
- Patient behaviors related to chemically mediated responses are related to dependence, intoxication, or overdose and vary according to the abused substances. Abused substances may include CNS depressants (e.g., alcohol, barbiturates, benzodiazepines), stimulants (e.g., amphetamines, meth, cocaine), opiates (e.g., heroin, morphine, prescription drugs), marijuana, hallucinogens, MDMA, PCP, inhalants, nicotine, caffeine, and date rape drugs.
- Consequences of abuse and dependence include accidents, self-directed and other-directed violence, self-neglect, fetal abnormalities, fetal substance dependence, and infection with blood-borne pathogens.
- A patient may have a substance use disorder, a psychiatric disorder, or both concurrently. The co-occurrence of psychiatric and substance use disorders, or dual diagnosis is common.
- Predisposing factors that lead to maladaptive chemically mediated responses include biological, psychological, and sociocultural perspectives.
- Withdrawal symptoms and drug cravings are powerful precipitating stressors for continued drug use. Most abused drugs interact with specific nerve cell receptors by imitating or blocking the actions of normally working neurotransmitters in the brain.
- Withdrawal from all depressant drugs (including alcohol) is similar and sometimes is referred to as the general depressant withdrawal syndrome. The time course of symptoms depends on the half-life of the particular drug, and the severity of symptoms depends on the drug dose and length of use.
- Coping resources include motivation, social supports, health, social skills, problem-solving skills, material and economic assets, and intellectual and personality traits.

CHAPTER IN REVIEW—cont'd

- Maladaptive coping mechanisms include denial, rationalization, projection, and minimization.
- Primary NANDA-I nursing diagnoses related to maladaptive chemically mediated responses are disturbed sensory perception, acute confusion, ineffective coping, and dysfunctional family processes: alcoholism.
- Medical diagnoses are dependence, abuse, intoxication, or withdrawal related to a particular substance.
- The expected outcome for patients in withdrawal from drugs or alcohol is that the patient will overcome withdrawal safely and with minimal discomfort.
- The expected outcome for patients dependent on drugs or alcohol is that the patient will abstain from all mood-altering chemicals.
- Long-range goals of treatment for patients with substance use disorders include abstinence or reduction in the use and effects of substances, reduction in the frequency and severity of relapse, and improvement in psychological and social functioning.
- Planning is based on first providing for safe withdrawal, followed by developing ways to maintain abstinence. Support systems, including family, friends, and self-help groups, should be involved whenever possible.
- Substances with potentially life-threatening courses of withdrawal include alcohol, benzodiazepines, and barbiturates. The possibility of seizures should always be considered.
- The process of helping a person with an addiction safely through withdrawal is called detoxification.
- Interventions to maintain abstinence are biological, psychological, and social.
- The first months after cessation of substance use represent the highest risk for relapse and offer the greatest opportunity for pharmacological interventions that can help patients decrease cravings and maintain abstinence.
- Addiction counselors now include motivational interviewing, family counseling, and cognitive behavioral strategies in their treatments.
- Motivational approaches focus on expressing empathy, identifying discrepancies, avoiding arguments, rolling with resistance, and supporting self-efficacy.
- Cognitive behavioral approaches are aimed at improving self-control, self-efficacy, and social skills to reduce drinking.
- Most people who try to stop using an addictive substance are not successful in their first attempt. Rather than being viewed as an indicator of treatment failure, relapse is dealt with as an error from which to learn—a temporary setback on the road to recovery.
- Effective relapse prevention strategies include identifying and coping with high-risk situations and triggers, enhancing self-efficacy, lapse management, social support, and cognitive restructuring.
- External triggers include the people, places, and things that have been associated with previous drug use. Internal triggers are the thoughts and feelings contributing to past drug use, such as loneliness, boredom, or anger.
- Reliable support from caring people is essential to the recovery of people with substance abuse. Addiction is a family problem.
- Self-help groups such as AA and its 12-step program can be helpful.
- Integrated treatment for co-occurring mental illness and substance abuse is an evidence-based practice.
- For the safety of the nurse and the nurse's patients, it is necessary to identify an impaired colleague and take action.
- Nurses should engage in primary (education), secondary (early screening and intervention) and tertiary (harm reduction) prevention strategies.
- Evaluation criteria for nursing care related to chemically mediated responses include goal achievement, increases in amount of sober time, negative breath test and urinalysis results, and improved psychosocial dimensions.

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CHAPTER

24

Eating Regulation Responses and Eating Disorders

Gail W. Stuart

Soon her eyes fell upon a little glass box that was lying under the table: she opened it, and found in it a very small cake, on which the words "EAT ME" were beautifully marked in currants. She ate a little bit, and said anxiously to herself, "Which way? Which way?" holding her hand on the top of her head to feel which way it was growing.

Lewis Carroll, *Alice's Adventures in Wonderland*

http://evolve.elsevier.com/Stuart/

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive eating regulation responses.
2. Identify behaviors associated with eating regulation responses.
3. Analyze predisposing factors, precipitating stressors, and the appraisal of stressors related to eating regulation responses.
4. Describe coping resources and coping mechanisms related to eating regulation responses.
5. Formulate nursing diagnoses related to eating regulation responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to eating regulation responses.
7. Identify expected outcomes and short-term nursing goals related to eating regulation responses.
8. Develop a family education plan to promote adaptive eating regulation responses.
9. Analyze nursing interventions related to eating regulation responses.
10. Evaluate nursing care related to eating regulation responses.

Food is essential to life. It supplies needed nutrients and sources of energy. Eating is a crucial self-regulatory activity. However, it also can assume importance and meaning beyond that of nutrition and can become a problem and a maladaptive coping response.

CONTINUUM OF EATING REGULATION RESPONSES

Properly controlled eating contributes to psychological, biological, and sociocultural health and well-being. **Adaptive eating responses are characterized by balanced eating patterns, appropriate caloric intake, and body weight that is appropriate for height.**

Although everyone eats, society has difficulty understanding the idea of unregulated eating. Everyone has at times overeaten, skipped one or more meals, or seen adolescent boys consume large amounts of food at a single meal. Many women have premenstrual cravings for salty, sweet, or other types of foods. These eating behaviors are not viewed as problematic.

However, food also can be used to satisfy unmet emotional needs, to moderate stress, and to provide rewards or

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

She was a medical student and a horse jockey. She was passionate about each and threw herself into both aspects of her life. But she also was depressed. Her boyfriend was threatening to break up with her. He felt she had no room in her life for him and he didn't feel like he could get close to her. He didn't understand it but knew that he was tired of fighting for her time and attention.

She stood just about 5 feet tall, trim and athletic. She came to all of her appointments but seemed unable to really engage. She felt her mother had unrealistic expectations of excellence for her and that they never really had a close relationship. This seemed to be a theme in her life. One evening her boyfriend arrived unexpectedly at her apartment and walked in as she was purging her dinner. He was shocked and insisted that she get treatment.

She admitted that from her early teens she had been bingeing and purging to control her weight. She thought she was fat. She said she thought her mother was anorexic because she would cook food and always serve the family but not sit down and eat herself. The patient also admitted bingeing and purging on alcohol. She said she hated herself, and she blamed her mother.

Case Critical Reasoning Questions

1. How would you assess this woman's illness?
2. What eating disorder does she have?
3. What predisposing factors contribute to her illness?
4. What nursing diagnoses would guide your interventions for this patient?
5. What are the health consequences and medical complications of disordered eating?
6. What treatment setting and interventions would you choose for this patient?

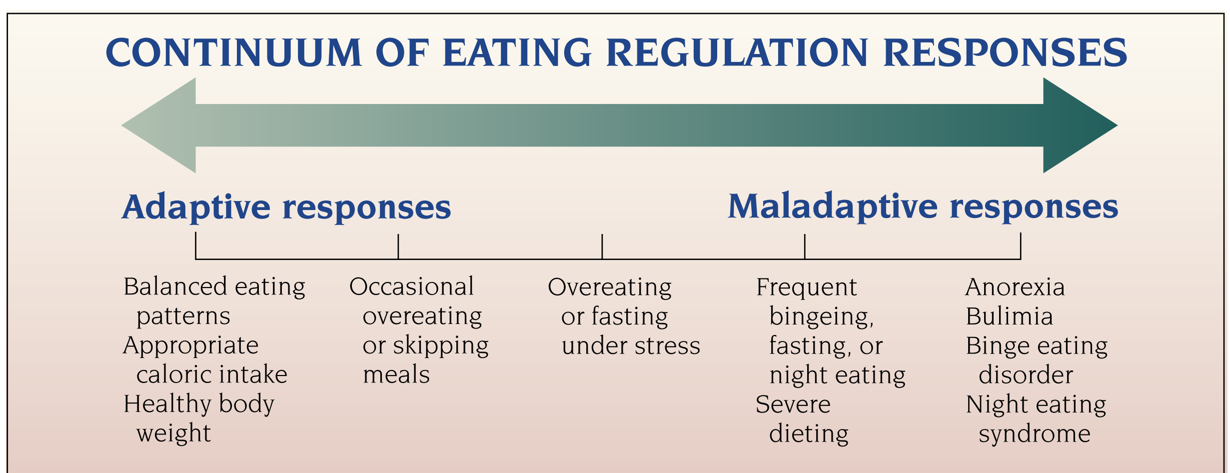

FIG 24-1 Continuum of eating regulation responses.

punishments. People can have unrealistic images of their ideal body size and desired body weight.

Research has shown that most people think they should weigh less than they do, and this can result in behaviors that range from fasting fads to severe dieting. The inability to regulate eating habits and the frequent tendency to overuse or underuse food interfere with biological, psychological, and sociocultural integrity.

Illnesses associated with maladaptive eating regulation responses include anorexia nervosa, bulimia nervosa, binge eating disorder, and night eating syndrome (Figure 24-1). They are potentially fatal (Crow et al, 2009).

Eating disorders occur across the life span. They are more commonly seen among females, with a male/female ratio ranging from 1:6 to 1:10. This gender difference in the prevalence of eating disorders may result from biological, sociocultural, or psychodynamic factors or from a greater reluctance on the part of men to seek treatment.

Among young women in the United States, eating disorders appear to be about as common in Hispanics as in whites, more common in Native Americans, and less common in African Americans and Asian Americans. African-American women are more likely to develop bulimia nervosa than anorexia nervosa, and they are more likely to purge with laxatives than by vomiting.

QUALITY AND SAFETY ALERT

- Eating disorders can cause biological changes that include altered metabolic rates, profound malnutrition, and possibly death.

Obsessions about eating can cause psychological problems that include depression, isolation, and emotional lability. Sociocultural ideals concerning body size can lead to an eating disorder by influencing people to perceive their body size as being larger or smaller than it actually is. This distorted body image may lead to an attempt to attain an unrealistic body size.

Before working with patients with maladaptive eating regulation responses, nurses must closely examine their own feelings and prejudices about weight and body size. It may be helpful for nurses to think about the following questions:

- What do I believe is the ideal body size and shape?
- How do I feel about people who are overweight?
- Can a person ever really be too thin?
- Do I worry about my weight a lot?
- Do I have biases about eating and weight that will interfere with my ability to care for patients with eating disorders?

Nurses who suspect that they have an eating disorder may not be able to provide care for patients who cannot regulate their eating responses (Hicks et al, 2008). These nurses should seek professional help for themselves before attempting to care for others.

Critical Reasoning Identify three sociocultural factors that influence the type and amount of food you eat and your perception of the ideal body size.

Prevalence of Eating Disorders

Anorexia Nervosa. Anorexia nervosa **is a serious mental illness that is characterized in part by intense and irrational beliefs about one's shape and weight, including fear of gaining weight.** It occurs in approximately 0.9% of females and 0.3% of males.

Its onset usually occurs between 13 and 20 years of age, but the illness can occur in any age-group, including elderly people and prepubertal children. Anorexia nervosa is also seen in males, who are thought to make up 5% to 10% of the anorexic population. The mortality rate from anorexia nervosa is estimated to be approximately 5% of those with the disorder.

Many patients with anorexia nervosa recover within 5 years. However, for some, anorexia nervosa is a chronic illness. Vomiting, binge eating, purging, obsessive-compulsive personality symptoms, and alcohol use are associated with the least favorable prognosis.

Bulimia Nervosa. Bulimia nervosa **is an eating disorder that is characterized by eating binges typically followed by efforts to purge calories**. It is more common than anorexia, with an estimated occurrence of 1.5% in women and 0.5% in men; among female high school and college students, the prevalence rates are 4% and 15%, respectively. The age at onset is typically 15 to 18 years. The male/female ratio for bulimia nervosa is about 1:11, but males and females with this eating disorder have similar clinical features.

An early response to treatment is a good predictor of a successful outcome in bulimia nervosa. A good outcome also is associated with a shorter duration between onset of symptoms and the first treatment intervention (Steinhausen and Weber, 2009). **Therefore, early identification of bulimia nervosa is important in preventing a chronic eating disorder**.

Bulimia and anorexia may be present in the same patient. As many as 50% of individuals with anorexia develop bulimic symptoms, and some people with bulimia develop anorexic symptoms. Bulimia usually occurs in people of normal weight, but it also may occur in those who are obese or thin.

Binge Eating Disorder. Individuals with binge eating disorder consume large amounts of calories but do not attempt to prevent weight gain. This disorder has a prevalence of approximately 2% to 4% of the population and is often chronic in nature. It has been estimated that 19% to 40% of obese people who seek treatment for weight control have binge eating disorder.

Night Eating Syndrome. Night eating syndrome is a severe eating problem that is under consideration for future inclusion in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* as a separate eating disorder. Individuals with night eating syndrome have symptoms of morning anorexia, difficulty staying asleep, and depression occurring mostly in the evening.

Night eaters average two awakenings per night, and these awakenings are associated with food intake. The prevalence of night eating syndrome has been estimated to be 1.5% in the general population, 8.3% in the obese population, and 27% among severely obese people seeking surgical treatment.

The overlapping relationships among the various maladaptive eating responses are depicted in Figure 24-2.

QUALITY AND SAFETY ALERT

- Assessment for binge eating disorder and night eating syndrome should be an important part of weight management programs for obese individuals.

ASSESSMENT

Patients with maladaptive eating regulation responses need to receive a comprehensive nursing assessment that includes complete biological, psychological, and sociocultural evaluations (Himmerich et al, 2010).

- A **full physical examination** should be performed, with particular attention given to vital signs, weight for height and age, skin, the cardiovascular system, and evidence of vomiting or abuse of laxatives, diet pills, or diuretics.
- A **dental examination** may be indicated, and is useful to assess growth, sexual development, and general indicators of physical development.
- A **psychiatric history,** including dieting history, substance use history, family assessment, and medication history, also is needed.

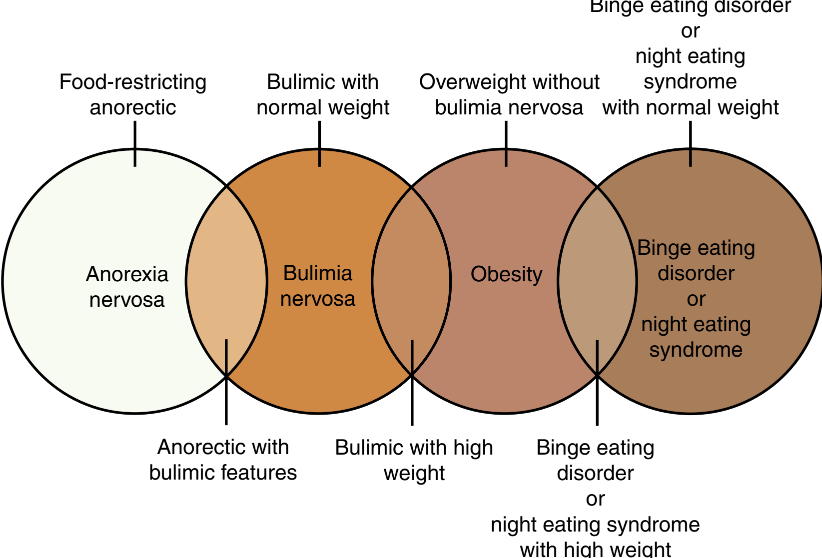

FIG 24-2 The overlapping relationships among eating disorders.

Specific attention should focus on the assessment of eating regulation responses. Several questionnaires and rating scales have been developed to screen for the presence of eating disorders. However, asking only the following two questions may be as effective as using more extensive questionnaires in identifying individuals with eating disorders:

- **Are you satisfied with your eating patterns?**
- **Do you ever eat in secret?**

These two questions can be easily incorporated into the nursing assessment of all patients.

If a patient is being evaluated for an eating disorder, additional information should be obtained, including the following:

- Actual and desired weight and weight history
- Onset and pattern of menstruation
- Food avoidances, restrictions, dieting, and fasting patterns
- Frequency, extent, and timing of binge eating or purging or both
- Unusual beliefs about nutrition
- Use of laxatives, diuretics, diet pills, and other methods of purging
- Chewing and spitting food
- Weight and shape preoccupations
- Body image disturbances
- Food preferences and peculiarities
- Compulsive exercise patterns

It also is helpful to ask the patient how the illness developed and what impact it has had on school, work, and social relationships so that a holistic view of the patient's world can be obtained.

Behaviors

Binge Eating.

Binge eating **involves the rapid consumption of large quantities of food in a discrete period of time.** There is no agreement on exactly how many calories constitute a binge. Patients with anorexia who binge may describe a binge of several hundred calories. Patients with bulimia who are not also anorexic may ingest several thousand calories at a sitting.

An emphasis on the patient's perception of loss of control and perceived excessive caloric intake is more important to the nursing assessment than the total number of calories consumed during a binge. Therefore, it is important that the nurse carefully assess exactly what each patient means by a binge.

People usually binge secretively, whether during the day or in the middle of the night. Considerable shame is often associated with their bingeing behavior. A person with bulimia typically is of average weight or slightly overweight and has a history of unsuccessful dieting. The severity of the bingeing can vary greatly, ranging from several times per week, to more than 10 times per day, to only occasional binges related to stressful situations.

Fasting or Restricting.

People with anorexia often consume less than 500 to 700 calories daily and may ingest as few as 200 calories daily, yet they see their intake as adequate for their energy needs. They may follow an unbalanced vegetarian diet, eliminating all meat, poultry, fish, and dairy products without substituting nonanimal sources of protein and other important nutrients.

They may be obsessive-compulsive about their eating habits and food choices, such as eating the same foods repeatedly, eating foods in a predetermined order, or eating at the same time every day. They may have bizarre food preferences, avoid foods that are considered fattening, or fast for days at a time.

Despite these restrictions, many people with anorexia are preoccupied or obsessed with food. They may do much of the family cooking or be employed in a food-related occupation. The following clinical example describes the fasting behavior seen in people with anorexia.

CLINICAL EXAMPLE

Barbara is a 15-year-old white female who has been restricting her food intake for 6 months because she feels too fat. Her weight at the beginning of her food restriction was 128 pounds (58 kg). This weight was appropriate for her age, her height (5 feet, 5 inches), and her small body frame. Her current weight is 102 pounds (46 kg), which is approximately 80% of what she should weigh. The patient denies having any eating problems and believes that her family is overreacting to her weight loss. She is willing to come for treatment only because her family wants her to do so.

Barbara was 13 years old at menarche and had regular periods until they stopped 2 months ago. She says she never tried or planned to lose weight but admits to becoming a vegetarian 6 months ago. Despite her low weight, Barbara thinks she needs to lose another 10 pounds (4.5 kg) because she thinks her thighs are too large. She is an avid ballet dancer and practices dancing 2 to 3 hours a day. Her family describes her as the perfect daughter.

Selected Nursing Diagnoses

- Imbalanced nutrition: less than body requirements related to restricted food intake, as evidenced by weight loss
- Disturbed body image related to eating disorder, as evidenced by continued desire to lose weight
- Ineffective denial related to eating problems, as evidenced by a lack of acceptance of realistic weight parameters

Purging. A variety of purging behaviors may be used by people with maladaptive eating regulation responses to prevent weight gain. Purging **includes excessive exercise, forced vomiting, and abuse of over-the-counter or prescription diuretics, diet pills, laxatives, or steroids.**

Laxatives are commonly abused by people with eating disorders, yet they are one of the most inefficient ways to lose calories. Laxative abuse often begins gradually but can increase to 60 doses per week in some people. Less well-known substances used to counteract weight gain include insulin, cocaine, heroin, thyroid replacements, nicotine, hallucinogens, analgesics, benzodiazepines, antidepressants, ipecac, and sorbitol. Many patients engage in more than one purging behavior.

For these patients, exercising often becomes a grueling, time-consuming affair. Running or participating in high-impact aerobics for 2 to 3 hours each day is typical of the compulsive exerciser. Many patients with an eating disorder exercise so much that they sustain major skeletal injuries, but this still does not deter them from continuing this maladaptive behavior. Such behavior is seen in the following clinical example.

CLINICAL EXAMPLE

Bill is a 30-year-old single male with a 7-year history of anorexia nervosa and bulimia nervosa. Bill exercises compulsively at least 3 hours daily; from age 23 until age 29 years he exercised 6 to 7 hours daily. Examples of current and previous exercise rituals include running 25 miles followed by a 2- to 3-mile swim and bicycling 25 miles before allowing himself to eat a meal. His athletic abilities have been rewarded with numerous trophies. He is receiving fewer trophies lately because of damage to his knees from overuse.

In addition to exercising compulsively, Bill vomits after bingeing and has periods of fasting that last 2 to 3 days. When he does eat a regular meal, he eats only certain foods and eats them in a certain order. Bill also writes obsessively and is methodical about the order of his personal hygiene. He is depressed about the fact that his life revolves around his eating, hygiene, and exercise rituals, and he is eager to receive treatment.

Selected Nursing Diagnoses

- Imbalanced nutrition: less than body requirements related to anxiety about body size, as evidenced by bingeing and fasting
- Disturbed body image related to fears of gaining weight, as evidenced by excessive exercise and food restrictions
- Risk for injury related to excessive exercise, as evidenced by knee injuries

Critical Reasoning Bingeing, fasting, and purging are sometimes described as addictive behaviors. Compare these behaviors with smoking, gambling, and substance abuse.

Medical Complications

People with a maladaptive eating regulation response usually have some type of associated physical problem. The various complications associated with eating disorders are listed in Box 24-1.

An assessment of the patient's physical status can reveal the seriousness of the eating problem. For example, patients who are 20% below or 40% above their ideal body weight demonstrate more physical abnormalities than those who are closer to their ideal weight.

QUALITY AND SAFETY ALERT

- Patients who are 30% below or 100% above their ideal body weight will have clinical and laboratory findings that are often life-threatening.
- People who vomit or use laxatives or diuretics, regardless of their weight, usually have significant and sometimes life-threatening clinical findings and laboratory abnormalities.

In anorexia nervosa, metabolic and endocrine abnormalities result from the reaction of the body to the malnutrition associated with starvation. All body systems are affected. Most commonly seen are amenorrhea, osteoporosis, and hypometabolic symptoms, such as cold intolerance and bradycardia (Smith and Wolfe, 2008). Starvation may cause hypotension, constipation, and acid-base and fluid-electrolyte disturbances, including pedal edema.

BOX 24-1 MEDICAL COMPLICATIONS ASSOCIATED WITH EATING DISORDERS

Central Nervous System
- Cortical atrophy
- Decreased rapid eye movement and short-wave sleep
- Fatigue
- Seizures
- Thermoregulatory abnormalities
- Weakness

Renal
- Hematuria
- Proteinuria
- Renal calculi

Hematological
- Anemia
- Leukopenia
- Thrombocytopenia

Gastrointestinal
- Dental caries and erosion
- Diarrhea (laxative abuse)
- Esophagitis, esophageal tears
- Gastric dilation
- Hypercholesterolemia
- Pancreatitis
- Parotid gland swelling

Metabolic
- Acidosis
- Dehydration
- Hypocalcemia
- Hypochloremic alkalosis
- Hypokalemia
- Hypomagnesemia
- Hypophosphatemia
- Osteoporosis

Endocrine
- Amenorrhea
- Decreased luteinizing hormone (LH) and follicle-stimulating hormone (FSH)
- Decreased triiodothyronine (T3), increased reverse triiodothyronine (rT3), abnormal thyroxine (T4), and abnormal thyroid-stimulating hormone (TSH)
- Irregular menses
- Regression of secondary sex characteristics

Cardiovascular
- Bradycardia
- Dysrhythmia, sudden death
- Postural hypotension
- Ventricular enlargement

In bulimia nervosa, potassium depletion and hypokalemia often are seen as a result of vomiting or laxative or diuretic abuse. Symptoms of potassium depletion include muscle weakness, cardiac arrhythmias, conduction abnormalities, hypotension, and other problems associated with electrolyte imbalance. Gastric, esophageal, and bowel abnormalities are common complaints in patients with bulimia. Those who vomit are subject to erosion of the dental enamel and enlargement of the parotid glands.

Serious health problems caused by excess weight or prior health problems exacerbated by increased weight are common for individuals with binge eating disorder and concurrent morbid obesity. **Excess weight is associated with hypertension, cardiac problems, sleep apnea, difficulties with mobility, and diabetes mellitus.** Some of the medical consequences of eating disorders are seen in the following clinical example.

CLINICAL EXAMPLE

Audrey is a 25-year-old African-American female with a 4-year history of restrictive intake and a 3-year history of binge eating and laxative abuse. Audrey has been concerned about her weight since high school, when she was a star basketball player, a competitive swimmer, and a participant in track, volleyball, and tennis. She bypassed her senior year in high school. She began to diet at 20 years of age, and her severe restriction of food at 21 years led to a 20-pound (9-kg) weight loss and amenorrhea. At 22 years old, she began to binge and use laxatives. Since that time she has binged two or three times each week and uses an average of 30 to 60 laxatives each week.

Audrey is constantly preoccupied with food and her weight and has periods of mood lability, sadness, lack of energy, social isolation, anxiety, irritability, and difficulty concentrating. Audrey also reports chronic constipation; bloating; edema of the hands, feet, legs, and face; and lightheadedness. She recently consulted a gastroenterologist for her severe constipation and was advised that her large intestine is grossly oversized. Audrey became very frightened by the report and immediately called a local eating disorder program for help.

Selected Nursing Diagnoses
- Imbalanced nutrition: less than body requirements related to fear of gaining weight, as evidenced by bingeing
- Disturbed body image related to anxiety about body size, as evidenced by excessive use of laxatives
- Constipation related to maladaptive eating patterns, as evidenced by pain, bloating, and enlarged intestine

Psychiatric Complications

Many patients seeking treatment for eating disorders show evidence of other psychiatric disorders, most particularly depression, anxiety disorders, and substance abuse. Co-morbid major depression or dysthymia has been reported in 50% to 75% of people with anorexia or bulimia, and obsessive-compulsive disorder may be found in as many as 25% of patients with anorexia nervosa.

Patients with bulimia have increased rates of anxiety disorders, posttraumatic stress disorder, substance abuse, and mood disorders (Hirth et al, 2011). People with antisocial personality disorders are six to seven times more likely to have bulimia than the general population.

Binge eating disorder has been found to be associated with higher rates of major depression, panic disorder, bulimia nervosa, borderline personality disorder, and avoidant personality disorder. Night eating syndrome is associated with increased rates of mood disorders characterized by a circadian pattern.

Predisposing Factors

Biological, psychological, and sociocultural factors may predispose a person to the development of an eating disorder (Roman and Reay, 2009). These factors are involved in the regulation and control of food intake and reflect a combination of genetic, neurochemical, developmental, personality, social, cultural, and familial elements (Figure 24-3).

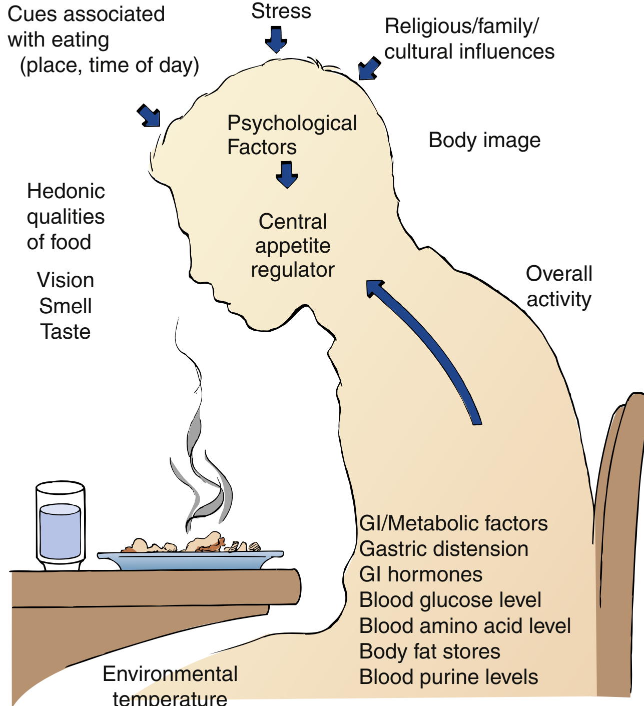

FIG 24-3 Major factors influencing food intake.

Biological. Both anorexia nervosa and bulimia nervosa are familial. The risk for eating disorders is higher in first-degree female relatives of people with eating disorders than in the general population. The concordance rates for eating disorders are 52% in monozygotic twins and 11% in dizygotic twins.

The risks for other eating disorders, depression, and substance abuse also are higher in first-degree relatives of people with eating disorders. Current genetic studies are exploring the chromosomal locations of the genes responsible for contributing to the development of eating disorders. In time, these findings may lead to better prevention programs for eating disorders.

Biological models of the etiology of eating disorders focus on the appetite regulation center in the **hypothalamus,** which controls specific neurochemical mechanisms for feeding and satiety. It has been hypothesized that the neurotransmitters, neuromodulators, and hormones that control feeding and satiety are dysregulated in patients with eating disorders.

Reduced **serotonin** is associated with reduced satiety, increased food intake, and dysphoric mood. When dietary tryptophan (the amino acid necessary for the brain to manufacture serotonin) is reduced, women with bulimia show a marked increase in eating behavior and mood changes, such as irritability, lability, and fatigue; this suggests a disturbance of serotonin activity. Single-photon emission computed tomography (SPECT) studies support the role of serotonin dysregulation in eating disorders.

Norepinephrine is reduced in eating disorders, and reduced **dopamine** has been found in obese individuals with binge eating disorder, suggesting a role for these neurotransmitters as well. It is hypothesized that decreases in dopamine receptors in this subset of eating disorder patients perpetuate pathological eating as a way to compensate for the decreased activation of reward circuits that are modulated by dopamine. Leptin, a protein that inhibits food intake, and the hormone, ghrelin, also may have a role in the neurobiology of eating disorders.

Finally, gray matter loss in the anterior cingulated cortex of the brain has been found to be related to the severity of anorexia nervosa, indicating an important role of this area in the pathophysiology of the disorder (Fladung et al, 2010). Ongoing research promises to shed more light on the biological factors that may predispose a person to maladaptive eating regulation responses (Brewerton, 2011; Marsh et al, 2011).

> **Critical Reasoning** Analyze the suggested role of serotonin in the development of eating disorders and depressive disorders, as well as the implications this has for the use of selective serotonin reuptake inhibitors (SSRIs) as a medication strategy for treatment of both disorders.

Psychological. Most patients with eating disorders exhibit psychological symptoms such as rigidity, ritualism, and meticulousness, often from early childhood. Women who have recovered continue to show an obsessive need for perfectionism, exactness, and symmetry, as well as greater risk avoidance, restraint, and impulse control.

Early separation and individuation conflicts, a pervasive sense of ineffectiveness and helplessness, difficulty interpreting feelings and tolerating intense emotional states, and a fear of biological or psychological maturity may predispose a person to an eating disorder. Women who binge also report great fluctuations of self-esteem, negative affect, shame, and guilt.

Environmental. A variety of environmental factors may predispose a person to develop an eating disorder. Early histories of patients with eating disorders are often complicated by medical and surgical illnesses, separations, and family deaths. Women with bulimia also describe growing up in a detached family environment and experiencing more behavioral disturbances such as drug abuse, suicide attempts, truancy, and other emotional problems.

Sexual abuse has been reported in 20% to 50% of patients with bulimia and anorexia. This rate is higher than in the general population.

TABLE 24-1 FAMILY EDUCATION PLAN

Preventing Childhood Eating Problems

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Describe self-demand feeding and its importance in healthy eating behaviors.	Explore parents' current feeding practices and understanding of healthy eating. Provide information to enhance knowledge of healthy eating behaviors.	Parents will identify healthy eating behaviors and self-demand feeding and begin to explore how their relationship with food influences their children's eating.
Describe the physiological and psychological signs of hunger and satiety, as well as the meaning and difference of both types of signs.	Explore parents' own signs of hunger and satiety, and have parents describe children's signs.	Parents will keep a hunger diary to record physical and psychological signs of hunger and satiety for themselves and their children.
Describe the danger of psychological hunger.	Explain the use of a hunger diary, which is a daily journal regarding signs of hunger.	Parents will be able to distinguish between psychological and physical hunger.
Explore myths about feeding, such as "cleaning the plate" and "eating because other children are starving."	Describe the importance of allowing children to determine their feeding needs and the relationship of healthy eating to children's ability to differentiate between physical and psychological signs of hunger and satiety. Give a homework assignment for each parent to interview three other adults about their current eating practices and memories of eating.	Parents will complete homework assignment, discuss interview experiences, and describe how perpetuating myths about feeding can harm their children.
Implement self-demand feeding at particular developmental stages of children.	Review the eating stages children experience and the potential problems they may have at each stage.	Parents will discuss the developmental stages of their children and plan to implement self-demand feeding.
Discuss parental experiences related to implementing self-demand feeding.	Review parents' expectations and experiences with implementing self-demand feeding.	Parents will relate any problem with implementing self-demand feeding. Nurse will evaluate family for further education and plan for follow-up if necessary.

Parents who overemphasize athletics, reward slimness, or express disapproval of overweight people are placing their children at risk for development of eating disorders. Parents who continually skip meals, eat when distressed, and otherwise role model poor nutritional habits are not teaching children about the appropriate value of food as nourishment. **An important preventive nursing intervention involves educating the parents of young children regarding healthy eating behaviors** (Table 24-1).

Sociocultural. Over the past 50 years, the incidence of diagnosed eating disorders, subclinical eating problems, and body image disturbances has steadily increased. Eating disorders are thought to be rare in cultures where plumpness is accepted or valued. **Shifting cultural norms for women, in particular, have forced them to face conflicting messages about their body.**

Thinness is highly valued, culturally rewarded, and associated with achievement. The contemporary U.S. ideal woman is lean, strong, graceful, and feminine. One advantage to this profile is its emphasis on fitness and health.

A disadvantage is the demand this norm places on women to focus on and control their bodies, often as a means for achieving desired goals. This leads to intense social pressure on women for self-discipline, rigorous exercise, dieting, and often obsessive concern about weight and body image. **The result is that at least 50% of U.S. women are on a diet at any given time, with people in the United States spending more than $5 billion on dieting products.**

Children, adolescents, and young adults who live in communities or go to schools where emphasis is placed on weight and size are often prone to the development of eating disorders. Activities or occupations that emphasize beauty or fitness also promote a preoccupation with weight and eating behaviors. Ballet dancers, models, actors, athletes, and fashion retailers have demands placed on them concerning body weight and size.

Although these occupations and activities in themselves do not cause eating disorders, they do attract people who may measure their self-esteem, self-worth, and ability to perform by their body measurements rather than by their accomplishments and personal satisfaction. **Psychosocial predisposing factors for the development of eating disorders are summarized in Box 24-2.**

Critical Reasoning Watch television for an evening, and count the number of men and women who are overweight. Explain any sociocultural bias you observe.

Precipitating Stressors

Having one or more predisposing factors puts a person at risk for an eating disorder. People who are predisposed are especially vulnerable to environmental pressures and stress.

BOX 24-2 PSYCHOSOCIAL PREDISPOSING FACTORS FOR THE DEVELOPMENT OF EATING DISORDERS

Personal Factors
- Weight
- Puberty/maturation
- Restrained eating/dieting
- Body image dissatisfaction
- Problems regulating affect
- Depression
- Perfectionism
- Low self-esteem
- Stress
- Low resiliency/confidence
- Poor coping skills
- Alcohol and substance use
- Sexual/physical abuse
- Early dating

Family Factors
- Parental attitudes
- Family functioning

Peers
- Attitudes about weight
- Bullying
- Teasing

Culture
- Media influences

Activities
- Gymnastics
- Professional dance
- Modeling

Lacking an integrated self-concept and realistic body image, they rely on external feedback, such as the reactions of others to their appearance and actions.

They are unable to perceive or interpret stimuli from within the body, have difficulty describing their feelings and self-concepts, and lack an internal center of initiative and regulation. Therefore they must rely on external cues to regulate themselves. Food becomes one of these cues, and it is used as an external replacement for a deficient internal regulator and inadequate integration of the body and mind.

Appraisal of Stressors

The person with an eating disorder is very susceptible to the impact of life stressors, such as loss of a significant other, interpersonal rejection, and failure. Some researchers have suggested that people predisposed to eating disorders exercise not as a way to lose weight but as an attempt to experience the reality of their bodies.

Controlling one's eating or vomiting is another attempt to avoid the anguish of emptiness, boredom, or tension. Although binge eating may momentarily release this tension, it sets in motion a cycle of bingeing and purging that, once begun, is very difficult to stop. The importance of a person's appraisal of stressors related to eating disorders is seen in the following clinical example.

CLINICAL EXAMPLE

Lydia is a 15-year-old female with a 6-year history of bingeing, a 2-year history of restricting food intake, and a 9-month history of purging. She is the only child of parents who separated when she was 3 years old and divorced when she was 6. Her father has a history of frequent mood swings and has been diagnosed with and treated for bipolar disorder. He has always been overly concerned not only about his body appearance but also about the appearance of his family.

When Lydia was 9 years old, her father moved to a city 500 miles away, and 2 years later he remarried. Lydia's mother remarried several months later, but her marriage lasted less than a year. Her new husband had concealed an alcohol problem, and Lydia and her mother were verbally abused by this man on many occasions. After her second divorce, Lydia's mother socialized very little and became overprotective of Lydia. She has often criticized Lydia's father for his extramarital behavior during their marriage. She supported him through college and dental school and was angry about her lowered standard of living since their divorce.

Lydia's parents continue to have a stormy relationship, and she feels caught between them at times. She avoids conflict by siding with her custodial parent (her mother) and by avoiding any discussion about her mother with her father. Lydia tries to be the perfect daughter and strives to avoid displeasing either parent.

She has become very overprotective of her mother and secretly despises her father. She feels that a number of people have hurt her mother and that she and her mother must protect each other. She is afraid to grow up because her mother will be left alone. She states, "I'm the center of my mom's universe. If she's alone, her world will crumble. … I'm happiest when I'm worrying about my mom." Lydia does not think she has any eating problems and is very resistant to treatment. Her parents feel otherwise.

Selected Nursing Diagnoses
- Imbalanced nutrition: less than body requirements related to unrealistic self-image, as evidenced by bingeing, purging, and restricting food
- Ineffective denial related to family conflict, as evidenced by overprotection of mother and ambivalence toward father

Coping Resources

One of the most important aspects of the assessment of patients with maladaptive eating regulation responses is their motivation to change their behavior. **Readiness to change, motivational interviewing, and decisional balance exercises—all strategies described in Chapter 27—are highly recommended.**

For example, patients can be asked to rate their desire for treatment on a scale of 1 to 10, with 10 representing high motivation and 1 representing low motivation for change. Patients also may be asked to identify the advantages and

disadvantages of giving up the behavior. This information can be used to evaluate a patient's insight, to identify coping resources, and to stimulate therapeutic issues for future discussion.

Areas that are important for engaging patients who are reluctant to treat their eating disorder include the following:

- Providing psychoeducational material
- Examining the advantages and disadvantages of symptoms
- Exploring personal values

The nurse might ask patients how their bingeing, fasting, and purging serve as a form of coping. Asking patients what precedes these episodes and how they feel afterward is an important element of the nurse's assessment.

The patient also should be asked how stress and tension have been handled adaptively in the past and what supports in the environment are available to help in the treatment process. Such supports may include family members, friends, work, and leisure activities.

Coping Mechanisms

People with anorexia nervosa are happiest when fasting, losing weight, or achieving their weight goals. **Their use of denial is severely maladaptive, and they are unlikely to seek help on their own.** Concerned family members, primary care practitioners, nurses, or school counselors are usually the ones who identify a problem and attempt to obtain help for the patient.

People with anorexia are usually angry or impatient with the concern shown by others. Interestingly, as the family becomes more distraught about the loss of weight or signs of malnutrition, the insistence of normalcy by the person with anorexia increases.

For people with anorexia, the issue is not really about weight. **The core issue is about controlling life and fears.** Those who fear maturity, independence, failure, sexuality, or parental demands believe they have found a solution to the problem by controlling their food intake and their bodies. As family concerns increase, people with anorexia are able to gain control over the focus of significant others as well. For them, anorexia seems to be the perfect solution for gaining control.

The defense mechanisms used by people with bulimia include avoidance, denial, isolation of affect, and intellectualization. Regardless of their weight, people with bulimia are usually very upset about their bingeing and purging behavior. They realize that their behavior is a sign that they are not in control or coping adaptively, but they do not know why. They are more likely to acknowledge that they have a problem than are patients with anorexia. However, they may regard the symptoms as preferable to the prospect of weight gain, and it may be years before they accept treatment.

People with binge eating disorder share the bulimic patient's distress about bingeing, but it is unclear how motivated they are to seek treatment. Obese binge eaters are more likely to seek assistance on their own or to accept referral by their primary care practitioner. Patients with night eating syndrome are also very distressed, especially if obese. They will readily seek treatment.

DIAGNOSIS

Nursing Diagnoses

In formulating the nursing diagnosis, the nurse should review all aspects of the assessment phase as identified in the Stuart Stress Adaptation Model (Figure 24-4). Nursing diagnoses related to eating disorders encompass biological, psychological, and sociocultural concerns. Because of the complexity of these disorders, many NANDA International (NANDA-I) nursing diagnoses may be appropriate.

The primary NANDA-I diagnoses for working with patients with maladaptive eating regulation responses include anxiety, disturbed body image, imbalanced nutrition, powerlessness, chronic or situational low self-esteem, and risk for self-mutilation. Primary NANDA-I nursing diagnoses and examples of complete nursing diagnoses are presented in Table 24-2.

Patients with moderate to extreme nutritional deficiencies exhibit symptoms of malnutrition that may be mistakenly related to other causes. Irritability, apathy, depression, obsessiveness, difficulty with concentration, anxiety, decreased interest in sex, and negativism are psychological symptoms that usually reverse with adequate nutrition.

The nurse may see a very different outward presentation in a patient who is no longer malnourished. Family members may offer important insights into the patient's premorbid functioning and may be able to give a clearer picture of the patient's personality before the eating disorder developed.

Medical Diagnoses

The medical diagnoses associated with maladaptive eating regulation responses include anorexia nervosa, bulimia nervosa, and binge eating disorder (American Psychiatric Association, 2000). Night eating syndrome is not yet a validated medical diagnosis, but it is under consideration for identification as a separate eating disorder. Medical terms and their definitions are described in Table 24-2. The key features distinguishing anorexia nervosa from bulimia nervosa are listed in Table 24-3.

OUTCOMES IDENTIFICATION

The **expected outcome** for the patient with maladaptive eating regulation responses is as follows: ***The patient will restore healthy eating patterns and normalize physiological parameters related to body weight and nutrition.***

For patients with anorexia nervosa or bulimia nervosa, this means eating 100% of all meals without bingeing, purging, or engaging in other compensatory behavior. Obese patients with binge eating disorder or night eating syndrome should be encouraged to leave something (no more

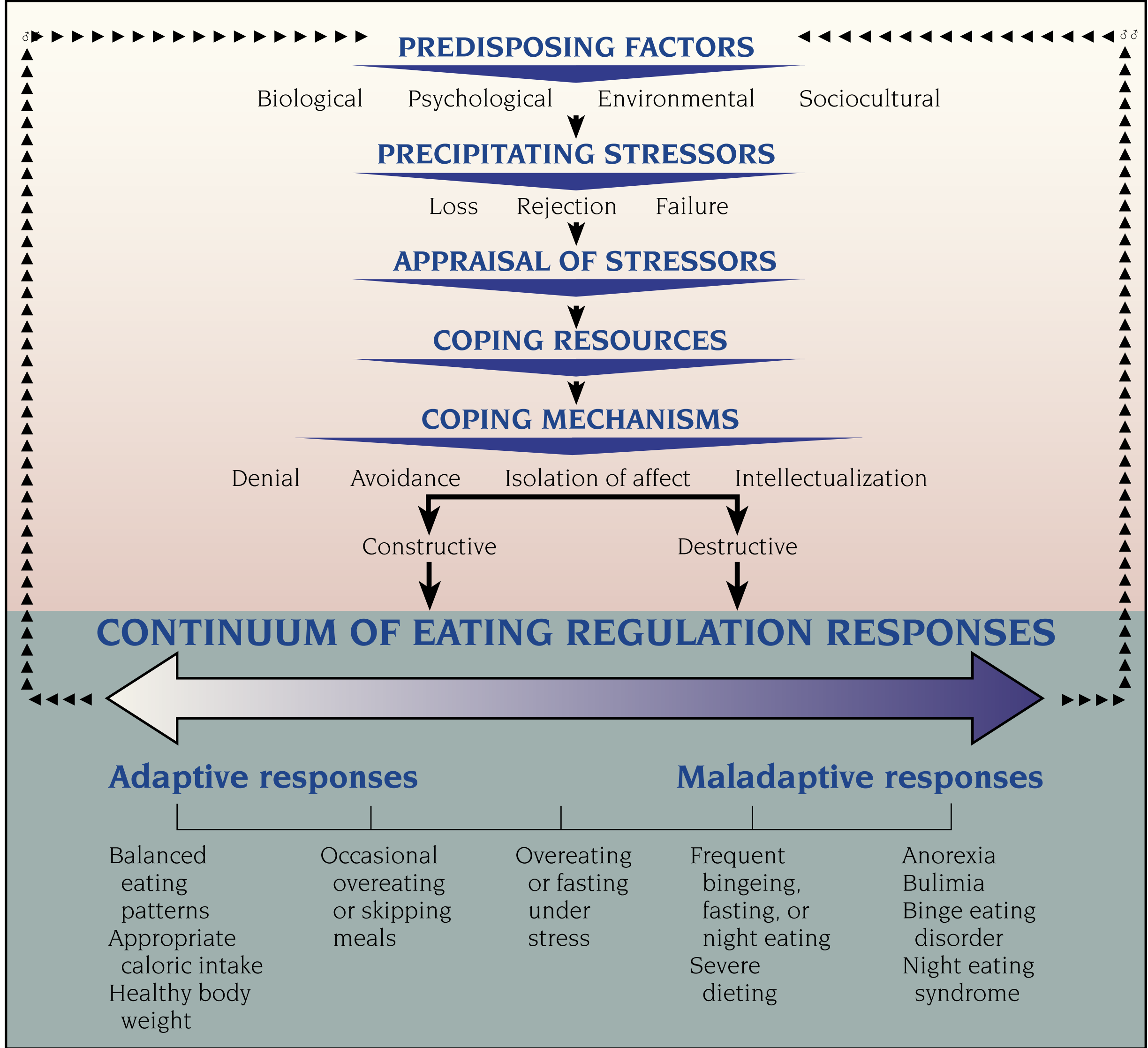

FIG 24-4 The Stuart Stress Adaptation Model as related to eating regulation responses.

than 5% and no less than 2%) on their plate at the end of each meal.

Short-term goals may further specify the steps the patient needs to take to demonstrate adaptive eating regulation responses. These steps might include the following:

- The patient will identify cognitive distortions about food, weight, and body shape.
- The patient will develop a week's worth of menus for nutritionally balanced meals.
- The patient will accurately describe body dimensions.
- The patient will exercise in moderate amounts only when nutritionally and medically stable.
- The patient will demonstrate positive family interactions and successful movement toward the achievement of separation and individuation issues.
- The patient will be able to describe the complications and medical sequelae of the eating disorder behavior.

PLANNING

Choice of Treatment Setting

Nursing care varies to some degree based on the treatment setting of the patient with maladaptive eating regulation responses. A number of factors affect the choice of treatment setting, including the patient's physical and psychological condition, financial resources, availability of treatment specialists, and patient preference (Grilo and Mitchell, 2010). Clinical criteria for inpatient treatment of eating disorders are listed in Box 24-3.

QUALITY AND SAFETY ALERT

- Inpatient care is needed if physiological status is compromised.
- Outpatient treatment allows the patient the greatest opportunity for self-control and autonomy.

TABLE 24-2 NURSING DIAGNOSES AND MEDICAL TERMS RELATED TO *Eating Regulation Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Anxiety	Anxiety related to fear of weight gain, as evidenced by rituals associated with food preparation and eating
Disturbed body image	Disturbed body image related to fear of weight gain, as evidenced by verbalization of being "fat" while actually being 30% below ideal body weight
Imbalanced nutrition: more than body requirements	Imbalanced nutrition, more than body requirements related to excessive intake of calories, as evidenced by body weight 40% above ideal, sleep apnea, and difficulty with mobility
Powerlessness	Powerlessness related to perceived lack of control over eating behaviors, as evidenced by inability to stop binge eating and avoidance of food-related settings
Chronic low self-esteem	Chronic low self-esteem related to feelings of low self-worth, as evidenced by verbalization of the sole standard of success being related to physical attractiveness
Risk for self-mutilation	Risk for self-mutilation related to feelings of inadequacy, as evidenced by injuries caused by excessive exercise and self-induced vomiting
MEDICAL TERM	**DEFINITION***
Anorexia nervosa	An eating disorder characterized by such behaviors as eating tiny portions, refusing to eat, and denying hunger, dressing in loose, baggy clothing to hide weight loss, exercising excessively and compulsively, feeling cold frequently, experiencing hair loss, sunken eyes, or pale skin, complaining of being fat, even when underweight, and developing *lanugo*, fine body hair that develops along the midsection, legs, and arms
Bulimia nervosa	An eating disorder characterized by such behaviors as eating little in public but overeating in private, disappearing after eating, spending a lot of time in the bathroom, sounding hoarse, experiencing bruised or callused knuckles, bloodshot eyes, or light bruising under eyes, hiding food wrappers and other evidence of binge eating, and experiencing severe dental problems (loss of enamel)
Binge eating	An eating disorder characterized by such behaviors as hiding food to eat later, eating little in public but overeating in private, and hiding food wrappers and other evidence of binge eating
Compulsive overeating	An eating disorder characterized by such behaviors as a history of repeating cycles of losing and regaining body weight (yo-yo dieting), believing that all problems could be solved by losing weight, eating little in public but overeating in private, and hiding food wrappers and other evidence of binge eating

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*Substance Abuse and Mental Health Services Administration: Clients with substance use and eating disorders, *SAMHSA Advisory*, 10(1), 2011.

TABLE 24-3 KEY FEATURES OF ANOREXIA NERVOSA AND BULIMIA NERVOSA

ANOREXIA NERVOSA (WITHOUT BINGEING OR PURGING)	BULIMIA NERVOSA
Rare vomiting or diuretic/laxative abuse	Frequent vomiting or diuretic/laxative abuse
More severe weight loss	Less weight loss
Slightly younger	Slightly older
More introverted	More extroverted
Hunger denied	Hunger experienced
Eating behavior may be considered normal and a source of esteem	Eating behavior considered foreign and source of distress
Sexually inactive	More sexually active
Obsessional and perfectionist features predominate	Avoidant, dependent, or borderline features as well as obsessional features
Death from starvation (or suicide, in chronically ill)	Death from hypokalemia or suicide
Amenorrhea	Menses irregular or absent
Fewer behavioral problems (these increase with level of severity)	Drug and alcohol abuse, self-mutilation, and other behavioral problems

An advantage to inpatient treatment is the availability of 24-hour nursing care to ensure patient safety, support needed behavioral change, and monitor physiological responses. Patients with eating disorders can present a unique challenge to staff, and care requires a high level of interdisciplinary collaboration, coordination, and consistency.

Outpatient treatment requires a high level of patient motivation, active support and involvement of family members, and ongoing physiological monitoring. Contingencies for outpatient treatment should be mutually agreed on expectations of behavioral change, including weight gain and decreased bingeing or purging, as well as the acceptance

BOX 24-3 CLINICAL CRITERIA FOR HOSPITALIZATION OF PATIENTS WITH AN EATING DISORDER

Medical

Need for extensive diagnostic evaluation
Weight loss: >25% of body weight over 3 months
Heart rate: <40 beats/min or >110 beats/min
Temperature: <97.0° F
Systolic blood pressure: 70 mm Hg or marked orthostatic hypotension (20 mm Hg/min standing)
Serum potassium: <2.5 mEq/L despite oral potassium replacement
Severe dehydration or vomiting of blood
Concurrent somatic illnesses (e.g., infection)

Psychiatric

Risk of suicide or self-mutilation
Severe depression
Substance abuse
Psychosis
Family crisis
Failure to comply with treatment contract or poor motivation
Inadequate response to outpatient treatment

of inpatient or more intense day treatment programs if the patient is not making progress.

Outpatient settings, including day treatment, intensive outpatient programs, and partial hospitalization programs, as well as weekly outpatient office care, are the current standard treatment settings. Unfortunately, resources, particularly health insurance, often restrict the settings for treatment and the number of treatment episodes. Reimbursement for inpatient programs, except under dangerous or severe conditions (e.g., suicidal intent), is often difficult to obtain.

Empirically validated treatments for bulimia nervosa are summarized in Table 24-4 (Nathan and Gorman, 2007).

Nurse-Patient Contract

Nurse-patient contracts can be formulated for patients with eating disorders who are seen in inpatient or outpatient settings. **The goal of these contracts is to engage the patient in a therapeutic alliance and to obtain commitment to the treatment process.**

Before a patient is admitted to an eating disorder treatment program, the patient's cooperation should be obtained with a nurse-patient contract. By signing such a contract, patients show that they understand what treatment they will be receiving and are able to make informed decisions about their commitment to the treatment process and their ability to honor the contract.

Critical Reasoning How would you respond to a patient who wants to receive treatment for an eating disorder but does not want to sign the nurse-patient contract because it is "too restrictive"?

TABLE 24-4 SUMMARIZING EVIDENCE-BASED TREATMENT FOR *Eating Disorders*

DISORDER	TREATMENT
Bulimia nervosa	Manual-based cognitive behavioral therapy is the treatment of choice. Several different classes of antidepressant drugs produced significant, short-term reductions in binge eating and purging. The long-term effects of antidepressant medications remain untested. There is little evidence that combining cognitive behavioral therapy with antidepressant medication significantly enhances improvement in the core features of bulimia nervosa, although it may aid in treating co-morbid anxiety and depression.

From Nathan PE, Gorman JM: *A guide to treatments that work,* ed 3, New York, 2007, Oxford University Press.

IMPLEMENTATION

Nutritional Stabilization

Healthy target weights and expected rates of controlled weight gain or loss should be set. In life-threatening circumstances, patients who are malnourished may need refeeding interventions, but these cases are the exception.

QUALITY AND SAFETY ALERT

- Stabilizing the patient's nutritional status is a high priority for nursing intervention.

Specific nursing interventions to promote weight stabilization and restore healthy eating patterns can be facilitated by program protocols that identify treatment goals, program components, and patient and staff responsibilities. These protocols may include some of the following:

- The time, frequency, and procedure for weighing the patient and whether the patient may view the weight reading
- The time when meals will be served and the number of meals that are to be eaten each day
- How the staff is to interact with the patient during mealtimes to maximize the therapeutic value of their presence
- The amount of time the patient will be allotted to eat each meal, and the consequences if the meal is not completed in that time
- Whether diet foods, condiments, or food substitutions will be allowed
- The amount of water the patient may drink each day
- The frequency of obtaining the patient's vital signs, intake and output, and required laboratory work

- Conditions regarding bathroom privileges
- Indications for close observation by staff

Once patients are able to master eating their meals, they can move toward having more independence over scheduling their meals and food selection. Selecting their own menus with assistance is next. The patient can then progress to shopping for and cooking food with supervision. By the time of discharge, the patient should have gained a high level of comfort with food and its preparation.

For outpatients with anorexia nervosa, stabilization of nutrition and promotion of weight gain usually require a motivated patient and a cooperative family. Obtaining the patient's agreement to stop trying to lose weight is the first obstacle the nurse must overcome; patients are often very resistant to such an idea.

Getting a patient with anorexia to gain weight is an even more difficult task. Nurse-patient contracts can be effective tools in working with these patients because their need for control of food is so great. For example, the nurse and patient may set a realistic goal of gaining 1 pound (0.45 kg) per week. The contract would stipulate that if the patient fails to gain 4 pounds (1.8 kg) in 1 month, the patient agrees to enter a hospital, day treatment program, or some other more intensive type of care.

Counseling about healthy eating patterns and behaviors is an essential aspect of nursing care for all patients, regardless of whether they need to gain, lose, or maintain weight. The nurse should also clarify with patients the effects of poor nutrition on the body. Collaboration with a dietitian may be helpful in teaching patients about proper eating habits and in planning menus with patients.

Nurses should teach, clarify, and reinforce knowledge about proper nutrition and the importance of planning healthy meals. Patients should be encouraged to make their own shopping lists; the nurse may even accompany the patient to the grocery store. **Nutritional assessment, education, and ongoing support are essential nursing care activities.**

The patient who is struggling with major issues regarding food will not be ready for intensive psychological interventions. As the patient feels less need to be in control of food and eating, issues underlying the eating disorder may start to surface. This can be a difficult time for the patient, who may actually begin to feel worse than at the time treatment began.

Patients in a hospital or a partial hospitalization program always have someone available to talk with, but this may not be true for the outpatient. Therefore the outpatient may need more frequent sessions with the nurse or more telephone contacts between sessions. After sufficient progress has been made toward nutritional rehabilitation, the patient will be better prepared both cognitively and emotionally to begin the next phase of treatment.

Exercise

As the patient's eating increases, the need to increase exercise or engage in a new purging or compensatory behavior also may increase. Patients on an inpatient or partial hospitalization unit can be closely monitored to prevent such compensatory activity. It is often appropriate to have the patient begin a gradual exercise program as the patient stabilizes and responds to treatment.

For patients who previously exercised compulsively, this time of restricted exercise can be the most difficult period of treatment. The nurse should initially allow patients limited amounts of exercise, with gradual increases over time.

The focus of the exercise program should be on physical fitness rather than on working off calories. Consultation with a recreational therapist or exercise physiologist may be helpful to maximize the therapeutic value of the exercise regimen.

Cognitive Behavioral Interventions

Cognitive behavioral therapy has been found to be the single most effective treatment for patients with eating disorders. It is important for the nurse to work with patients in regard to their cognitive distortions or faulty thinking about body shape, weight, and food (Peterson et al, 2009; Debar et al, 2011; Mitchell et al, 2011).

Box 24-4 presents a list of cognitive distortions that are common among patients with eating disorders and an example of each. Cognitive distortions and behavior change strategies are discussed in detail in Chapter 27.

Helping the patient become aware of cognitive distortions is the first step in changing them. The patient should

BOX 24-4 COGNITIVE DISTORTIONS RELATED TO MALADAPTIVE EATING REGULATION RESPONSES

Magnification: Overestimating the significance of undesirable events. Stimuli are embellished with meaning not supported by objective analysis. "I've gained 2 pounds, so I can't wear shorts anymore."

Superstitious thinking: Believing in the cause-and-effect relationship of noncontingent events. "If I eat a sweet, it will instantly be turned into stomach fat."

Dichotomous or all-or-none thinking: Thinking in extreme or absolute terms, such as that events can only be black or white, right or wrong, good or bad. "If I gain 1 pound, I'll go on to gain 100 pounds."

Overgeneralization: Extracting a rule on the basis of one event and applying it to other, dissimilar situations. "I used to be of normal weight and I wasn't happy. So I know gaining weight isn't going to make me feel better."

Selective abstraction: Basing a conclusion on isolated details while ignoring contradictory and more important evidence. "The only way I can be in control is through eating."

Personalization and self-reference: Egocentric interpretations of impersonal events or overinterpretation of events related to the self. "Two people laughed and whispered something to each other when I walked by. They were probably saying that I looked unattractive. I have gained 3 pounds."

be asked to monitor and record eating, bingeing, and purging behavior and thoughts and feelings regarding weight, shape, and food. The goal of these exercises is for patients to better understand the following aspects of their behavior:

- **Cues that trigger problematic eating responses**
- **Thoughts, feelings, and assumptions associated with the specific cues**
- **Connections between these thoughts, feelings, and assumptions and eating regulation responses**
- **Consequences resulting from the eating responses**

Cues. **Cues that trigger maladaptive eating behavior can be social, situational, physiological, or psychological.** Examples of social cues are loneliness, interpersonal conflict, social awkwardness, and holiday celebrations. Examples of situational cues include advertisements and walking by a store that sells snack food for binge eating. Hunger and fatigue are the two most common physiological cues. Memory and mental images are two examples of psychological cues.

Specific cues such as these can trigger cognitive distortions and lead to maladaptive eating regulation responses. For example, when stepping on the scale, a patient may see that she has gained 1 pound (0.45 kg). She then may use dichotomous thinking: "Since I've gained 1 pound, I will probably gain 20 pounds (9 kg) in the next week. I'd better take a package of laxatives so that I can lose the pound by tomorrow." In this situation,

- Stepping on the scale is the cue.
- Believing she will gain 20 pounds is the related irrational thought.
- Taking the laxatives is the maladaptive eating regulation response connected to the cognitive distortion.
- Beginning another purge cycle is the consequence resulting from the maladaptive response.

Cues also can be used as a strategy for promoting change. Rearranging cues, avoiding a cue, and changing the response to a cue are ways of altering maladaptive responses. After continued learning about eating, bingeing, and purging behaviors as well as thoughts and feelings about food, shape, and weight, it is hoped that the patient will begin to see the connections between thoughts and behaviors and recognize the consequences of the harmful activity.

Thoughts, Feelings, and Assumptions. **The nurse helps patients challenge their faulty thoughts, feelings, and assumptions by questioning the evidence supporting or challenging a particular belief.** In the previous example, the nurse might ask the patient what specifically happened in the past when she gained 1 pound. Did she gain 19 more pounds in the same week? If so, how often has it happened in the past? If not, why does the patient believe it will happen this time?

It is also important for the nurse to ask the patient about the implications of this type of thinking. Do other people have the same problem if they gain 1 pound? If so, how do they deal with it? The nurse can help the patient consider alternative explanations for the patient's thoughts, thereby gradually modifying the irrational assumptions that underlie these beliefs. These and other cognitive behavioral techniques may be successfully used in patients with maladaptive eating regulation responses (Box 24-5).

BOX 24-5 A PATIENT SPEAKS

Learning to separate my feelings from my eating has been the hardest part but also the greatest benefit of treatment for my eating disorder. From early childhood, food had been my main outlet for almost every emotion. When I was sad, I comforted myself by eating. When I was happy, I celebrated by eating. Feelings of loneliness could be lessened by gathering up all my "food friends" and eating. Feeling angry at anyone other than myself was unacceptable, so I would eat and then have a "good reason" to be angry and focus it all on myself.

Discovering that everything in life is not black or white, good or bad, perfect or imperfect, or hungry or full has helped me be kinder to myself and more accepting of my imperfections. I now realize that shades of gray do exist when making a decision, performing a task, feeling an emotion, and even experiencing hunger. Another benefit of this insight is a decrease in my level of anxiety and in my feelings of worthlessness.

Each day is no longer a battle to control all aspects of my life, especially my food consumption. The struggle with food and my weight still remains, but now it doesn't completely overshadow everything else that happens in my life. Food is no longer the only friend and enemy life offers. I learned all this from a nurse who took the time to get to know me and in turn helped me to get to know myself.

Eating Regulation Responses. The patient with an eating disorder needs help in **solving problems** and **making decisions.** Rather than resorting to maladaptive responses, the patient must be helped to distinguish between adaptive and maladaptive coping responses and to find alternative solutions.

One way of doing this is to encourage the patient to make a list of high-risk situations that cue maladaptive eating and purging behaviors. The high-risk situation may be a certain day of the week, time of the day, season of the year, person, group, event, or emotional response, such as anger or frustration. The nurse can then help the patient identify specific, alternative, and more adaptive ways of handling these high-risk situations.

Decision-making strategies also may need to be reviewed and modified. Many patients with eating disorders know what they need to do in a given situation but feel inadequate or shy about carrying out a certain plan of action. These people may benefit from assertiveness training and role-modeling sessions with the nurse.

Consequences. It is particularly important for the nurse and patient to explore the positive and negative consequences that result from cognitive distortions and maladaptive responses. **These consequences can be biological, psychological, and**

TABLE 24-5 CONSEQUENCES OF MALADAPTIVE EATING REGULATION RESPONSES

POSITIVE CONSEQUENCES	NEGATIVE CONSEQUENCES
Biological	
Reduced fear of fatness	Weakness, fatigue, dizziness
Reduced perception of hunger	Poor concentration
	Electrolyte disturbance
Avoidance of biological maturity	Dental problems
Psychological	
Relief from tension, anger, and stress	Depression, guilt, shame
Relief from boredom	Tendency to overreact emotionally
Emotional anesthesia	Increase in negative self-reference or guilt-related behavior
Feelings of nurturance or pleasure	
Thoughts about avoiding weight gain	
Sociocultural	
Avoidance of interpersonal conflict	Social withdrawal
Social reinforcement for not gaining weight	Lying and lack of trust in relationships
Distraction from unpleasant tasks	Occupational problems
	Financial problems
Avoidance of responsibility and independence	Legal problems

sociocultural, with positive and negative consequences resulting from each behavior.

Some of these consequences are presented in Table 24-5. A maladaptive behavior such as bingeing is maintained because the positive consequences are more immediate or are more valued than the negative consequences.

Strategies for change that focus on consequences involve the use of rewards that increase the likelihood of behavior change. In the case of a patient who takes laxatives in response to a 1-pound weight gain, rewards would be given if the person were able to resist taking the laxative. The reward should be received immediately following the desired behavior change. It should be something pleasurable and can be either a material item or a psychological reinforcer, but it should not involve food.

Critical Reasoning Should overweight nurses be assigned to care for patients with eating disorders? Why or why not?

Body Image Interventions

Body image distortions are one of the most difficult-to-treat aspects of eating disorders. Body image distortion in the eating disorders involves perceptions, attitudes, and behaviors (Figure 24-5).

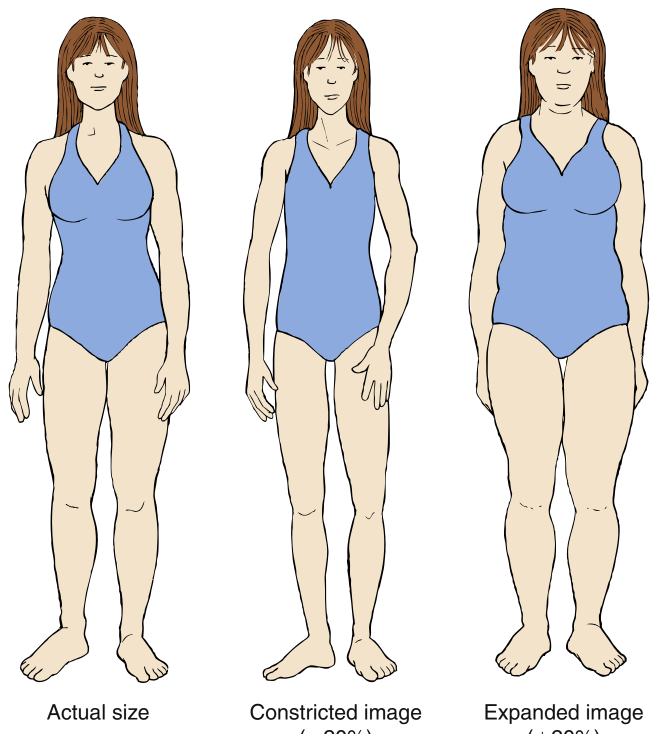

FIG 24-5 The perception of body shape and size can be evaluated through the use of special computer drawing programs that allow a subject to distort the width of an actual picture of a person's body by as much as 20%, larger or smaller. Both anorectic and normal subjects adjusted the figures of other people's bodies to normal dimension. However, anorectic subjects consistently adjusted their own body picture to a size 20% larger than its true form, which suggests they have a major problem with the perception of self-image.

A distinction between body image distortion and body dissatisfaction must be made.

- **Body image distortion** is a discrepancy between the patient's actual size and the patient's perceived body size.
- **Body dissatisfaction** is the degree of unhappiness that a person feels in relation to body size.

All people may express dissatisfaction with their bodies at some point in their lives, but such dissatisfaction is constant in persons with anorexia or bulimia. People with eating disorders place so much value on their appearance that it begins to totally define their self-worth.

Behavioral features of body image disturbance are seen in a lifestyle that revolves around a self-concern about the body. Examples of such behaviors include constantly measuring body weight, wearing baggy clothes, and avoiding social situations that focus on appearance. Overestimation of body size or of a body part is a common perceptual distortion in anorexia and bulimia.

When intervening in body image problems, the nurse should first determine whether the patient has problems with perception, attitude, or behavior and then devise a treatment program targeting the specific problem area. Cognitive behavioral interventions are effective, as are dance and movement therapies, which create pleasant body experiences and can enhance the integration of mind and body, clarify body boundaries, and modulate negative feelings about the body. Other therapeutic approaches include the use of imagery and relaxation, working with mirrors, and depicting the self through art.

Family Involvement

Families should be engaged from the beginning of treatment and should be included in family meetings and treatment planning sessions. The nurse should gather information about the family system and explore how the maladaptive eating response might serve a specific function within the family. Questions the nurse might ask include the following:

- What part does the eating disorder serve in stabilizing the family system?
- How has the family attempted to deal with the eating disorder?
- What is the central theme surrounding the eating behavior?
- What would be the consequences of change for each family member?
- What is the underlying therapeutic issue from a family perspective?

Many young patients need intensive family therapy after successfully completing the refeeding stage. The initial issue of such therapy is centered on the separation and individuation of the patient within the context of the family. This process requires much openness on the part of the family, and not every family may be able to complete the process (Goddard et al, 2011). However, the nurse should work with identified family strengths and help involved family members work toward change (Box 24-6).

Group Therapies

Many models of group therapy are used for patients with eating disorders, including cognitive behavioral, psychoeducational, psychodynamic, and interpersonal models. Reality testing, support, and communicating with peers are essential therapeutic factors provided by group intervention. Outpatient support groups may be helpful if they reinforce social alliances and encourage members to identify and express feelings. Therapeutic groups are described in detail in Chapter 31.

In addition, self-help groups show promise for treating eating disorders. Two mutual-help groups that focus on people with eating disorders and offer face-to-face, online, and telephone meetings are as follows:

- Overeaters Anonymous (OA), which is based on the 12-step model
- Eating Disorders Anonymous (EDA), which is appropriate for anyone with an eating disorder

BOX 24-6 A FAMILY SPEAKS

We have a 19-year-old daughter who has had an eating disorder for 4 years. These past 8 years have been most painful for our family—we went from doctor to doctor, counselor to counselor, and therapist to therapist, all with little or no results. What clinicians don't realize is how hard the day-to-day struggle is for families who want so much for their child to be healthy and happy but who feel so helpless in knowing how to make this happen.

Then we were referred to a nurse who specialized in eating disorders, and slowly our lives began to change. Clearly, this nurse knew about our daughter's illness, and together we went about treating it. We went through individual and family therapy, all in an attempt to help our daughter recover. At times it was painful and even frustrating. In the family sessions the nurse helped family members be aware of the part they had to play in our daughter's struggle and helped us realize that it would take a family team effort to help her get well.

The most important part is that all of the hard work of our daughter, each family member, and our nurse has been worth it. Our daughter now knows how to control her eating disorder. She has had very few problems in the last 6 months, and our family has become even closer as we look back on the past with relief and into the future with hope.

Medications

Patients with anorexia often resist medication, and no drugs have been found to be completely effective for this disorder. Medications should not be used as the sole or primary treatment for anorexia.

The selective serotonin reuptake inhibitor (SSRI) fluoxetine has been approved by the U.S. Food and Drug Administration for the treatment of bulimia nervosa and is commonly used to treat binge eating disorder. Topiramate may also be effective for both disorders. Preliminary research has demonstrated that:

- Trazodone and desipramine may be effective treatments for bulimia nervosa.
- SSRIs (other than fluoxetine), imipramine, and sibutramine may be effective treatments for binge eating disorder.

The role of antidepressants is usually best assessed after weight gain, when the psychological effects of malnutrition are resolving (Bissada et al, 2008). An antidepressant medication may be helpful with co-morbid depression, mood swings or irritability, and obsessions about food and fat.

Antidepressant medications have a therapeutic effect on many patients with bulimia. Medication-induced benefits include decreases in the frequency of binge eating and of weight-regulatory behaviors such as vomiting. Chapter 26 discusses these medications in detail. They are most effective when used with other psychotherapeutic interventions.

A Nursing Treatment Plan Summary for a patient with imbalanced nutrition is presented in Table 24-6. A Nursing Treatment Plan Summary for a patient with disturbed body image is presented in Table 24-7.

TABLE 24-6 NURSING TREATMENT PLAN SUMMARY

Eating Regulation Reponses

Nursing Diagnosis: Imbalanced nutrition: more than body requirements
Expected Outcome: The patient will restore healthy patterns and normalize physiological parameters related to body weight and nutrition.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will engage in treatment and acknowledge having an eating disorder.	Help the patient identify maladaptive eating responses. Discuss the positive and negative consequences of maladaptive eating responses. Contract with the patient to engage in treatment.	The first step of treatment is for the patient to acknowledge the illness and see the need for help.
The patient will be able to describe a balanced diet based on the five food groups.	Complete a nutritional assessment, including eating-related behaviors and preferences. Teach, clarify, and reinforce the patient's knowledge of proper nutrition.	Knowledge of healthy nutrition is essential to establishing and maintaining adaptive eating responses.
The patient's nutritional status will be stabilized by a specified date.	Monitor physiological status for signs of compromised nutrition. Administer medications and somatic treatments for the management of symptoms. Monitor and evaluate the patient's response to somatic treatments. Implement nursing activities as specified in the program contract and protocol.	Weight stabilization must be a central and early goal for the nutritionally compromised patient. Medications may assist the appetite regulation center and neurochemical response to feeding and satiety.
The patient will participate in a balanced exercise program on a daily basis.	Review established exercise routines. Modify exercise patterns, focusing on physical fitness rather than on weight reduction. Reinforce new exercise and fitness behaviors.	The focus of a balanced exercise program should be on physical fitness rather than on caloric reduction to lose weight.

TABLE 24-7 NURSING TREATMENT PLAN SUMMARY

Eating Regulation Reponses

Nursing Diagnosis: Disturbed body image
Expected Outcome: The patient will express clear and accurate descriptions of body size, body boundaries, and ideal weight.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will correct body image distortions.	Modify body image misperceptions through cognitive and behavioral strategies. Use dance and movement therapies to enhance the integration of mind and body. Use imagery and relaxation interventions to decrease anxiety related to body perceptions.	Body image distortions involve perceptions, attitudes, and behaviors that place so much emphasis on appearance that they define self-worth.
The patient will modify cognitive distortions about body weight, shape, and eating responses.	Help the patient identify cues that trigger problematic eating responses and body image concerns; the thoughts, feelings, and assumptions associated with each cue; the connections between these thoughts, feelings, assumptions, and eating regulation responses; and the consequences of the eating responses.	Cognitive distortions result in lowered self-esteem. Behavioral change results from an increased awareness of feelings and faulty cognitions.
The patient will identify social support systems that will reinforce accurate body perceptions and adaptive eating responses.	Include family members in the evaluation and treatment planning process. Assess the family as a system and the impact of the eating disorder on family functioning. Initiate group therapy to mobilize social support and reinforce adaptive responses.	Patients with eating disorders benefit from the involvement of family members and supportive group work.

EVALUATION

Patients with maladaptive eating regulation responses present special challenges to psychiatric nursing care. The evaluation of their care should begin with a focus on the therapeutic nurse-patient relationship.

Nurses should determine whether they have provided effective role modeling, emotional support, biological monitoring, and reinforcement of the patient's attempts to explore and experiment with new cognitive and behavior patterns. Evaluation activities can then address three specific aspects of care:

1. Have normal eating patterns been restored?
2. Have the biological and psychological sequelae of malnutrition been corrected?
3. Have the associated sociocultural and behavioral problems been resolved so that relapse does not occur?

In answering these questions, the nurse should review each aspect of the nursing process and modify care as needed to achieve the identified outcomes.

LEARNING FROM A CLINICAL CASE OUTCOME

1. How would you assess this woman's illness?

This patient has been bingeing and purging for many years, reporting depressed mood and substance use. Therefore she needs to be assessed for all three problems. Because of the length of time she has been bingeing and the complexity of the comorbidity of depression and substance abuse, the treatment can be expected to take some time. A complete physical examination and a psychiatric evaluation must be conducted. Her beliefs about her body, its size, and triggers for bingeing and purging should be explored. A dental consultation also would be important.

2. What eating disorder does she have?

She has an appropriate body mass index (BMI) for her height and reports bingeing and purging for many years. This confirms her medical diagnosis of bulimia nervosa.

3. What predisposing factors contribute to her illness?

She believes that her mother had an eating disorder. Individuals who have a first-degree relative with an eating disorder are at higher risk for the disease. She felt that her mother had unrealistic expectations for her and only asked casually how she was doing in school. She felt that whenever her mother saw her, she immediately focused on her weight and appearance. Therefore, she had distanced herself from her family.

Her family emphasized athletics and especially horseback riding. This young woman was particularly competitive, and her desire to ride as a jockey and the pressures of medical school all contributed to her level of stress.

4. What nursing diagnoses would guide your interventions for this patient?

The nursing diagnoses of body image disturbed, coping ineffective, identity disturbed, family processes interrupted, and social interaction impaired would guide in planning her nursing interventions.

5. What are the health consequences and medical complications of disordered eating?

Health consequences for this patient would focus on potassium depletion, which causes muscle weakness and cardiac abnormalities such as hypotension and irregular heart rate. In addition, gastric, esophageal, and dental problems related to purging are a risk. People with starvation eating disorders may have amenorrhea and subsequent infertility. Ultimately, osteoporosis in later life is a threat from disordered eating.

6. What treatment setting and interventions would you choose for this patient?

This patient was treated in an outpatient setting. Motivational interviewing assessed her readiness to change, and cognitive and behavior change strategies were implemented. Her depression, substance use, and eating disorder were all targeted in treatment. Her mother was not willing to participate in therapy.

Case Outcome

The patient was motivated to change once her "secret" of bulimia was discovered. She engaged in cognitive behavioral therapy identifying triggers and exploring her distortions about her health and her body. Over time, her bingeing and purging became less frequent; however, medical school was stressful, and she had occasional relapses during the next year. Her boyfriend sustained his commitment to her and supported her treatment. As she learned more about herself, she became more forgiving of her mother's behavior. She responded well to therapy and SSRI medication. She continued to ride horses but rarely competed because of the danger of the sport. She and her boyfriend eventually married.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Leigh Alexander, RN, MSN, APRN

I entered the community meeting to find only one seat open—beside a newly admitted patient. Little did I realize how this opportunity would impact my understanding of how a person with anorexia survives each day.

The patient, L, was pale and thin and had open sores on her extremities from self-harm actions. She had short brown hair that had lost its luster and was broken off at the ends. Long lashes fringed her blue eyes, which darted about the room. Her appearance was like a frail rag doll with very little muscle tone. I could see the protruding veins in her hands and noted the slow pulse beating in her temple. She was 30 years old and currently unemployed. Her diminished physical status no longer allowed her to work as a day care attendant in a senior citizen center. In addition, the complexity of her illness had caused her to drop the college courses she was taking toward earning a degree in health education. The meeting began, and so did our therapeutic relationship.

Each day, L would struggle with consuming adequate calories to meet her physiological demands. Her obsession to overexercise and restrict her intake was the major treatment battle. With intense inpatient supervision, L was able to progress to a day treatment program. She returned to part-time employment working with the elderly and also began to enter local and regional sporting events. Her name began to appear in the newspaper—she took first, second, or third place in many of the competitive sporting events she enjoyed.

Our treatment goals focused on caloric levels, exercise, self-esteem, body image, and relationships. L had been overweight at one time in her life and was terrified that she would be fat again. Using cognitive behavioral therapy, we focused on eliminating self-harm behaviors. I often wondered how this unique person, who was so bright, giving, and creative, could survive with minimal nutritional intake and the relentless compulsions to be thin and to hurt herself. Her cracked, dry lips were often my first indicator that she was restricting her intake too much—sometimes to the degree that periodic hospitalizations were necessary to provide safety, stabilization, and further education.

I am pleased to say that L survived this harrowing experience with anorexia. She is now in her mid-30s. Periodically, she writes me of her progress. She continues weekly individual therapy and has entered a university to further her education. Her appearance has changed. Her slight build now has well-defined muscles. She styles her hair, and the self-harm episodes have decreased in frequency. Her eyes now shine with the increased knowledge of her self-worth and positive body image. Her love of sports is rarely impeded by her eating disorder, although occasional lapses of appropriate caloric intake do still occur. But, over time, L has learned to individualize her dietary regimen to accommodate her physiological and psychological demands.

I knew she was following the path to recovery when the letters she sent me no longer closed with "Love, L." She now closes her letters without the word "love" and confidently uses her full name.

CHAPTER IN REVIEW

- Adaptive eating regulation responses include balanced eating patterns, appropriate caloric intake, and body weight that is appropriate for height.
- Maladaptive responses include anorexia nervosa, bulimia nervosa, binge eating disorder, and night eating syndrome.
- Eating disorders are more commonly seen among females, with a male/female ratio ranging from 1:6 to 1:10. They occur in 1% to 4% of adolescent and young adult women.
- These disorders can cause biological changes that include altered metabolic rates, profound malnutrition, and possibly death. Obsessions about eating can cause psychological problems that include depression, isolation, and emotional lability.
- Anorexia nervosa is a serious mental illness that is characterized in part by intense and irrational beliefs about one's shape and weight, including fear of gaining weight.
- Bulimia nervosa is an eating disorder characterized by eating binges typically followed by efforts to purge calories.
- Individuals with binge eating disorder consume large amounts of calories but do not attempt to prevent weight gain.
- Night eating syndrome is a severe eating problem. Night eaters average two awakenings per night, and these awakenings are associated with food intake.
- Patients with maladaptive eating regulation responses need to receive a comprehensive nursing assessment that includes complete biological, psychological, and sociocultural evaluations.
- Binge eating involves the rapid consumption of large quantities of food in a discrete period of time.
- Purging includes excessive exercise, forced vomiting, and use of over-the-counter or prescription diuretics, diet pills, laxatives, or steroids.
- Assessment of patients should include a full physical examination, dental examination, and psychiatric history.
- Medical complications can include starvation, potassium depletion, and hypokalemia.
- Psychiatric complications include co-morbid depression, anxiety disorders, and substance abuse.
- Both anorexia nervosa and bulimia nervosa are familial. Models of biological predisposing factors are focused on the hypothalamus and on serotonin, norepinephrine, and dopamine neurotransmitters.
- Psychological, environmental, and sociocultural factors also can predispose an individual to the development of an eating disorder.

CHAPTER IN REVIEW—cont'd

- Precipitating stressors that affect eating responses include peer pressure, interpersonal rejection, and daily solitude.
- The patient's level of motivation to change behavior is an important coping resource to assess. Readiness to change, motivational interviewing, and decisional balance exercises are highly recommended.
- A variety of maladaptive coping mechanisms may be used, including denial, avoidance, intellectualization, and isolation of affect.
- Primary NANDA-I nursing diagnoses are anxiety, disturbed body image, imbalanced nutrition, powerlessness, chronic or situational low self-esteem, and risk for self-mutilation.
- Medical diagnoses are anorexia nervosa, bulimia nervosa, and binge eating disorder. Night eating syndrome is under consideration for future inclusion in the *DSM* as a separate disorder.
- The expected outcome of nursing care is that the patient will restore healthy eating patterns and normalize physiological parameters related to body weight and nutrition.
- Planning activities involve decisions related to choice of treatment setting and the formulation of a nursing care plan contract.
- Interventions include nutrition stabilization, exercise, cognitive behavioral interventions, body image interventions, family involvement, group therapies, and medications.
- The nurse and patient together should evaluate whether normal eating patterns have been restored and whether associated biopsychosocial problems have been resolved.

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CHAPTER 25

Sexual Responses and Sexual Disorders

Susan G. Poorman

I locked myself away from you
Too long,
Tossing aside my feelings
For you.
Looking for a way out, an excuse
Not to touch you;
Because I want to,
Inciting a riot within me.
To reach out for you
Is difficult,
But less difficult
Than turning away.

Leslie Bertel

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the continuum of adaptive and maladaptive sexual responses.
2. Identify behaviors associated with sexual responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to sexual responses.
4. Describe coping resources and coping mechanisms related to sexual responses.
5. Formulate nursing diagnoses related to sexual responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to sexual responses.
7. Identify expected outcomes and short-term nursing goals related to sexual responses.
8. Develop a patient education plan to promote adaptive sexual responses.
9. Analyze nursing interventions related to sexual responses.
10. Evaluate nursing care related to sexual responses.

Sexuality refers to all aspects of being sexual and is one dimension of personality. It includes more than the act of intercourse and is an integral part of life. It is evident in the person's appearance and in beliefs, behaviors, and relationships with others. Four aspects of sexuality are as follows:

1. **Genetic identity,** which is a person's chromosomal gender
2. **Gender identity,** which is a person's perception of his or her own maleness or femaleness
3. **Gender role,** which is the cultural role attributes of a person's gender, such as expectations regarding behavior, cognitions, occupations, values, and emotional responses
4. **Sexual orientation,** which is the gender to which a person is romantically attracted

Accepting a broad concept of sexuality allows nurses to explore ways in which people are sexual beings and understand more fully their feelings, beliefs, and actions. Nurses

LEARNING FROM A CLINICAL CASE

This case can help you understand some of the issues you will be reading about. Read the case background and then, as you read the chapter, think about your answers to the Case Critical Reasoning Questions. Case outcomes are presented at the end of the chapter.

Case Background

He came to the family practice office saying that he was depressed and confused and that he had thoughts of hurting himself. You observe that he is young, fit, alert, and energetic. He did not appear to be depressed in his affect or body language. While completing your assessment, you ask him about his sexual orientation. He looks straight at you and says he is gay. When you ask him if he is "out" to his family, he looks down and shrugs "no." When you ask him if his visit is related to being gay, he says he is having a difficult time in his relationship with his boyfriend and that he does not have anyone to talk to.

He comes from a religious family and is active in his church. He is a dispatcher locally for 911 and works weekend shifts. He has been involved with the same man for several years, but it is a secret, and no one knows. Lately, he has seen his partner with another man, and he feels betrayed. He is in love and thinks people who love each other should be faithful. His boyfriend thinks that idea is simplistic and does not hold the same beliefs.

He is very concerned about being "outed" because he wants to be a highway patrolman in the future. He believes that if his sexual orientation becomes public, he will not be recommended for the job, which has been his dream since he can remember. He has never considered any other career for himself. His brother is already a highway patrolman, and he wants to follow in his footsteps. He denies any real plan for hurting himself. He said just getting the appointment and coming to talk made him feel hopeful.

Case Critical Reasoning Questions

1. How has the stigma of homosexuality affected the mental health of this young man?
2. Why is it important for the nurse to examine one's own beliefs about homosexuality before providing care to this patient?
3. Do public barriers, such as employment, exist related to sexual orientation?
4. How would you intervene to assist this patient to "obtain the maximum level of adaptive sexual responses to enhance or maintain health"?
5. What health education would you provide?
6. What are your nursing actions in relation to this patient's concern about "coming out"?

are often called on to intervene in the sexual concerns of patients when providing holistic patient care. It is important to develop skills and competence in addressing sexual issues by increasing awareness through education.

As nurses become educated in the basic principles of sexuality, they can better understand sexual needs and problems. If nurses are comfortable with sexual issues, they will convey this to the patient, who will feel more comfortable in discussing these issues. Patients are often experiencing pain and change as a result of threats to health or even as a part of normal growth and development. It is important that the nurse-patient relationship allows for honest discussions about sexuality.

Nurses need the following in relation to sexuality:

- **Awareness of their own sexual feelings and values**
- **Education about all aspects of sexuality to provide quality patient care**
- **Understanding that many patients may have beliefs, feelings, and values that differ from their own**

Becoming educated about sexuality allows nurses to develop confidence in their ability to discuss sexual issues with patients, learn interviewing skills for sexual assessment, and counsel or refer patients to appropriate resources.

CONTINUUM OF SEXUAL RESPONSES

Adaptive and Maladaptive Sexual Responses

Experts in sexuality do not agree on what is normal sexual behavior. For years, many people believed that only sexual relations between married heterosexual partners for procreation were normal. Today, people view sexual behavior with a wider range of attitudes.

On a continuum, sexuality ranges from adaptive to maladaptive (Figure 25-1). **Adaptive responses meet the following criteria:**

- **Between two consenting adults**
- **Mutually satisfying to both**
- **Not psychologically or physically harmful to either**
- **Lacking in force or coercion**
- **Conducted in private**

Sexual behavior sometimes can meet the criteria for adaptive responses but be altered by what society considers to be acceptable or unacceptable. Unfortunately, society often decides this based on fear, prejudice, and lack of information rather than on data and facts. For example, the homosexual person may have the potential for healthy responses but be impaired by anxiety concerning societal disapproval.

Maladaptive sexual responses are behaviors that do not meet one or more of the criteria for adaptive responses. The degree to which these behaviors are maladaptive varies. Some sexual behaviors may not meet any of the criteria. For example, incest may include force and be psychologically harmful. However, other sexual responses may meet four of the five criteria for adaptive responses but still be maladaptive.

Caution must be used when attempting to label sexual behaviors as adaptive or maladaptive. Disagreements and exceptions to the rule will always exist. The continuum shown in Figure 25-1 is free of moral judgment and was constructed to help the nurse develop self-awareness and understand the range of sexual responses.

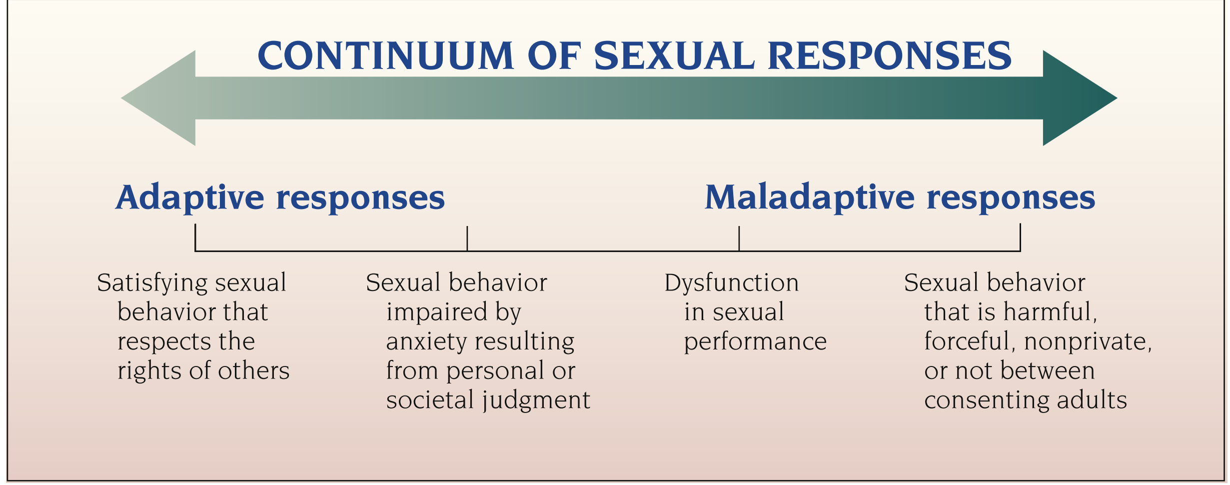


FIG 25-1 Continuum of sexual responses.

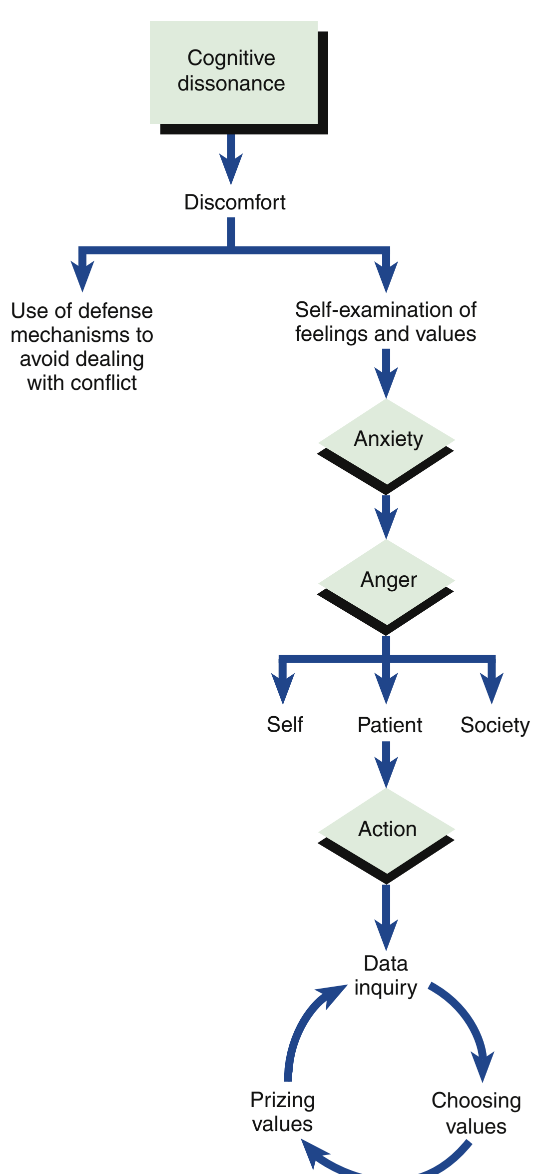


FIG 25-2 Phases of the nurse's growth in developing awareness of human sexuality.

Critical Reasoning How do you define *normal* sexuality? Compare your views with those of a friend, a family member, and a health care provider.

Self-Awareness of the Nurse

The first step in developing self-awareness involves clarification of values regarding human sexuality. Figure 25-2 illustrates four phases of the nurse's growth: cognitive dissonance, anxiety, anger, and action (Foley and Davies, 1983).

Cognitive Dissonance. Cognitive dissonance arises when two opposing beliefs exist at the same time. For example, nurses grow up learning what society, family, and friends believe about sexual issues. If a nurse is raised in an environment that teaches "it is impolite to talk about sex; it is too personal a subject," the nurse will carry those beliefs into nursing practice. When a patient wants to discuss a sexual concern, the nurse may feel two opposing reactions: "I should not ask questions about a subject as personal as sex, but as a professional, I should be able to discuss any problem, including sexual problems, with my patient."

These opposing thoughts, based on different role expectations, make the nurse uncomfortable. However, the discomfort can be positive because it forces the nurse to examine feelings about the issue. The nurse resolves the cognitive dissonance in one of two ways: by continuing to believe that sexual concerns are too personal to discuss with patients or by examining the fact that sexuality is an integral part of being human.

Both beliefs have consequences that involve how the nurse relates to patients who express sexual concerns. If the nurse continues to believe that sex is too personal to discuss with the patient, the nurse may become uncomfortable and choose not to follow up on sexual issues. This discomfort may be projected onto the patient, with the nurse stating, "The patient seemed too upset to talk about that right now." In this case, the nurse should explore personal values and beliefs about

sexuality and ask, "Do I believe these ideas about discussing sexual concerns because I have researched the facts and have accurate, current information?"

Only when the nurse has examined the available information and made an informed choice on values will clarification of those values occur. If the nurse examines personal and professional values and believes that sexuality is an integral part of being human, a second phase of growth will occur.

Anxiety. Most people think that anxiety is a negative emotion. However, a mild level of anxiety can be positive because it can promote an awareness of danger, give extra energy, or stimulate professional growth by creating enough discomfort to initiate some type of action.

In this second phase, the nurse realizes that uncertainty, insecurity, questions, and problems regarding sexuality are normal. The nurse begins to understand that everyone is capable of a variety of sexual feelings and behaviors and that anyone can have a sexual dysfunction or question sexual identity.

The nurse experiencing anxiety may exhibit behaviors that hinder the discussion of sexual issues, such as talking too much (not allowing patients to express their feelings), failing to listen (not picking up on patients' cues and messages), and diagnosing and analyzing (becoming preoccupied with facts rather than feelings). As the anxiety level rises, the nurse becomes more uncomfortable and tries to reduce that feeling. Learning about sexuality and facing conflicting values bring the nurse to the third phase of growth.

Anger. Anger usually arises after anxiety, fear, and shock. It can be self-directed or directed toward the patient or society. The nurse begins to recognize that issues associated with sex or sexuality can be highly emotional.

Rape, abortion, birth control, equal rights, child abuse, pornography, and religious issues are related to sexuality and give rise to controversy and debate. This realization often leads to anger in the nurse. For example, the nurse may become angry with a colleague or a friend who makes judgmental remarks about pro-life or pro-choice activists.

During this phase of anger, the nurse tends to choose words and actions that may be as judgmental as the attitudes the nurse is fighting against. The nurse may lecture other nurses about the need for sex education or critically judge a teenager who does not fear the consequences of having unprotected sex with someone known to be positive for human immunodeficiency virus (HIV) infection.

The nurse also may be angry with society for perpetuating ignorance about sexuality. Near the end of this phase, the nurse begins to understand that blaming self or society for lack of awareness does not help patients with sexual concerns. This realization helps defuse the anger, and the nurse is then ready for the final phase.

Action. The final step in the growth experience is the action phase. Several behaviors emerge during this final phase of the growth experience: **data inquiry, choosing values,** and **prizing values.**

- Data inquiry occurs when the nurse seeks out additional information about sexual issues. After the information is obtained, the nurse may discuss and debate the issues.
- These are healthy ways of exploring and deciding what to believe, and the nurse will eventually make some choices about a value position.
- The final behavior is prizing the value position, in which the nurse is willing to share it publicly. Although prizing values is the final step in a positive growth experience, it does not mean that what is valued will not change. Values are never static; they evolve and shift as a person changes, grows, and has new experiences. A person who once opposed abortion may later become understanding and empathetic toward women who have abortions.

The next clinical example shows the growth health professionals experience while increasing their awareness about sexuality. Chapter 2 has additional content on developing self-awareness and the nurse's therapeutic use of self.

CLINICAL EXAMPLE

Carol was a new staff nurse at a rehabilitation hospital. At the monthly staff meeting, the nursing supervisor asked whether there were any concerns the staff would like to discuss. Carol offered, "I wonder if any of you could help me with a suggestion. Over the past several weeks, I've seen a number of patients masturbating. One patient was in the lounge, and another was in his room when I came in to give him his meds. I was so embarrassed that I didn't know what to do. I ignored it both times, but part of me wanted to say 'stop that—that's not appropriate for a hospital!' I guess I could use some help with this one."

Another staff nurse followed up and said, "That's what I feel like saying when I see that kind of behavior." Several other staff members in the room began to snicker. The nursing supervisor interrupted and asked, "Can anyone give Carol some suggestions on how to handle this therapeutically?" After several moments of silence, other staff members admitted that they also were uncomfortable dealing with patients who were masturbating.

With the help of the supervisor, the staff began to brainstorm about how to handle this situation. Staff agreed that dealing with patients who are masturbating is a difficult issue for many nurses and that the problem is most often the nurses' rather than the patients' because masturbation is a normal form of sexual expression. They decided that when they observe a patient masturbating in a public area, an appropriate nursing response would be to have the patient return to his or her room for privacy. If a nurse walks in on a patient masturbating in the patient's room, the nurse should ensure the patient's privacy by saying, "Excuse me," and telling the patient that the nurse will return at a later time.

Critical Reasoning In which phase of growth are you in relation to the development of awareness of human sexuality?

ASSESSMENT

Any basic health history must include questions about sexual history. A nurse who is comfortable discussing sexuality says that it is normal to talk about sexual health in a health assessment interview. Nurses who are composed and professional can ask questions about patients' sexual health naturally. The patient can then discuss sexual matters openly and without embarrassment.

Effective interviewing skills are an essential part of a sexual assessment (Magnan and Norris, 2008; Zakhari, 2009; Jaarsma et al, 2010). Nurses sometimes may be uncomfortable addressing sexual issues. However, the principles of effective interviewing are the same even when addressing sexual issues.

Open-ended questions are one of the most effective ways of promoting a discussion on sexual issues, although some nurses report that direct questions also can be helpful in opening up the subject. Regardless, it is important to remember that questions must be asked at the patient's level of understanding, with sensitivity to the patient's cultural background because each person is unique.

The time and number of questions needed to discuss a problem vary depending on the patient. Often just a few questions during an interview can obtain the relevant information. Examples of questions nurses may ask related to a patient's sexual health include the following:

- Tell me what you understand about (menstruation, intercourse, sexual changes with aging, menopause).
- Since you've been diagnosed, what questions have you had regarding your sexuality?
- Are there any changes you have noticed in your sexual patterns since becoming ill?
- Have you noticed any differences or problems in your sexual responses since taking this medication?
- Often people have questions about masturbation, sexual frequency, safe sex, alternate positions. Do you?
- Sometimes it is uncomfortable to talk about sexual issues with your partner. How is this for you and your partner?

Behaviors

There are many types of sexual expression. In a classic work, Kinsey et al (1953) suggested that most people are not exclusively heterosexual or homosexual. Their studies indicated that a substantial percentage of men and women had experienced both heterosexual and homosexual activity.

> **QUALITY AND SAFETY ALERT**
>
> - Stigmatizing and judgmental attitudes toward diverse expressions of sexual behavior are an impediment to the provision of quality and holistic health care.
> - Such attitudes can create significant psychological distress for individuals and families.

Heterosexuality. **Heterosexuality** is sexual attraction to members of the opposite gender. It is the predominant sexual orientation among people in U.S. society. The coupling of a man and a woman in a sexual partnership has legal and religious sanctions, and it influences the culture, values, and norms of contemporary life.

Homosexuality. **Homosexuality** is sexual attraction to members of the same gender. The term **gay** is used to refer to male and female homosexuals; however, some use the term to refer only to male homosexuals and use the term **lesbian** to refer to female homosexuals.

An individual's attraction to people of the same gender, opposite gender, or both genders is called **sexual orientation** or *sexual preference*. Some prefer the term *sexual orientation* to *sexual preference* because preference implies that homosexuals choose to be homosexual. Although sexual behaviors do involve choice, research has indicated that sexual orientation is affected by genetics and biochemical events (Blanchard, 2008; Francis, 2008; Hall and Schaeff, 2008; Miller et al, 2008; Bogaert, 2010).

It is difficult to estimate the actual incidence of homosexuality in the United States. The estimates have ranged from 2% to 6% of the population (McCabe, 2009). However, many people have had a sexual experience with a member of the same gender at one time in their lives, and this is typically not identified when surveys are taken. One of the reasons that it is difficult to obtain an accurate incidence of homosexuality is that **social stigma is still attached to labeling oneself as homosexual,** and it is possible that many individuals do not report their true sexual identity.

No conclusive evidence supports any one specific cause of homosexuality; however, most researchers agree that biological and social factors influence the development of sexual orientation. Some sexuality experts question the need to find a cause for homosexuality rather than simply accepting the fact that it exists. If current estimates of homosexuality are accurate, nurses come into contact with homosexuals daily but often know little about homosexuality and often assume that all patients are heterosexual.

> **Critical Reasoning** How are health care providers' views of homosexuality influenced by social norms and cultural values?

Bisexuality. **Bisexuality** is sexual orientation or attraction to both men and women. Many studies on bisexuality include homosexuals in their research samples, and this has made the understanding of bisexuality more difficult. Some people believe that bisexuality is a distinct sexual orientation, some view bisexuality as a transition from one sexual orientation to another, and some contend that bisexuality can be an individual's attempt to deny a true homosexual identity.

Interest in the behavior and characteristics of bisexual men has increased in light of the acquired immunodeficiency syndrome (AIDS) and the need to design effective preventive interventions for HIV infection. The degree of sexual risk behaviors of bisexual men is quite high, but their lack of identification with and participation in the homosexual

community makes them unlikely to be reached by the gay community's safe sex and AIDS prevention programs.

Transvestism. Transvestism is cross-dressing, or dressing in the clothes of the opposite gender. The transvestite who seeks treatment usually is male; very little is known about female transvestism. No reliable statistics concerning the incidence of transvestism are available, but many professionals believe it is more common than usually assumed.

Transvestites tend to be married men who report heterosexual behavior. Although they occasionally or frequently dress in female clothes, they do not want hormonal or surgical gender change. Many transvestites try to find willing partners, and their activities of cross-dressing typically do not prevent sexual relationships with others.

Transsexualism. Transsexualism is the desire to become a member of the opposite gender. It is a condition in which a person has a profound discomfort with his or her own gender and a strong and persistent identification with the opposite gender.

A transsexual is an individual with a **gender identity disorder.** Transsexuals experience a mismatch between their biological gender and their gender identity. They live as members of the opposite gender part or full time and may seek to change gender through hormone therapy and gender reassignment surgery.

Transsexual patients often describe themselves as "feeling trapped in the wrong body." Transsexuals genuinely believe that they belong to the other gender. Many experience intense emotional turmoil because of stigma from society. No accurate estimates of the incidence of transsexualism are available; however, postoperative transsexuals in the United States number in the thousands.

Transsexuality is different from homosexuality in that homosexuals are comfortable with their anatomical identity and do not want to change their gender. Many transsexuals are heterosexual and express distaste for homosexual activity. Transsexuals are essentially heterosexual, not homosexual, but they are often mistaken by others or themselves as homosexual, as seen in the next clinical example.

CLINICAL EXAMPLE

Mr. L is a 21-year-old biological male who was admitted to the psychiatric unit for evaluation after a serious suicide attempt. Mr. L told his nurse that he tried to kill himself because he has been "sexually mixed up for years" and is tired of feeling like a freak of nature. He said that his friends make fun of him and tell him he is a homosexual. Although he does feel sexually attracted to other men, he does not believe he is a homosexual. "I guess I don't feel like a man, I feel like a woman inside a man's body, and as a woman I am attracted to men."

Selected Nursing Diagnoses

- Ineffective sexuality pattern related to conflicting sexual feelings, as evidenced by verbalizations of confusion and happiness
- Risk for self-directed violence related to sexual identity confusion, as evidenced by suicide attempt

BOX 25-1 STAGES OF THE SEXUAL RESPONSE CYCLE

Stage 1: Desire
Sexual fantasies and the desire for sexual activity

Stage 2: Excitement
Subjective sense of sexual pleasure along with physiological changes, including penile erection in the male and vaginal lubrication in the female

Stage 3: Orgasm
Peaking of sexual pleasure and the release of sexual tension accompanied by rhythmical contractions of the perineal muscles and pelvic reproductive organs

Stage 4: Resolution
Sense of general relaxation, muscular relaxation, and well-being
Females may be able to respond to additional stimulation almost immediately during this stage, but most males need some time before they can be restimulated to orgasm.

Critical Reasoning Think of a patient you took care of last week. How would your care have been different if you knew this patient was a homosexual, bisexual, transvestite, or transsexual?

The Sexual Response Cycle. In addition to modes of sexual expression or sexual orientation, the physiological and psychological responses to sexual stimulation can be described. **The four stages of the sexual response cycle are desire, excitement, orgasm, and resolution** (Box 25-1).

Experts have begun to look at the lack of research regarding female sexual response. It is commonly believed that female sexual functioning is more complicated than and not as linear as male sexual functioning (Kingsburg and Althof, 2009; Sobczak, 2009a; Jordan et al, 2011).

Impairment in sexual response may occur in any one of the phases of the sexual response cycle. For example, both men and women may experience low levels of sexual desire. If the excitement phase is inhibited, it may produce erectile dysfunction in males and problems with arousal in females. If the orgasm stage of the cycle is disrupted, premature, inhibited, or retrograde ejaculation may occur in males, and females may experience vaginismus or pain. Although sexual dysfunction can occur when any phase is disrupted, resolution phase inhibition is rarely responsible for specific sexual dysfunctions.

Men and women experience sexual dysfunctions very differently. Men are more likely to report problems with sexual performance and erectile dysfunction (Diaz and Close, 2010), including difficulty with obtaining or maintaining an erection and premature or delayed ejaculation. Women are motivated to seek help for concerns about sexual feelings, including lack of desire or sexual pleasure (Leiblum, 2007; Jordan et al, 2011).

The causes of sexual dysfunction are varied and complex. Emotional and stress-related problems can increase the risk of sexual dysfunction in all phases of the sexual response cycle for men and women. Sex therapists agree that many sexual dysfunctions are caused by psychological factors ranging from unresolved childhood conflicts to adult problems, such as performance anxiety, lack of knowledge, or failure to communicate with a partner.

Sexual dysfunction also can be caused by physiological factors. Medical problems such as circulatory, endocrine, or neurological disorders and medication side effects can contribute to sexual problems. The interaction between physiological illness and the psychosocial aspects of that illness also can lead to sexual problems.

Predisposing Factors

Biological Factors. Biological factors are initially responsible for the development of gender—whether a person is genetically male or female. Somatotype includes chromosomes, hormones, internal and external genitalia, and gonads. Sex differentiation is determined by the Y chromosome. Research in humans confirms the general rule that maleness and masculinity depend on fetal and perinatal androgens.

A biological female typically has XX chromosomes, with estrogen as the predominant hormone, appropriate internal and external genitalia, and ovaries. A biological male typically has XY chromosomes, with androgen as the predominant hormone, appropriate internal and external genitalia, and testicles. However, each of these typical configurations may vary.

A person may have triple chromosomes, such as XXX, XXY, or XYY, or a single chromosome, XO. There is no YO chromosomal pattern. The triple pattern XXX and the single pattern XO (Turner syndrome) result in a female body, whereas the triple patterns XXY (Klinefelter syndrome) and XYY result in male bodies. Assuming no variation occurs, the biological factors result in a single, fully developed gender, either male or female.

Based on family studies and DNA samples of homosexual brothers, it has been suggested that a gene may be related to homosexuality. Early work in the field suggested that homosexuality may be inherited from the maternal side of the family through the X chromosome. Before such research is accepted as definitive, however, it needs to be validated by replication, and similar studies of lesbians have not been completed. These findings cannot account for all cases of homosexuality, but they do support a possible biological basis.

Behavioral Factors. Behaviorists view sexual behavior as a measurable physiological and psychological response to a learned stimulus or reinforcement event. They specifically are interested in sexual difficulties that result from sexual abuse in childhood. Although men and women are affected differently by childhood sexual abuse, both can experience sexual difficulties in later life.

- Women are more likely to report sexual inhibitions and relationship problems. They also experience flashbacks, dissociative episodes, feelings of shame and guilt, compulsive sexual behavior, and sexual aversion.
- Men who were sexually abused as children often demonstrate sexually aggressive behavior, multiple sexual partners, fear of intimacy, compulsive sexual behavior, and confusion about their sexual orientation.

For both women and men, sexual dysfunction is more likely to be found when the incidence of abusive episodes is high and the types of abuse are many. The care of people who have experienced abuse and violence is described in detail in Chapter 38.

> **QUALITY AND SAFETY ALERT**
>
> - Screening for past and present sexual abuse must be an essential part of every health history.

Precipitating Stressors

Physical Illness and Injury. Physical illness may alter sexuality. Nurses often care for patients with sexual dysfunctions or altered sexuality patterns; they need to discuss and intervene in patients' responses to these changes. For example, a person with rheumatoid arthritis may have body disfiguration and a change in body image caused by swollen areas around joints. The same patient may have decreased sexual interest because of joint pain during intercourse.

People who have had a myocardial infarction may have decreased sexual interest because they fear sexual arousal may cause a heart attack. Vascular disease associated with diabetes may affect adequate arousal. Cardiovascular disease may inhibit intercourse because of dyspnea. Urinary incontinence may cause discomfort or embarrassment, leading to dysfunction or decreased sexual activity.

Gynecological conditions also can contribute to sexual difficulties. Hysterectomy, gynecological malignancies, and breast cancer present medical and mortality concerns and may alter perceptions of femininity that may result in decreased sexuality (Hughes, 2008). Normal changes in a woman's reproductive life related to puberty, pregnancy, postpartum, and menopause can present unique problems.

Puberty may lead to concerns regarding sexual identity. Pregnancy and the postpartum period are often associated with a decrease in sexual activity, desire, and satisfaction, which may be prolonged with lactation. The state of menopause may result in physical changes, alterations in mood, and decreased libido (Woods et al, 2010). As women age, they may also experience a decline in desire and frequency of intercourse.

Psychiatric Illness. Psychiatric illness affects a person's sexuality and the sexual behavior and satisfaction of the person's partner (Box 25-2). In a study of inpatients with a psychiatric illness, 71% reported an impairment in their sexuality. Although sexual dysfunction was found in all diagnostic groups, it was particularly prevalent among those with depression (Cohen et al, 2007).

Depression can be the result or cause of sexual dysfunction. Many depressed patients have decreased sexual desire and decreased frequency of intercourse. Most often,

BOX 25-2 A FAMILY SPEAKS

Our daughter was diagnosed with schizophrenia 5 years ago when she was 17 years old. Since that time, we have received very good care for her. Although we understand that she may never be completely well, she has her illness under control and has even started taking some courses at the local community college. She has also met some people her age and seems to enjoy their company.

However, since she began doing better, we have had the added concern about her sexual needs and activities. As involved parents, we raised this issue with the different health care providers who were managing her care over the years. In each case, almost without exception, we were told, "Don't worry about such things; be grateful your daughter is as healthy as she is." Although their intentions may have been good, they didn't help resolve our questions or fears. Then our daughter was assigned to a nurse who we were told would be her case manager.

The first time they met, the nurse took a detailed history and asked our daughter the unthinkable: What sexual feelings did she have, and how was she managing her sexual needs? It was as if the floodgate had opened for all of us, and that session marked the beginning of an ongoing discussion we would all have about the topic we had been worrying so much about.

For that nurse asking just the right question, we will always be grateful, and if we could share one thought with future nurses in training, it would be to remember that patients are whole people and that sexuality is as important to those with psychiatric illness as it is to people everywhere.

depressed men engage in intercourse less often; depressed women may participate in sex but with less enjoyment.

In contrast, hypersexuality may be the first symptom of a manic episode. People with bipolar illness have decreased sexual inhibitions, often impulsively choose sexual partners or begin extramarital affairs, display inappropriate sexual behavior, or act seductively or flirtatiously.

The sexual expression of patients with psychotic illnesses may be inappropriate and sometimes intrusive. Delusions and hallucinations may present with sexual content. The patient with a psychotic illness may not be able to understand or control sexual thoughts or impulses. For example, a patient may openly masturbate on an inpatient unit or inappropriately touch others. Thinking and judgment also may be impaired, resulting in sexual behavior that may be detrimental to the patient's health, such as unsafe sexual practices.

Questions also have been raised about the sexual lives of persons with serious and persistent mental illness who live in residential treatment facilities. Each facility and group of staff members caring for residents need to identify ways to acknowledge and respect the normal sexual needs of these individuals and balance this with the need to keep the residents safe from sexually transmitted diseases, unwanted pregnancies, and nonconsensual sexual advances or assaults.

The nurse can help the patient identify and express needs related to sexuality. This includes helping the patient form healthy relationships with others, learn about safe sex practices, engage in healthy sexual expression, and decrease potentially dangerous sexual encounters.

A study examining the sexual needs and relationship experiences of patients with schizophrenia revealed that 83% were currently experiencing sexual feelings and had a need for an intimate relationship. Unfortunately, only 10% of the staff recognized the need for sexual expression in their patients (McCann, 2010). These findings support the need for a discussion of sexuality as an integral part of treatment.

Medications. Some medications contribute to sexual dysfunction, and nurses need to be knowledgeable about the medications they administer. The index of medications that can create sexual side effects continues to grow. These medications, which may include antihypertensives, antihistamines, anticholinergics, chemotherapeutic agents, and antiseizure drugs, can cause diminished sexual desire or orgasmic disorders in women and men. Some medications, especially antihypertensive agents, can cause erectile difficulties in men.

The sexual side effects of psychiatric medications are well documented. In a study of men and women with schizophrenia, 52% reported a sexual dysfunction. No differences were reported for the atypical, conventional, and combination antipsychotics (Ucok et al, 2007).

Sexual dysfunctions are a common side effect of selective serotonin reuptake inhibitors (SSRIs). These antidepressants can cause problems in any phase of the sexual response cycle. Although stopping the drugs for a specified period, sometimes known as drug holidays, has been proposed to treat these problems, drug holidays may lead to decreased efficacy and noncompliance with treatment. Alternatively, other antidepressant agents or additional medications can be used to treat the dysfunction. Psychiatric medications and their side effects are described in Chapter 26.

Nurses should be familiar with the sexual side effects of medications, educate their patients about them, and encourage patients to notify a health care professional when these effects occur. For example, a man may not be aware that his medication can cause impotence, but he may be embarrassed and hesitate to talk with the physician or nurse about the problem. The medication or the dosage often can be changed to correct the problem.

Abuse of alcohol or nontherapeutic drugs also may have a debilitating effect on sexuality. Although many people believe alcohol is a sexual stimulant, prolonged use can cause erectile difficulty and other dysfunctions.

Critical Reasoning Consider two medications that you commonly administer to patients. Do you know whether they have sexual side effects, and have you talked about this possibility with your patients?

HIV/AIDS. Fear of contracting a sexually transmitted disease (STD) may create a change in sexual behavior. The most frightening STD is AIDS, which is caused by HIV infection. HIV/AIDS is a leading worldwide health problem despite the

attempts by health care professionals to educate society about the following **safe-sex practices**:

- **Using condoms**
- **Reducing the number of sexual partners**
- **Promoting sexual behaviors that decrease the exchange of body fluids**

In the United States, most of those infected with HIV are males (76%). According to the Centers for Disease Control and Prevention (CDC), between 2006 and 2009 the incidence of HIV among males remained stable, whereas it declined among females. Heterosexual contact is the most common mode of transmission in women. The number of people infected through intravenous drug use has steadily declined.

In contrast, the number of people living with AIDS has increased. From 2006 through 2008, the rate per 100,000 of people living with AIDS was lowest among people younger than age 20 and older than age 65 years, but the number of persons diagnosed with HIV who are middle aged is concerning. In 2008, 41% of people living with AIDS were between the ages of 40 and 49 years (Centers for Disease Control and Prevention, 2011). Although the success of treatment for AIDS is promising, the effects of this illness have a significant impact on all aspects of society.

Many people infected with HIV also may have psychiatric and drug dependence problems and may experience more problems with HIV care (Fremont et al, 2007; Dyer and McGuinness, 2008). Nurses and other health care providers need to actively identify those at risk and work with clinicians and policymakers to ensure the availability of appropriate testing, counseling, and treatment for these individuals. Advanced practice nurses can be particularly effective in delivering community-based care in tailored interventions to improve outcomes of individuals with HIV and co-occurring serious mental illness (Blank et al, 2011).

The Aging Process. In the past, researchers suggested that sexual activity decreased with aging. Later studies indicate that patterns of sexual activity remain stable over middle and late adulthood years, with only a small decline occurring in later life. In a study of 430 men and women between the ages of 60 and 99 years, sexual activity was found to be a significant predictor of quality of life (Robinson and Molzahn, 2007).

Nothing in the biology of aging automatically shuts down sexual functioning; however, in a national study of women and men between the ages of 57 and 85 years, aging was positively correlated with certain sexual problems.

- Women reported decreased lubrication, lack of interest in sex, difficulty reaching orgasm, and finding sex was not pleasurable and more often painful than when they were younger.
- Men reported erectile difficulties, lack of interest in sex, climaxing too quickly, anxiety about performance, and an inability to climax. Older men often need more direct penile stimulation for ejaculation to occur, and the orgasm is less intense (McMahon and McMahon, 2008).

In Western culture, the myth of the older adult as asexual often prevails. When health professionals care for older people who express an interest in sex or are sexually active, the professional may regard them to be an exception to the rule.

Older adults themselves may accept society's false beliefs about sexuality and aging. Some deny sexual attractions and feelings because they have been socialized to believe that sexual behavior in older people is abnormal or perverted.

One important variable affecting sexuality in older adults is the lack of knowledge about the normal changes that occur with the aging process. Nurses and older adults often mistake a side effect of a medication or a symptom of a chronic medical illness for an expected part of the aging process.

It is important for the nurse to understand the normal changes that occur with aging so that the nurse can teach patients about these changes. This allows patients to learn what to expect and how they can compensate for the normal changes related to aging and sexual behavior.

It is equally important for nurses to realize that organic illness can affect sexual functioning. Many disease states seen in the elderly can interfere with sexual expression. People with arthritis have limited range of motion. Persons with chronic obstructive pulmonary disease (COPD) can experience dyspnea on exertion. A stroke can cause problems with nerve pathways that can lead to erectile dysfunction in men and anorgasmy in women, and it can change a person's body image, leading to feelings of unattractiveness and worthlessness.

Medications taken by the elderly can lead to difficulties with sexual functioning. Use of β-blockers and diabetes can contribute to impotence in men, and testosterone deficiency can create anorgasmy in women. These problems can be significant, but they often can be successfully treated.

Psychological factors, such as self-esteem, influence sexual activity in older adults. Older adults may be less inclined to be sexually active if they believe the physical changes that occur with aging make them unattractive.

Marital status can influence sexuality. Because men die at younger ages than women, women are more likely to be widowed and live the last part of their lives alone. Because there are fewer men in the population, it is more difficult for older women to find partners than it is for older men.

Opportunities for sexual activity may be limited for individuals who become dependent on others for their care. Older adults who must move in with their adult children or move to a personal care facility or a nursing home may find it difficult to engage in any form of sexual expression.

Many nursing homes restrict physical activity, and residents lack privacy from staff members, who tend to care for older adults in a parental way. Physical contact among nursing home residents is often discouraged by nursing home staff members, and many residents may feel restricted in their sexual expression.

However, nurses are becoming more sensitive to the sexual needs of nursing home residents. By recognizing their sexual needs, nurses can act as advocates and help residents with sexual expression by encouraging discussion of sexual concerns,

closing doors to ensure privacy, and allowing socialization with sexual partners.

> **Critical Reasoning** While working in a long-term care facility, you walk into a patient's room and see two patients engaged in sexual relations. How would you respond?

Appraisal of Stressors

Perceptions about oneself as a sexual being change throughout the life cycle, and they are influenced by stressful situations. Sexual identity cannot be separated from self-concept or body image. When body or emotional changes occur, sexual responses also change.

Coping Resources

It is important for the nurse to assess the patient's coping resources, including the person's knowledge about sexuality, positive sexual experiences the patient has had in the past, supportive people in the patient's environment, and social or cultural norms that encourage healthy sexual expression.

It is also helpful to include the person's sexual partner whenever possible. This allows the nurse to evaluate the quality of this relationship and to frame all nursing interventions within the context of a supportive, loving partnership.

Coping Mechanisms

Coping mechanisms related to sexual response may be adaptive or maladaptive, depending on how and why they are being used. **Fantasy** is a coping mechanism used to enhance sexual experiences. Men and women may escape to erotic fantasies with unknown lovers during sex with their spouses. Fantasies are often a creative way to increase sexual excitement and enjoyment and do not usually indicate dissatisfaction with a current partner. However, excessive fantasy can be maladaptive when used as a replacement for actual sexual expression or the development of intimate relationships with others.

Maladaptive coping mechanisms may result from problems with self-concept. One member of a sexually dysfunctional couple may use **projection** in blaming the partner for the total problem, without taking any responsibility: "I never had a sex problem with any of my previous lovers; I think you are the problem."

Projection also is the coping mechanism used when a person's thoughts and feelings are unacceptable and anxiety producing. For example, a wife constantly accuses her husband of wanting to have an affair when actually the wife is the one thinking about having an affair. Because her feelings are unacceptable to her, she projects them onto her husband and accuses him.

Denial and **rationalization** also are common coping mechanisms. Both allow the person to avoid dealing with sexual issues.

- **Denial:** "I don't have a problem with sex" or "I never feel sexual."
- **Rationalization:** "I don't need sex; I'm fine without it. Besides, a good marriage is a lot more than just sex."

To cope with unacceptable feelings about becoming vulnerable and the resulting ambivalent feelings about intimacy, some people **withdraw** from any form of sexual behavior. Others may engage in **increased sexual behavior** with multiple partners to protect themselves from one intimate relationship.

DIAGNOSIS

Nursing Diagnoses

When developing nursing diagnoses for variations in sexual response, the nurse should consider all the information gathered in the assessment phase and the components of the Stuart Stress Adaptation Model (Figure 25-3). The identified nursing diagnoses serve as a foundation for future problem solving.

Two primary NANDA International (NANDA-I) nursing diagnoses are concerned with sexual response. The first is **ineffective sexuality pattern,** which includes difficulties, limitations, or changes in sexual behaviors or activities. The second is **sexual dysfunction,** which includes lack of sexual satisfaction, alterations in perceived sex role, and conflicts involving values.

Related nursing diagnoses that address additional behavioral problems also may need to be included. For example, a patient may be sexually functional, but sexual identity may be unclear. The primary NANDA-I diagnoses are presented in Table 25-1.

Medical Diagnoses

Many people who have transient variations in sexual response do not have a medically diagnosed health problem. **Those with more severe or persistent problems are classified in one of three categories of variations in sexual response according to the *Diagnostic and Statistical Manual of Mental Disorders,* ed 4, text revision *(DSM-IV-TR):* sexual dysfunctions, paraphilias (sexual perversions or deviations), or gender identity disorders** (American Psychiatric Association, 2000). Medical terms and their definitions are described Table 25-1.

OUTCOMES IDENTIFICATION

Goals must be formulated realistically, remembering the uniqueness of each person. The **expected outcome** for patients with maladaptive sexual responses is as follows: ***The patient will obtain the maximum level of adaptive sexual responses to enhance or maintain health.*** This outcome can be made more specific through the use of short-term goals. These goals must be mutually identified with the patient, priorities must be established, and criteria used to measure progress toward the goals must be defined. Examples of short-term goals include the following:

- The patient will describe personal values and beliefs regarding sexuality and sexual expression.
- The patient will identify sexual questions and problems.
- The patient will relate accurate information about sexual concerns.

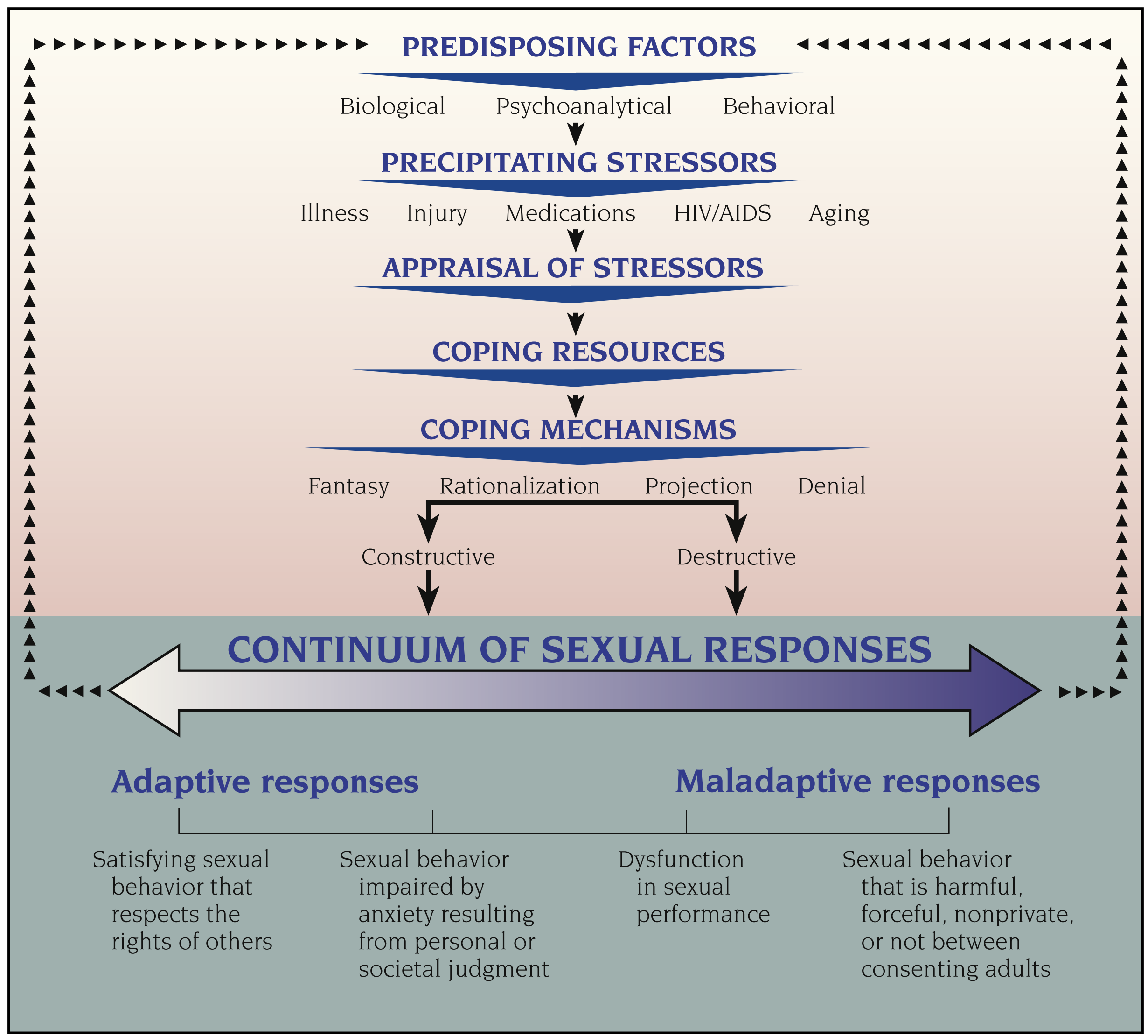


FIG 25-3 The Stuart Stress Adaptation Model as related to sexual responses.

- The patient will implement one new behavior to enhance sexual functioning.
- The patient will report decreased anxiety and greater satisfaction with sexual health.

After identifying goals in partnership with the patient, the nurse begins to implement the appropriate nursing interventions. Outcome indicators related to sexual identity from the Nursing Outcome Classification (NOC) project are presented in Box 25-3 (Moorhead et al, 2008).

> **Critical Reasoning** Review the outcomes listed in Box 25-3, and assess your own level of sexual identity based on these criteria. What actions should you take to enhance your own sexual health?

PLANNING

The nurse's level of expertise determines the degree of planning. The planning phase can involve simply reviewing assessment data, exploring options, and making referral sources known and available. This phase also can include sexual instruction for the patient or the patient and partner together. The nurse and patient can discuss a specific sexual issue and approaches that will provide the needed information.

IMPLEMENTATION

Nursing care focuses on providing health education, managing sexual responses within the nurse-patient relationship, and intervening in maladaptive sexual responses and dysfunctions of the sexual response cycle. Very few empirical studies assess the successful treatment of the medical categories of paraphilias or gender identity disorders. **Empirically validated treatments for sexual dysfunctions are summarized in Table 25-2** (Nathan and Gorman, 2007).

Health Education

Before engaging in health education or counseling, nurses must examine their values and beliefs about sexual behavior.

TABLE 25-1 NURSING DIAGNOSES AND MEDICAL TERMS RELATED TO *Sexual Responses*

NANDA-I DIAGNOSIS STEM	EXAMPLES OF EXPANDED DIAGNOSIS
Sexual dysfunction	Sexual dysfunction related to prenatal weight gain, as evidenced by verbal statements of physical discomfort with intercourse Sexual dysfunction related to joint pain, as evidenced by decreased sexual desire
Ineffective sexuality pattern	Ineffective sexuality pattern related to financial worries, as evidenced by inability to reach orgasm Ineffective sexuality pattern related to mastectomy, as evidenced by statements such as “My husband won’t want to touch me” and “I don’t feel like a woman” Ineffective sexuality pattern related to fear of pregnancy, as evidenced by stopping before penetration

MEDICAL TERM	DEFINITION*
Premature ejaculation	Occurs when male sexual climax (orgasm) occurs before a man wishes it or too quickly during intercourse to satisfy his partner
Dyspareunia	Pain during sexual intercourse
Vaginismus	A usually prolonged and painful contraction or spasm of the vagina.
Exhibitionism	An abnormal compulsion to expose the genitals with the intent of provoking sexual interest in the viewer
Fetishism	Obtaining sexual arousal using or thinking about an inanimate object or part of the body
Frotteurism	When sexual arousal or orgasm is achieved by actual or fantasized rubbing up against another person, usually in a crowded place with an unsuspecting victim
Pedophilia	The act or fantasy on the part of an adult of engaging in sexual activity with a child or children
Sexual masochism	Deriving sexual gratification, or the tendency to derive sexual gratification, from being physically or emotionally abused
Sexual sadism	Deriving sexual gratification or the tendency to derive sexual gratification from inflicting pain or emotional abuse on others
Voyeurism	Deriving sexual gratification from observing the naked bodies or sexual acts of others, especially from a secret vantage point

Nursing Diagnoses—Definitions and Classification 2012-2014. Copyright © 2012, 1994-2012 by NANDA International. Used by arrangement with Blackwell Publishing Limited, a company of John Wiley and Sons, Inc.
In order to make safe and effective judgments using NANDA-I nursing diagnoses, it is essential that nurses refer to the definitions and defining characteristics of the diagnoses listed in the work.
*Source: http://medical-dictionary.thefreedictionary.com/.

BOX 25-3 NOC OUTCOME INDICATORS FOR SEXUAL IDENTITY

- Affirms self as a sexual being
- Exhibits clear sense of sexual orientation
- Exhibits comfort with sexual orientation
- Integrates sexual orientation into life roles
- Sets resilient boundaries with respect to societal prejudice or discrimination
- Uses healthy coping behaviors to resolve sexual identity crises
- Challenges negative images of sexual self
- Seeks support of peers
- Reports healthy intimate relationships
- Reports healthy sexual functioning
- Describes risks associated with sexual activity
- Uses precautions to minimize risks associated with sexual activity
- Describes personal sexual value system
- Sets personal sexual boundaries

From Moorhead S et al, editors: *Nursing outcomes classification (NOC)*, ed 4, St Louis, 2008, Mosby.

TABLE 25-2 SUMMARIZING EVIDENCE BASED TREATMENTS FOR *Sexual Responses*

SEXUAL DYSFUNCTION DISORDER	TREATMENT
Erectile dysfunction	The efficacy of sildenafil as a treatment for erectile dysfunction has been demonstrated repeatedly. The efficacy of psychological interventions for erectile dysfunction has also been established.
Rapid ejaculation	Fluoxetine, sertraline, clomipramine, and paroxetine can be used to delay ejaculatory latency in men with rapid ejaculation. An array of individual, conjoint, and group therapy approaches employing behavioral strategies such as “stop-start” or “squeeze” techniques have evolved as the psychological treatments of choice for rapid ejaculation.

From Nathan PE, Gorman JM: *A guide to treatments that work,* ed 3, New York, 2007, Oxford University Press.

This can be done by exploring myths about human sexuality. Table 25-3 lists some common sexual myths, the results of believing them, and the facts related to each one.

Education can help prevent sexual problems. The content and methods of sex education have changed little over the past several decades. Many people receive most of their sex education from friends, who may not provide accurate information. Too few parents discuss sexual issues with their children, and school sex education programs—to avoid discussion of controversial subjects—often focus only on biological factors, which is insufficient for the needs of current youth.

More comprehensive sex education programs are needed, beginning as early as preschool and kindergarten. **Sex education is a lifelong process with the primary goal of promoting sexual health.** This includes helping people develop

TABLE 25-3 TEN COMMON MYTHS AND FACTS ABOUT HUMAN SEXUALITY

MYTH	RESULT OF MYTH	FACT
Patients become embarrassed when nurses bring up the subject of sexuality and prefer that nurses not ask questions about sex.	If nurses believe this, they deny the patients the opportunity to ask questions and clarify concerns related to sexual issues.	Patients prefer that nurses initiate discussions of sexuality with them.
Excessive masturbation is harmful.	People often feel guilty or ashamed about masturbating; some people deny themselves this experience because of uncomfortable feelings perpetuated by society.	There is no evidence that masturbation causes physical problems. If masturbation leads to satisfaction and pleasure, it is unlikely to be a problem.
Sexual fantasies about having sex with a partner other than a lover or spouse indicate relationship difficulties.	People may become uncomfortable about having a fantasy with a different partner. They may feel guilty and view the fantasy as a sign of infidelity.	Imagining sex with a different partner is a common sexual fantasy and does not necessarily indicate a desire to act out the fantasy.
Sex during menstruation is unclean and harmful.	Women often view their bodies as unclean and even unfit or inferior during menstruation. Women use menstruation as an excuse to avoid intercourse rather than simply saying no without a "good reason."	Medically, menstrual flow is in no way harmful or dirty. If women desire, there is no reason to abstain from intercourse during menstrual flow.
Oral and anal intercourse is perverted and dangerous.	Many people refrain from these behaviors or indulge in them only to feel ashamed and guilty afterward.	Oral and anal intercourse is not harmful if certain precautions are taken when performing anal intercourse, such as avoiding contamination of the vaginal tract and wearing a condom to prevent the transmission of disease.
Most homosexuals molest children.	Known homosexuals are often fired from teaching jobs, and many parents do not allow their children to spend any time with anyone who is homosexual.	Research shows that the adult heterosexual male poses a far greater risk to the underage child than does the adult homosexual male.
Homosexuals are sick and cannot control their sexual behavior.	Homosexuals are denied jobs and are sometimes jailed for their homosexuality. Children may be taken away from homosexual parents by courts.	Most homosexuals' social and psychological adjustment is the same as the heterosexual majority, and objectionable sexual advances are far more likely to be made by a heterosexual (usually male to female) than by a homosexual.
Because of sex education programs, most adolescents and young adults are aware of the risks of getting sexually transmitted diseases and practice safe sex.	When health educators believe that young adults have adequate knowledge about sexually transmitted diseases, they may not take the time to assess, add to this knowledge, and correct any misperceptions.	A study of more than 500 first-year students at a large university reported that of those who had multiple partners, fewer than 50% used condoms to lower the risk of disease.
Advancing age means the end of sex.	Many older adults become victims of this myth not because their bodies have lost the ability to perform but because they believe that they have lost the ability to perform.	Sexually, men and women in good health can function effectively throughout their lives.
Alcohol ingestion reduces inhibitions and therefore enhances sexual enjoyment.	Many people use alcohol in the hope that it will increase their sexual pleasure and performance. Alcohol ingestion can also provide an excuse for engaging in sexual behaviors—"I would never have gone to bed with him if I hadn't had all that wine."	Data do not support the belief that alcohol ingestion reduces inhibitions and enhances sexual enjoyment.

positive views of sexuality, gain information and skills about taking care of their sexual health, and acquire decision-making abilities regarding sexual issues. Schools and communities develop their own curriculum for sexual education. These programs range from abstinence-only-until-marriage to comprehensive sexual education.

Abstinence-only-until-marriage programs encourage abstinence from all sexual behaviors outside of marriage. They often support marriage as the only morally acceptable context for sexual behavior. The U.S. government has allocated $250 million from 2010 to 2014 for programs that teach abstinence from sexual activity outside marriage (Sexuality Information and Education Council of the United States, 2011), but evidence questions the effectiveness of these programs.

In a 6-year study by the U.S. Department of Health and Human Services, 1209 participants in the abstinence-only program were compared with a control group of 848 participants. No significant difference was found between the control group and the program group in sexual abstinence, rates of unprotected sex, age at first intercourse, or number of sexual partners. The control group was more likely to report that condom use can prevent STDs than the abstinence-only program group (Trenholm et al, 2007).

Comprehensive sex education programs include information about human development, building positive relationships, enhancing interpersonal skills, promoting responsible sexual behavior, maintaining sexual health, and understanding societal and cultural influences on sexuality. **Comprehensive sexuality programs have been found to be effective in delaying both sexual intercourse and teen pregnancy** (Kohler et al, 2008).

However teaching information about sex and sexuality is not enough. **For a sex education program to be effective, it must promote behavioral change.** The most effective sex education programs are comprehensive and skill based. For example, it is not enough to teach individuals to say no to sex; they must be taught *how* to say no. This can be done by teaching decision-making and assertiveness skills and by role playing potentially difficult sexual situations.

Critical Reasoning Which sexual myth from Table 25-3 did you believe before reading this chapter? How will knowing the truth affect your nursing practice?

Sexual Responses Within the Nurse-Patient Relationship

Sexual Responses of Nurses to Patients. A clinical situation in which a nurse feels a sexual attraction to a patient is a problem that has received little attention in the nursing literature. One reason for this is that nurses often deny sexual feelings for their patients. However, sexual attraction and sexual fantasies are part of the human experience. If these feelings are not examined, they can interfere with the quality of care by shifting the focus from the patient's needs to those of the nurse.

Nurses must acknowledge their feelings without judging them. Nurses often try to ignore or deny these feelings because they are uncomfortable and frightening. They make judgments about themselves, such as "What's wrong with me? I shouldn't feel this way about my patients. I must be really weird" or "I'm sure I'm the only nurse who ever had these feelings."

The nurse who admits these feelings without judging them is able to deal with them. One of the best ways to begin to deal with these feelings is to seek consultation from a more experienced nurse.

A nurse should not tell the patient about these feelings because it will only further complicate the issue. It is not the patient's responsibility to respond to the nurse's feelings. Rather, it is always the nurse's responsibility to preserve professional boundaries, even when a nurse feels sexually attracted to a patient.

It is never acceptable for a nurse to engage in sexual behavior of any kind with a patient. Such activity is unethical and can lead to charges of professional misconduct and litigation.

QUALITY AND SAFETY ALERT

- Any and all intimate behavior and sexual exchanges with a patient are serious boundary violations.
- Sexual contact of any kind is never therapeutic and never acceptable within the nurse-patient relationship.
- Nurses engaging in intimacy and sexual boundary violations are vulnerable to patient-initiated lawsuits.

Sexual Responses of Patients to Nurses. Hospitalized patients can sometimes display seductive behavior toward the nurse. This includes making passes and sexual comments, inappropriate touching, asking for a phone number, and requesting a date. Nurses are often extremely uncomfortable with such behaviors.

If a patient makes a sexual advance, the nurse should let the patient know that the behavior is unacceptable. The nurse needs to respond in a firm, matter-of-fact manner that clearly states what limits are being set, such as "Mr. Dean, you need to take your hand off my chest," or "Ms. Moore, I am uncomfortable when you suggest that I get into bed with you. Please stop saying that."

Nurses are sometimes embarrassed or afraid to confront patients and attempt to laugh it off or ignore it. Patients do not have the right to be verbally offensive or to touch nurses' bodies without permission. Nurses are taught to be accepting of patients' behavior; however when the behavior violates nurses' rights, limits must be set.

Nurses have a responsibility as professionals to attempt to understand sexual behaviors and analyze their possible meanings. Seductive behavior is often a way to get the nurse's attention. Hospitalized patients also can feel unattractive or insecure about themselves sexually; seductive behaviors may be a request for reassurance.

Patients sometimes confuse their gratitude for and appreciation of the nurse with sexual attraction. These feelings may generate thoughts such as "Wouldn't my nurse make a wonderful wife? She's so giving and understanding all the time." In this case, the patient views professional behavior and concern as self-sacrificing and altruistic.

Patients may have difficulty understanding the difference between a professional and a social relationship. In many ways, the nurse-patient relationship is idealized for the patient. The patient receives all the attention and caring and is not expected to give anything in return. It is easy to see how the patient could be confused about the relationship with the nurse. The next clinical example illustrates this point. Table 25-4 summarizes nursing considerations in sexual responses of patients to nurses.

CLINICAL EXAMPLE

Mr. P has been hospitalized with a chronic illness for the past 3 weeks. The following is a conversation between Mr. P's primary nurse and the patient the day before his discharge.

Mr. P: I wish my wife were more like you.

Nurse: Mr. P, I'm not sure I understand what you are saying.

Mr. P: Well, it's just that you are always so concerned about me. You always try to make me feel good and want to help me all the time. Sometimes, my wife's a grouch; she's so wrapped up in her job and the kids, and she doesn't always pay as much attention to me as you do.

Nurse: I'm glad you feel taken care of, but it's impossible to compare my role as your nurse with your wife's role.

Mr. P: I'm not sure I follow you.

Nurse: They are very different types of relationships. It's nice to have someone take care of us when we can't take care of ourselves, but when we are healthy, we don't need someone to take care of us all the time. Your relationship with your wife is more of a sharing one with mutual benefits. You take care of her needs, and she takes care of your needs in return. If you feel that your relationship with your wife is not a satisfying one, perhaps you need to talk this over with her.

Maladaptive Sexual Responses

Resulting from Illness. Stress, physical and emotional illness, injury, and aging can lead to changes in sexuality and sexual functioning. These changes and related nursing interventions depend on whether the illness is acute or chronic.

It is important for the nurse to obtain complete information on the nature and course of the illness, the types of medications used in its treatment, the patient's appraisal of the impact of the illness, and any physical limitation imposed by the illness that affects the patient's sexual health.

TABLE 25-4 SUMMARY OF NURSING CONSIDERATIONS IN SEXUAL RESPONSES OF PATIENTS TO NURSES

Goal: Maintain a professional nurse-patient relationship that will enable the nurse to provide therapeutic nursing care.

PRINCIPLE	RATIONALE	NURSING CONSIDERATIONS
Establish a trusting relationship.	An atmosphere of trust allows for open, honest communication between patient and nurse; this enables the nurse to aid the patient in discovering the underlying issues related to sexual feelings and behavior.	Express nonsexual caring and concern for the patient. Be a responsive listener, especially to feelings and needs that the patient may not be able to express directly. Reinforce the purpose of the therapeutic nurse-patient relationship.
Gain awareness of nurse's own feelings and thoughts.	Being aware of one's own feelings and thoughts enables the nurse to understand how they influence behavior; with increased self-awareness the nurse can increase the effectiveness of interactions with patients.	Recognize own feelings and thoughts. Identify any specific patient interaction or behavior that influences the nurse's feelings and thoughts. Identify the influence of the nurse's feelings and thoughts on one's behavior in an attempt to increase the effectiveness of nursing interventions.
Decrease patient's inappropriate expressions of sexual feelings and behaviors.	If the nurse is able to help the patient see that the patient's sexual interactions and behaviors are being expressed to an inappropriate partner (the nurse), the sexual acting out will usually decrease; this allows the nurse to help the patient begin to identify the reasons for the behavior.	Set limits on patient's sexual behavior. Use a calm, matter-of-fact approach without implying judgment. Reaffirm nonsexual caring for the patient. Explore the meaning of the patient's feelings and behaviors.
Expand patient's insight into sexual feelings and behaviors.	Once the patient begins to identify the reasons for sexual feelings and behaviors, the patient can see that the nurse is not an appropriate outlet for these feelings and behaviors and can move toward a more appropriate and therapeutic relationship.	Clarify misconceptions regarding any feeling the patient may have about the nurse as a possible sexual partner. Point out the futile nature of the patient's romantic or sexual interest in the nurse. Redirect the patient's energies toward appropriate health care issues.

Several nursing interventions can then be implemented to facilitate the patient's adaptive sexual responses. **The first is for the nurse to act in a supportive way and to help the patient express feelings, fears, and problems.**

Open communication between the patient and partner should be encouraged. The nurse can reinforce the positive qualities of the patient, prevent social isolation, mobilize coping resources, and support adaptive coping mechanisms that have helped the patient deal with stressors in the past.

The nurse can offer anticipatory guidance and give accurate information about the illness or injury, including what the patient may expect from medical or psychiatric treatment and its impact on sexual health (see Box 25-4).

The nurse can initiate counseling about sexuality and alternative means of sexual expression. Relaxation techniques, autoerotic activities, and variations in movement and positions may be suggested. The nurse should emphasize that pleasure can be obtained in a variety of ways and stress the importance of a loving relationship.

If the problem is complex or of a long duration, the patient should be referred for psychotherapy or sex therapy from a qualified professional. A Patient Education Plan for patients recovering from an organic illness is presented in Table 25-5.

BOX 25-4 A PATIENT SPEAKS

It is bad enough to be depressed, but how is a person supposed to feel when the people taking care of him do not give him all the information he needs? From what I can see from talking to other patients in my group, my story is not that unusual.

For about 6 months I felt myself slipping deeper and deeper into the black hole of depression. I saw some ads on television and decided that maybe I needed some outside help, because I clearly wasn't getting better by myself. So off I go to a nearby clinic, where I see someone who diagnoses me with depression and gives me some pills to take. In the beginning, the drugs made me kind of jittery, but I gradually got over it. In a couple of months I almost felt like my old self again (except for sex). In that one area of my life, I simply couldn't experience the satisfaction I used to have and didn't know what was going on. Well, it turns out that the pills I'm on limit my sexual performance, but nobody ever bothered to mention this to me. I guess they thought it wasn't important or something, but they were really wrong.

Now that I understand what's going on, I can work around it, because the drugs have helped me in almost every other way. Still, it would be nice if the people that you turn to for help could give you all the information you need and not just talk about the parts that they think are important or limit themselves to the topics they are comfortable talking about.

Critical Reasoning Should sexual behavior be permitted among patients who are residents of a long-term psychiatric facility? If so, what issues must be addressed by staff members? If not, how will the sexual needs of these patients be met?

Difficulties With Sexual Orientation. Most heterosexuals, homosexuals, and bisexuals accept their sexual orientations, although some have difficulty and seek professional help. For example, it is possible that a person's sexual behavior may not match his or her sexual desire. Someone in a heterosexual relationship may wish to be in a homosexual one, or vice versa, and feel constrained to act because of personal, sociocultural, legal, economic, or religious reasons. This can create internal conflict and distress, and the person may seek counseling.

Homosexuality is not a psychiatric disorder or mental illness. However, gay, lesbian, and bisexual youth are at increased risk for suicidal and self-harm behaviors and certain mental health problems (Coker et al, 2010). Although the reasons for this increased risk are complex, it has been suggested that society's lack of acceptance of homosexuality is a major contributing factor.

A national sample of students between the ages of 13 and 21 years examined the experiences of lesbian, gay, bisexual, and transgendered (LGBT) students with regard to their school climate. Most students reported being distressed by frequently hearing the word *gay* used in a negative way and by hearing homophobic remarks using words such as *dyke* and *faggot* while at school. Most felt unsafe at school because of their sexual orientation. In addition to verbal and physical

TABLE 25-5 PATIENT EDUCATION PLAN

Sexual Responses After an Organic Illness

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Describe the variety of human sexual response patterns.	Discuss the range of sexual desires, modes of expression, and techniques.	The patient identifies personal sexual orientation and typical level of sexual functioning.
Define the patient's primary organic problem.	Provide accurate information regarding the disruption caused by the organic impairment.	The patient understands the specific organic illness.
Clarify relationship between the organic problem and patient's level of sexual functioning.	Reframe distorted or confused perceptions regarding the impact of the illness on patient's sexual functioning.	The patient accurately describes the impact of the illness on sexual functioning.
Identify ways to enhance patient's sexual functioning and improve interpersonal communication.	Describe additional experiences that would add to the sexual satisfaction and the relationship between the patient and patient's partner.	The patient and partner report reduced anxiety and greater satisfaction with their sexual responses.

abuse, many were also victims of cyber-bullying. Unfortunately, most of these students did not report the incident to school staff because they believed little or no action would be taken. Of the students who did report an incident, 33% said that the school staff did nothing in response.

The study also found that experiences of harassment and assault were related to poor psychological well-being for LGBT students. Specifically, increased levels of victimization were related to increased levels of depression and anxiety and decreased levels of self-esteem (Gay, Lesbian and Straight Education Network, 2009). Another study of LGBT youth found that family acceptance predicted greater self esteem, social support, and general health. It also protected against depression, substance abuse, and suicidality (Ryan et al, 2010).

QUALITY AND SAFETY ALERT

- Gay, lesbian, and bisexual youth are at increased risk for suicidal and self-harm behaviors.

Negative attitudes expressed or felt by health care providers and society at large can greatly affect the health care received by homosexuals and other sexually diverse patients. **Homophobia,** which is an irrational fear of homosexuals accompanied by negative attitudes and hostility toward them, can significantly reduce the quality of care provided to these patients.

Homophobia, much like racism and sexism, is a learned behavior. It can be unlearned. Nurses can play an important role in combating homophobia and protecting individuals who are gay, lesbian, or bisexual from psychological distress. Ways to do this include the following (Irwin, 2007; Payne, 2009):

- **Inform people who harass others who are gay or bisexual that this is a form of abuse and that it will not be tolerated**.
- **Challenge homophobic comments such as when a coworker tells a homophobic joke**.
- **Remember that acceptance is very different from tolerance and that homosexuals are striving for equal rights, not special rights**.

Another prevailing attitude among health care workers is that all patients are heterosexual. This assumption, also called **heterosexism,** may distance homosexual and bisexual patients from the care they require. Heterosexism is often evident in standards of care, teaching materials, and the language used when talking with patients (Irwin, 2007; Payne, 2009). These concerns require serious self-analysis by every nurse.

Great sensitivity must be displayed by the nurse toward patients to show acknowledgement and acceptance of the fact that patients may display a range of sexual responses. **Replacing the term *spouse* with *partner* when addressing patients is a good place to start.** Committing to this one simple change is a daily reminder that not all patients are heterosexual.

Other strategies that may increase the homosexual's comfort with nurses are encouraging partners to visit and be involved in the patient's health care planning; conducting health teaching with the patient's significant other; having all members of the health care team acknowledge the partner as the person who should be informed of the patient's status during procedures or postoperatively; and offering partners the same respect and privileges as spouses of heterosexual patients.

Bisexuals often encounter many of the same difficulties stemming from societal attitudes as homosexuals. The following patient story provides an example.

> Although I identify myself as a bisexual male I have been in a relationship with a man for almost a year. Recently, I have been having a series of diagnostic tests for a flare-up of my ulcerative colitis. In the past when my partner was a woman, she was always included when the doctor discussed my test results, instructions, or discharge teaching. That is not happening now.
>
> Last week after a colonoscopy, I sat in the treatment room waiting for my doctor to come in and give me the results of my test. I was still groggy from the medication they had given me and wanted to make sure my partner heard the results of my tests along with any discharge instructions. I asked two different nurses if my partner, who was in the waiting room, could be with me to hear what the doctor had to say. Both nurses said that they would check into it, but my partner never came in.
>
> He later told me no one gave him the opportunity to come and be with me. While having to deal with the return of the painful symptoms of ulcerative colitis is extremely frustrating, it is even more frustrating to me to learn how differently many health care workers treat you when you are not heterosexual.

Another factor that may present a problem for the bisexual is isolation from a support group. Bisexuals may lack social support, and friends and family may pressure them to decide on one sexual orientation (usually heterosexual) so that they will be accepted by society.

Coming out, or disclosing one's homosexuality is often a time of stress and anxiety. An important step in working with patients who are attempting to come to terms with their homosexuality or bisexuality is to help them explore their beliefs about sexually diverse lifestyles, where these came from, and whether they are based in fact or fiction.

For example, the patient may have internalized some of society's prejudices, such as "Homosexuality is a sick and abnormal behavior; because I am a homosexual, I am sick and abnormal and should not act on my sexual feelings because they are wrong." Responses can vary and include denial, confusion, and sexual promiscuity, especially among those trying to prove to themselves that they are not gay.

It is helpful to have patients list their beliefs about homosexuality and bisexuality and to discuss each one. However, a review of beliefs about sexuality may not be sufficient. Encouraging the person to read about sexual diversity is also helpful. Throughout this process, the patient will be extremely sensitive to the nurse's acceptance or rejection.

Confidentiality is a central issue. It is helpful for the nurse to demonstrate an appreciation for patients' concerns about unwanted exposure of their homosexuality to family members, friends, or co-workers. The nurse should not encourage or discourage the patient's disclosure of homosexual concerns but rather help the patient explore and process the choice of disclosure or lack of disclosure with others, as in the next clinical example.

CLINICAL EXAMPLE

Ms. A, a 25-year-old, single woman, came to the mental health clinic with the complaint of a "sexual problem." Her history revealed that she had been sexually inactive for the past 5 years. At 20 years of age, Ms. A had a brief sexual encounter with a man she had been dating for 2 years. She ended the relationship shortly afterward because she had no interest in maintaining a sexual relationship with the man. She recently became involved in a relationship with a woman that was very satisfying to her. She felt she had to end the relationship because she would not tolerate thinking of herself as a homosexual. During one of the initial counseling sessions, Ms. A told the nurse that she must end the relationship before "it" happens again.

Nurse: What are you afraid will happen?
Ms. A: I'm afraid I'll feel attracted to her again.
Nurse: What about that frightens you?
Ms. A (becoming upset): That will mean I'm homosexual!
Nurse: What does being homosexual mean for you?
Ms. A: It means I'm sick. It's a sin. I couldn't go to church anymore.
Nurse: Are all homosexuals sick?
Ms. A: Yes.
Nurse: How do you know this?
Ms. A: Everybody knows that homosexuality is morally wrong. Homosexuals have a lot of emotional problems.
Nurse: Do you know any homosexual people?
Ms. A: Well, not exactly.
Nurse: What have you read about homosexuality?
Ms. A: Nothing.
Nurse: It looks to me as if you are basing all of your conclusions on hearsay rather than real knowledge. I think that you and I need to explore your beliefs in more detail, and then you can do some reading to find out the facts.

Selected Nursing Diagnoses

- Ineffective sexuality pattern related to questions about sexual orientation related to recent interpersonal relationship, as evidenced by current attraction to a woman
- Spiritual distress related to conflicting values, as evidenced by questions about religious beliefs

After the interaction in the preceding clinical example, the nurse and Ms. A developed a plan often used in sexual counseling to explore homosexuality. Some of the interventions included the following:

- Ms. A described her beliefs about homosexuality and homosexuals.
- The nurse encouraged Ms. A to explore the literature on homosexuality and suggested readings to help dispel the myths.
- The nurse then discussed these with Ms. A and suggested that she attend a social gathering for gay people to test out her new knowledge. The nurse suggested the social gathering because many people struggling with a homosexual identity are frightened to test out situations that would dispel the myths.
- The nurse helped Ms. A explore her responses to these activities and integrate them into a positive view of self.

QUALITY AND SAFETY ALERT

- Sexual minority youth, or teens who identify themselves as gay, lesbian, or bisexual, are bullied two to three times more than heterosexuals.
- It is estimated that between 30% and 40% of LGBT youth, depending on age and sex groups, have attempted suicide.
- It is impossible to know the exact suicide rate of LGBT youth because sexuality and gender minorities are often hidden and even unknown, particularly in this age group.

Difficulties With Gender Identity. **Gender identity** is a person's perceptions of his or her own maleness or femaleness. **Gender identity disorder,** or gender dysphoria, is a profound discomfort with one's gender and a strong and persistent identification with the opposite gender. It can be experienced along a continuum of responses, with transsexualism being the most severe form of this disorder.

Treatment of the transsexual person has been controversial. Standards of care for gender identity disorders provide guidelines for health professionals who work with patients who have gender problems (World Professional Association for Transgendered Health, 2001). These standards were developed because of the serious consequences of available treatments.

Patients who believe they are transsexual and request surgical reassignment must meet these standards. Hormonal treatment alone may be sufficient for some transgendered individuals. For other transgendered individuals, surgery may be an option.

The standards of care require that two therapists agree that the surgical reassignment is appropriate, the patient be of legal age, and the patient live in the role of the preferred gender for at least 1 year. The standards also recommend that long-term postoperative follow-up care be provided. This follow-up care is associated with a positive psychosocial outcome.

It also is important that patients receiving hormonal treatment receive regular follow-up. This is done to prevent and treat any medical conditions specific to hormonal replacement. Psychological assessment and psychotherapy are suggested and sometimes required (Martin, 2007; Fraser, 2009). The patient and therapist must be certain that implementing the treatment plan is the best approach because the surgery is not reversible.

Pedophilia. **Pedophilia** is the sexual attraction to prepubescent children. It may involve fantasizing, arousal, and

sexual urges (American Psychiatric Association, 2000). **It is a maladaptive sexual response and criminal act because it involves sex with children.**

It is a type of **paraphilia,** a condition in which one experiences intense sexually arousing fantasies, sexual urges, or sexual acts involving: (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other nonconsenting persons (American Psychiatric Association, 2000).

Psychiatric nurses are in a position to care for the victim or the offender. However, very few pedophiles seek treatment. One of the primary problems in the treatment of pedophilia is the high rate of recidivism. It has been proposed that continued compliance with a comprehensive treatment program may reduce relapse.

A comprehensive treatment program may involve behavioral and pharmacological management along with close legal monitoring. Although these interventions may help control the pedophile's urges, they have not been found to change the pedophile's attraction to children (Hall and Hall, 2007; Seto, 2009).

The effects of child sexual abuse are long lasting, and nurses must be equipped to care for child and adult survivors. Abuse can influence health in many ways. It can lead to maladaptive coping mechanisms, such as substance abuse, sexually acting out behavior, and withdrawing from people. **Revictimization** is another problem that many survivors of sexual abuse encounter, since they may become adult victims of sexual assault.

An extensive review of the literature on the link between child sexual abuse and later sexual exploitation found that the international incidence of child sexual abuse has increased dramatically in the past 10 years and that child sexual abuse victims are at risk for sexual revictimization and high-risk sexual behavior as adults (Lalor and McElvaney, 2010). They are more likely to have multiple sex partners, become pregnant as teenagers, and experience sexual assault as adults.

In a study of sexually abused children followed for up to 43 years, child sexual abuse substantially increased the risk of psychopathology in both childhood and adulthood. Clinical disorders identified included psychosis, mood, anxiety, substance abuse, and personality disorders. They also found that the severity of the child sexual abuse and older age at sexual abuse were associated with an even higher risk for psychopathology (Cutajar et al, 2010). Care for survivors of abuse and violence is discussed in Chapter 38.

Nurses can care for patients by incorporating questions about a history of sexual abuse in their nursing assessments (Sobczak, 2009b). If a patient does have a history of sexual abuse, the nurse can evaluate whether current health problems are related. Referral can be made to a clinician who specializes in helping victims of sexual abuse.

Patients can be assisted in realizing that they are in control of their thoughts and behavior. They then can be taught ways to decrease anxiety, build trusting relationships, and decrease overall stress, improving health.

A Nursing Treatment Plan Summary for maladaptive sexual responses is presented in Table 25-6.

Critical Reasoning What role do social institutions, such as churches, schools, and health centers have in protecting youth from sexual improprieties?

Dysfunctions of the Sexual Response Cycle

All nurses should have knowledge about the causes and treatment of sexual dysfunction. Although treating sexual dysfunctions is beyond the scope of most nurses, they should be aware of the principles involved and know sex therapists in the community for referral of patients.

Two common models of sex therapy are the Masters and Johnson and the Helen Singer Kaplan models. They have been reported to be useful for several types of sexual dysfunction, and some long-term follow-up studies have shown the positive sustained effect of therapy on individuals' and couples' sense of sexual satisfaction.

Masters and Johnson Model. The Masters and Johnson (1970; Masters et al, 1986) treatment model includes short-term education with step-by-step instructions regarding the physical aspects of sexual activity and supportive psychotherapy. According to this model, attitudes and ignorance are responsible for most sexual dysfunctions.

This approach to patients begins with obtaining a detailed sexual and background history. The couple is instructed to carry out a sensate focus exercise in which each partner instructs the other in specific ways of caressing for sensual pleasure without involving the breasts or genitalia. The next day, the exercise is repeated, including breasts and genital areas, but without coitus.

The exercise's purpose is to alleviate performance anxiety and to enhance warm, comfortable feelings between partners. After the sensate focus exercises are completed, the therapy is directed to the sexual dysfunction. The Masters and Johnson model emphasizes education, communication, and cooperation between partners.

Helen Singer Kaplan Model. The Kaplan (1975, 1979) treatment model begins with an extensive evaluation, including marital, psychiatric, sexual, medical, and family history from both partners. If serious psychological problems are identified, the couple may be referred to individual or conjoint therapy and not accepted for sex therapy at that time.

Like Masters and Johnson, Kaplan uses sensate focus exercises and variations, such as showering together, to begin sex therapy or to further evaluate a person's suitability for sex therapy. Therapy itself consists of erotic tasks performed at home plus weekly or semiweekly meetings with the therapist. Couples and the therapist explore feelings experienced during the erotic exercises. The exercises take into account the motivations and dynamics of the relationship. The role of the therapist includes education, clarification, and support. Both Kaplan and Masters and Johnson emphasize communication between partners and exploration of the relationship and emotional concerns.

TABLE 25-6 **NURSING TREATMENT PLAN SUMMARY**

Maladaptive Sexual Responses

Nursing Diagnosis: Ineffective sexuality pattern

Expected Outcome: The patient will obtain the maximum level of adaptive sexual responses to enhance or maintain health.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will describe values, beliefs, questions, and problems regarding sexuality.	Listen to sexual concerns implied and expressed. Communicate respect, acceptance, and openness to sexual concerns. Help the patient explore sexual beliefs, values, and questions. Encourage open communication between the patient and partner.	An accepting therapeutic relationship will allow patients to be free to question, grow, and seek help with sexual concerns.
The patient will relate accurate information about sexual concerns.	Clarify sexual misinformation. Dispel myths. Provide specific education about sexual health practices, behaviors, and problems.	Accurate information is helpful in changing negative thoughts and attitudes about particular aspects of sexuality. It can also prevent or limit dysfunctional behavior.
	Give professional "permission" to continue sexual behavior that is not physically or emotionally harmful.	Giving permission allows the person to continue the behavior and alleviates anxiety about normalcy.
	Reinforce positive attitudes of the patient.	It allows patients to incorporate sexual behavior into a positive and accepting self-concept.
The patient will implement one new behavior to enhance sexual response.	Set clear goals with the patient. Identify specific behaviors that can be carried out that focus on enhancing self-concept, role functioning, and sex. Encourage relaxation techniques, redirection of attention, positional changes, and alternative ways of sexual expression as appropriate.	Giving a patient direct behavioral suggestions can help relieve a sexual problem or difficulty and is a useful intervention when the problem is of recent onset and short duration.
	Become familiar with the sex therapy resources available in the community. Refer the patient to a qualified sex therapist as needed.	Although all nurses need to screen for maladaptive sexual responses and provide basic nursing care, complex problems should be referred to qualified sex therapists for further treatment.

Pharmacological Treatment. Medications used to treat male sexual problems are widely available. SSRIs may be used to treat premature ejaculation, and the three most common drugs used to treat erectile dysfunction are sildenafil (Viagra), tadalafil (Cialis), and vardenafil (Levitra).

These drugs act by causing local vasodilation, increasing blood flow to the penis, leading to erection. They have been effective for many men with erectile dysfunction; however, sex therapists caution that although they may eliminate a physical cause for erectile dysfunction, they are not a magic pill that will cure all.

Although some patients may prefer to be treated with only medications, others may benefit from a combination of counseling and drugs. It also is helpful to include the patient's partner in treatment. Relationship issues should be addressed for satisfactory treatment of this dysfunction.

Although there are a few clinical trials involving pharmacotherapy for treating female sexual dysfunction, the U.S. Food and Drug Administration (FDA) has not approved any drugs for female sexual dysfunction; however, off-label prescribing of sildenafil for women has been reported. Perhaps this is because sexual dysfunction in women is more commonly associated with the woman's feelings and sexual desire and may not be as responsive to a medication.

EVALUATION

In the evaluation phase, the nurse works with the patient to evaluate the effectiveness of the sexual counseling or intervention. Factors to consider include the following:

- **Sense of well-being.** How does the person feel about oneself? Have these feelings improved during the treatment?
- **Functioning ability.** If the person was dysfunctional, is functional ability restored? Somewhat improved? What about the person's ability to function within primary relations at work? With friends?
- **Satisfaction with treatment.** Does the patient believe that the treatment was helpful? Were the patient's goals adequately met?

Evaluation of any form of sexual counseling or intervention should be ongoing. The nurse and patient should work together on goals, problems, and alternatives.

LEARNING FROM A CLINICAL CASE OUTCOME

1. How has the stigma of homosexuality affected the mental health of this young man?

This young man has a 'secret" about who he is. This can cause a serious problem related to his self-identity. Research shows that homosexual youths are at risk for self-harm and suicide. They also are at risk for other mental illnesses such as depression and substance abuse. Therefore addressing his feelings regarding this issue is critical.

2. Why is it important for the nurse to examine one's own beliefs about homosexuality before providing care to this patient?

Nurses, like many other people, have their own beliefs about sexual orientation. Nurses who do not examine their own values and beliefs might avoid the subject or project discomfort and therefore, perceived rejection, onto the patient. This could create a situation that validates the patient's worst fears. It is only after examining one's own beliefs that the barriers can come down and this person's vulnerability can be felt and respected.

3. Do public barriers, such as employment, exist related to sexual orientation?

The social norms in this country, while undergoing change, continue to fluctuate regarding this issue. There are many misconceptions about homosexuality that many people feel are a threat to their own beliefs such as same sex civil union vs. marriage. This issue of sexuality continues to make some people feel uncertain and therefore, unable to reveal their true feelings and identity in many settings.

4. How would you intervene to assist this patient to "obtain the maximum level of adaptive sexual responses to enhance or maintain health"?

The secrecy of his sexual orientation appears to be of concern in three areas of his life: his family, his boyfriend, and his career choice. These should be discussed separately, giving him an opportunity to examine his own values and beliefs, and then problem solve an approach to these issues individually. The nurse must take a "real world" approach to this issue by also being informed of community norms. These should be discussed openly in a nonjudgmental manner.

5. What health education would you provide?

As with other risk factors, this patient needs to be educated about illnesses for which he may be at risk. This would include depression, substance abuse, and self-harm, as well as sexually transmitted diseases such as HIV.

6. What are your nursing actions in relation to this patient's concern about "coming out"?

Surveys show that "coming out" to one's family is a particularly emotional issue for homosexuals. Therefore, this patient may want to prepare for this event. The nurse can ask this young man how he thinks his family will respond and then role play the situation. The possibility of rejection must be broached and options for support explored.

Case Outcomes

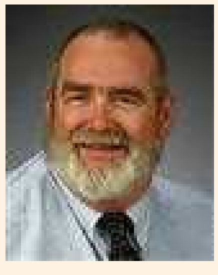
On his return visit he reported that he had told his family about being gay. They were not surprised and were very supportive. For now he has decided not to tell anyone else. He has only four more months as a dispatcher before he can apply to become a patrolman. He also told his boyfriend that he believes that people who love each other should be faithful and he would no longer be in a relationship with him. He said it had been very hard but he really felt it was the right thing to do. Two weeks later, the boyfriend returned saying he had made a terrible mistake and wanted to be forgiven. The patient said they would have to be friends for a bit of time and see if he they could really get back together.

The patient said that he felt "whole" for the first time in a long while and was energized by the strength of his family's support. He has decided that the most important thing for him was being himself and feeling good about that. Even if he has to sacrifice a job in the future he wouldn't go back to keeping that secret. He was no longer experiencing the symptoms of depression but said he would call for another appointment if those feelings returned.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Donald Ribelin, RN, C



I was working as an evening charge nurse on an adult acute care psychiatric unit when one of the mental health assistants came to the desk to report that he had seen Mr. B and Ms. G sneaking into the solarium and that they appeared to be "getting it on." Almost every nurse has had to confront patients, visitors, or both in a sexual situation of one type or another. We'd had our share of such encounters in the past, but the staff reacted very differently this time.

To begin with, Mr. B was a 72-year-old "street" person who had been admitted with a diagnosis of rule-out dementia, and Ms. G was a lovely 70-year-old widow with a diagnosis of situational depression. Mr. B's apparent dementia had proven to be secondary to malnutrition and vitamin B_{12} deficiency. After he had received treatment for these, we had found him to be a remarkable person whose ready sense of humor lightened many an evening group. Ms. G had been admitted with one of the flattest affects I had ever seen. Her family reported that she had been increasingly depressed since her husband's death 3 years ago. This depression increased dramatically around the anniversary of Mr. G's death, which was right around this time of the year.

During the past week, Ms. G's depression had lifted noticeably. She could be seen talking, laughing, and joking with Mr. B during any free moment. They seemed to always be together,

COMPETENT CARING—cont'd

A Clinical Exemplar of a Psychiatric Nurse

Donald Ribelin, RN, C

sitting next to each other during groups or meals or walking side by side on outings. We had all commented on how much they had helped each other and what a nice couple they made. Suddenly, Mr. B and Ms. G had stopped being a nice old couple and had become two psychiatric patients sneaking off to have sex.

I found myself torn between several reactions to this news. The empathic nurse in me responded, "This is great. Two lonely people in the twilight years of their lives have found love and companionship." The analytical nurse in me wondered whether this relationship would really be therapeutic for them both. But the administrative nurse in me won out, thinking that I don't let other patients behave in this manner, so I have to intercede.

Somewhat loudly I walked down the hall and into the solarium, taking a very long time fumbling for the light switch. The lights revealed Ms. G and Mr. B sitting side by side, holding hands and red faced. Ms. G's blouse was only partially buttoned, and she was obviously upset. I apologized to them, explaining that I had planned to spend my break in the solarium and hadn't meant to startle them. As they quickly stood up and headed toward their rooms, I could see a look of sadness and possibly shame replacing the happy smile that we had been seeing the past few days on Ms. G's face. Mr. B also looked sad, and for a moment, I thought I saw the return of the shuffling gait he had at admission. By doing the "right" thing, I now felt like I had done the very worst thing possible.

During my shift report, I gave the incident only brief comment. Talking more about the possible therapeutic benefits of the relationship, I didn't mention the sexual aspects at all. Guilt can be a great censor and rewriter of history, and I was obviously really feeling guilty. Well, time may heal all wounds, but it only gives rumors time to grow. I was very surprised when, on returning to work the next evening, my nurse manager asked for the incident report on Mr. B and Ms. G having sex in the solarium. She also wanted to know why I hadn't documented the incident in my nursing notes.

By the time I had explained the previous evening's happenings, what had started as two people wanting to be together had become a major event. Damage control began with a meeting of all unit staff, where we discussed what had and had not happened. It didn't stop there. A psychiatric unit is often like a small town where there are no secrets.

That evening in group, the patients brought up our hapless couple's "making out." I again found myself in a position in which I felt anything I said could and probably would be wrong. After careful thought, I responded by first reminding them that this was a hospital and there were certain rules of conduct that had to be adhered to, even when we might personally disagree with them. Members of the group were asked to share their feelings about these rules and why they were or were not necessary. As the group proceeded, I kept a careful eye on Ms. G and Mr. B. They were sitting about as far from each other as possible, and both were very quiet. As the patients talked, I kept trying to think of something to say or do to alleviate the obvious pain and embarrassment of our elderly couple, who were now the center of attention.

Suddenly Mr. B stood up, smiled at the group, and said, "You know, I've been feeling real bad today. I felt like I had done something wrong and that I was just waiting for my punishment to come." Then he stated, "Yeah! I was feeling real bad until just a moment ago, when I remembered a button I saw once. It said, 'Old people need love, too,' and you know that's right because everyone needs to know that someone cares about them, needs them, and loves them. So it really doesn't matter what any of you think because I've found someone to love me and for me to love." I still remember that moment because it was a time that patients and staff stopped to really think about life and realized he was absolutely right!

CHAPTER IN REVIEW

- Sexuality is defined as a desire for contact, warmth, tenderness, and love. Adaptive sexual behavior is consensual, free of force, performed in private, neither physically nor psychologically harmful, and mutually satisfying.
- The nurse's level of self-awareness is a critical component of discussions with patients regarding sexual issues. Developing self-awareness involves clarification of values regarding human sexuality and four phases of the nurse's growth: cognitive dissonance, anxiety, anger, and action.
- Patient behaviors related to sexual responses include heterosexuality, homosexuality, bisexuality, transvestism, and transsexualism. The physiological and psychological responses to sexual stimulation consist of four stages: desire, excitement, orgasm, and resolution.
- Predisposing factors for variations in sexual response are described from biological, psychoanalytical, and behavioral perspectives.
- Precipitating stressors that may change sexuality include physical illness and injury, psychiatric illness, medications, and HIV/AIDS.
- Coping mechanisms used with expressions of sexuality include fantasy, projection, denial, and rationalization.
- Primary NANDA-I diagnoses are sexual dysfunction and ineffective sexuality pattern.
- Medical diagnoses are categorized as sexual dysfunctions, paraphilias, and gender identity disorders.
- The expected outcome of nursing care is that the patient will obtain the maximum level of adaptive sexual responses to enhance or maintain health.
- Education is the most common method of primary prevention of sexual problems. Sex education is a lifelong process with the primary goal of promoting sexual health.

CHAPTER IN REVIEW—cont'd

- It is always the nurse's responsibility to preserve professional boundaries, even when a nurse feels sexually attracted to a patient. It is never acceptable for a nurse to engage in sexual behavior of any kind with a patient.
- If a patient makes a sexual advance, the nurse should let the patient know that the behavior is unacceptable. Nurses have a responsibility as professionals to attempt to understand sexual behaviors and analyze their possible meanings.
- Interventions in maladaptive sexual responses include providing support, anticipatory guidance, counseling, and referral.
- Negative attitudes by health care providers and society at large can affect the health care received by patients who are sexually diverse.
- Pedophilia, which is the sexual attraction to prepubescent children, is a crime.
- Dysfunctions of the sexual response cycle should be referred to sex therapists for treatment. Medications are also available to treat sexual dysfunctions.
- In evaluating nursing care, the nurse and patient should consider the patient's sense of well-being, functional ability, and satisfaction with treatment.

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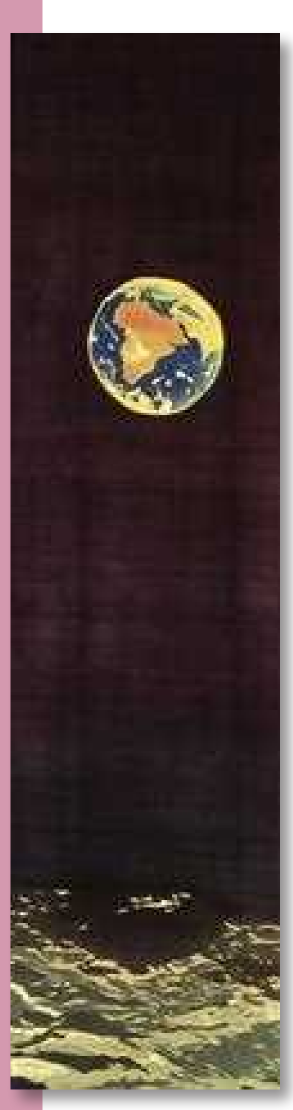
UNIT 4

Treatment Modalities



CHAPTER 26

Psychopharmacology

Donald L. Taylor

Medicines are nothing in themselves, if not properly used, but the very hands of the gods, if employed with reason and prudence.

Herophilus

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the role of the nurse in psychopharmacological treatments.
2. Examine pharmacological actions, drug co-administration, and drug interactions.
3. Analyze the mechanism of action, clinical use, and side effects related to antianxiety, sedative-hypnotic, antidepressant, mood-stabilizing, and antipsychotic drugs.
4. Evaluate the implications of new psychopharmacological agents and genomics.
5. Discuss psychiatric nursing practice issues related to psychopharmacology.

This chapter discusses **psychopharmacology** and important principles of drug therapy in the treatment of patients with neurobiological brain disorders, or mental illnesses. The pharmacological agents described in this chapter are all approved by the U.S. Food and Drug Administration (FDA), although not always for the indications described. Dietary supplements and herbal preparations used to treat the symptoms of mental illness are described in Chapter 30.

This chapter views drug therapy as a complement to other evidence-based therapies, such as cognitive behavioral, psychosocial, interpersonal, psychodynamic, and complementary and alternative interventions. Drug therapy is not viewed as a quick fix or miracle pill. Psychopharmacological agents treat specific symptoms of neurobiological illnesses with significant effectiveness, although side effects and adverse reactions of drug therapy require expertise and sound clinical judgment on the part of the nurse.

Psychopharmacology is an established standard in the treatment of neurobiological illnesses. However, drugs alone do not treat the patient's personal, social, or environmental components of or responses to these illnesses. This underscores the need for an integrated and comprehensive approach to the treatment of persons with mental illness.

ROLE OF THE NURSE IN PSYCHOPHARMACOLOGY

Psychopharmacological treatment should be integrated with the principles of psychiatric nursing practice presented throughout this book. The psychiatric nurse has a wealth of knowledge and competencies that make the nursing care provided to people with psychiatric disorders unique in many ways. Following are some examples of the nurse's role in psychopharmacological treatment of persons with neurobiological illness.

Patient Assessment

Psychoactive drugs treat specific symptoms of neurobiological brain disorders. However, not all patient behaviors are treated by drug therapy, and not every symptom of illness is targeted for treatment with drugs.

It is essential that a thorough patient baseline assessment—including history, physical, and laboratory examination (Chapter 5); psychiatric evaluation (Chapter 6); sociocultural assessment (Chapter 7); and a medication history (Box 26-1) be completed for each patient before beginning any treatment. This information helps distinguish aspects of the psychiatric illness from aspects of the patient's personality that were present before the onset of illness.

As a result of the baseline assessment a diagnosis is made and psychiatric symptoms are identified as appropriate targets for drug treatment. An integrated treatment plan is then developed. Residual symptoms of the patient's illness may need specific interventions to enhance treatment effectiveness. Problematic personality characteristics not related to the psychiatric disorder can be addressed by nonpharmacological treatments as needed.

Drug side effects that emerge after treatment begins should be identified and appropriately treated as they appear. Symptoms of organ system dysfunction, being either a component of an illness or a side effect of drug treatment, should be identified and treated.

Current nonpsychiatric diagnoses and treatments are documented at the baseline level, as well as the use of over-the-counter remedies and complementary and alternative treatments the patient may be taking.

Finally, careful baseline assessment of each patient can help identify undiagnosed medical illnesses that co-exist with the psychiatric illness or that may be causing the psychiatric symptoms. See Box 26-1 for a medication assessment tool to guide the nurse in taking a drug and substance use history.

BOX 26-1 MEDICATION ASSESSMENT TOOL

Prescribed and Over-the-Counter Medications

For each of the following categories of drugs taken by the patient:

- Prescribed psychiatric medications ever taken
- Prescribed nonpsychiatric medications taken in the past 6 months or taken for major medical illnesses if more than 6 months ago
- Over-the-counter medications taken in the past 6 months
- Supplements, herbs, essential oils, and other complementary and alternative remedies

Obtain the following information from the patient and other sources:

- Name of the drug/remedy
- Reason taken
- Dates started and stopped
- Highest daily dose
- Who prescribed it?
- Was it effective?
- Side effects or adverse reactions
- Was it taken as directed? If not, how was it taken?
- History of drug(s) taken by first-degree relative

Other Substances

For each of the following categories of drugs taken by the patient:

- Alcohol
- Tobacco
- Caffeine
- Street drugs

Obtain the following information from the patient and other sources:

- Name of substance
- Dates and schedule of use
- Description of effects
- Adverse reactions/withdrawal symptoms
- Attempts to stop/treatments to stop
- Impact of substance on the following:
  - Quality of life
  - Relationships/spouse/children
  - Occupation/education
  - Health/productivity
  - Self-image
  - Finances

Coordination of Treatment Modalities

The nurse has an important role in designing a comprehensive treatment program. The most appropriate treatment choices should be individualized for each patient and reflected in the treatment plan. The coordination of care is often the primary responsibility of the nurse who works with the patient in an ongoing therapeutic alliance as part of the health care team. The nurse integrates drug treatments with the wide range of nonpharmacological treatments in a manner that is knowledgeable, safe, effective, and acceptable to the patient.

Drug Administration

Nurse have a significant impact on the patient's experience with psychopharmacological agents. In many inpatient, day treatment, home health, and other outpatient settings the nurse works out a dosing schedule based on drug requirements and the patient's needs and preferences, administer the medication, and are continually alert for and treat drug effects. This role defines the nurse as a key professional in maximizing therapeutic effects of drug treatment and minimizing side effects in such a way that the patient is a true collaborator in managing the medication regimen.

Monitoring Drug Effects

The nurse has the important role of consistently monitoring the effects of psychopharmacological drugs. This includes making standardized measurements of drug effects on baseline target symptoms, evaluating and minimizing side effects, treating adverse reactions, and noting the often subtle effects of the medication on the patient's self-concept, trust, and confidence in the treatment.

A drug should be given within the recommended dose range and for the appropriate amount of time before

determining whether it has had an adequate therapeutic trial for a particular patient. Therapeutic drug monitoring is important because some drugs have a narrow therapeutic range (e.g., lithium), some can cause sudden serious adverse reactions (e.g., neuroleptic malignant syndrome), and some drugs are often co-administered, thereby altering the drug metabolism and clearance rates.

Almost all drugs are metabolized by one of the many families of metabolic enzymes, or "cytochromes," usually referred to as the *CYP-450 system*, found predominantly in the liver. Some drugs, called **inducers,** speed up one or more of these systems, thus decreasing the blood level of drugs metabolized by that system and potentially causing a lack of effectiveness of those drugs. Other drugs, called **inhibitors,** slow down one or more systems, thus increasing blood levels of the drugs metabolized by that system and potentially causing increased side effects or even toxicity from those drugs. This is known as **cytochrome P-450 inhibition**.

Some racial and ethnic groups have genetic predispositions toward deficiencies in these enzymes, making them at greater risk for CYP-450 problems. The medication prescriber is responsible for anticipating these possibilities and prescribing accordingly. The nurse should be vigilant for signs of drug effects that seem inconsistent with the doses prescribed or that are adverse reactions (Howland, 2011a).

Medication Education

The nurse is in a central position to educate the patient and the family about medications. This includes teaching complex information to the patient so that it can be understood, discussed, and accepted.

Patients should be well informed about each drug prescribed for them, including the expected benefits and potential risks, other available treatments for their condition, and what to do and who to contact if a question or problem arises. **Medication education is an important key to effective and safe use of psychotropic drugs, patient collaboration in the treatment plan, and patient adherence with drug treatment regimens.**

Drug Maintenance Programs

For some patients the drug maintenance program may last many months and perhaps even a lifetime. The nurse can assume the important role of continuing a therapeutic alliance with a patient on drug maintenance.

The nurse is often the contact for patients who may have ongoing questions about their current drug regimen, drug effects on lifestyle and concurrent illnesses, and new treatments as they become available. Advanced practice nurses may be the primary health care provider for patients during acute, continuation, and maintenance phases of treatment.

Clinical Research Drug Trials

As a member of the interdisciplinary research team the nurse can contribute to the body of scientific knowledge, often adding a nursing perspective to team research efforts. The nurse can be included on many levels from research data collector to principal investigator to funding agency monitor and consultant. Nurses involved in psychopharmacological **randomized controlled trials (RCTs)** can enhance the research experience for the patient, who will need information about informed consent, double-blind randomization, experimental treatments, placebo-controlled trials, and patient rights.

Prescriptive Authority

Legislation has been passed in every state in the United States authorizing **advanced practice registered nurses (APRNs)** to have at least some degree of authority to prescribe medications, and in some states APRNs have full autonomy in this role (Pearson, 2011). Psychiatric–mental health nurse practitioners, and in some states this includes clinical nurse specialists, who are qualified under their state nurse practice acts are thus able to prescribe pharmacological agents to treat the symptoms and improve the functional status of patients with psychiatric illnesses (NONPF, 2011).

Thus the role of nurses in psychopharmacological treatments has been expanded to include medication prescriptive authority in order to utilize the expertise of APRNs to increase patient access to quality and cost-effective health care. Collaborative relationships with supervisors, other health care providers, peers, and agencies involved in the care of patients are important aspects of the nurse prescriber's role.

> **Critical Reasoning** Does your state grant medication prescriptive authority to psychiatric–mental health APRNs? If so, what are the requirements for prescriptive practice?

PHARMACOLOGICAL PRINCIPLES

Pharmacokinetics

Pharmacokinetics is the study of how the body affects a drug. It answers the question: How does the body get drugs to and from their intended target? Pharmacokinetic properties include:

- **Absorption**—how the drug is moved into the bloodstream from the site of administration
- **Distribution**—how much drug is moved into various body tissues
- **Metabolism**—how the drug is altered, usually by liver enzymes, into its active and inactive parts
- **Elimination**—how much of the drug is removed from the body in a specific amount of time

The time course and location of drug concentrations in the body can be predicted, appropriate dosing schedules can be designed, side effects can be anticipated, and the time it takes a drug to become effective can be estimated by using pharmacokinetic models. Additional pharmacokinetic properties that assist in understanding the mechanisms of psychopharmacological agents and how the body affects a drug are described in the following sections.

Bioavailability. **Bioavailability is how much of the drug reaches systemic circulation unchanged.** It is an estimate

used to compare various drug preparations, particularly if several different manufacturers make the same generic drug.

In general, generic drugs are prescribed to ensure more accuracy of the bioavailability estimate since trade name drugs can differ from one another. Using generic drug names also takes advantage of price differences among manufacturers and prevents possible confusion when a drug later becomes available as a generic.

Once a drug does become a generic, the patient should be instructed to always use the same company brand of the drug because the bioavailability of psychoactive drugs may vary significantly from one company to another, thus affecting drug dose and steady state. The patient can be taught to use one pharmacy regularly, and the pharmacist can be asked to use the same manufacturer every time when filling generic prescriptions of a particular drug, again to ensure a constant bioavailability.

Half-life. **A drug's half-life is the time it takes for the dose amount of drug in the body to decrease by 50%.** For example, the benzodiazepine (BZ) alprazolam has a half-life of approximately 11 hours, so it takes about 2.5 days for nearly all traces of the drug to be eliminated from the body after taking a single dose.

Half-life determines how long it will take the body to achieve steady state. **Steady state is the point at which the plasma drug concentration remains relatively constant between doses because the amount of drug excreted equals the amount ingested.** This equilibrium occurs in approximately five half-lives of any given drug.

Until steady state is reached, the drug level in the body continues to fluctuate, accounting for some acute side effects and preventing determination of the optimum dose for a particular patient. Assessing a blood level measurement is not an accurate method of determining a proper dose range. The daily dose may have to be divided in order to minimize the peak level of drug concentration after each ingestion.

Termination of drug treatment is also affected by half-life. The effects of drugs with a long half-life or with active metabolites can last a long time (sometimes weeks) after the last dose has been taken. Drugs with a shorter half-life usually must be discontinued gradually (tapered) over several days or weeks.

In general, most psychoactive drugs should be tapered to avoid uncomfortable discontinuation symptoms. Drugs with addiction potential, such as BZs, must be tapered gradually to avoid serious withdrawal symptoms.

Drug Interactions. Drug interactions can be the result of pharmacokinetic properties. **One drug may interfere with the absorption, metabolism, distribution, and elimination of another drug, thus raising or lowering the levels of the second drug in the blood and tissue.** As noted above, some drugs inhibit and others induce the activity of drug-metabolizing liver enzymes, thereby affecting the liver's ability to keep levels of psychopharmacological drugs stable.

For example, most of the antidepressants, some of the typical antipsychotics, the mood stabilizers, and even grapefruit juice can inhibit drug-metabolizing liver enzymes in the CYP-450 system, potentially causing toxic levels of other drugs. The mood stabilizer carbamazepine, St. John's wort, and even smoking cigarettes can markedly reduce many psychotropic drug levels, rendering them ineffective (Fuller and Sajatovic, 2009).

Pharmacodynamics

Pharmacodynamics is the study of the effects of a drug on the body and, in particular, the interaction of a drug on the receptor that is its targeted site of action. Pharmacodynamics answers the question: What does a drug do once it gets where it is going?

By using pharmacodynamic models, the time course and intensity of drug effects on the body can be determined; drug interactions can be better understood; and safety profiles that affect clinical decision making can be developed. Several pharmacodynamic properties related to how drugs affect the body include those listed here.

Receptor Mechanisms. **Receptors are channels on cells that act as gatekeepers of brain communication.** They recognize and respond to molecules (messengers) that affect their biological function. Thus receptors are targets for drugs acting as messengers, which modify the biological activity of the receptors, bringing a dysfunctional system back toward normal.

A drug modifies a receptor by attaching (binding) to one subtype of receptor (like a key in a single lock) or many subtypes of receptors (like a master key for many locks) in several ways. A drug can act as the following:

- Agonist—stimulates the receptor to fully open its channel
- Partial agonist—stimulates the receptor to partially open its channel
- Antagonist—inhibits or blocks another chemical agonist from stimulating the receptor to open its channel
- Inverse agonist—directly closes the receptor channel

For example, BZs are *agonists* for the gamma-aminobutyric acid (GABA) system because they enhance the activity of GABA, an inhibitory neurotransmitter. Most antipsychotic drugs are *antagonists* at dopamine (DA) receptors because they inhibit the activity of dopamine.

Dose-Response Curve. If the concentration of the drug is plotted against the effects of the drug on a graph, the curve produced is a measure of drug potency. Potency is the amount of dose required to achieve certain effects. It answers the question: **How much of this drug is needed to get these results?**

This concept is helpful when comparing the actions of one drug with another. For example, atypical antipsychotics differ in potency—risperidone is more potent than clozapine, therefore requiring lower doses to achieve a therapeutic effect.

Therapeutic Index. The **therapeutic index is a relative measure of the safety and toxicity of a drug**. The ratio produced by measuring the amount of drug necessary for 50% of

patients to experience a therapeutic effect (median effective dose) and the highest amount of drug at which a toxic effect is produced in 50% of patients (median toxic dose) is called the therapeutic index. It answers the questions: **What is the lowest dose of this drug needed to begin to produce a therapeutic effect, and what is the highest dose at which a toxic effect is produced in the average patient?**

A **low therapeutic index** means that the difference between the amount of drug needed to achieve the desired effect and the amount that would cause toxic effects has a narrow range (like a window with a narrow opening). For example, the mood stabilizer lithium has a low therapeutic index and requires frequent blood level checks and careful monitoring and stabilizing measures to ensure its safe use.

On the other hand, the typical antipsychotic haloperidol has a **high therapeutic index** and thus is safely prescribed in a wide range of doses (like a window opened very wide). Individual patient differences, such as age, gender, and race, also can affect the therapeutic index of a specific drug.

Tolerance, Dependence, and Withdrawal Symptoms. Some patients become less responsive to the same dose of a particular drug over time, which is called **tolerance,** requiring that higher doses of the drug be given over time to obtain the same initial therapeutic effect. The development of tolerance to some drugs, such as BZs or opioids, also may be associated with physical dependence on the drug, requiring tapering during discontinuation to avoid uncomfortable withdrawal symptoms (Chapter 23).

Abruptly stopping many psychotropic medications, including antidepressants, BZs, and atypical antipsychotics, can trigger **discontinuation syndrome,** characterized by the following:

- **A rebound or recurrence of original symptoms**
- **Uncomfortable new physical and psychological symptoms**
- **Physiological withdrawal**

Gradual tapering from medication can help to prevent this syndrome (Preskorn, 2011).

Drug Co-Administration

Once generally discouraged, the use of more than one psychopharmacological drug in the same patient at the same time has become standard clinical practice under specific circumstances. Patients who are prescribed multiple medications or are taking over-the-counter medications in addition to their prescribed medications can potentially receive benefits from these combinations but also may be at risk for increased side effects, drug interactions, confusion about which drug is causing which effect, complex dosing schedules, and higher costs of treatment.

- Box 26-2 lists guidelines for drug co-administration.
- Box 26-3 alerts the nurse to patients who may be at higher risk for drug interactions.
- Table 26-1 is a reference list for the more common interactions of psychotropic drugs and other substances.

The following drug co-administration principles will guide the nurse when multiple medications are prescribed.

BOX 26-2 GUIDELINES FOR DRUG CO-ADMINISTRATION

- Identify specific target symptoms for each drug.
- If possible start with one drug and evaluate effectiveness and side effects before adding a second drug.
- Be alert for adverse drug interactions.
- Consider the effects of a second drug on the absorption and metabolism of the first drug.
- Consider the possibility of additive side effects.
- Change the dose of only one drug at a time, and evaluate results.
- Be aware of increased risk of medication errors.
- Be aware of increased cost of treatment.
- Be aware of decreased patient adherence when medication regimen is complex.
- In follow-up treatment eliminate as many drugs as possible and establish the effective dose of the drugs used.
- Patient education programs regarding concomitant drug regimens must be particularly clear, organized, and effective.
- Patient follow-up contacts should be more frequent.
- If a patient has more than one prescriber, integration of care is required.

BOX 26-3 INCREASED RISK FACTORS FOR DEVELOPMENT OF DRUG INTERACTIONS

- Drug co-administration
- High doses
- Geriatric patients
- Debilitated/dehydrated patients
- Concurrent illness
- Compromised organ system function
- Inadequate patient education
- History of nonadherence
- Failure to include patient in treatment planning

Primary Medication. The medication used to treat the **target symptoms** of the patient's primary diagnosis is the primary medication in a drug treatment regimen. For example, antidepressants are the primary medications used in treatment of a primary diagnosis of major depression.

Combination Drug Therapy. Combination drug therapy refers to simultaneous use of two or more psychopharmacological drugs in the same class for long-term treatment. For example, in a patient who gains only partial relief from a mood stabilizer given for bipolar disorder, a second mood stabilizer may be added to the drug regimen to increase the treatment effect in long-term treatment.

Augmentation or Adjunctive Therapy. **Augmentation** is the addition of another class of medication to supplement the effectiveness of the primary medication. It is becoming a widely accepted clinical practice. This is done when the primary medicine falls short of expectation and needs to have its effectiveness augmented.

TABLE 26-1 INTERACTIONS OF PSYCHOTROPIC DRUGS AND OTHER SUBSTANCES

PSYCHOTROPIC CATEGORY	POSSIBLE INTERACTIONS
Antianxiety Agents	
Benzodiazepines with:	
Central nervous system (CNS) depressants (alcohol, barbiturates, antipsychotics, antihistamines, cimetidine)	Potential additive CNS effects, especially sedation and decreased daytime performance
Selective serotonin reuptake inhibitors (SSRIs), disulfiram, estrogens	Increased benzodiazepine effects
Antacids, tobacco	Decreased benzodiazepine effects
Sedative-Hypnotics with:	
CNS depressants (alcohol, antihistamines, antidepressants, narcotics, antipsychotics)	Enhancement of sedative effects; impairment of mental and physical performance; may result in lethargy, respiratory depression, coma, death
Anticoagulants (oral)*	Decreased warfarin plasma levels and effect; monitor and adjust dose of warfarin
Antidepressants	
Tricyclic Antidepressants (TCAs) with:	
Monoamine oxidase inhibitors (MAOIs)*	May cause hypertensive crisis
Alcohol and other CNS depressants	Additive CNS depression; decreased TCA effect
Antihypertensives* (guanethidine, methyldopa, clonidine)	Antagonism of antihypertensive effect
Antipsychotics and antiparkinsonian agents	Increased TCA effect; confusion, delirium, ileus
Anticholinergics	Additive anticholinergic effects
Antiarrhythmics (quinidine, procainamide, propranolol)	Additive antiarrhythmic effects; myocardial depression
Selective serotonin reuptake inhibitors (SSRIs)*	Increased TCA serum level/toxicity through inhibition of cytochrome P-450 system
Anticonvulsants	Decreased TCA effect; seizures
Tobacco	Decreased TCA plasma levels
SSRIs with:	
Clomipramine, maprotiline, bupropion, clozapine	Increased risk of seizures
MAOIs*	Serotonin syndrome
Barbiturates, benzodiazepines, narcotics	Increased CNS depression
Carbamazepine	Neurotoxicity: nausea, vomiting, vertigo, tinnitus, ataxia, lethargy, blurred vision
Aripiprazole	Fluoxetine and paroxetine lower levels; increased blood levels of aripiprazole
Risperidone	Fluoxetine and paroxetine may increase risperidone to toxic levels
Selegiline*	Hypertensive crisis; increased serotonergic effects; mania
St. John's wort, naratriptan, rizatriptan, sumatriptan, zolmitriptan, tramadol*	Serotonin syndrome
Haloperidol	Decreased effect of either drug
Calcium channel blockers	Neurotoxicity: dizziness, nausea, diplopia, headache
Valproate	Decreased valproate serum concentration
Cimetidine, erythromycin, isoniazid, fluconazole	Somnolence, lethargy, dizziness, blurred vision, ataxia, nausea; increased carbamazepine levels
Clozapine*	Avoid because of increased risk of agranulocytosis
Rifampin	Decreased carbamazepine levels
Antipsychotics with:	
Antacids, tea, coffee, milk, fruit juice	Decreased phenothiazine effect
CNS depressants (narcotics, antianxiety drugs, alcohol, antihistamines, barbiturates)	Additive CNS depression
Anticholinergic agents (levodopa)*	Additive atropine-like side effects and increased antiparkinsonian effects
SSRIs	Increased neuroleptic serum level and extrapyramidal side effects (EPS)

TABLE 26-1 INTERACTIONS OF PSYCHOTROPIC DRUGS AND OTHER SUBSTANCES—cont'd

PSYCHOTROPIC CATEGORY	POSSIBLE INTERACTIONS
Antipsychotic	
Clozapine with:	
Carbamazepine*	Additive bone marrow suppression
Benzodiazepines*	Circulatory collapse, respiratory arrest
SSRIs*	Increased risk of seizures
Anticonvulsant	
Lamotrigine with:	
Carbamazepine	Carbamazepine increases metabolism of lamotrigine
Valproate	Valproate decreases metabolism of lamotrigine; increased risk of serious rash
Oral hormonal contraceptives	Oral contraceptive products (OCPs) increase metabolism of lamotrigine; carbamazepine and oxcarbazepine increase metabolism of OCPs, thereby possibly decreasing the efficacy

*Potentially clinically significant.

An example is the addition of a BZ (e.g., lorazepam) to the primary antidepressant paroxetine (an SSRI) to treat persistent anxiety symptoms or to alleviate only partial remission of symptoms in a patient with generalized anxiety disorder. This is also done when the primary drug treats target symptoms effectively, but other symptoms remain. For example, an antidepressant is added to the primary antipsychotic drug for persistent symptoms of depression in a patient with schizophrenia.

Concurrent Pharmacology. Some patients with more than one illness need drug treatments for each illness. An example is the diabetic patient taking insulin who also needs an antidepressant for a concurrent depression. Great effort must be taken to properly integrate the care of such a patient in order to optimize treatments and avoid incompatible therapies, complex dosing regimens, and high drug costs.

Polypharmacy. Polypharmacy is the use of multiple psychopharmacological medications in the treatment of psychiatric disorders. The relative effectiveness of polypharmacy has not been well studied; however, it may be a reasonable treatment option for some patients. It is an increasingly important topic, and clinicians should use clear criteria in deciding to use polypharmacy in practice.

> **Critical Reasoning** Why do you think patients often fail to report over-the-counter remedies when asked what medicines they are taking? How can you, as a nurse, be sure to obtain this information?

Special Populations

Although this chapter focuses on the adult patient, special populations, such as youth (Chapters 35 and 36), the elderly (Chapter 37), and members of racially and ethnically diverse or disadvantaged groups, are regularly given psychoactive drugs, even though these drugs may not have been adequately tested in randomized clinical trials on these populations. An understanding of relevant issues will help the nurse administer psychopharmacological agents safely to persons who are members of special populations.

Youth. Few systematic studies of psychotropic drugs in children and adolescents have been conducted, even though children and adolescents can experience severe psychiatric illnesses. Generally children metabolize drugs more rapidly than adults and therefore do not usually need lower doses than adults simply because they may weigh less and have a smaller body size.

However, children and young adolescents do exhibit a variable response to these drugs and thus need vigilant monitoring. In 2003, the FDA issued a warning regarding antidepressant treatment in children and adolescents related to suicide risk. These concerns grew into the 2004 black box warning of increased suicide risk with antidepressant therapies in all age-groups.

Elderly Patients. Drug distribution, hepatic metabolism, and renal clearance are all affected by age. This often results in the elderly having slower metabolism and elimination of drugs and increased susceptibility to side effects. **The FDA has issued an advisory stating that atypical antipsychotic medications increase mortality among elderly patients.** Some research suggests that conventional antipsychotics may carry a similar risk. Both antipsychotics and BZs can impair cognitive functioning in the elderly.

With the elderly it is important to begin with a lower than recommended adult dose and titrate up at a rate slower than the usual recommended adult rate—or "start low and go slow." Geriatric patients often take multiple

medications, so the nurse should be aware of the increased risk for drug interactions, complex dosing regimens, and cost.

Pregnant and Lactating Women. If a pregnant woman takes psychoactive drugs, the unborn infant may experience drug effects in utero and even withdrawal symptoms after birth. Because pregnant women are systematically excluded from randomized clinical trials, knowledge of drug reactions in animal studies and in human anecdotal reports is often the primary source of information when prescribing for pregnant and lactating women, as is the FDA rating system for pregnancy risk of drugs.

The FDA categories related to use during pregnancy are as follows:

- A—controlled studies show no risk
- B—no evidence of risk in humans
- C—risk cannot be ruled out
- D—positive evidence of risk; however, potential benefits may outweigh potential risks
- X—contraindicated in pregnancy

The FDA has not approved any psychotropic medication for use during pregnancy or lactation; therefore it is up to the provider and patient to individually weigh the risks and benefits of medication use (Howland, 2009). A careful risk-benefit analysis of the psychiatrically symptomatic mother should include these risks: inattention to prenatal care, poor maternal health, adverse effect on mother-infant bonding, increased stress levels on the fetus and infant, history of adverse drug effects on the fetus, and blood levels of the drug measured in breast milk (Bansil et al, 2010). When the benefits of psychotropic treatment outweigh the risks, some psychotropic drugs may be given during pregnancy and breast-feeding (Meltzer-Brody et al, 2008; Pilowsky et al, 2008).

Cross-Cultural Perspectives, Ethnopsychopharmacology, and Gender. Various cultural groups can differ in the ways in which their members seek help for illness, express symptoms of illness, relate to health care professionals of different backgrounds, and believe in the effectiveness of treatments. Cultural heritage can affect individual and family attitudes, beliefs, and practices regarding health and illness. This diversity challenges the communication needed for accurate diagnosis and successful treatment outcomes.

Race, ethnicity, and gender also can affect biological response to medications. Genetic differences can affect how an individual or a group with common genetic ancestry may metabolize psychotropic drugs. Pharmacokinetic and pharmacodynamic processes that are biologically or biochemically mediated have the potential to exhibit differences among racial and ethnic groups.

The field of **psychopharmacogenetics** deals with genetic and environmental factors that control or influence psychotropic drug–metabolizing enzymes, such as the CYP-450 metabolic enzyme system. Differences in the genetically determined structure of these enzymes can account for the ethnic variations that have been reported in drug responses (Chaudhry et al, 2008).

There is an increasing interest in these individual differences because the population is increasingly more diverse and new psychopharmacological agents are continuing to be developed. In addition, provider bias toward racially and ethnically diverse or disadvantaged patients has been shown to negatively affect treatment selection, thereby increasing disparities in health status associated with racial and ethnic populations.

Gender differences in pharmacokinetics, pharmacodynamics, and reproductive changes should be taken into account when psychotropic drugs are prescribed. Compared with men, women receive more prescriptions and experience more side effects. Women are at higher risk for tardive dyskinesia from conventional antipsychotics and for activating side effects caused by antidepressants.

The following issues should be considered when prescribing psychotropic drugs for women (Seeman, 2010):

- **Differences in pharmacokinetics:** Gastric emptying is slower, gastric acidity is lower, blood volume is lower, renal clearance of drugs is decreased, and percentage of body fat is higher. Thus women experience greater biological activity than men and often require lower doses of most psychotropic medicines.
- **Dosage adjustment across the menstrual cycle and after menopause:** Pharmacokinetics can differ significantly at different phases of a woman's menstrual cycle, necessitating dosage adjustment across the cycle for some drugs. Women of reproductive age require lower doses of antipsychotic drugs. Increased prolactin levels caused by some antipsychotic drugs can inhibit ovulation and cause menstrual cycle irregularity.
- **Interactions between psychotropic agents and prescribed hormones:** Oral contraceptives can magnify pharmacokinetic differences, sometimes requiring dosage adjustments. Drugs that induce hepatic enzymes, such as carbamazepine, can increase the metabolism of oral contraceptives, resulting in unwanted pregnancy. In women with bipolar disorder, hormone replacement therapy can trigger rapid cycling.

Medically Ill Patients. Medically ill patients with concurrent psychiatric illness may have an increased sensitivity to the adverse effects of psychotropic drugs, changes in metabolism and excretion, and interactions with coadministered medications. Patients with liver disease are extremely sensitive to most psychoactive drugs, and patients with renal impairment are particularly sensitive to lithium.

It is important to collaborate with all the prescribers treating the patient to ensure the compatibility of prescriptions. As with children and the elderly, good clinical practice for medically ill patients involves beginning with lower doses and titrating up slowly while evaluating frequently for both clinical benefit and adverse effects.

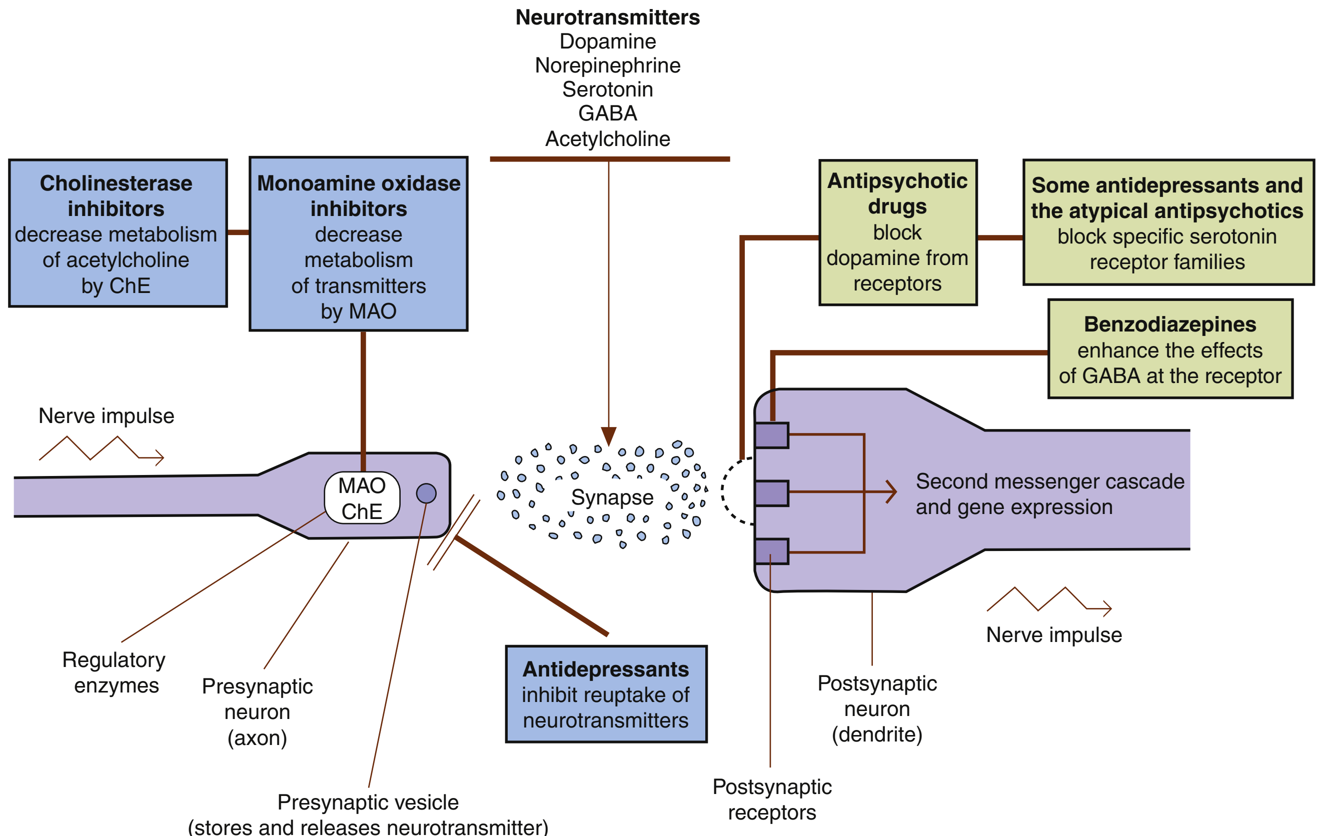


FIG 26-1 Neurotransmission and drug effects at the synapse. *ChE,* Cholinesterase; *GABA,* gamma-aminobutyric acid; *MAO,* monoamine oxidase.

Biological Basis for Psychopharmacology

All communication in the brain involves neurotransmission, or neurons "talking" to each other across synapses at receptors. **Neurons** are the basic functional unit of the brain structures of the nervous system (Chapter 5). The following description is a basic frame of reference from which to understand neuropharmacological mechanisms.

The **synapse** is a narrow gap separating two neurons: the presynaptic cell and the postsynaptic cell (Figure 26-1). Most receptors are three-dimensional "gates" (channels) located on cells (neurons) that are targets for chemical first messengers (e.g., neurotransmitters, peptides, drugs).

Depending on the message it receives, the receptor opens or closes its channel, allowing or stopping a flow of electrolytes (ions) into and out of the neuron, affecting the electrical nerve impulse of the neuron (stimulating or inhibiting its biological activity).

This process causes a cascade of activity by the chemical second messengers within the neuron, activating the neuron's genetic code (gene expression). **Gene expression** is what tells the neuron how to respond and continue the process of communication to the next neuron. This genetically determined communication within and between neurons controls how the brain functions and ultimately how the body responds and the person behaves.

Neurochemical messengers are synthesized (manufactured) from certain dietary amino acids (called *precursors*) by a chain of enzyme activity within the cell. These messengers are then stored in the presynaptic cell waiting to be released into the synapse.

After neurotransmission takes place at a synapse, neurochemicals remaining in the synapse either are reabsorbed **(reuptake)** and stored by the presynaptic cell for later use or are metabolized (broken down) by enzymes, such as monoamine oxidase (MAO) and cholinesterase (ChE).

Many psychiatric disorders are thought to be caused by a dysregulation (imbalance) in the complex process of brain structures communicating with each other through neurotransmission. For example:

- Psychosis is thought to involve excessive dopamine and serotonin dysregulation.
- Mood disorders are thought to result from disruption of normal patterns of neurotransmission of norepinephrine, serotonin, and other transmitters.
- Anxiety is thought to be a dysregulation of GABA and other transmitters.
- Alzheimer disease is thought to result from a dysregulation of acetylcholine and other transmitters.

If a particular psychiatric illness is known to result from a dysregulation or imbalance of neurotransmission in a particular neurotransmitter system, and if the mechanism of action of psychiatric drugs is understood, it provides guidance to selecting the pharmacological strategies that could be used in treatment.

This process of cell-to-cell communication at the synapse resulting in brain function can be affected by drugs in several important ways:

- **Release:** More neurotransmitter is released into the synapse from the storage vesicles in the presynaptic cell.
- **Blockade of postsynaptic receptors:** The neurotransmitter is prevented from binding to the target receptor.
- **Blockade of alpha$_2$ presynaptic autoreceptors:** This negative feedback system is prevented from turning off the release of norepinephrine into the synapse.
- **Receptor sensitivity changes:** The receptor becomes more or less responsive to the neurotransmitter.
- **Reuptake inhibition:** The presynaptic cell does not reabsorb the neurotransmitter well, leaving more neurotransmitter in the synapse and therefore enhancing or prolonging its action.
- **Interference with storage vesicles:** The neurotransmitter is either released again into the synapse (more neurotransmitter) or released to metabolizing enzymes (less neurotransmitter).
- **Precursor chain interference:** The process that makes the neurotransmitter is either facilitated (more is synthesized) or disrupted (less is synthesized).
- **Synaptic enzyme inhibition:** Less neurotransmitter is metabolized, so more remains available in the synapse and the presynaptic neuron.
- **Second-messenger cascade:** A chemical chain reaction within the cell is initiated by neurochemical effects at the receptor during neurotransmission, activating genetically determined brain function.

Not all of these strategies have yielded clinically relevant treatments to date. Those that have are emphasized in this chapter (see Figure 26-1):

- **Antipsychotic** drugs block *dopamine* from the receptor site.
- **Antidepressants** block the reuptake of *norepinephrine and/or serotonin* and regulate the areas of the brain that manufacture these chemicals.
- **Monoamine oxidase inhibitors (MAOIs)** decrease enzymatic metabolism of *norepinephrine and serotonin.*
- **Cholinesterase (ChE) inhibitors** decrease the metabolism of *acetylcholine.*
- **BZs** potentiate (enhance the effects of) *GABA.*
- **Some antidepressants and atypical antipsychotics** block specific subtypes of *serotonin* receptors (thought to be responsible for serotonin side effects), thereby enhancing serotonin transmission at serotonin receptors implicated in depression.

Understanding synaptic and cellular functions has led to various treatment approaches in pharmacotherapy that attempt to modify one or more steps in neurotransmission. It has also led to research focused on developing drugs with more specificity (drugs that go to areas in the brain specifically targeted for their action, such as the brain regions implicated in mental illness, rather than also going to nonspecific or untargeted areas, causing drug side effects).

The future of psychopharmacology holds much promise as new discovery techniques, changes in the way drugs are developed, and new theories about drug metabolism are proven. Drug effects on gene expression and receptor function are most likely the bases of psychopharmacological efficacy in the treatment of psychiatric disorders.

ANTIANXIETY AND SEDATIVE-HYPNOTIC DRUGS

Anxiety is a normal response to threat and is part of the fight-or-flight instinct necessary for survival (Chapter 15). The diagnosis of anxiety (symptoms of anxiety that are disproportionate to the circumstances) is based on the patient's description, the nurse's observation of behaviors, assessment of *DSM-IV-TR* (APA, 2000) diagnostic criteria, and the elimination of alternative diagnoses.

The possibility of a nonpsychiatric cause for anxiety symptoms also must be considered. Hyperthyroidism, hypoglycemia, cardiovascular illness, severe pulmonary disease, and a variety of medications and substances are often associated with high levels of anxiety. In addition to a careful physical assessment and a review of laboratory tests, the patient should be asked about the use of prescription and over-the-counter drugs, as well as "recreational" substances, such as alcohol, caffeine, nicotine, and street drugs.

Anxiety also accompanies many psychiatric disorders. For example, **depression and anxiety are often co-morbid illnesses.** In general, the primary disorder should be treated with the appropriate medication. For example, anxiety associated with a primary diagnosis of schizophrenia or major depression often decreases when the target symptoms for the primary disorder are treated successfully.

This section divides antianxiety and sedative-hypnotic drugs into two categories: the BZs and several non-BZ antianxiety drugs. **The BZs are the most widely prescribed drugs in the world.** Their popularity is related to their effectiveness, prompt onset of action, and wide margin of safety. Concerns that are largely unfounded regarding physiological dependence, withdrawal, and abuse potential have limited their use somewhat.

Although BZs have almost entirely replaced barbiturates in the treatment of anxiety and sleep disorders, they recently have been considered to be second-line agents after the antidepressants in the long-term treatment of anxiety disorders such as panic disorder and social phobia. Antidepressants are discussed in detail in the following section.

> **Critical Reasoning** What sociocultural factors may help explain why BZs are the most commonly prescribed medications in the United States?

Benzodiazepines

The BZs are thought to reduce anxiety because they are powerful receptor agonists of the inhibitory neurotransmitter GABA. A postsynaptic receptor site specific for the

BOX 26-4 TARGET SYMPTOMS FOR ANTIANXIETY AND SEDATIVE-HYPNOTIC BENZODIAZEPINES

Psychological
- Irritability, uneasiness, worry, fear
- Sense of impending doom or panic
- Insomnia

Physical
- Flushed skin
- Hot or cold flashes
- Sweating
- Dilated pupils
- Dry mouth
- Nausea or vomiting
- Diarrhea
- Tachycardia, palpitations
- Dizziness
- Shortness of breath
- Hyperventilation
- Paresthesias
- Tremor
- Restlessness
- Headache
- Urinary frequency

BZ molecule is located next to the GABA receptor. The BZ molecule and GABA bind to each other at the GABA receptor site. The result is an enhancement of the actions of GABA, resulting in an **inhibition** of neurotransmission (a decrease in the firing rate of neurons) and thus a clinical decrease in the person's level of anxiety.

Clinical Use. The major indications for the use of BZs include anxiety and anxiety disorders, insomnia, alcohol withdrawal, anxiety associated with medical disease, skeletal muscle relaxation, seizure disorders, anxiety and apprehension experienced before surgery, and substance-induced (except for amphetamines) and psychotic agitation in emergency rooms.

Used in higher doses, the high-potency BZs alprazolam and clonazepam have been effective in the treatment of panic disorder and social phobia. The target symptoms for the use of BZs are listed in Box 26-4.

Another clinical indication for the use of BZs is as a sedative-hypnotic to improve sleep. **Insomnia includes difficulty falling asleep, difficulty staying asleep, or awakening too early with an inability to go back to sleep.** It is a symptom with many causes and often responds to nonpharmacological strategies, such as talking about problems, increased daytime exercise, elimination of stimulants such as caffeine, and incorporating physical comfort measures into the nighttime routine (Chapter 16).

When used as hypnotics, the BZs should induce sleep rapidly, and their effect should be gone by morning. Any BZ can be an effective sedative-hypnotic when administered at bedtime, although the choice of drug should be tailored to the patient's complaints. For example, BZs with a short half-life are effective for patients who have trouble falling asleep, but they may wear off too soon to help patients with early-morning awakening.

Because the BZs are in the same pharmacological class as alcohol, they can be used to suppress the alcohol withdrawal syndrome and are the treatment of choice for this indication (Chapter 23). The ingestion of these two substances together is contraindicated, particularly for the patient using dangerous equipment or driving a car, because it can produce extreme sedation.

The BZs have no significant clinical advantages over each other, although differences in half-life can be clinically useful (Table 26-2). For example, patients with persistent high levels of anxiety should take a drug with a long half-life. Patients with fluctuating anxiety might do better with either a short-acting drug or a drug with a sustained-release formulation (alprazolam, clorazepate, diazepam). Sustained-release BZs blunt the peaks of toxicity and the lows of symptom breakthrough and are a popular alternative to the original formulations.

In addition, the **lipid solubility** of each BZ determines the rapidity of onset and the intensity of effect. This should be considered when selecting a BZ. For example, diazepam is more lipid soluble than lorazepam; thus it more readily moves into and then out of the central nervous system (CNS) and is more extensively distributed to peripheral sites, particularly to fat cells.

The **rate of absorption** from the gastrointestinal tract varies considerably among the different BZs, thus affecting the rapidity and intensity of onset of their acute effects. Antacids and food in the stomach slow down absorption when these drugs are taken by mouth.

The injectable BZs (lorazepam, midazolam) have proven reliable when administered in the deltoid muscle. Diazepam results in predictable and rapid rises in the blood level when used intravenously. Concentrations of BZs in the blood have not yet been firmly correlated to clinical effects, so blood level measurements are not clinically helpful.

Some patients may need to take antianxiety drugs for extended periods of time. **Because of the potential disadvantages of BZs, they should always be used along with nonpharmacological treatments for the patient with chronic anxiety or insomnia.** Psychotherapy, behavioral techniques, environmental changes, stress management, sleep hygiene, and an ongoing therapeutic relationship continue to be important in the treatment of anxiety disorders and insomnia.

Treatment with BZs generally should be brief and used during a time of specific stress or for a specific indication. The patient should be observed frequently during the early days of treatment to assess target symptom response and monitor side effects so that the dose can be adjusted as needed. Some patients, such as those with panic disorder, may require regular daily dosing and long-term BZ treatment.

Side Effects and Adverse Reactions. BZ side effects are common, dose related, usually short-term, and almost always harmless. Table 26-3 summarizes these reactions and nursing considerations.

The BZs generally do not live up to their reputation of being strongly addictive, especially if they are discontinued

TABLE 26-2 ANTIANXIETY AND SEDATIVE-HYPNOTIC DRUGS: BENZODIAZEPINES

GENERIC NAME (TRADE NAME)	ACTIVE METABOLITES	APPROXIMATE HALF-LIFE (hr)	USUAL ADULT DOSAGE RANGE (mg/day)*	PREPARATION
Antianxiety Drugs				
Alprazolam (Xanax)	Yes (not significant)	14	1-4	PO, L, SR, ODT
Chlordiazepoxide (Librium)	Yes	20-30	10-40	PO, IM
Clonazepam (Klonopin)	No	>20	0.5-10	PO, ODT
Clorazepate (Tranxene)	Yes	60	10-40	PO, SD
Diazepam (Valium)	Yes	10-60	2-40	PO, IM, IV, L
Halazepam (Paxipam)	Yes	60	60-160	PO
Lorazepam (Ativan)	No	14	1-6	PO, IM, IV
Oxazepam (Serax)	No	9	15-120	PO
Sedative- Hypnotic Drugs				
Estazolam (ProSom)	Yes	16	1-4 hs	PO
Flurazepam (Dalmane)	Yes	100	15-30 hs	PO
Temazepam (Restoril)	No	8	7.5-30 hs	PO
Triazolam (Halcion)	No	3	0.125-0.5 hs	PO
Quazepam (Doral)	Yes	39	7.5-15 hs	PO

*Dosage ranges are approximate and should be individualized for each patient.
hs, At bedtime; *IM*, intramuscular; *IV*, intravenous; *L*, oral liquids; *ODT*, orally disintegrating tablet; *PO*, oral tablet or capsule; *SD*, single dose; *SR*, oral slow-release tablet.

TABLE 26-3 BENZODIAZEPINE SIDE EFFECTS AND NURSING CONSIDERATIONS

SIDE EFFECTS	NURSING CONSIDERATIONS
Common	
Drowsiness, sedation	Activity helps; use caution when using machinery
Ataxia, dizziness	Use caution with activity; prevent falls
Feelings of detachment	Discourage social isolation
Increased irritability or hostility	Observe; support; be alert for disinhibition
Anterograde amnesia	Inability to recall events that occur while on drug
Cognitive effects with long-term use	Interference with concentration and memory of new material
Tolerance, dependency, rebound insomnia/ anxiety	Short-term use; discontinue, using a slow taper; contraindicated with drug or alcohol abuse
Rare	
Nausea	Dose with meals; decrease dose
Headache	Usually responds to mild analgesic
Confusion	Decrease dose
Gross psychomotor impairment	Dose related; decrease dose
Depression	Decrease dose; antidepressant treatment
Paradoxical rage reaction	Discontinue drug

BOX 26-5 BENZODIAZEPINE WITHDRAWAL SYMPTOMS

- Agitation
- Anorexia
- Anxiety
- Autonomic arousal
- Dizziness
- Generalized seizures
- Hallucinations
- Headache
- Hyperactivity
- Insomnia
- Irritability
- Nausea and vomiting
- Sensitivity to light and sounds
- Tinnitus
- Tremulousness

gradually, have been used for appropriate purposes, and their use has not been complicated by other factors, such as long-term use of other CNS depressants (e.g., barbiturates or alcohol). Because of BZs' calming effects, they have the reputation of being frequently misused.

Tolerance can develop to the sedative effects of BZs, but it is unclear whether tolerance also develops to induced sleep or antianxiety effects. These drugs should be tapered to minimize withdrawal symptoms (Box 26-5) and rebound symptoms of insomnia or anxiety. If these symptoms occur, the dose should be raised until symptoms are gone and then tapering resumed at a slower rate.

Because the BZs have a very high therapeutic index, overdoses of BZs alone almost never cause fatalities. The BZ antagonist flumazenil (Romazicon) can reverse all BZ actions and is marketed as a treatment for BZ overdose.

Elderly patients are more vulnerable to side effects because the aging brain is more sensitive to sedatives. Dosing ranges from one half to one third of the usual daily dose used for adults. The BZs with no active metabolites (see Table

26-2) are less affected by liver disease, the age of the patient, or drug interactions.

BZs have been used successfully in **children** in single doses to allay anticipatory anxiety and to treat panic, sleepwalking, generalized anxiety disorder (GAD), and avoidant personality disorder. In general, however, they can increase anxiety and produce or aggravate behavior disorders, especially attention deficit hyperactivity disorder (ADHD).

Use of BZs during **pregnancy** has been associated rarely with palate malformations and intrauterine growth retardation, especially when used during the first trimester. When used late in pregnancy or during breast-feeding, these drugs have been associated with floppy infant syndrome, neonatal withdrawal symptoms, and poor sucking reflex. **Thus they are not recommended for use during pregnancy or while breastfeeding.**

Nonbenzodiazepine Antianxiety Agents

Buspirone, a non-BZ anxiolytic drug, is a potent antianxiety agent with no addictive potential and has FDA approval for the treatment of GAD (Table 26-4). Buspirone does not exhibit muscle-relaxant or anticonvulsant activity, interaction with CNS depressants, or sedative-hypnotic properties. It is not effective in the management of drug or alcohol withdrawal or panic disorder. Generally it takes several weeks for buspirone's antianxiety effects to take effect. It probably is most effective in patients who have never taken BZs and therefore are not expecting immediate effects from drug treatment.

Propranolol (a beta-blocker) and clonidine (an $alpha_2$ receptor agonist) have been used for the **off-label treatment of anxiety.** These classes of drugs act by blocking peripheral or central noradrenergic (norepinephrine) activity and many of the manifestations of anxiety (e.g., tremor, palpitations, tachycardia, sweating). Propranolol is used in the treatment of performance anxiety found in some forms of social phobia and in panic disorder if rapid heartbeat is a significant deterrent to the patient's ability to function.

Clonidine is also used to block physiological symptoms of opioid withdrawal and the tachycardia and excessive salivation seen with the atypical antipsychotic clozapine (Schatzberg et al, 2010).

Pregabalin, an anticonvulsant medication, is showing positive results in both research and off-label treatment for anxiety disorders. Pregabalin acts by binding to a subunit of voltage-gated calcium channels, thus affecting the neuron's reactivity to stimulation.

Despite the delayed onset of symptom relief, SSRIs and the newer antidepressants are taking first-line status in the treatment of anxiety disorders. Most of these antidepressants are showing beneficial actions for the majority of anxiety symptoms and have received FDA approval for the following indications:

- Duloxetine: generalized anxiety disorder (GAD)
- Escitalopram: GAD
- Fluoxetine: obsessive-compulsive disorder (OCD), panic disorder, bulimia, and premenstrual dysphoric disorder (PMDD)
- Paroxetine: OCD, panic disorder, PMDD, social anxiety disorder (SAD), GAD, and posttraumatic stress disorder (PTSD)
- Sertraline: OCD, panic disorder, PMDD, SAD, and PTSD
- Venlafaxine: GAD, panic disorder, and SAD

Clomipramine is the only tricyclic antidepressant (TCA) shown to be effective in the treatment of OCD, and studies have shown that the TCA imipramine and the MAOI phenelzine effectively treat panic disorder. The antidepressant drugs are discussed later in this chapter.

TABLE 26-4 NONBENZODIAZEPINE ANTIANXIETY AND SEDATIVE-HYPNOTIC AGENTS

GENERIC NAME (TRADE NAME)	USUAL ADULT DOSAGE RANGE (mg/day)	HALF-LIFE (hr)
Antianxiety Agents		
Buspirone (BuSpar)	15-60	2-5
Chlordiazepoxide (Librax, Librium)	15-100	24-48
Clonidine (Catapres)	0.2-0.6	6-20
Meprobamate (Miltown)	1200-1600	10-11
Propranolol (Inderal)	20-160	3
Pregabalin (Lyrica)	50-600	6
Sedative-Hypnotic Agents		
Zolpidem (Ambien, Ambien CR)	5-20	1.5-4.5
Zaleplon (Sonata)	5-10	1
Eszopiclone (Lunesta)	1-3	6
Ramelteon (Rozerem)	8	1-5
Antihistamines (Also Used for Sleep)		
Diphenhydramine (Benadryl)	25-300	1-8
Hydroxyzine (Atarax, Vistaril)	25-600	8-25
Antidepressant		
Doxepin (Silenor)	3-6	15
Trazodone (Desyrel)	25-300	4-9

Nonbenzodiazepine Sedative-Hypnotic Agents

Zolpidem, zaleplon, and eszopiclone are a new class of compounds for treatment of insomnia. Structurally unrelated to BZs, they bind more selectively to neuronal receptors involved in inducing sleep (BZ_1 receptors on the BZ/GABA receptor complex) and have fewer of the BZ side effects. They are well tolerated and have few antianxiety, anticonvulsant, or muscle-relaxant properties. Side effects include daytime drowsiness, dizziness, and gastrointestinal upset. The primary difference among these drugs is their half-life and subsequent length of action. **All three drugs are Schedule IV controlled substances.**

A nonscheduled sleep aid is ramelteon (Rozerem). Ramelteon is a specific melatonin agonist, bending to melatonin$_1$ and melatonin$_2$ receptors, thus affecting the endogenous melatonin system, which is involved in the regulation of circadian rhythms and the sleep/wake cycle. Side effects include dizziness, daytime sedation, and gastrointestinal upset.

Antihistamines are sometimes used as sedative-hypnotic agents for their sedating effects. They usually are not as effective as the BZs but do not cause physical dependence or abuse and are easily obtained by patients as over-the-counter drugs. **A disadvantage of the antihistamines is that they lower the seizure threshold and cause anxiety and insomnia in some people**.

Trazodone is an antidepressant with significant sedating effects and is the preferred antidepressant used for insomnia. It is not well studied for this use but is popular because it offers sedation with few cholinergic effects, has a much greater safety profile in overdose compared with TCAs, and shows no evidence of dependence or withdrawal. Side effects include orthostatic hypotension, anxiety, and a rare but very serious adverse effect called **priapism** (sustained and painful penile erection), which can occur with daily doses as low as 50 to 200 mg, the doses recommended for sleep.

Barbiturates and Older Antianxiety and Sedative-Hypnotic Drugs

Barbiturates (secobarbital, pentobarbital) and other older non-BZ antianxiety and sedative-hypnotic agents (e.g., meprobamate, alcohols, chloral hydrate) have many disadvantages that have led to their greatly decreased use. These disadvantages include the following:

- **Tolerance develops to their antianxiety and sedative effects.**
- **They are very addictive.**
- **They cause serious, even lethal, withdrawal reactions.**
- **They are dangerous in cases of overdose.**
- **They cause CNS depression.**
- **They can cause a variety of dangerous drug interactions, particularly when mixed with CNS depressants such as alcohol.**

ANTIDEPRESSANT DRUGS

Over the past two decades the use of antidepressants has grown. They are now the third most commonly prescribed class of medication in the U.S. Much of this growth is due to an increase in antidepressant prescriptions by primary care providers without an accompanying psychiatric diagnosis (Mojtabal and Olfson, 2011). This suggests the need for strong collaboration among primary care and mental health providers.

It has been proposed that serotonin, norepinephrine, and other neurochemicals are dysregulated in mood disorders. The biological understanding of antidepressant drug actions supports this theory. Many antidepressants are available. **They all have similar efficacy.**

Antidepressants enhance the neurotransmission of these transmitters by several actions: they can block the reuptake of neurotransmitters at the presynaptic neuron, inhibit their metabolism and subsequent deactivation, and affect the activity of receptors on the postsynaptic neuron.

Thus antidepressant drugs regulate neurotransmitter systems and their balance with each other. They enhance communication in brain structures responsible for mood and emotion, as well as many of the anxiety disorders, because the biochemical underpinnings of mood and anxiety are similar.

These actions at the synapse are immediate, but it takes several weeks for antidepressants to affect mood. This delay of clinical efficacy is the subject of considerable research. One proposal is that depression occurs when a depletion of neurotransmitters in the synapse causes the postsynaptic receptors for these transmitters to increase in number (up-regulation), as if they were adjusting to too little available transmitter. As the antidepressants make more transmitter available again in the synapse, it takes the receptors several weeks to return their numbers back to normal, allowing a normalization of synaptic activity. This timeframe matches the several weeks it takes to see clinical improvement after initiation of antidepressant therapy.

- Table 26-5 lists the primary clinical indications and other suggested uses for antidepressant drugs.
- Box 26-6 lists the antidepressant drug target symptoms.
- Table 26-6 presents antidepressant synaptic activity and receptor binding actions.
- Table 26-7 identifies possible clinical effects of synaptic activity.
- Table 26-8 lists the antidepressant drugs and dosages.

Patients who respond to the initial course of treatment with an antidepressant should continue taking the medication at the same effective dosage for a continuation phase of at least 6 to 9 months. If they are symptom free during that time, they can then be tapered off the medication and monitored for potential relapse.

Patients who have relapses after the continuation phase treatment is completed may require maintenance phase medication of 1 or more years' duration to prevent recurring depression. Patients who have had three or more episodes of major depression have a 90% chance of having another and are therefore potential candidates for long-term maintenance medication.

Patients who have a history of suicide attempts, severe disability when depressed, recurrent severe depression, concurrent anxiety disorders, or depression in first-degree relatives also may be candidates for long-term antidepressant treatment. The long-term maintenance medication is generally given at the same dose that was effective in the acute phase of treatment.

When treating anxiety disorders with antidepressants, dose ranges are usually the same as those used for the treatment of depression, although the initial dose usually is lower, titration up to a therapeutic range may be slower, and for some patients, doses may have to be ultimately higher for the treatment of anxiety disorders such as obsessive-compulsive disorder and panic disorder.

TABLE 26-5 INDICATIONS FOR ANTIDEPRESSANT DRUGS

Primary Indications	
Major depression	Acute depression, maintenance treatment of depression and prevention of relapse, bipolar depression (when used with a mood stabilizer), atypical depression, and dysthymic disorder
Anxiety disorders	Panic disorder, obsessive-compulsive disorder (OCD), social anxiety disorder, generalized anxiety disorder (GAD), posttraumatic stress disorder (PTSD)
Evidence for Other Antidepressant Categories	
Selective serotonin reuptake inhibitors (SSRIs)	*Additional U.S. Food and Drug Administration (FDA) indications:* bulimia nervosa, premenstrual dysphoric disorder (full- and half-cycle administration) *Moderate evidence:* obesity, substance abuse, impulsivity, and anger associated with personality disorders, pain syndromes *Preliminary evidence:* body dysmorphic disorder, hypochondriasis, anger attacks associated with depression, attention deficit hyperactivity disorder (ADHD)
Other newer antidepressant agents	*Additional FDA indications:* bupropion: smoking cessation, seasonal affective disorder; duloxetine: diabetic neuropathy, fibromyalgia, chronic musculoskeletal pain *Moderate evidence:* trazodone: insomnia, dementia with agitation, minor sedative-hypnotic withdrawal; bupropion: ADHD, sexual side effects of antidepressants
Tricyclic antidepressants	*Strong evidence:* panic disorder (most), OCD (clomipramine), bulimia (imipramine, desipramine), enuresis (imipramine), insomnia (doxepin) *Moderate evidence:* separation anxiety, ADHD, phobias, GAD, anorexia, headaches, diabetic neuropathy and other pain syndromes (amitriptyline, doxepin), sleep apnea (protriptyline), cocaine abuse (desipramine)
Monoamine oxidase inhibitors (MAOIs)	*Strong evidence:* panic disorder, bulimia *Moderate evidence:* other anxiety disorders, anorexia, body dysmorphic disorder

BOX 26-6 TARGET SYMPTOMS FOR ANTIDEPRESSANT DRUGS

- Middle and terminal insomnia
- Appetite disturbances
- Anxiety and anxiety disorders
- Fatigue
- Poor motivation
- Somatic complaints
- Agitation
- Motor retardation
- Dysphoric mood
- Subjective depressive feelings (anhedonia, poor self-esteem, pessimism, hopelessness, self-reproach, guilt, helplessness, sadness)
- Suicidal thoughts

Critical Reasoning A patient who has been taking antidepressant medication for 2 months tells you that he feels better and wants to stop taking it. How would you respond?

Antidepressants have no known long-term adverse effects, tolerance to therapeutic effects does not usually develop, and persistent side effects often can be minimized by a small decrease in dose without loss of effectiveness. Table 26-9 presents comparative side effect profiles of many antidepressant drugs.

Because antidepressants do not cause physical addiction, psychological dependence, or euphoria, they have no abuse potential. Their long half-life (24 hours or longer) allows most of them to be conveniently administered once per day after steady state is reached. If the patient experiences drowsiness, the drug should be taken at night. If the patient is more active after taking the drug, it should be taken in the daytime.

Patients with bipolar illness may be inadvertently switched into mania by antidepressants. Thus they should be given concurrent mood stabilizers and watched closely for increased activity, greater difficulty in concentrating and eating, and decreased sleeping patterns if an antidepressant is added to their drug regimen. **Prescribers also must be alert to CYP-450 problems when antidepressants are co-prescribed.**

Selective Serotonin Reuptake Inhibitors

All SSRIs inhibit the reuptake of serotonin at the **presynaptic** membrane. This results in an increase of available serotonin in the synapse and therefore at **postsynaptic** receptors, **promoting serotonin neurotransmission.** Although their actions and effectiveness are similar, structurally they differ from each other, accounting for some variation in their side effect profiles and some differences in effectiveness in some patients.

Many initial side effects are short term, and tolerance may develop, although some side effects may last for as long as the patient takes the drug. Thus if a patient cannot tolerate one of the SSRIs (because of side effects) or receives only minimal effectiveness (the patient is an SSRI partial responder or nonresponder), other SSRIs can be considered. SSRIs can cause weight gain in some patients, thus making it necessary to watch the patient for this side effect and put the patient on

TABLE 26-6 ANTIDEPRESSANT DRUG SYNAPTIC ACTIVITY

ANTIDEPRESSANT DRUG	PRIMARY SYNAPTIC ACTIVITY
All TCAs	Receptor blockade: H_1, ACh, $alpha_1$, $5\text{-}HT_2$
Particularly tertiary amines	Reuptake inhibition: 5-HT
Particularly secondary amines	Reuptake inhibition: NE
MAOIs	Receptor blockade: ACh Enzymatic inhibition: MAO
SSRIs	Reuptake inhibition: 5-HT
Other Antidepressants	
Amoxapine	Reuptake inhibition: 5-HT, NE Receptor blockade: D_2, ACh, H_1
Atomoxetine	Reuptake inhibition: NE
Bupropion	Reuptake inhibition: NE, DA
Duloxetine	Reuptake inhibition: 5-HT, NE, DA
Maprotiline	Reuptake inhibition: NE Receptor blockade: H_1, ACh
Mirtazapine	Presynaptic autoreceptor inhibition: $alpha_2$ Receptor blockade: $5\text{-}HT_2$, $5\text{-}HT_3$, H_1
Nefazodone	Reuptake inhibition: 5-HT, NE Receptor blockade: $5\text{-}HT_2$, $alpha_1$
Trazodone	Reuptake inhibition: 5-HT Receptor blockade: $5\text{-}HT_2$, H_1, $alpha_2$, $alpha_1$
Venlafaxine	Reuptake inhibition: 5-HT, NE, DA
Vilazodone	Reuptake inhibition: 5-HT Partial agonist: $5\text{-}HT_1$

ACh, Acetylcholine; *$alpha_1$* and *$alpha_2$*, norepinephrine receptors; *D_2*, dopamine receptor; *DA,* dopamine; *H_1*, histamine receptor; *5-HT,* serotonin; *$5\text{-}HT_2$* and *$5\text{-}HT_3$*, serotonin receptors; *MAO,* monoamine oxidase; *MAOIs,* monoamine oxidase inhibitors; *NE,* norepinephrine; *SSRIs,* selective serotonin reuptake inhibitors; *TCAs,* tricyclic antidepressants.

TABLE 26-7 POSSIBLE CLINICAL EFFECTS OF SYNAPTIC ACTIVITY BY PSYCHOTROPIC DRUGS

SYNAPTIC ACTIVITY	POSSIBLE CLINICAL EFFECTS
Serotonin (5-HT) reuptake inhibition	Reduced depression, antianxiety effects, gastrointestinal disturbances, sexual dysfunction
Norepinephrine (NE) reuptake inhibition	Reduced depression, tremors, tachycardia, erectile/ejaculatory dysfunction, insomnia, diaphoresis
Dopamine (DA) reuptake inhibition	Reduced depression, psychomotor activation, antiparkinsonian effects
$5\text{-}HT_1$ receptor blockade	Reduced depression, antianxiety effects, reduced aggression
$5\text{-}HT_2$ receptor blockade	Reduced depression, reduced suicidal behavior, antipsychotic effects, hypotension, ejaculatory dysfunction, sedation/drowsiness, weight gain
Dopamine (D_2) receptor blockade	Extrapyramidal movement disorders, reduced psychosis, sexual dysfunction
Muscarinic/cholinergic (ACh) receptor blockade	Anticholinergic side effects (blurred vision, dry mouth, constipation, sinus tachycardia, urinary retention, cognitive dysfunction)
Histamine (H_1) receptor blockade	Sedation/drowsiness, hypotension, weight gain
$Alpha_1$-adrenergic receptor blockade	Postural hypotension, dizziness, drowsiness, memory dysfunction, reflex tachycardia, potentiation of antihypertensive effect of prazosin and terazosin
$Alpha_2$-adrenergic receptor blockade	Priapism, blockade of the antihypertensive effects of clonidine and alpha-methyldopa

weight-reducing activities or switch the patient to an antidepressant without this side effect.

For problems with SSRI side effects (Table 26-10), **choices include:**

- Lowering the dose, at least temporarily, to see whether side effects improve without a simultaneous loss of effectiveness
- Waiting for tolerance of the side effects to develop
- Using one of the nursing strategies identified in Table 26-11 to decrease side effects
- Using drug co-administration strategies to treat the side effect (e.g., sildenafil for sexual dysfunction in men and women as shown in Table 26-12)
- Switching the patient to another antidepressant with a different side effect profile

TABLE 26-8 **ANTIDEPRESSANT DRUGS**

GENERIC NAME (TRADE NAME)	USUAL ADULT DAILY DOSE (mg/day)*	PREPARATIONS
Selective Serotonin Reuptake Inhibitors (SSRIs)		
Citalopram (Celexa)	20-40	PO, L
Escitalopram (Lexapro)	10-20	PO, L
Fluoxetine (Prozac)	20-60	PO, L
Fluvoxamine (Luvox)	100-200	PO
Fluvoxamine maleate (Luvox CR)	100-200	PO
Paroxetine (Paxil)	20-60	PO, CR, L
Sertraline (Zoloft)	50-200	PO, L
Other Antidepressant Drugs		
Bupropion (Wellbutrin)	150-450[†]	PO, SR, XR
Maprotiline (Ludiomil)	50-200	PO
Mirtazapine (Remeron)	15-45	PO, ODT
Vilazodone (Viibryd)	10-40	PO
Serotonin Antagonist and Reuptake Inhibitors (SARIs)		
Nefazodone (Serzone)	300-500	PO
Trazodone (Desyrel)(Oleptro XR)	150-300	PO
Serotonin-Norepinephrine Reuptake Inhibitor (SNRIs)		
Desvenlafaxine (Pristiq)	50-100	PO
Duloxetine (Cymbalta)	30-120	PO
Milnacipran (Savella)	12-100	PO
Venlafaxine (Effexor)	75-300	PO, XR
Tricyclic Antidepressant Drugs (TCAs)		
Tertiary (Parent)		
Amitriptyline (Elavil)	150-300	PO, IM
Amoxapine (Asendin)	200-300	PO
Clomipramine (Anafranil)	100-250	PO
Doxepin (Sinequan)	150-300	PO, L
Imipramine (Tofranil)	150-300	PO
Trimipramine (Surmontil)	150-300	PO
Secondary (Metabolite)		
Desipramine (Norpramin)	150-300	PO, L
Nortriptyline (Pamelor)	50-150	PO, L
Protriptyline (Vivactil)	15-60	PO
Tetracyclics		
Amoxapine (Asendin)	150-300	PO
Maprotiline (Ludiomil)	75-200	PO
Monoamine Oxidase Inhibitors (MAOIs)		
Isocarboxazid (Marplan)	20-60	PO
Phenelzine (Nardil)	45-90	PO
Selegiline (Eldepryl)	10-50	PO
Selegiline (Emsam)	6-12	TS
Tranylcypromine (Parnate)	20-60	PO

*Dosage ranges are approximate; initiate at lower dose for most patients.
[†]Antidepressants with a ceiling dose because of dose-related seizures.
CR, Controlled release; *IM*, intramuscular; *L*, oral liquid; *ODT,* orally disintegrating tablet; *PO,* oral tablet/capsule; *SR,* sustained release; *TS,* transdermal system patch; *XR,* extended release.

For SSRI nonresponders, choices include:

- Raising the dose to the limits of the therapeutic range and the patient's tolerance
- Augmenting the primary antidepressant with another drug (e.g., another antidepressant, a stimulant, lithium, thyroxine, or buspirone) to increase effectiveness
- Switching to another SSRI or antidepressant.

The SSRIs have antidepressant effects comparable with those of the other classes of antidepressant drugs, yet without significant anticholinergic, cardiovascular, or sedative side effects. In addition, **SSRIs are fairly safe in overdose.** These properties have made them very

TABLE 26-9 COMPARATIVE SIDE EFFECT PROFILES OF SOME ANTIDEPRESSANT MEDICATIONS

	CENTRAL NERVOUS SYSTEM			CARDIOVASCULAR		OTHER	
	ANTICHOLINERGIC*	DROWSINESS	INSOMNIA/ AGITATION	POSTURAL HYPOTENSION	CARDIAC ARRHYTHMIA	GASTROINTESTINAL DISTRESS	WEIGHT GAIN (>6 kg)
Amitriptyline	4	4	0	4	3	0	4
Clomipramine	4	4	1	3	3	1	3
Desipramine	1	1	1	2	2	0	1
Doxepin	3	4	0	2	2	0	3
Imipramine	3	3	1	4	3	1	3
Nortriptyline	1	1	0	2	2	0	1
Protriptyline	2	1	1	2	2	0	0
Trimipramine	1	4	0	2	2	0	3
Amoxapine	2	2	2	2	3	0	1
Duloxetine	1	1	3	0	0	3	0
Maprotiline	2	4	0	0	1	0	2
Mirtazapine	1	4	1	2	0	1	2
Nefazodone	1	3	1	2	0	3	0
Venlafaxine	1	1	3	0	0	3	0
Trazodone	0	4	0	1	1	1	1
Bupropion	0	0	2	0	1	1	0
Fluoxetine	0	0	2	0	0	3	0
Paroxetine	0	0	2	0	0	3	0
Sertraline	0	0	2	0	0	3	0
Fluvoxamine	0	0	2	0	0	3	0
Citalopram	0	1	2	0	1	3	0
MAOIs	1	1	2	2	0	1	2

*Dry mouth, blurred vision, urinary hesitancy, constipation.
0, Absent or rare; *1*, *2*, in between; *3*, *4*, common; *MAOIs,* monoamine oxidase inhibitors.

TABLE 26-10 **ANTIDEPRESSANT DRUG SIDE EFFECTS**

	RECEPTORS/NEUROTRANSMITTERS	SIDE EFFECTS
Antidepressants		
TCAs	H_1	Sedation/drowsiness, hypotension, weight gain
	ACh	Anticholinergic side effects: blurred vision, dry mouth, constipation, tachycardia, urinary retention, cognitive dysfunction
	$Alpha_1$	Postural hypotension, dizziness, tachycardia, memory dysfunction
	5-HT_2	Hypotension, ejaculatory dysfunction
	5-HT	Gastrointestinal disturbances (nausea, diarrhea), sexual dysfunction
	NE	Tremors, tachycardia, erectile/ejaculatory dysfunction
MAOIs	ACh	Anticholinergic side effects
SSRIs	5-HT	Gastrointestinal disturbances (nausea, diarrhea), sexual dysfunction
Other Antidepressants		
Amoxapine	NE	Tremors, tachycardia, erectile/ejaculatory dysfunction
	5-HT	Gastrointestinal disturbances (nausea, diarrhea), sexual dysfunction
	D_2	Extrapyramidal symptoms, tardive dyskinesia (rare)
	ACh	Anticholinergic side effects
	H_1	Sedation/drowsiness, hypotension, weight gain
Bupropion	DA	Psychomotor activation
	NE	Tremors, tachycardia, erectile/ejaculatory dysfunction
Desvenlafaxine	NE	Tremors, tachycardia,erectile/ejaculatory dysfunction
	5-HT	Gastrointestinal disturbances (nausea, diarrhea), sexual dysfunction
	DA	Psychomotor activation
Duloxetine	NE	Tremors, tachycardia, erectile/ejaculatory dysfunction
	5-HT	Gastrointestinal disturbances (nausea, diarrhea), sexual dysfunction
	DA	Psychomotor activation
Maprotiline	NE	Tremors, tachycardia, erectile/ejaculatory dysfunction
	H_1	Sedation, drowsiness, hypotension, weight gain
	ACh	Anticholinergic side effects
Mirtazapine	H_1	Sedation, drowsiness, hypotension, weight gain
	ACh	Anticholinergic side effects
Nefazodone	5-HT	Gastrointestinal disturbances (nausea, diarrhea), sexual dysfunction
	NE	Tremors, tachycardia, erectile/ejaculatory dysfunction
	5-HT_2	Hypotension, ejaculatory dysfunction
	$Alpha_1$	Postural hypotension, dizziness, tachycardia, memory dysfunction
Trazodone	5-HT	Gastrointestinal disturbances (nausea, diarrhea), sexual dysfunction
	5-HT_2	Hypotension, ejaculatory dysfunction
	H_1	Sedation/drowsiness, hypotension, weight gain
	$Alpha_1$	Postural hypotension, dizziness, tachycardia, memory dysfunction
	$Alpha_2$	Priapism
	ACh	Dry mouth, constipation, tachycardia, urinary retention
Venlafaxine	NE	Tremors, tachycardia, erectile/ejaculatory dysfunction
	5-HT	Gastrointestinal disturbances (nausea, diarrhea), sexual dysfunction
	DA	Psychomotor activation
Vilazodone	5-HT	Gastrointestinal disturbances (nausea, diarrhea), sexual dysfunction
Additional Side Effects and Adverse Reactions of Antidepressant Drugs Less Clearly Related to Receptor/Neurotransmitter Effects		
TCAs		ECG changes, dizziness/lightheadedness
		TCA withdrawal syndrome (malaise, muscle aches, chills, nausea, dizziness, coryza), hallucinations, delusions, activation of schizophrenic or manic psychosis, excessive perspiration
MAOIs		Hypertensive crisis, lightheadedness, drowsiness, insomnia, weight gain, sexual dysfunction
SSRIs		Nervousness, activation, headache, cytochrome P-450 inhibition, serotonin syndrome, insomnia
Venlafaxine		Sweating, nausea, constipation, vomiting, somnolence, dry mouth, dizziness, anxiety, blurred vision, headache, hypertension, insomnia

ACh, Acetylcholine; *alpha$_1$* and *alpha$_2$*, norepinephrine receptors; *D_2*, dopamine receptor; *DA,* dopamine; *ECG,* electrocardiogram; *H_1*, histamine receptor; *5-HT,* serotonin; *5-HT_2*, serotonin receptor; *MAOIs,* monoamine oxidase inhibitors; *NE,* norepinephrine; *SSRIs,* selective serotonin reuptake inhibitors; *TCAs*, tricyclic antidepressants.

TABLE 26-11 NURSING CONSIDERATIONS FOR ANTIDEPRESSANT DRUG SIDE EFFECTS

SIDE EFFECT	NURSING CARE AND TEACHING CONSIDERATIONS
Anticholinergic Side Effects	
Blurred vision	Temporary; avoid hazardous tasks.
Dry mouth	Encourage fluids, frequent rinses, sugar-free hard candy and gums; check for mouth sores.
Constipation	Increase fluids, dietary fiber and roughage, exercise; monitor bowel habits; use stool softeners and laxatives only if necessary.
Tachycardia	Temporary, usually not significant (except with coronary artery disease) but can be frightening; eliminate caffeine; beta-blockers might help; supportive therapy.
Urinary retention	Encourage fluids and frequent voiding; monitor voiding patterns; administer bethanecol; catheterize.
Cognitive dysfunction	Temporary; avoid hazardous tasks, adjust lifestyle; supportive therapy.
Cytochrome P-450 inhibition*	SSRIs inhibit the liver isoenzyme cytochrome P-450, which is instrumental in the metabolism of a variety of drugs (TCAs, trazodone, barbiturates, most benzodiazepines, carbamazepine, narcotics, neuroleptics, phenytoin, valproate, verapamil). This effect can be potentially life threatening because it increases serum concentrations as well as therapeutic and toxic effects of these drugs.
Dizziness/lightheadedness	Dangle feet; adequate hydration, elastic stockings; protect from falls.
ECG changes	Careful cardiac history; pretreatment ECG for patients older than 40 years and children; ST segment depression, T wave flattened or inverted, QRS prolongation; worsening of intraventricular conduction problems; do not use if recent myocardial infarction or bundle branch block.
Ejaculatory dysfunction	Take after sexual intercourse, not immediately before.
Gastrointestinal disturbances (nausea, diarrhea)	Take with meals or hs; adjust diet if indicated.
Hallucinations, delusions, activation of schizophrenic or manic psychosis	Change to another antidepressant class of drug; initiate antipsychotics or mood stabilizers if appropriate.
Hypertensive crisis*	Can cause intracerebral hemorrhage and death. (See Box 26-9.)
Hypotension	Frequent BP; hydrate; elastic stockings; may need to change drug. For postural hypotension: lying and standing BP, gradual change of positions, protect from falls.
Insomnia	Take as early in the day as possible; sleep hygiene, decrease evening activities; eliminate caffeine; relaxation techniques; sedative-hypnotic therapy.
Memory dysfunction	Temporary; encourage concentration, make lists, provide social support, adjust lifestyle.
Perspiration (excessive)	Frequent change of clothes, cotton/linen clothing, good hygiene; increase fluids.
Priapism	Change dose; change drug.
Psychomotor activation	Take drug in morning rather than hs, adjust lifestyle.
Sedation/drowsiness	Administer drug hs; avoid hazardous tasks.
Serotonin syndrome (SS)*	SS is a life-threatening emergency resulting from excess central nervous system 5-HT caused by combining 5-HT-enhancing drugs or administering SSRIs too close to the discontinuation of MAOIs. (See Box 26-7.)
Sexual dysfunction	Take after sexual intercourse, use lubricant if vaginal dryness is present; antidotes such as sildenafil, bupropion, or bethanecol.
Tachycardia	See anticholinergic side effects.
TCA withdrawal syndrome	Symptoms: malaise, muscle aches, chills, nausea, dizziness, coryza; when discontinuing drug, taper over several days or weeks.
Tremors	Temporary; adjust lifestyle if indicated.
Weight gain	Increase exercise; reduced calorie diet if indicated; may need to change class of drug.

*Potentially life threatening.

NOTE: Always educate the patient and use the techniques in this table. Consider decreasing or dividing drug dose. Change drug only if necessary.

BP, Blood pressure; *ECG,* electrocardiogram; *hs,* at bedtime (hour of sleep); *5-HT,* serotonin; *MAOIs,* monoamine oxidase inhibitors; *SSRIs,* selective serotonin reuptake inhibitors; *TCAs,* tricyclic antidepressants.

popular, even though they cost more than the older tricyclic compounds.

Particular care must be taken when combining SSRIs with other serotonin drugs and with drugs that are metabolized by liver enzymes that SSRIs may inhibit. **Combining serotonergic drugs can cause serotonin syndrome, a life-threatening crisis** (Box 26-7).

Because the SSRIs may inhibit the cytochrome P-450 enzymes, which are responsible for the metabolism of many other drugs, care also must be taken to monitor patients

TABLE 26-12 ADJUNCTIVE AGENTS FOR ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION

DRUG	USUAL ADULT DOSE
Buspirone	20-60 mg/day
Bupropion	75-150 mg/day
Sildenafil	50-100 mg/prn
Ginkgo biloba	60-240 mg/day
Amantadine	100-300 mg/day
Cyproheptadine	4-12 mg prn
Yohimbine	5.4 mg tid

prn, As needed; *tid,* three times daily.

taking multiple medications for signs of **cytochrome P-450 inhibition.** The resulting toxicity also may be life threatening. Genotyping for CYP-450 and CYP-2C19 variations is emerging as a potentially useful clinical tool to help clinicians prescribe psychiatric medications for patients. Table 26-11 describes the side effects and nursing considerations of antidepressant drugs.

Many **pregnant women** resist taking antidepressants during pregnancy because they worry about birth defects. One antidepressant, paroxetine, has been found to possibly be linked to birth defects when used in the first trimester of pregnancy as compared with pregnant women taking other antidepressants. The FDA changed this drug's pregnancy category from C to D.

However, studies also indicate that being depressed while pregnant can pose a risk to the fetus in that the hormonal and vascular changes associated with depression during pregnancy may create a poor environment for fetal development. This can result in negative pregnancy outcomes, such as preeclampsia, preterm labor, and low infant birth weight.

Further, pregnancy is not "protective" with respect to risk of relapse of major depression. Women who are pregnant and discontinue their antidepressant medication are at significant risk for relapse. Thus the risks and benefits of medication should be carefully and individually evaluated (Wisner et al, 2009).

Finally considerations about antidepressant use in the postpartum period should include potential risks to the mother as well as the baby. Not treating depression in the mother can result in poor maternal-child bonding and possible negative effects on cognition, language, and development in the child. Evidence suggests that most, but not all, SSRIs and tricyclics are reasonable choices (Meltzer-Brody et al, 2008).

Other Antidepressant Drugs

A growing number of new antidepressant drugs differ chemically from each other and from other classes of antidepressants. They also differ significantly in their effects at the synapse. They therefore have varying side effect profiles, although their effectiveness generally is the same as that of other antidepressants, as is the length of time required for antidepressant or antianxiety effects to occur (several weeks at optimal dose).

Like SSRIs, the other newer antidepressants are safer than TCAs and MAOIs in side effect profiles and overdose. Some of these drugs appear to have more specificity than many of the other antidepressants. These include the following:

- Bupropion is a norepinephrine and dopamine reuptake blocker (NDRI).
- Mirtazapine increases serotonin and norepinephrine in the synapse by antagonism of α_2 autoreceptors, is an agonist at the serotonin 5-HT_1 postsynaptic receptor, and antagonizes the 5-HT_2 receptor. Mirtazapine can be sedating due to its blockade action at histamine receptors; therefore it is typically administered at bedtime.
- Nefazodone and trazodone antagonize both a subtype of the serotonin 5-HT_2 postsynaptic receptor (associated with side effects) and serotonin reuptake; thus they are serotonin antagonists and reuptake inhibitors (SARIs). Nefazodone has been associated with liver toxicity and is decreasing in use.
- Duloxetine, venlafaxine, and desvenlafaxine are "dual" reuptake inhibitors because they inhibit both norepinephrine and serotonin reuptake (SNRIs).

BOX 26-7 SEROTONIN SYNDROME

Overview

- Serotonin syndrome occurs most often occurs when two drugs that affect the body's level of serotonin are taken together at the same time.
- The drugs cause too much serotonin to be released or to remain in the brain area.
- It is more likely to occur when medication is first started or the dosage is increased.
- Patients may get slowly worse and can become severely ill if not quickly treated.
- Untreated serotonin syndrome can be deadly.
- With treatment, symptoms can usually go away in less than 24 hours.

Symptoms Occur Within Minutes to Hours

- Agitation or restlessness
- Diarrhea
- Fast heartbeat
- Hallucinations
- Increased body temperature
- Loss of coordination
- Nausea
- Overactive reflexes
- Rapid changes in blood pressure
- Vomiting

Treatment

- Discontinue all serotonergic drugs immediately
- Anticonvulsants for seizures
- Serotonin antagonist drugs may help
- Clonazepam for myoclonus
- Lorazepam for restlessness/agitation
- Other symptomatic care as indicated
- Do not reintroduce serotonin drugs.

Tricyclic Antidepressants

Although the TCAs as a class include some drugs that are structurally dissimilar, they are all quite similar in their clinical effects and adverse reactions as seen in Table 26-10). To varying degrees, TCAs all have the same primary actions, such as serotonin and norepinephrine reuptake inhibition (therapeutic effects), as well as blockade of three receptors not implicated in depression: muscarinic cholinergic receptors (anticholinergic side effects), histamine H_1 receptors (sedation, weight gain), and alpha$_1$-noradrenergic receptors (orthostatic hypotension, dizziness).

TCAs can have dangerous cardiac side effects. This requires obtaining electrocardiograms (ECGs) in adults older than 40 years, all children and young adolescents, and any patient with cardiac conduction problems before prescribing TCAs.

TCAs also are lethal in overdose. Thus careful baseline and ongoing suicide assessment is important. Elderly patients and patients with a medical illness may require lower doses of these drugs than healthy adults and careful assessments for side effects while they are taking the drugs.

The TCAs (except amoxapine and trimipramine) have clinically relevant blood levels, making monitoring therapeutic doses more precise if necessary. TCAs are as effective as the newer drugs, and because they have been on the market for many decades, many of them are much less expensive than most drugs used to treat depression and anxiety, so they may be a good choice for some patients.

Monoamine Oxidase Inhibitors

MAOIs are very effective antidepressant, antipanic, and antiphobic drugs and were the first clinically effective antidepressants to be discovered in the 1950s. The MAOIs used to treat depression are listed in Table 26-8.

MAOIs inhibit both types of the enzyme (MAO A and MAO B) that metabolizes serotonin and norepinephrine. This inhibition is irreversible; lasting until the body is able to manufacture new MAO after the drug is discontinued, and is linked to the control of blood pressure because of its inhibition of norepinephrine.

A dangerous elevation in blood pressure can result from high levels of norepinephrine not metabolized by MAO.

- **Patients taking MAOIs must avoid foods** (Box 26-8) **and drugs** (Table 26-13) **that are norepinephrine agonists.**
- **These must be avoided or they can produce a hypertensive crisis** (Box 26-9), **which can cause intracerebral hemorrhage and death.**

Careful patient education is required with the use of these drugs. The MAOI drug selegiline is available in a transdermal patch (Emsam). Because this formulation bypasses the digestive system, it has the benefit of no diet restrictions at most doses; however, it does not eliminate the drug interactions.

MAO B is thought to convert some amines into toxins that may cause damage to neurons. Drugs that are selective inhibitors of MAO B have no antidepressant properties, have

BOX 26-8 FOOD CAUTIONS FOR PATIENTS TAKING MONOAMINE OXIDASE INHIBITORS (MAOIs)

Foods to Be Avoided

- Any cheeses *except* cottage and cream cheese
- Overripe (aged) fruit
- Fava beans
- Sausage, salami
- Sherry, liqueurs, red wine
- Sauerkraut
- Monosodium glutamate
- Pickled or smoked fish
- Brewer's yeast
- Beef and chicken liver
- Fermented products

Foods to Be Eaten in Moderation and With Caution

- Alcohol, beer, white wines
- Caffeine-containing beverages
- Ripe avocado
- Yogurt
- Soy sauce
- Ripe bananas
- Chocolate
- Figs
- Meat tenderizers
- Raisins

TABLE 26-13 DRUGS TO AVOID IN COMBINATION WITH MAOIs

DRUGS THAT MAY INTERACT WITH MAOIs	NATURE OF DRUG INTERACTION
Other MAOIs	Potentiation of side effects, seizures
SSRIs, fenfluramine, L-tryptophan	Serotonin syndrome
TCAs, carbamazepine, cyclobenzaprine	Severe side effects, hypertension, convulsions
Stimulants, buspirone, direct sympathomimetics, nasal and sinus decongestants, allergy and asthma remedies	Hypertension
Indirect sympathomimetics	Hypertensive crisis
Meperidine	Severe, potentially fatal interaction
Hypoglycemics (including insulin)	Worsening of hypoglycemia
Dextromethorphan	Reports of brief psychosis

MAOIs, Monoamine oxidase inhibitors; *SSRIs,* selective serotonin reuptake inhibitors; *TCAs,* tricyclic antidepressants.

BOX 26-9 SIGNS AND TREATMENT OF MAOI-INDUCED HYPERTENSIVE CRISIS

Warning Signs
- Increased blood pressure
- Palpitations
- Headache

Symptoms of Hypertensive Crisis
- Sudden elevation of blood pressure
- Explosive occipital headache
- Head and face flushed and feel "full"
- Palpitations, chest pain
- Sweating, fever, nausea, vomiting
- Dilated pupils, photophobia

Treatment
- Hold MAOI doses
- Do not lie down (elevates blood pressure in head)
- IM chlorpromazine 100 mg, repeat if necessary (*mechanism of action:* blocks norepinephrine)
- IV phentolamine, administered slowly in doses of 5 mg (*mechanism of action:* binds with norepinephrine receptor sites, blocking norepinephrine)
- Manage fever by external cooling techniques
- Evaluate diet, adherence, and teaching

IM, Intramuscular administration; *IV,* intravenous administration; *MAOI,* monoamine oxidase inhibitor.

no risk of hypertension, and are used to prevent progression of neurodegenerative diseases, such as Parkinson disease.

A novel class of MAOIs called *reverse inhibitors of monoamine oxidase A (RIMAs)* (moclobemide, brofaromine) has antidepressant effectiveness comparable with that of other antidepressants and is reversible and selective for inhibitors of MAO A. Unlike the irreversible and nonselective MAOIs, RIMAs are short-acting drugs, allowing the recovery of enzyme activity in hours rather than weeks. Thus they have fewer side effects (specifically the absence of severe hypertensive interaction) and do not require food and drug restrictions. RIMAs may prove to be valuable additions to the list of antidepressant drugs.

MOOD-STABILIZING DRUGS

Bipolar disorder is a common, recurrent, and often severe psychiatric illness associated with high rates of morbidity and mortality if left untreated (Chapter 18). Yet treatment is sophisticated and complex. The goals of treatment are the same as for any chronic illness: rapid, complete remission of acute episodes, prevention of further episodes, suppression of symptoms that remain after the syndrome has been successfully treated (subsyndromal symptoms), and optimization of functional outcome and quality of life.

It is important to develop a comprehensive treatment plan for the patient with bipolar disorder, including individual, family, and psychosocial therapies. Psychopharmacology is also a critical component. Mood-stabilizing drugs approved by the FDA for the treatment of bipolar disorder are few, but a range of other drugs are commonly used in clinical practice for this illness.

The mood stabilizers include lithium, several types of anticonvulsants, atypical antipsychotics, BZs, and calcium channel blockers. Table 26-14 lists the mood-stabilizing drugs. The nurse is advised to frequently refer to current administering and prescribing updates when treating patients taking mood-stabilizing drugs.

Lithium

Lithium, a naturally occurring salt, is a first-line treatment for patients with acute mania and for the long-term prevention of recurrent episodes. Lithium also has a role in the treatment of recurrent bipolar depression, unipolar depression, aggressive behaviors, conduct disorder, and schizoaffective disorder.

The exact mechanism of action of lithium is not fully understood, but many neurotransmitter functions are altered by the drug. It has been suggested that lithium may correct an ion exchange abnormality in the neuron; normalize synaptic neurotransmission of norepinephrine, serotonin, dopamine, and acetylcholine; and regulate second-messenger systems during neurotransmission.

The use of lithium requires a comprehensive and vigilant approach. **Because lithium is excreted by the kidneys, can adversely affect the thyroid, has a narrow therapeutic index and can quickly become fatal, initial and ongoing health assessment and laboratory monitoring is required.**

Health teaching of the patient, family, and support system is critical. The patient must be able to differentiate side effects from potentially life-threatening toxic effects and maintain a stable lithium level. **Lithium toxicity is a medical emergency requiring rapid treatment.**

- Box 26-10 lists the target symptoms of mania and of depression for mood-stabilizing drug therapy for patients with bipolar disorder.
- Box 26-11 describes the prelithium work-up.
- Box 26-12 identifies lithium side effects and toxicity.
- Box 26-13 describes stabilizing lithium levels.
- Box 26-14 focuses on managing lithium toxicity.

Lithium may take weeks to months to significantly treat the symptoms of bipolar illness, and many patients may still continue to experience at least some symptoms of mood swings, anxiety, and psychosis. Therefore it is not uncommon to augment lithium with additional agents, such as another mood stabilizer, antidepressant, BZ, or atypical antipsychotic agent, depending on the target symptoms.

The nurse working with a patient taking lithium needs a solid understanding of the principles of lithium administration in order to keep lithium blood levels within the therapeutic range (between 0.6 and 1.4 mEq/L for adults), side effects minimized, quality of life maximized, and the bipolar patient adherent to the treatment regimen.

Intensive medication management and ongoing patient education and support are the gold standard for the long-term treatment of the patient with bipolar illness. **Use of**

TABLE 26-14 MOOD-STABILIZING DRUGS

DRUG CLASS GENERIC NAME (TRADE NAME)	HALF-LIFE (hr)	USUAL ADULT DOSE (mg/day)*	PREPARATIONS
Antimania			
Lithium (Eskalith, Lithobid)	18-36	600-2400	PO, CR, SR
Lithium citrate	18-36	600-2400	L/S
Anticonvulsants			
Valproic acid (Depakene); valproate (Depacon), divalproex (Depakote)	9-16	15-60 mg/kg/day	PO, L/S, ER, IM
Lamotrigine (Lamictal)	25-32	50-500	PO, Ch
Carbamazepine (Tegretol)	25-65	200-1600	PO, Ch
Oxcarbazepine (Trileptal)	2-9	600-2400	PO, S
Topiramate (Topamax)	20-30	200-400	PO
Tiagabine (Gabitril)	7-9	4-32	PO
Atypical Antipsychotics (See Table 26-15)			
Benzodiazepines (See also Table 26-2)			
Calcium Channel Blockers			
Verapamil (Calan)	3-7	240	PO
Nifedipine (Adalat, Procardia)	4	60-180	PO

Data from Schatzberg AF, Cole JO, DeBattista C: *Manual of clinical psychopharmacology,* ed 6, Washington, DC, 2007, American Psychiatric Publishing.

*The dosage range is approximate and must be individualized for each patient.

Ch, Chewable tablets; *CR*, controlled release; *ER*, sustained release; *IM*, intramuscular; *L/S*, liquid/syrup; *PO*, oral tablets or capsules; *S*, suspension; *SR*, slow release.

BOX 26-10 TARGET SYMPTOMS FOR MOOD-STABILIZING DRUG THERAPY

Mania

- Irritability
- Expansiveness
- Euphoria
- Manipulativeness
- Lability with depression
- Sleep disturbance (decreased sleep)
- Pressured speech
- Flight of ideas
- Motor hyperactivity
- Assaultiveness/threatening behavior
- Distractibility
- Hypergraphia
- Hypersexuality
- Persecutory and religious delusions
- Grandiosity
- Hallucinations
- Ideas of reference
- Catatonia

Depression

- Irritability
- Sadness
- Pessimism
- Anhedonia
- Self-reproach
- Guilt
- Hopelessness
- Somatic complaints
- Suicidal ideation
- Motor retardation
- Slowed thinking
- Poor concentration and memory
- Fatigue
- Constipation
- Decreased libido
- Anorexia or increased appetite
- Weight change
- Helplessness
- Sleep disturbance (insomnia or hypersomnia)

lithium during pregnancy is not recommended, particularly during the first trimester (0.01% to 0.02% risk for cardiac anomalies: category D).

Critical Reasoning A patient's wife calls you and is upset because her husband says he enjoys his manic highs and does not want to take his medication, which dulls his enjoyment of life. How would you help this family?

Anticonvulsants

A variety of anticonvulsant drugs have beneficial effects in the treatment of bipolar disorder, and several have FDA approval for this indication. It is thought that the anticonvulsant mood-stabilizing drugs work in bipolar disorder by enhancing the effects of the inhibitory neurotransmitter GABA and by desensitizing the "kindling" effect in bipolar illness.

BOX 26-11 PRELITHIUM WORK-UP

Renal: urinalysis, blood urea nitrogen (BUN), creatinine, electrolytes, 24-hour creatinine clearance; history of renal disease in patient or family; diabetes mellitus, hypertension, diuretic use, analgesic abuse

Thyroid: thyroid-stimulating hormone (TSH), T_4 (thyroxine), T_3 resin uptake, T_4 I (free thyroxine index); history of thyroid disease in patient or family

Other: complete physical, history, electrocardiogram (ECG), fasting blood sugar, complete blood count (CBC)

Maintenance Lithium Considerations

- **Every 3 months:** lithium level (for the first 6 months)
- **Every 6 months:** reassessment of renal status, lithium level, TSH
- **Every 12 months:** reassessment of thyroid function, ECG
- Assess more often if patient is symptomatic

BOX 26-12 LITHIUM SIDE EFFECTS AND TOXICITY

Body Image

- Weight gain (60% of patients)

Cardiac

- Electrocardiogram (ECG) changes, usually not clinically significant

Central Nervous System

- Fine hand tremor (50% of patients), fatigue, headache, mental dullness, lethargy

Dermatological

- Acne, pruritic maculopapular rash

Endocrine

- Thyroid dysfunction: hypothyroidism (5% of patients); replacement hormone
- Diabetes mellitus: diet or insulin therapy

Gastrointestinal

- Gastric irritation, anorexia, abdominal cramps, mild nausea, vomiting, diarrhea (give with food or milk; further divide dose)

Renal

- Polyuria (60% of patients), polydipsia, edema
- Nephrogenic diabetes insipidus: decrease dose; drink plenty of fluids; thiazide diuretics paradoxically reduce polyuria
- Microscopic structural kidney changes (10% to 20% of patients taking lithium for 1 year); does not cause clinical morbidity

Lithium Toxicity/Usually Dose Related

- Prodrome of intoxication (lithium level ≥0 mEq/L): anorexia, nausea, vomiting, diarrhea, coarse hand tremor, twitching, lethargy, dysarthria, hyperactive deep tendon reflexes, ataxia, tinnitus, vertigo, weakness, drowsiness
- Lithium intoxication (lithium level ≥5 mEq/L): fever, decreased urine output, decreased blood pressure, irregular pulse, ECG changes, impaired consciousness, seizures, coma, death

BOX 26-13 STABILIZING LITHIUM LEVELS

Common Causes for an Increase in Lithium Levels

- Decreased sodium intake
- Diuretic therapy
- Decreased renal functioning
- Fluid and electrolyte loss, sweating, diarrhea, dehydration, fever, vomiting
- Medical illness
- Overdose
- Nonsteroidal antiinflammatory drug therapy

Ways to Maintain a Stable Lithium Level

- Stabilize dosing schedule by dividing doses or use of sustained-release capsules.
- Ensure adequate dietary sodium and fluid intake (2 to 3 L/day).
- Replace fluids and electrolytes lost during exercise or gastrointestinal illness.
- Monitor signs and symptoms of lithium side effects and toxicity.
- If patient forgets a dose, a dose may be taken if less than 2 hours have elapsed; if longer than 2 hours, the dose should be skipped and the next dose taken as scheduled; never double up on doses.

BOX 26-14 MANAGEMENT OF SERIOUS LITHIUM TOXICITY

- Assess quickly; obtain rapid history of incident, especially dosing; offer support and explanations to the patient.
- Hold all lithium doses.
- Check blood pressure, pulse, rectal temperature, respirations, and level of consciousness. Be prepared to initiate stabilization procedures, protect airway, and provide supplemental oxygen.
- Obtain lithium blood level immediately; obtain electrolytes, BUN, creatinine, urinalysis, CBC when possible.
- Electrocardiogram; monitor cardiac status.
- Limit lithium absorption; if acute overdose, provide an emetic; nasogastric suctioning.
- Vigorously hydrate: 5 to 6 L/day; balance electrolytes; IV line; indwelling urinary catheter.
- Patient will be bedridden: range of motion, frequent turning, pulmonary toilet.
- Ascertain reasons for lithium toxicity, increase health teaching efforts, mobilize postdischarge support system, arrange for more frequent clinical visits and blood level checks, assess for depression and suicidal intent.

In moderately severe cases:

- Implement osmotic diuresis with urea or mannitol.
- Increase lithium clearance with aminophylline, and alkalinize the urine with IV sodium lactate.
- Ensure adequate intake of sodium chloride to promote excretion of lithium.
- Implement peritoneal dialysis or hemodialysis in the most severe cases (serum levels between 2.0 and 4.0 mEq/L) with decreasing urinary output and deepening CNS depression.

BUN, Blood urea nitrogen; *CBC,* complete blood count; *CNS,* central nervous system; *IV,* intravenous.

Kindling occurs when the brain becomes neurochemically sensitized to events such as stress, trauma, or the effects of street drugs, which eventually seems to cause the brain to spontaneously respond in a dysfunctional manner even in the absence of these events (Chapter 5). Kindling is used to explain the cause of cyclical illnesses, such as bipolar illness and the intermittent symptoms of other illnesses, such as panic attacks or the craving of substances of abuse.

Divalproex (Depakote), a derivative of valproic acid, has a superior therapeutic index, a better toxicity profile, and a wider range of effectiveness in subtypes of bipolar disorder (e.g., rapid cycling and mixed mood states) as compared with lithium. For these reasons it has surpassed lithium as the drug most commonly used to treat bipolar disorder in the United States.

It is effective in both the manic and depressed phases of bipolar disorder and in schizoaffective disorder. Response usually occurs in 1 to 2 weeks, and it can be used in long-term maintenance alone or with other drugs such as lithium, antipsychotics, or antidepressants. Divalproex is well tolerated in general.

Side effects include gastrointestinal complaints such as anorexia, nausea, vomiting, and diarrhea; neurological symptoms of tremor, sedation, headache, dizziness, and ataxia; and increased appetite and weight gain. Thrombocytopenia with bruising, petechiae, hematoma, and bleeding may necessitate a decrease in dose or discontinuation of the drug.

Very rare but serious side effects include pancreatitis and severe hepatic dysfunction. Thus comprehensive laboratory tests are conducted at baseline and are repeated every 1 to 4 weeks for the first 6 months and then every 3 to 6 months.

Divalproex can be lethal in overdose. It is not recommended in patients during pregnancy (category D) or in those with hepatic disease, blood dyscrasias, organic brain disease, or renal function impairment.

Lamotrigine (Lamictal), another FDA-approved anticonvulsant, is useful in delaying the onset of mood episodes in patients receiving standard treatment for acute mood episodes in bipolar disorder. It appears to decrease glutamate release, modulate the reuptake of serotonin, and generally block the reuptake of monoamines, including dopamine. It is thought that these mechanisms may explain its mood-stabilizing effects.

Lamotrigine is generally well tolerated. Common side effects include dizziness, headache, double vision, unsteadiness, sedation, and uncomplicated rash. Lamotrigine is started at 25 mg/day for the first week, and the dosage is increased by 25 to 50 mg every 2 weeks with an initial target dose of 200 mg but may be given to a therapeutic effect of 400 mg or more per day.

Lamotrigine increases the risk of serious skin reactions, including Stevens-Johnson syndrome, which may be fatal to 1 in 1000 adults and 1 in 100 children. The risk is increased further by too rapid dose titration (Schatzberg et al, 2010). When used in conjunction with divalproex, doses of lamotrigine should be lowered because serum levels are increased. When used in conjunction with carbamazepine, higher doses of lamotrigine may be needed because serum levels are decreased.

Overdoses can be serious. Lamotrigine is identified by the FDA as category C for pregnancy; however it is becoming the anticonvulsant mood stabilizer of choice during pregnancy as studies have shown rates of birth defects with its use to be similar to that of the general population (Cunnington and Tennis, 2005).

Carbamazepine (Tegretol, Equetro) is another FDA-approved agent for the treatment of bipolar disorder. It has its peak effects within 10 days of administration and is used either alone or in combination with other drugs. Side effects include drowsiness, dizziness, ataxia, double vision, blurred vision, nausea, and fatigue. Less common are gastrointestinal upset and a variety of skin reactions occasionally requiring discontinuation of the drug. A temporary, benign 25% decrease in the white blood cell count does not require discontinuation.

Because carbamazepine induces the CYP-450 liver enzyme system, it could cause a decrease in serum concentrations of other anticonvulsants, BZs, anticoagulants, and oral contraceptives, causing a decrease in effectiveness of these drugs. A rare but serious side effect is carbamazepine-induced **agranulocytosis,** a significant decrease in the white blood cell count that does not return to normal. Blood cell and platelet counts and hepatic and renal function tests are taken at baseline and intermittently throughout treatment.

Carbamazepine can be lethal in overdose. It is not recommended during pregnancy, and should not be used in patients with other medical illnesses, such as diabetes and bone marrow suppression.

Oxcarbazepine (Trileptal) does not appear to induce liver enzymes as much and generally is better tolerated. Although it is not being actively studied in large-scale trials for the treatment of bipolar disorder, some practitioners have begun to use it for that purpose instead of carbamazepine. It remains to be seen whether evidence-based data will support this practice.

Two other anticonvulsants are popular in the treatment of bipolar disorder. They are topiramate (Topamax) and tiagabine (Gabitril). Although few systematic double-blind studies to date have assessed the safety and efficacy of these drugs in the treatment of bipolar disorder, they have reportedly been successful in treating mixed states and rapid cycling in people who have not received adequate benefit from—or are intolerant of—lithium, carbamazepine, or valproic acid.

Topiramate is the only anticonvulsant mood stabilizer not associated with weight gain and in fact is associated with weight loss in up to 50% of patients. Tiagabine has mixed results thus far in open label studies. More controlled studies are needed to document the safety and efficacy profiles of these drugs in the treatment of bipolar disorder.

Atypical Antipsychotics

The atypical antipsychotics aripiprazole, olanzapine, quetiapine, risperidone, and ziprasidone all have FDA approval for treatment of acute mania in bipolar disorder

and are becoming more first-line treatments because of the side effect profile and tolerability compared with other mood stabilizers.

Off-label clinical practice and research are showing these medications to be effective for depressive episodes associated with bipolar disorder as well as maintenance therapy for bipolar disorder (preventing and increasing the time between acute manic and depressive episodes). One advantage to adding another entire class of drugs as treatments for a disorder is that it enables the prescriber to better fit a patient's individual needs to a greater selection of more diverse and hopefully more effective treatments.

Benzodiazepines

BZs have benefits in the treatment of acute mania. Use of BZs allows for rapid induction of sleep with earlier resolution of mania without necessitating high dosages of antipsychotic medications in the acute phase. Given the symptoms of bipolar disorder, the clinician should monitor the bipolar patient taking BZs carefully for multiple substance use and poor judgment that BZs may exacerbate.

Calcium Channel Blockers

Dysregulation of intracellular calcium may be involved in some affective disorders, and this has led to the investigation of a class of drugs primarily used to treat hypertension, angina, and supraventricular arrhythmias. Calcium channel blockers (verapamil, nifedipine, nimodipine) modulate mood by inhibiting calcium channels in the postsynaptic neuron, affecting the noradrenergic neurotransmitter system, and are used primarily when other mood stabilizers have failed.

This action is similar to that of lithium, and these drugs have shown benefits similar to those of lithium in clinical use. Clinicians are using them for bipolar disorder in some patients. Patients who have responded well to lithium are likely to also respond to calcium channel blockers.

Calcium channel blockers may be best used in bipolar patients with hypertension or supraventricular arrhythmias or for pregnant bipolar patients because the teratogenic risk is much lower than that in standard mood-stabilizing agents. Side effects include dizziness, headache, and nausea. Serious but rare side effects include malignant arrhythmias, hepatotoxicity, severe hypotension, and syncope.

ANTIPSYCHOTIC DRUGS

The original drugs from the 1950s used to treat psychosis are called "typical" or "conventional" antipsychotic drugs. They revolutionized the treatment of schizophrenia and other psychotic disorders.

The newer, or second-generation, antipsychotic drugs from the 1990s are called "atypical" or "novel" antipsychotic drugs and offer a different pharmacological mechanism of action, an expanded spectrum of therapeutic effectiveness, and a different side effect profile. They are often considered first-line choices by many clinicians for the treatment of psychotic and bipolar disorders.

However, a large clinical trial comparing the effectiveness of one typical and four atypical antipsychotics found that the typical and atypical antipsychotics had similar effectiveness. A disappointing finding was that 74% of the patients discontinued their medicine within a few months and many left the trial before trying other options (Lieberman et al, 2005).

The major uses for antipsychotic drugs are in the treatment of schizophrenia, schizoaffective disorder, organic brain syndrome with psychosis, delusional disorder, and bipolar disorders, in both acute and maintenance regimens (Chapter 20). Several atypical drugs have been approved for the treatment of agitation associated with Alzheimer disease and for bipolar disorder.

Short-term use may be indicated in severe depression with psychotic features and in substance-induced psychosis. Antipsychotic drugs also treat the aggressiveness and behavioral problems seen in patients with pervasive developmental disorders and in elderly patients with dementia and delirium with agitation and psychosis. They also decrease the vocal tics in Tourette syndrome. The antipsychotic drugs are listed in Table 26-15.

The clinical symptoms of psychosis that are considered the major target symptoms for pharmacotherapy with the antipsychotic drugs are listed in Box 26-15. The initial nursing treatment plan should address target symptoms; selection of drug, dose, response, and observed side effects and their treatment; and patient safety, education, and reassurance.

Although the relationship the nurse establishes with the patient who is psychotic forms the basis for an ongoing therapeutic alliance, active nonpharmacological treatment of the residual symptoms of psychosis is more successful when the patient's behavior, mood, and thought processes begin to show improvement with pharmacotherapy.

Atypical Antipsychotics

All the atypical drugs exert blocking effects at the dopamine$_2$ (D_2) and serotonin$_2$ (5-HT_2) postsynaptic receptors. Thus they are DA and 5-HT antagonists. Aripiprazole is unique in that it is the first of a new generation of atypical antipsychotics, a dopamine-serotonin stabilizer. It is a partial agonist (enhancer) at D_2 and 5-HT_{1A} receptors and has antagonistic (blocking) activity at 5-HT_{2A} receptors.

Like the typical antipsychotics, the atypical antipsychotics improve the positive symptoms of schizophrenia, but unlike the typical drugs, they also improve the negative symptoms. Atypical drugs are reported to treat mood symptoms, hostility, violence, suicidal behavior, difficulty with socialization, and the cognitive impairment seen in schizophrenia (Howland, 2011b).

The atypical drugs have two important disadvantages:

- **They can result in metabolic syndrome with problems related to weight gain, diabetes, and dyslipidemia, often resulting in cardiovascular disease.**
- **They cost considerably more than the typical antipsychotics.**

TABLE 26-15 ATYPICAL ANTIPSYCHOTIC AND TYPICAL ANTIPSYCHOTIC DRUGS

GENERIC NAME (TRADE NAME)	THERAPEUTIC EQUIVALENT (POTENCY, mg)	HALF-LIFE (hr)	USUAL ADULT DAILY DOSE: RANGE (mg)*†	PREPARATIONS
Atypical Antipsychotic Drugs				
Aripiprazole (Abilify)	5	50-80	5-30	PO, IM, L
Asenapine (Saphris)	2.5-5	24	10-20	ODT
Clozapine (Clozaril)	50	8-12	100-900	PO, ODT
Iloperidone (Fanapt)	1	18-33	12-24	PO
Lurasidone (Latuda)	40	18	40-80	PO
Olanzapine (Zyprexa, Zydis)	5	27	5-20	PO, ODT, IM
Paliperidone (Invega)	1	23	3-12	PO
Risperidone (Risperdal Consta, M-Tabs)	0.5	3-24	1-8 (25-50 mg L-A/2 wk)	PO, L, L-A, ODT
Quetiapine (Seroquel)	50-100	7	150-750	PO
Ziprasidone (Geodon)	40	5	40-160	PO, IM, L
Typical Antipsychotic Drugs				
Phenothiazines				
Chlorpromazine (Thorazine)	100	23-37	200-1000	PO, IM, L, Sup
Thioridazine (Mellaril)	100	24-36	200-800‡	PO, IM, L
Mesoridazine (Serentil)	50	24-42	75-300	PO, IM, L
Perphenazine (Trilafon)	10	9	8-32	PO, IM, L
Trifluoperazine (Stelazine)	5	24	5-20	PO, IM, L
Fluphenazine (Prolixin)	2	22	2-60	PO, IM, L, L-A
Fluphenazine decanoate (Prolixin D)	0.25 mL/mo	q2-3 weeks	12.5-50 q2-4 weeks	L-A
Thioxanthene				
Thiothixene (Navane)	4	34	5-30	PO, L, IM
Butyrophenones				
Haloperidol (Haldol)	2	24	2-20*	PO, IM, L
Haloperidol decanoate (Haldol D)	50-300	3 weeks	50-300 q3-4 weeks	L-A
Dibenzoxazepine				
Loxapine (Loxitane)	10	4	20-100	PO, IM, L
Diphenylbutylpiperidine				
Pimozide (Orap)	2	55	2-6	PO

*Dose is for PO unless noted.
†Dose range varies by patient and should be individualized.
‡Upper limit to avoid retinopathy.
IM, Intramuscular injection; *L,* oral liquid, elixir; *L-A,* long-acting injectable preparation; *ODT,* orally disintegrating tablets; *PO,* oral tablet, capsule; *Sup,* suppository.

Cost/benefit analyses suggest that the cost may be outweighed by the improved effectiveness and quality of life experienced by patients taking these drugs. Costs estimates would rise, however, if problems associated with weight gain, diabetes and cardiovascular disease were considered.

Although the atypical drugs are similar in their effectiveness compared with each other, they differ in side effects (Table 26-16) because of their different receptor-binding profiles (Schatzberg et al, 2010):

- Risperidone tends to **elevate serum prolactin levels** and may cause extrapyramidal symptoms (EPS) at higher doses.
- Weight gain and **metabolic disturbances** are common and problematical side effects of these drugs (with the probable exception of ziprasidone and aripiprazole). Olanzapine and clozapine seem to have the highest likelihood of causing these problems. Educational interventions can help patients minimize weight gain.
- **Sedation** is commonly observed in patients taking quetiapine, olanzapine, or clozapine.
- Because ziprasidone has been associated with **mild to moderate Q–T interval** (corrected for heart rate [Q–Tc]) **prolongation** in up to 5% of patients, if given to patients with a current or past history of cardiac disease, careful monitoring of ECGs and cardiac functioning is necessary.

BOX 26-15 TARGET SYMPTOMS FOR ANTIPSYCHOTIC DRUGS

Typical and Atypical Antipsychotics

Positive Symptoms: An Excess or Distortion of Normal Function*

Psychotic disorders of thinking

- Delusions (somatic, grandiose, religious, nihilistic, or persecutory themes)
- Hallucinations (auditory, visual, tactile, gustatory, olfactory)

Disorganization of speech and behavior

- Positive formal thought disorder (incoherence, derailment, illogicality)
- Bizarre behavior (catatonic motor behaviors, disorders of movement, deterioration of social behavior)

Atypical Antipsychotics

Negative Symptoms: A Diminution or Loss of Normal Function†

- Affective flattening: limited range and intensity of emotional expression
- Alogia: restricted thought and speech
- Avolition/apathy: lack of initiation of goal-directed behavior
- Anhedonia/asociality: inability to experience pleasure or maintain social contacts
- Attentional impairment: inability to mentally focus

Mood Symptoms, Cognitive Impairment, and Difficulty with Socialization

*Responsive to traditional and atypical antipsychotics.
†Unresponsive to traditional antipsychotics, responsive to atypical antipsychotics.

- Clozapine is often reserved for patients with treatment-resistant illness because of its side effects of **agranulocytosis, seizures, and myocarditis.** Prescribers must follow a treatment protocol that includes entering patients in a national registry, monitoring white blood cell count weekly for 6 months and then biweekly for as long as patients are taking the drug, and writing prescriptions for only 1 to 2 weeks at a time. For the refractory patient, however, clozapine may make a significant difference in treatment outcome.
- An FDA warning was issued about possible **severe allergic reaction including anaphylaxis** to Saphris in 2011.

Although these drugs offer some relief from many symptoms of schizophrenia, patients taking them often need help with other aspects of their psychosocial functioning. Psychoeducation, social skills training, group support, and other rehabilitative interventions are beneficial in improving their overall level of functioning and quality of life (Chapter 14).

Critical Reasoning How would you help a patient and family evaluate the risk/benefit ratio for clozapine treatment?

Typical Antipsychotics

The typical antipsychotic drugs are predominantly dopamine (DA) antagonists. They block postsynaptic D_2 receptors in several DA tracts in the brain, accounting for a decrease in positive symptoms of schizophrenia (see Box 26-15) as well as EPS. They have other synaptic effects in other transmitter systems, accounting for their broad side effect profile. Thus selection of a drug is determined by the extent, type, and severity of side effects.

For example, a low-potency drug such as chlorpromazine can reduce the risk of EPS, and a high-potency drug such as haloperidol can minimize postural hypotension, sedation, and anticholinergic effects (Table 26-17). These typical antipsychotics are equally effective in treating the positive symptoms but are less effective in treating the negative symptoms as compared with atypical antipsychotics. In addition, they have not been particularly effective in treating cognitive impairment and mood symptoms, the other symptom dimensions of schizophrenia.

The side effects of antipsychotic drugs and treatment considerations are listed in Table 26-18. Side effects can range from merely uncomfortable and easily treated to a life-threatening emergency.

Extrapyramidal symptoms (EPS) and tardive dyskinesia are side effects of the typical antipsychotic drugs. They often result in patient nonadherence with drug regimens (Box 26-16).

- Most EPS side effects are common and are often painful and disabling. They are also stigmatizing but usually can be prevented or minimized and effectively treated. Drug strategies to treat EPS include lowering the dose of the drug, changing to a drug with a lower incidence of that extrapyramidal symptom, or administering one of the drugs in Table 26-19.
- Tardive dyskinesia is different because no effective treatment has been found to date (Howland, 2011c,d).

A rare but potentially fatal (14% to 30% mortality) side effect of antipsychotic drugs is neuroleptic malignant syndrome (NMS) (Box 26-17)**.** Symptoms of NMS include fever, tachycardia, sweating, muscle rigidity, tremor, incontinence, and stupor. **Treatment for NMS includes stopping the triggering drug and initiating supportive care** (Strawn et al, 2008; Agar, 2010).

It is important to minimize the patient's fears, decrease any sense of stigmatization, and enhance adherence to drug treatment through effective patient education, support, and intensive and comprehensive medication management. Because of the importance in managing patients taking psychotropic medications and the side effects they cause, medication-induced movement disorders are coded on Axis I of the *DSM-IV-TR* (APA, 2000).

General Pharmacological Principles

Dosage requirements for individual patients vary considerably and must be adjusted as the target symptoms change and side effects are monitored. Some patients begin to respond to the sedating effects of the typical drugs in 2 to 3 days, and some take as long as 2 weeks. Full benefits may take 4 or more weeks.

The atypical drugs may begin to work in 1 week but take several months to reach maximum efficacy. Thus the patient,

TABLE 26-16 COMPARISON OF TYPICAL AND ATYPICAL ANTIPSYCHOTIC DRUGS

CLINICAL EFFICACY	TYPICAL ANTIPSYCHOTICS	CLOZAPINE	RISPERIDONE	OLANZAPINE	QUETIAPINE	ZIPRASIDONE	ARIPIPRAZOLE
Dosage (mg/day)	Various	25-600	2-8	5-20	150-750	80-160	5-30
Acute psychosis overall	+++	+++	+++	+++	+++	+++	+++
Acute positive symptoms	+++	+++	+++	+++	+++	+++	+++
Acute negative symptoms	+	+++	+++	+++	+++	+++	+++
Treatment-refractory psychosis	0	++	?	?	?	?	?

Side Effect Profile of Typical Antipsychotics

Agitation	+ to ++
Agranulocytosis	Rare
Anticholinergic effects	+ to +++
EPS	+ to +++
Dose-related increase in EPS	Yes
Nausea/dyspepsia	+
Orthostatic hypotension	+ to +++
Elevation of prolactin levels	+ to ++
Sedation	++ to +++
Seizures	+
Tardive dyskinesia	+++

Side Effect Profile of Atypical Antipsychotics

	SEDATION	EPS	WEIGHT GAIN
Clozapine	High	Low	High
Risperidone	Low	Low	Moderate
Olanzapine	High	Low	High
Quetiapine	Moderate	Low	Moderate
Ziprasidone	Low	Low	Low
Aripiprazole	Low	Low	Low

Data from Fuller MA, Sajatovic M: *Drug information handbook for psychiatry: a comprehensive reference of psychotropic, nonpsychotropic, and herbal agents,* ed 7, Hudson, Ohio, 2009, Lexi-Comp.
EPS, Extrapyramidal symptoms.
Efficacy: +, mild; ++, moderate; +++, marked; +/-, minimal; ?, uncertain; 0, none.
Side effects: +, mild; ++, moderate; +++, marked; +/-, minimal; ?, uncertain; 0, none.

TABLE 26-17 ACUTE SIDE EFFECT PROFILE: ANTIPSYCHOTIC DRUGS

DRUGS	SEDATION	EXTRAPYRAMIDAL SYMPTOMS	ANTICHOLINERGIC EFFECTS	POSTURAL HYPOTENSION
Low Potency				
Chlorpromazine	4	2	3	4
Thioridazine	4	1	4	4
Clozapine	4	1	4	3
Olanzapine	2	0	2	2
High Potency				
Trifluoperazine	2	3	2	2
Thiothixene	2	3	2	1
Loxapine	2	3	2	2
Mesoridazine	3	2	3	3
Perphenazine	2	3	2	2
Fluphenazine	1	4	2	1
Haloperidol	1	4	1	1
Risperidone	2	1	1	2

1, Lowest incidence; *4,* highest incidence.

TABLE 26-18 NURSING CONSIDERATIONS FOR ANTIPSYCHOTIC DRUG SIDE EFFECTS

SIDE EFFECTS	NURSING CARE AND TEACHING CONSIDERATIONS
Central Nervous System	
Extrapyramidal symptoms (EPS)	General treatment principles: Tolerance usually develops by the third month. Decrease dose of drug. Add a drug to treat EPS; then taper after 3 months on the antipsychotic. Use a drug with a lower EPS profile. Give patient education and support.
Acute dystonic reactions: oculogyric crisis, torticollis	Spasms of major muscle groups of neck, back, and eyes; occur suddenly; frightening; painful; medicate—parenteral works faster than PO; have respiratory support available; more common in children and young males and with high-potency drugs. Taper dose gradually when discontinuing antipsychotic drugs to avoid withdrawal dyskinesia.
Akathisia	Cannot remain still; pacing, inner restlessness, leg aches are relieved by movement; rule out anxiety or agitation; medicate.
Parkinson syndrome: akinesia, cogwheel rigidity, fine tremor	More common in males and elderly; tolerance may not develop; medicate with DA agonist amantadine (must have good renal function).
Tardive dyskinesia (TD)	Can occur after use (usually long use) of conventional antipsychotics; stereotyped involuntary movements (tongue protrusion, lip smacking, chewing, blinking, grimacing, choreiform movements of limbs and trunk, foot tapping); if using typical antipsychotics, use preventive measures and assess often; consider changing to an atypical antipsychotic drug; there is no treatment at present for TD.
Neuroleptic malignant syndrome (NMS)*	Potentially fatal: fever, tachycardia, sweating, muscle rigidity, tremor, incontinence, stupor, leukocytosis, elevated creatine phosphokinase (CPK), renal failure; more common with high-potency drugs and in dehydrated patients; discontinue all drugs; supportive symptomatic care (hydration, renal dialysis, ventilation, and fever reduction as appropriate); can treat with dantrolene or bromocriptine; antipsychotic drugs can be cautiously reintroduced eventually.
Seizures*	Occur in approximately 1% of people taking these drugs; clozapine has a 5% rate (in patients taking 600 to 900 mg/day); may have to discontinue clozapine.
Other Side Effects	
Agranulocytosis*	This is an emergency; it develops abruptly, with fever, malaise, ulcerative sore throat, leukopenia. High incidence (1% to 2%) is associated with clozapine; must do weekly CBC and prescribe only 1 week of drug at a time; discontinue drug immediately; may need reverse isolation and antibiotics.
Photosensitivity	Use sunscreen and sunglasses; cover body with clothing.
Anticholinergic effects	Symptoms: constipation, dry mouth, blurred vision, orthostatic hypotension, tachycardia, urinary retention, nasal congestion; see Table 26-11 for nursing care.
Metabolic syndrome: weight gain, diabetes, dyslipidemia, often resulting in cardiovascular disease	Patient education on healthy lifestyle—eating, exercise, smoking cessation.

*Potentially life threatening.
CBC, Complete blood count; *DA,* dopamine; *PO,* oral tablet/capsule.

BOX 26-16 EPS AND TARDIVE DYSKINESIA

- Extrapyramidal symptoms are divided into two categories:
  - Dyskinesias are movement disorders.
  - Dystonias are muscle tension disorders.
- Dyskinesias are movement disorders and can include any of a number of repetitive, involuntary, and purposeless body or facial movements:
  - Tongue movements, such as "tongue thrusts" or "fly-catching" movements
  - Lip smacking
  - Finger movements
  - Eye blinking
  - Movements of the arms or legs.
- An individual may or may not be aware of these movements.
- These movements are recognizable, and many people fear that others will know they are taking an antipsychotic medication due to these unusual movements.
- **Tardive dyskinesia** symptoms appear during long-term treatment (often after several years) with an antipsychotic. They are more likely to be permanent even after the medication is stopped.

TABLE 26-19 DRUGS TO TREAT EXTRAPYRAMIDAL SIDE EFFECTS

GENERIC NAME (TRADE NAME)	ADULT DOSAGE RANGE (mg/day)	PREPARATIONS
Anticholinergics		
Benztropine (Cogentin)	2-6	PO, IM
Trihexyphenidyl (Artane)	4-15	PO, L
Biperiden (Akineton)	2-8	PO
Antihistamine		
Diphenhydramine (Benadryl)	50-300	PO, IM, L
Dopamine Agonist		
Amantadine (Symmetrel)	100-300	PO, L
Benzodiazepines		
Diazepam (Valium)	2-6	PO, IV
Lorazepam (Ativan)	0.5-2	PO, IM
Clonazepam (Klonopin)	1-4	PO

IM, Intramuscular; *IV,* intravenously; *L,* oral liquid; *PO,* oral tablet/capsule.

family, and clinician must not increase the dose prematurely because this strategy usually increases side effects and not effectiveness. A brief course of a BZ may help the patient maintain control during this time.

BOX 26-17 NEUROLEPTIC MALIGNANT SYNDROME (NMS)

NMS is a life-threatening neurological disorder most often caused by an adverse reaction to neuroleptic or antipsychotic drugs.

Symptoms

- Fever—greater than 100.4° F
- Tachycardia
- Confused or altered consciousness
- Diaphoresis/sweating
- Rigid muscles
- Tremor
- Incontinence
- Autonomic imbalance

Treatment

- NMS is an emergency, and can lead to death if untreated.
- Stop neuroleptic drugs.
- Treat the hyperthermia aggressively, such as with cooling blankets or ice packs to the axillae and groin.
- Many cases require intensive care and circulatory and ventilatory support.
- Benzodiazepines, dantrolene, and dopaminergic agents can be used to treat NMS.
- If it is recognized early enough, NMS is not fatal, but 10% of cases do result in patient death.

A patient who is unresponsive to an adequate antipsychotic trial often responds to another antipsychotic drug, so a second trial is given. Clozapine is usually considered only after a second trial failure (at which point the patient is considered treatment resistant), particularly if the patient failed to respond to the atypical drugs. To avoid destabilizing the patient when switching from one antipsychotic to another, one drug is gradually decreased while the new drug is gradually increased **(cross-titration),** usually by 25% each for 2 to 4 days.

Several typical (e.g., haloperidol) and atypical (e.g., ziprasidone, olanzapine) antipsychotic drugs have a short-acting injectable preparation and can be administered by intramuscular routes for use in acutely agitated patients. This approach often provides relief for the acutely ill patient while the oral formulations begin to work or until the acute crisis is resolved.

For maintenance treatment of the patient who is unable to adhere adequately to a daily dosing regimen, several long-acting injectable preparations (haloperidol decanoate, fluphenazine decanoate, risperidone [Risperdal Consta], paliperidone [Invega Sustenna]) of both the typical and atypical drugs are available (see Table 26-15). The patient's ability to tolerate these drugs should be tested first by administering the oral form for several days before administering an injection of a drug that may last for many weeks.

The antipsychotic drugs should be tapered slowly over several days to weeks to avoid dyskinetic reactions and some rebound side effects and because precipitous discontinuation is associated with increased risk for relapse.

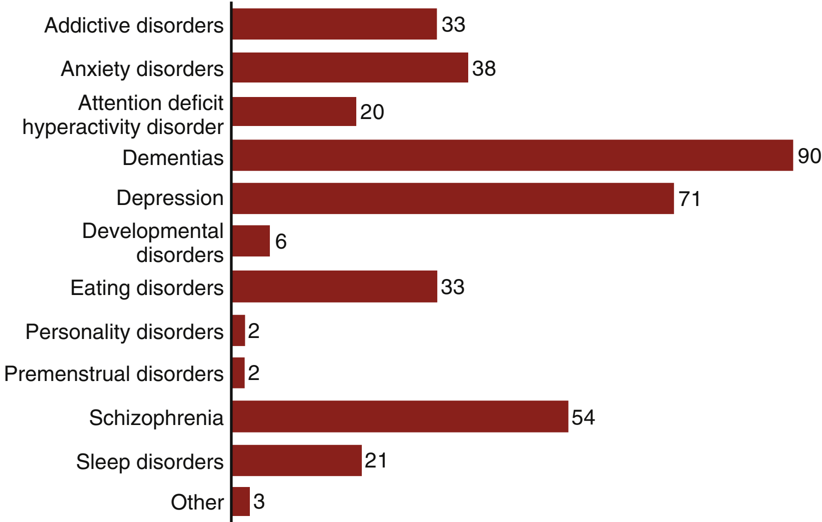


FIG 26-2 Medicines in development for mental illnesses. Some medicines are in development for more than one disorder. (From Pharmaceutical Research and Manufacturers of America, Washington, DC, 2010.)

Antipsychotic drugs do not cause chemical dependency, and tolerance to their antipsychotic effects does not develop. They have a very low abuse potential, and they are relatively safe in overdose. The effects of antipsychotics on the fetus are inconclusive, although what is best for a psychotic pregnant mother must be carefully considered.

The nurse should remain up-to-date with the treatment approaches for psychotic disorders to provide the best care for these patients. Over the next few years additional third-generation and even fourth- and fifth-generation antipsychotic drugs are likely to be available, which will again revolutionize the treatment of psychosis. In the near future, as it becomes more feasible to accurately identify individuals who are vulnerable to schizophrenia, the currently controversial proposal of preventing psychosis in vulnerable individuals by pretreating them with atypical antipsychotic drugs may become common clinical practice.

FUTURE DEVELOPMENTS

New Psychopharmacological Agents

Currently, over 300 medicines for psychiatric illnesses are in development (Figure 26-2). It is important to evaluate new drugs very carefully as they come into clinical use. The nurse should determine the advantages and disadvantages of a new drug as compared with the standard drugs in that class and in relation to the patient's reactions and preferences.

The following list is a partial guide to help evaluate new drugs. Ask whether a new drug, compared with current drugs, has the following:

- A different mechanism of action that is more specific to the desired biological actions
- Quicker onset of action
- Fewer drug interactions
- A lower side effect profile
- No addictive or abuse potential
- No long-term adverse effects
- No suicide potential
- Permanent or curative effects on neurotransmitter regulation
- Several routes of administration
- A wide therapeutic index
- Fewer discontinuation problems
- Advantage in cost-effectiveness

The drug development and approval process includes the following steps:

- Preclinical testing: laboratory and animal studies to assess biological activity and safety
- Phase I: safety and dosage studies of healthy volunteers
- Phase II: small trials designed to evaluate effectiveness and look for side effects
- Phase III: final phase of experimental drug testing designed to confirm effectiveness and monitor adverse reactions from long-term use
- IND application filed: all study results submitted to the FDA for drug approval
- Phase IV: postmarketing studies to support the indication and document safety of the drug over time

The next decade should bring a variety of other new approaches to the pharmacological treatment of depression.

Genomics

In the foreseeable future, gene research will make it possible to provide gene therapy that can prevent illness and diagnostic tests that can genetically identify persons at risk (Figure 26-3). Pharmacogenomics will make it possible to predict which drug will be most effective and produce the fewest side effects for any given individual, and new drugs will be developed that specifically target brain receptors for focused treatments (Schatzberg et al, 2010; Ma and Lu, 2011).

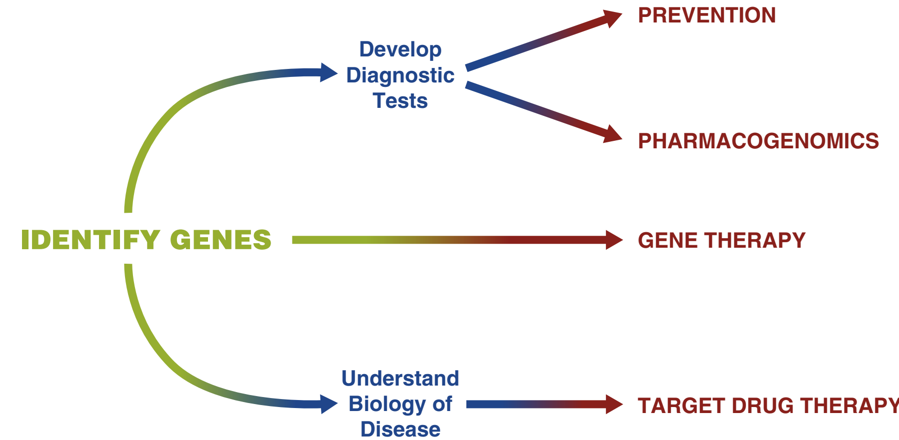


FIG 26-3 Gene discovery: new avenues to prevention and treatment. (From Collins F: *NAMI Advocate*, p 29, Summer/Fall, 2003.)

PSYCHIATRIC NURSING PRACTICE

The psychiatric nurse should make use of the best evidence and current clinical guidelines to stay up-to-date on emerging theories and treatments for psychiatric illnesses. In addition, the safe practice of clinical psychopharmacology requires that nurses have competencies in diagnosis and biological assessment, as well as knowledge of available drugs and the design of medication regimens. Nurses should also have competence in prescriptive practice at the advanced level.

Other important aspects of the psychiatric nurse's role are the ability to provide patient education regarding medications and the ability to identify side effects and then appropriately intervene to stop or reduce the side effects experienced by patients as a result of their medication regimens.

Documentation

In addition to routine documentation of pharmacological activities, the following categories of information are particularly important to document when working with psychiatric patients:

- Drugs administered outside usual recommended levels
- Rationale for medication or dose changes
- Drugs used for indications other than those approved by the FDA
- Continued use of a drug that is causing clinically significant side effects
- Co-administration, augmentation, and polypharmacy rationale
- Patient and family knowledge, attitudes, and preferences

Patient Education

Patients taking psychotropic drugs must be knowledgeable about them. Serious consequences can result from not adhering to what may appear to the patient as minor changes in some of the instructions for drug use, such as skipping medication one day, eating cheese, or failing to recognize certain side effects.

Patients and their families need thorough and ongoing instruction on psychotropic drug treatment. Nursing programs focused on patient education need to address essential elements, such as missed medication doses, focus on self-management, and recording symptom improvement and side effects.

> **Critical Reasoning** Many chronically mentally ill people have social workers as their case managers. What skills and knowledge would psychiatric nurses bring to this patient population that differ from those of social workers?

Patient Assistance Programs

Because of limitations on health care coverage for persons with psychiatric diagnoses and rising health care costs in general—including the increased expense of newer drugs and long-term maintenance therapy regimens—patients are finding it more difficult to afford their medications. In addition, many psychiatric patients are unable to earn a living unless they are on successful treatment regimens, including psychopharmacology.

An important part of the nursing role is to assist with this problem by educating the patient about patient assistance programs (PAPs) offered by many pharmaceutical companies. These programs have limitations, and they cannot provide assistance to all patients, but they can be of great assistance to those who qualify.

Although each manufacturer has different requirements, most programs require an application either from the patient or the prescriber documenting the patient's financial status and need for the drug. Some patients who qualify for Medicaid, have private insurance, or exceed the income cap may be ineligible. More detailed information can be obtained by calling the drug manufacturers or by going to their websites. Two resource listings of available patient assistance programs are available at the following websites:

- www.needymeds.com
- www.pparx.org

BOX 26-18 RISK FACTORS FOR PATIENT MEDICATION NONADHERENCE

- Failure of clinician to form a therapeutic alliance with the patient
- Devaluation of pharmacotherapy by treatment staff
- Inadequate patient and family education regarding treatment
- Poorly controlled side effects
- Insensitivity to patient's beliefs, wishes, complaints, or opposition to the idea of taking medication
- Multiple daily dosing schedule
- Polypharmacy
- History of nonadherence
- Social isolation
- Expense of drugs
- Failure of clinician to appreciate patient's role in drug treatment plan
- Lack of continuity of care
- Increased restrictions on patient's lifestyle
- Unsupportive significant others
- Remission of target symptoms
- Increased suicidal ideation
- Increased suspiciousness
- Unrealistic expectations of drug effects
- Concurrent substance use
- Failure to target residual symptoms for nonpharmacological therapies
- Relapse or exacerbation of clinical syndrome
- Failure to alleviate intrafamilial and environmental stressors that precipitate symptoms
- Potential for stigmatization
- Bothered by the idea of chronic illness

TABLE 26-20 INTERVENTIONS TO IMPROVE PATIENT MEDICATION ADHERENCE

PROBLEM	INTERVENTIONS
Lack of a mutual treatment plan	Elicit the patient's understanding of reason for taking the medication.
Explore patient's understanding of one's diagnosis	Align taking the medication with the self-identified goals of the patient.
Negative beliefs about taking medication	Ask, "What does taking medicine mean to you?" Acknowledge possible medication adverse effects. Encourage patient to persist through mild side effects. Compare medication side effects with those of treatments for other illnesses (i.e., cancer, pulmonary disease, etc.). Provide objective information about the medicine as well as the experience of other patients who have taken it.
Lack of insight	Help patient identify the early signs of illness. Encourage patient to consider what life is like with and without the medication. Suggest that the patient ask a trusted family member or friend how the patient is different with and without the medication.
Forgetting to take the medication	Help the patient set up a medication routine and stick with it. Suggest setting an alarm clock to go off when it is time to take the medication. Encourage patients to keep the medicine in a place they see every day—bathroom sink, bedside table. Provide a medication organizer to divide medicine by dose and day.

Promoting Patient Adherence and Compliance

Patients who do not take their medications as prescribed or who do not recognize warning signs of illness exacerbation or drug side effects are at risk for unsuccessful results, adverse reactions, and poor quality of life. Poor medication compliance in psychiatric treatment is a major problem that contributes to prolonging the effects of illness and the economic cost of the illness.

The threats to patient adherence are many. Some of them come from the mental health team, others from the patient or family, and still others reflect a shared failure of the therapeutic alliance. Nurses, patients, and families should work together to minimize misunderstandings and unnecessarily complex medication regimens.

Too often clinicians blame patients for nonadherence without completing the following:

- Fully evaluating the treatment plan from the patient's perspective
- Aligning the treatment plan with the patient's life goals (rather than the clinician's goals)
- Designing the treatment plan based on all aspects of the patient's life, rather than merely the reduction of symptoms
- Understanding the patient's reasons for nonadherence

Shared decision making about treatment is preferred by patients**. Lack of shared decision making often results in lack of compliance to the medication treatment**. Other risk factors for potential patient nonadherence are listed in Box 26-18. Understanding this issue from the patient's perspective will allow the nurse to anticipate problems and design nursing interventions that can target areas of potential difficulty.

Effective medication management includes the following:

- **Using a systematic approach to medications based on current treatment guidelines**
- **Involving patients and families or other support systems in the decision-making process**

- **Treating all symptoms with a specific plan and in the context of the patient's life**
- **Using the simplest medication regimen possible**
- **Identifying specific strategies to promote adherence**
- **Monitoring results and documenting and adjusting medications as necessary**

Interventions to improve patient medication adherence are listed in Table 26-20. Patients should be encouraged to discuss their questions, fears, problems, and concerns about medication before treatment is initiated and during the course of treatment.

The nurse should realize that in addition to the quality of the nurse-patient relationship and the strength of the therapeutic alliance, understanding an individual patient's reasons for nonadherence plays an extremely important role in whether a patient will adhere to a pharmacological treatment plan and be successful in the recovery process.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Diana Laikam, MS, RN, CS

Henry David Thoreau wrote: "If one advances confidently in the direction of his dreams, and endeavors to lead the life which he imagined, he will meet with a success unexpected in common hours." Thirty years ago I confidently began my sojourn into the field of nursing. The journey led to my role as a psychiatric clinical nurse specialist with prescriptive authority. From the beginning of my practice as a psychiatric nurse, I have known that working with the severely and persistently mentally ill was to be my life's work.

Psychotropic medications are the primary means of treating the symptoms of these illnesses. The medication treatment goals for my patients include managing, reducing, and eliminating symptoms; obtaining partial or complete remission; preventing relapse symptoms; and minimizing treating side effects. I have learned over time that medication compliance is critical if the severely mentally ill patient is to avoid hospitalization. And I have had some success in this area.

One such success involved Mr. M, a 40-year-old man with a diagnosis of bipolar affective disorder, recurrent. Throughout his 20-year history of mood lability, he had been prescribed many antipsychotic and mood-stabilizing drugs. Most of his hospitalizations occurred as a result of medication noncompliance. He was referred to me on discharge from the inpatient psychiatric unit for medication monitoring, and I readily accepted the challenge.

My first glance at Mr. M was of him sitting in the waiting area before his appointment with me. He had a large, crumpled, brown paper bag at his feet. An anxious Mr. M brought the brown bag into my office. The bag contained 22 bottles of assorted medications. He told me that he was feeling much better but that his medications had all been changed while he was an inpatient. He was confused regarding the names of the medications, the dosages he should take, and the times that he should take the medications. Some of the medicines were for his medical illnesses and some for his psychiatric illness.

As the appointment progressed, it became clear to me that even after sorting out the medications and explaining how to take them, Mr. M was still feeling overwhelmed. With his involvement, a plan evolved. Prescriptions were rewritten with medication names he recognized (brand rather than generic) and, whenever possible, prescribed at times convenient to his daily routine. Medication information was transferred to a sheet of paper so he could read which medication to take and when to take it. He found this particularly helpful because he could not read the small print on the bottles. A medication reminder was to be filled weekly with my assistance until he could manage his own medication.

A year has passed. Medication treatment goals have been met. Mr. M is quite proud that he now takes his medication in an organized way without a medication reminder. He is very aware of subtle changes in his mental status and knows how to observe for side effects. Most importantly, he has not required hospitalization. So each day Mr. M's spirit rejuvenates me in a very real way as I proceed in the direction of my dreams—practicing the profession I love.

CHAPTER IN REVIEW

- Psychopharmacology is an established standard in the treatment of mental illness, and the psychiatric nurse makes a unique contribution to the implementation of this important modality.
- Various principles of psychopharmacology relate to pharmacokinetics, pharmacodynamics, drug co-administration, and the role of neurotransmitters in the development of psychiatric disorders.
- Benzodiazepines, the most widely prescribed class of drugs, have almost completely replaced the class of barbiturates as antianxiety and sedative-hypnotic agents. They are therapeutic and have a wide margin of safety in overdose. They can be addictive, especially when taken in high doses over a long time. Common side effects include drowsiness, dizziness, slurred speech, and blurred vision.

CHAPTER IN REVIEW—cont'd

- Antidepressant drugs are effective and nonaddicting, but some can be lethal in overdose. Tricyclic antidepressants, selective serotonin reuptake inhibitors, and some newer drugs are more commonly used than monoamine oxidase inhibitors because they are safer in combination with other substances. Many of them are now first-line treatments for several anxiety disorders as well. Side effects of antidepressants are usually mild.
- The mood stabilizers include lithium, a range of anticonvulsants, atypical antipsychotics, and calcium channel blockers. These classes of drugs are not addictive, but several of them can be toxic. This requires that patients be well educated concerning the effects of these drugs and that laboratory values be closely monitored.
- The various classes of typical antipsychotic drugs have similar therapeutic effects but are dissimilar in side effect profiles. Side effects are varied and can be disabling and life threatening. The newer atypical antipsychotic agents offer a different pharmacological mechanism of action, an expanded spectrum of therapeutic effectiveness, and a generally more acceptable side effect profile.
- New psychopharmacological agents are being tested in clinical drug trials throughout the United States. Many of them will benefit patients with psychiatric illness.
- The findings from genomics research will change the future of drug discovery and psychopharmacology forever. With the complete decoding of all the genes that make up a human, researchers will have almost unlimited targets for drug development.
- Important issues related to psychopharmacology and psychiatric nursing practice includes following psychopharmacology guidelines, documentation, patient education, patient assistance programs, and promoting patients' adherence to their pharmacological treatment plans.

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CHAPTER

27

Behavior Change and Cognitive Interventions

Gail W. Stuart

Behavior is a mirror in which everyone displays his own image.

Johann Wolfgang von Goethe

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe behavior and behavior change strategies, including readiness to change and motivational interviewing and motivational interventions.
2. Examine the role of cognitions in adaptive and maladaptive coping responses.
3. Describe characteristics of cognitive behavioral interventions.
4. Identify elements of a cognitive behavioral assessment.
5. Apply the cognitive behavioral change interventions of cognitive restructuring and learning new behavior in nursing practice.
6. Analyze the role of the nurse in cognitive behavioral change interventions.

The goal of all nursing interventions is to help patients change in ways that promote their health and adaptive functioning. To do this, nurses must believe that change is possible and that new perspectives, behaviors, and experiences are open to evaluation and change.

Promoting health and adapting to illness often means that individuals, families, and communities must give up current behaviors and learn new ones. These changes can be related to any aspect of one's life, including exercise, eating habits, medication adherence, use of drugs, self-defeating thoughts, denial of problems, or unresolved interpersonal issues. **Behavior change is the most powerful aspect of health care.**

Research has shown that cognitive behavioral interventions are effective in reducing symptoms and relapse rates with or without medication in a wide range of clinical problems, particularly depression, anxiety, eating disorders, personality disorders, and schizophrenia (Dobson, 2010; Ledley et al, 2010). They can be used in any treatment setting and have much to contribute to nursing practice.

BEHAVIOR

Behavior is any observable, recordable, and measurable act, movement, or response. **A behavior is what is observed—not the conclusion, inferences, or interpretations drawn from the observation.** For example, hyperactivity is not a behavior but is a conclusion drawn from observing a set of behaviors. Hyperactivity cannot be measured. What can be measured is the number of times a child gets out of one's seat, interrupts a conversation, drops a book, or completes required homework assignments. Thus treatment for the child should focus not on hyperactivity but on the specific behaviors that interfere with the child's adjustment to school, home, or the community.

A clear definition of a behavior minimizes subjective interpretations. **It is measurable, not subject to interpretation, and states what the person does.** Other examples of inferences rather than behaviors are the labeling of patients as uncooperative, aggressive, difficult, noncompliant, or hostile.

These adjectives globally describe a person but do not reflect the specific behavior that led to such conclusions.

> **Critical Reasoning** Think about your experiences in psychiatric–mental health nursing. In your view, how much treatment is based on inference rather than on behavior? What impact does this have on patient adherence to treatment plans?

BEHAVIOR CHANGE STRATEGIES

Behavior change strategies apply learning theories to problems of living with the aim of helping people overcome difficulties in everyday life. These difficulties often occur along with most medical or psychiatric conditions.

Nurses can use the following principles to guide their behavior change interventions:

- **All change is self-change.** Patients are the active participants and primary agents of change. Nurses and other health care providers are the coaches, not the doers.
- **Self-efficacy is critical.** Patients need to feel that they are in control of their own lives and accept responsibility for their efforts. All patients have strengths.
- **Knowledge does not equal change.** Education is only one part of the change process. Patients need to transfer what they know into the actions they take.
- **A therapeutic alliance helps patients initiate and maintain change.** The responsive and action dimensions of the nurse-patient relationship (Chapter 2) are critical ingredients for change.
- **Hope is essential.** All effective interventions are based on the positive and hopeful expectations that life can be better (Stuart, 2010).

Behavior change strategies can be applied to school, work, home, family, and leisure activities. In these situations treatment strategies help people achieve personal growth by expanding their coping skills. **Behavior change strategies can be used by nurses with any background and in any health care setting to promote healthy coping responses and to change maladaptive behavior.**

Readiness to Change

The only reason people change their behavior is because they want to do so. Readiness to change is tied to a person's motivation or what is referred to as **motivational readiness.** A central element in increasing motivation and eventual behavioral change is to take into account the person's readiness to change. Behavior change occurs in stages over time (Prochaska et al, 1992; Center for Substance Abuse Treatment, 2008).

The first stage of change is precontemplation. In this stage people do not think that they have a problem; thus they are not likely to seek help or participate in treatment. In working with these patients the goal is to listen to the patient and create a climate in which the patient may consider, explore, or see value in the benefits of changing.

The second stage of change is contemplation. This is characterized by the notion of "yes, but." Often patients recognize that a change is needed, but they are unsure and indecisive about whether it is worth the time, effort, and energy to achieve it. They are ambivalent about what they might have to give up if they make a change. In working with these patients, the goal is to create a supportive environment in which the patient can consider changing without feeling pressured to do so. If patients are pushed to change in this phase, they are likely to actively resist.

The third stage of change is preparation. At this time the patient has made a decision to change and is assessing how that decision feels. Patients can be helped to select realistic treatment goals and different ways to reach those goals. They need to be actively involved in designing their own strategies for change.

The fourth stage of change is action. Patients now have a firm commitment to change and have identified a plan for the future. They should be offered emotional support and help in evaluating and modifying their plan of action to be successful.

The fifth stage of change is maintenance. Change continues, and focus is placed on what the patient needs to do to maintain or consolidate gains. Anticipating potential threats for relapse and developing prevention plans are essential. Any relapses should be seen as part of the change process and not as failure.

The sixth and final stage is termination. It is based on the notion that one will not engage in the old behavior under any circumstances. As such, it may be more of an ideal than an achievable stage. Most people stay in the stage of maintenance where they are aware of possible threats to their desired change and monitor what they need to do to keep the change in place.

Patients are more likely to engage in behavior change when their provider assesses their readiness for change and tailors their interventions accordingly. Table 27-1 summarizes these stages of change. Figure 27-1 shows the stages of change model applied to substance use disorders.

Motivational Interviewing

Motivation to change comes from within the individual. Without the desire or motivation to change, a person will not change one's behavior. **Motivational interviewing is a patient-centered, directive counseling method for enhancing a person's internal motivation to change by identifying, exploring, and resolving ambivalence** (Rollnick et al, 2008).

Everyone has ambivalence about changing, and there are always advantages and disadvantages to making a change. A person is motivated to change when one's values and goals conflict with one's current behavior and when the benefits of change outweigh the benefits of staying the same.

Ambivalence → Discrepancy → Behavior Change

Most people are aware of their unhealthy behaviors. Clinicians seeing these behaviors point them out and advise change; however, too often patients' natural responses are to defend themselves and resist any suggestion of change.

TABLE 27-1 STAGES OF CHANGE MODEL

STAGE OF CHANGE	CHARACTERISTICS	GOALS	TECHNIQUES
Precontemplation	Not currently considering change: "ignorance is bliss"	Raise doubt Increase awareness of the problem	Validate lack of readiness Clarify: decision is patient's Encourage reevaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "sitting on the fence" Not considering change within the next month	Tip the balance to consider making a change	Validate lack of readiness Clarify: decision is patient's Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and is trying to change: "testing the waters" Planning to act within 1 month	Help patient determine the best course of action	Identify and assist in problem solving about obstacles Help patient identify social support Verify that patient has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Help the patient take steps to change	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles Combat feelings of loss, and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior After 6 months to 5 years	Help prevent relapse	Plan for follow-up support Reinforce internal and external rewards Identify prevention strategies to avoid relapse
Termination			Support change and adaptive coping strategies

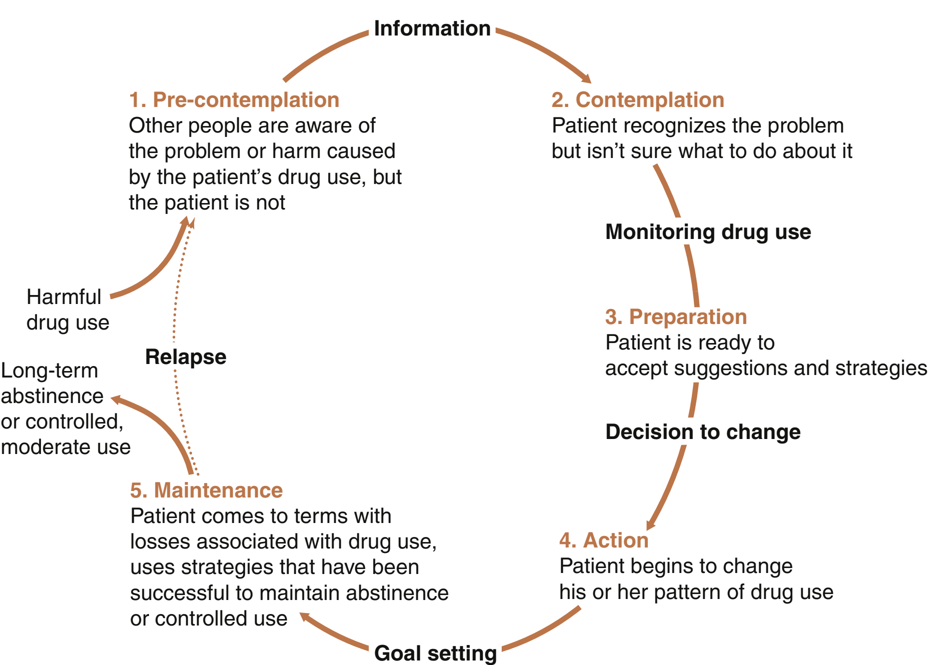

FIG 27-1 A model of change in substance use disorders. (Modified from Prochaska J, DiClemente C: Towards a comprehensive model of change. In Miller W, Heather N, editors: *Treating addictive behaviors: process of change,* New York, 1986, Plenum.)

The four key elements of motivational interviewing are as follows:

1. **Express empathy.** Acceptance of the patient facilitates change. Ambivalence is normal, and the use of reflective listening expresses understanding.
2. **Identify the discrepancy.** Ask the patient about the pros and cons of changing. Change is motivated by perceived discrepancy between present behaviors and important goals and values.
3. **Roll with resistance.** Avoid arguing about change. Offer new perspectives, but remember that the patient is the primary resource to identifying problems and finding solutions. It is helpful to emphasize personal choice and control.
4. **Support self-efficacy.** Belief in the possibility of change and hope in the future are important motivators. The patient is responsible for choosing and carrying out change; however, the clinician's belief in the patient's ability to change can become a self-fulfilling prophecy.

Motivational Interventions

A number of interventions can be used to enhance a patient's motivation to change. The use of open-ended questions can help to identify the patient's agenda. Affirming, hopeful, and reinforcing statements can emphasize that change is possible. One can also focus on the disadvantages of the way things are and the advantages of change.

The nurse can ask simple questions about how important the change is to the patient and how confident the patient is about making the change based on a scale of 1 to 10 (10 being the highest) to help to gain a sense of where the patient is in the stages of change. In working with patients, nurses must be sensitive to issues of mutuality, which means not prescribing solutions to the patient as the passive recipient of care. It also means not labeling problems or placing blame, both of which are likely to decrease the motivation to change.

Critical aspects of effective motivational interventions include the FRAMES approach and decisional balance exercises. FRAMES stands for the following basic elements of motivational counseling:

- **F**eedback regarding personal risk or impairment is given to the patient after assessment of the problem.
- **R**esponsibility for change is placed explicitly on the patient, with respect for the patient's right to make personal choices.
- **A**dvice about changing problematic behavior is given to the patient clearly and nonjudgmentally by the clinician.
- **M**enus of self-directed change options and treatment alternatives are offered.
- **E**mpathic counseling—showing warmth, respect, and understanding—is emphasized.
- **S**elf-efficacy—or optimistic empowerment—is fostered in the patient to encourage change.

Decisional balance exercises are specific ways that the clinician can assist the patient to explore the pros and cons of old and new behaviors for the purpose of tipping the scales toward a decision for positive change. The items are identified by the patient with gentle help from the clinician and then written in a grid. This is shown in Figure 27-2 for a patient who has an alcohol use problem. The four blocks of the grid add a new twist to the traditional two-column "pros and cons" list.

One advantage of the four-block grid is recognition that there are positive elements about the old behavior that must be acknowledged. For example, if drinking helps the patient relax, part of recovery may include finding other ways to relax without alcohol. Even more important than the number of items in each block is the weight of each item. For example, the negative impact on the family may more than outweigh the social pleasures of drinking.

The clinician then summarizes the list of concerns and presents them to the patient in a way that expresses empathy, develops discrepancy, and weighs the balance toward change. The objective is to meet the patients where they are in their thinking, walk with them through the process and help them commit to making needed changes in their lives.

DECISIONAL BALANCE GRID	
Old Behavior	**New Behavior**
Pros/Benefits Like the taste of alcohol Helps me to relax Source of fun and socialization Makes me forget my problems	Pros/Benefits Better relationship with spouse No more DWIs Save money Feel better about myself More time for other activities and people in my life
Cons/Costs Costs a lot of money Led to DWI—costly, embarrassing, and inconvenient Spouse gets upset Poor role model for children Feel bad about myself If I lose my driver's license, I could lose my job	Cons/Costs Will miss my drinking friends Don't know how to have fun without it It will be harder to face my problems I'll feel left out, "different" I'll be more up-tight, less relaxed

FIG 27-2 Decisional balance grid.

The nurse should be proactive and summarize the patient's perception of the problem, areas of ambivalence, and desire to change. Asking the key question, "What is the next step?" is critical. **Setting goals, listing all possible options, supporting the patient's decision to engage in a plan of action, and reinforcing success in achieving it are essential nursing interventions.**

COGNITIVE STRATEGIES

Cognition is the act or process of knowing. **Cognitive strategies are based on the thinking that it is not the events themselves that cause anxiety and maladaptive responses but rather people's expectations, appraisals, and interpretations of these events.** They suggest that maladaptive behaviors can be altered by dealing directly with a person's thoughts and beliefs (Beck, 1976, 1995).

Specifically, maladaptive responses can arise from **cognitive distortions.** These distortions include errors of logic, mistakes in reasoning, or individualized views of the world that do not reflect reality. The distortions may be either positive or negative.

For example, someone may consistently view life in an unrealistically positive way and thus take dangerous chances, such as denying health problems and claiming to be "too young and healthy for a heart attack." Cognitive distortions also may be negative, such as those expressed by a person who interprets all unfortunate life situations as proof of a complete lack of self-worth. Common cognitive distortions are listed in Table 27-2.

Cognitive interventions are problem-focused, goal-oriented, and deal with here-and-now issues. They view the individual as the primary decision maker regarding goals and issues to be dealt with during treatment. **The goal of cognitive interventions is to change irrational beliefs, faulty reasoning, and negative self-statements that underlie behavioral problems.**

> **Critical Reasoning** Give an example from your personal experiences of each cognitive distortion listed in Table 27-2. What was the consequence of each distortion, if any?

COGNITIVE BEHAVIORAL INTERVENTIONS

The characteristics of cognitive behavioral interventions are listed in Box 27-1. These interventions are patient-centered. The person is seen as a unique individual who has a problem of living rather than a psychopathological condition. Maladaptive behaviors, as well as adaptive coping responses, are believed to be acquired through the process of learning.

Emphasis is placed on behavioral monitoring and on the completion of homework by the patient to reinforce the skills learned in treatment and to promote their use in real life. Rather than trying to remove problems by changing subconscious dynamics, the clinician works with the patient to plan experiences that encourage the development of new skills.

Another important characteristic is the high degree of mutuality in the treatment process. **Cognitive behavioral interventions are based on collaboration with the patient in defining the problem, identifying goals, formulating treatment strategies, and evaluating progress.**

TABLE 27-2 COGNITIVE DISTORTIONS

DISTORTION	DEFINITION	EXAMPLE
Overgeneralization	Draws conclusions about a wide variety of things on the basis of a single event	A student who has failed an examination thinks, "I'll never pass any of my other exams this term, and I'll flunk out of school."
Personalization	Relates external events to oneself when it is not justified	"My boss said our company's productivity was down this year, but I know he was really talking about me."
Dichotomous thinking	Thinking in extremes—that things are either all good or all bad	"If my husband leaves me I might as well be dead."
Catastrophizing	Thinking the worst about people and events	"I'd better not apply for that promotion at work because I won't get it and then I'll feel terrible."
Selective abstraction	Focusing on details but not on other relevant information	A wife believes her husband doesn't love her because he works late, but she ignores his affection, the gifts he brings her, and the special vacation they are planning together.
Arbitrary inference	Drawing a negative conclusion without supporting evidence	A young woman concludes "my friend no longer likes me" because she did not receive a birthday card.
Mind reading	Believing that one knows the thoughts of another without validation	"They probably think I'm fat and lazy."
Magnification/minimization	Exaggerating or trivializing the importance of events	"I've burned the dinner, which goes to show just how incompetent I am."
Perfectionism	Needing to do everything perfectly to feel good about oneself	"I'll be a failure if I don't get an A on all my exams."
Externalization of self-worth	Determining one's value based on the approval of others	"I have to look nice all the time or my friends won't want to have me around."

BOX 27-1 CHARACTERISTICS OF COGNITIVE BEHAVIORAL INTERVENTIONS

Evidence-based. Research supports cognitive behavioral methods for the treatment of many clinical problems.

Goal-oriented. Explicit treatment goals are mutually identified by the patient and clinician. They are then used to evaluate the patient's progress and treatment outcome.

Practical. The patient and clinician focus on defining and solving current problems of living. They discuss the here and now, not the history of the patient.

Collaborative. Collaboration with the patient and active participation by the patient in the treatment process are the norm. Cognitive behavioral interventions help people change.

Open. The therapeutic process is open and explicit. The patient and clinician share an understanding of what is going on in treatment.

Homework. The patient is often given homework assignments for data collecting, skill practice, and reinforcement of new responses.

Measurements. Baseline measurements of the problem behavior are made during the assessment process. These measurements are repeated at regular intervals during and at the completion of treatment. Thus the treatment process is rigorously monitored.

Active. Change and progress in treatment must be meaningful to the patient and have a positive impact on the quality of the patient's life. Both the patient and the clinician are active in therapy. The clinician serves as a teacher and coach, and the patient practices the strategies learned in therapy.

Because the focus is on the patient's self-control, **cognitive behavioral interventions are seen as educational and skill building**. The therapeutic relationship and the responsive dimensions of genuineness, warmth, and empathy are all critically important, and full recognition is given to their significance in influencing the effectiveness of treatment. They also rely on an objective assessment process—specifically the use of standardized measurement tools on which to base ongoing evaluation of patient progress.

Cognitive Behavioral Assessment

Cognitive behavioral interventions start with an assessment of the patient's actions, thoughts, and feelings in particular situations. Assessment includes collecting information, identifying problems from the data, defining the problem behavior, deciding how to measure the problem behavior, and identifying environmental variables that influence the problem behavior. It also includes a review of the patient's strengths and deficits and minimizes the use of assumptions and unvalidated inferences.

Critical Reasoning Nurses form conclusions about the physiological problems of patients after using a variety of tools and tests to collect objective evidence. Do you think nurses dealing with psychosocial problems often forget to use the scientific approach and instead base their care on unsubstantiated inferences?

FIG 27-3 Phases of behavior.

It is important that the patient's problem be defined as clearly as possible. Initially the nurse addresses the following questions:

- What is the problem?
- Where does the problem occur?
- When does the problem occur?
- Who or what makes the problem occur?
- What is the feared consequence related to the problem?

The nurse can then assess the frequency, intensity, and duration of the problem.

The next step is to find out more about the patient's experience with the problem by using a behavioral analysis (Figure 27-3). This analysis consists of three parts (**the *ABC*s of behavior**):

1. **Antecedent:** the stimulus or cue that occurs before the behavior and leads to its manifestation
2. **Behavior:** what the person does or does not say or do
3. **Consequence:** what type of effect (positive, negative, or neutral) the person thinks results from the behavior

Antecedents can include the physical environment; the social environment; or the person's behavior, feelings, or thoughts. Behaviors can be broken down into discrete actions or a series of steps. Consequences can be viewed as powerful rewards or punishments of a person's actions. Thus each is a critical element of the assessment.

An example of a behavioral analysis is as follows:

- **Problem** = Anxiety
- **Feared consequence** = Fear of losing control or dying
- **Antecedent** = Leaving the house
- **Behavior** = Avoiding stores, restaurants, and public places
- **Consequence** = Restriction of daily activities

Another way to assess a person's experiences is to consider the three systems (**the *ABC*s of treatment**) that are interrelated in this treatment framework:

- **Affective:** emotional or feeling responses
- **Behavioral:** outward manifestations and actions
- **Cognitive:** thoughts about the situation

Figure 27-4 shows that these three elements are interrelated in explaining human behavior because of the following:

- **Feelings influence thinking**
- **Thinking influences actions**
- **Actions influence feelings**

An assessment of each of these areas has important implications for understanding the problem and treating it effectively.

Another aspect to be considered in the assessment process is whether the problem is expressed as an observable behavior and whether this behavior is current and predictable. Mutually agreed on treatment goals and strategies can then be determined. Finally, throughout the treatment process, cognitive behavioral therapists use various methods to measure problem severity, including standardized rating scales.

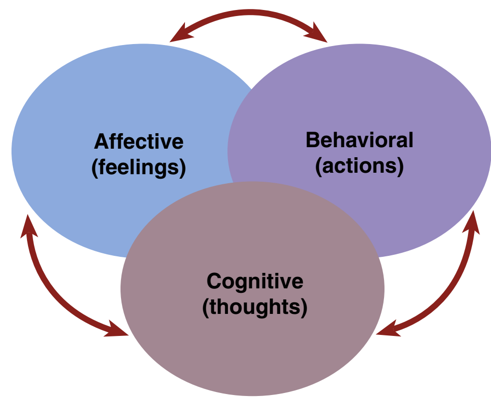

FIG 27-4 Interacting systems in human behavior.

Critical Reasoning In your mental health setting, are standardized rating scales used by staff members who work with patients? If so, how are they used? If not, how could their use influence patient care?

BOX 27-2 COGNITIVE BEHAVIORAL STRATEGIES

Cognitive Restructuring
- Monitoring thoughts and feelings
- Questioning the evidence
- Examining alternatives
- Decatastrophizing
- Reframing
- Thought stopping

Learning New Behavior
- Behavioral activation
- Modeling
- Shaping
- Token economy
- Role playing
- Social skills training
- Aversive therapy
- Contingency contracting

Cognitive Behavioral Implementation

Cognitive behavioral interventions have the strongest evidence base to support their efficacy in the treatment of a wide variety of clinical problems. They are useful in working with children, adolescents, adults, elderly people, and families and may be implemented both individually and in groups. In general, cognitive behavioral treatment strategies are aimed at the following:

- **Increasing activity**
- **Reducing unwanted behavior**
- **Increasing desired behavior**
- **Increasing pleasure**
- **Enhancing social skills**

The cognitive behavioral treatment strategies that can be used by all nurses are listed in Box 27-2. These techniques may be used alone or in combination. They also require practical skills and efforts from both the nurse and the patient. This may include activities outside the clinical setting, such as taking a bus ride, riding an elevator, or going to a supermarket with a patient.

Cognitive Restructuring

Monitoring Thoughts and Feelings. Changing cognitions begins with identifying what is reinforcing and maintaining the patient's dysfunctional thinking and maladaptive behavior. **An important first step is for patients to become more aware of and monitor their own thinking and feeling.** Patients can be helped to do this through the use of the Daily Record of Dysfunctional Thoughts Form (Figure 27-5).

Patients use this form by recording information in each of five columns, beginning with a brief description of a particular situation or event in the first column. They write down feelings or emotions as well as their automatic thoughts in response to the situation. The patients also rate the strength of each. They are then encouraged to think of a more rational response to the situation and record that in the fourth column. Finally, in the last column, patients reevaluate their level of belief in the automatic thought and subsequent emotions.

By using such a form, patients are taught to distinguish between thoughts and feelings and to identify more adaptive responses to problematical situations. They also begin to recognize the connection between certain thoughts and maladaptive emotions and behaviors.

Questioning the Evidence. **The next step is for the patient and therapist to examine the evidence that is used to support a certain belief.** Questioning the evidence also involves examining the source of the data. Patients with distorted thinking often give equal weight to all sources of information or ignore all data except those that support their distorted thinking. Having patients question their evidence with staff, family, and other members of their social support network can clarify misinformation and result in more realistic and appropriate interpretations of the evidence.

Examining Alternatives. Many patients see themselves as having lost all options. This type of thinking is particularly evident in suicidal patients. **Examining alternatives involves working with patients to generate additional options based on their strengths and coping resources.**

Decatastrophizing. Decatastrophizing is also called the "what-if" technique. It involves helping patients evaluate whether they are overestimating the catastrophic nature of a situation. Questions that the nurse can ask include, "What is the worst thing that can happen?" "Would it be so terrible if that really took place?" "How would other people cope with such an event?" **The goal of this intervention**

Date	Situation Describe: 1. Actual event leading to unpleasant emotion, or 2. Stream of thoughts, daydream, or recollection leading to unpleasant emotion	Emotion(s) 1. Specify sad, anxious, angry, etc. 2. Rate degree of emotion, 1-100.	Automatic Thought(s) 1. Write automatic thought(s) that preceded emotion(s). 2. Rate belief in automatic thought(s) 0-100%.	Rational Response 1. Write rational response to automatic thought(s). 2. Rate belief in rational response 0-100%.	Outcome 1. Rerate belief in automatic thought(s), 0-100%. 2. Specify and rate subsequent emotions, 0-100.
10/9/04	1. Event- My boyfriend was supposed to call me tonight to discuss our plans but he never did. 2. He must be too busy for me. Maybe he's seeing someone else and wants to break it off with me.	1. Anxious - 90 2. Sad - 50 3. Angry - 10	1a. I'll never be able to keep a boyfriend - 60% 1b. I am not a "good enough" date or girlfriend - 70%	1. Lots of men at school seem to enjoy talking and spending time with me - 80% 2. I'll have plenty of time in the future to meet more men and develop relationships - 50%	1a. I'll never be able to keep a boyfriend - 30% 1b. I am not a "good enough" date or girlfriend - 40% 2. Anxious - 20 Sad - 5 Angry - 30

Explanation: When you experience an unpleasant emotion, note the situation that seemed to stimulate the emotion. (If the emotion occurred while you were thinking, daydreaming, etc., please note this.) Then note the automatic thought associated with the emotion. Record the degree to which you believe this thought: *0%*, not at all; *100%*, completely. In rating degree of emotion: *1*, a trace; *100*, the most intense possible.

FIG 27-5 Daily Record of Dysfunctional Thoughts Form. (Modified from Beck A et al: *Cognitive therapy of depression,* New York, 1979, The Guilford Press.)

is to help the patient see that the consequences of life's actions are generally not "all or nothing" and thus are less catastrophic.

Reframing. Reframing is a strategy that changes a patient's perception of a situation or behavior. **It involves focusing on other aspects of the problem or encouraging a patient to see the issue from a different perspective.**

Patients who dichotomize events may see only one side of a situation. Weighing the advantages and disadvantages of maintaining a particular belief or behavior can help patients gain balance and develop a new perspective. By understanding both the positive and negative consequences of an issue, the patient can attain a broader perspective of it. For example, suggesting that a mother's overinvolvement with her son is actually a sign of her loving concern may help a family see the situation in a new light.

This strategy also creates an opportunity to help challenge the meaning of a problem or behavior; once the meaning of a behavior changes, the person's response will also change. For example, this strategy might involve helping a patient see an adversity as a potentially positive event. The loss of a job may be perceived as a stressor, but it also can be viewed as an opportunity for pursuing a new job or career.

> **Critical Reasoning** Think of a problem you encountered in the past year. How might you have used the technique of cognitive reframing to see the situation in a more positive way?

Thought Stopping. Dysfunctional thinking often can have a snowball effect on patients. What begins as a small or insignificant problem can over time gather importance and momentum that can be difficult to stop. The technique of **thought stopping** is best used when the dysfunctional thought first begins. The patient can picture a stop sign, imagine a bell going off, or envision a brick wall to stop the progression of the dysfunctional thought.

To begin, the patient identifies the problematical thought and talks about it as the problem scene is imagined. The nurse interrupts the patient's thoughts by shouting "STOP." Thereafter the patient learns to interrupt thoughts in a similar way. Finally, the patient converts the "stop" into an inaudible phrase or image and thus learns to use the technique quietly in everyday situations.

Learning New Behavior

Behavioral Activation. **Behavioral activation** is an effective approach for treating depression (Green et al, 2009; Ekers et al, 2011; Erickson and Hellerstein, 2011). It seeks to help people understand environmental sources of their depression, and to target behaviors that might maintain or worsen the depression.

Behavioral activation proposes that life events, which can include specific trauma or loss, biological predispositions to depression, or the daily hassles of life, lead to individuals experiencing low levels of positive reinforcement in their lives. Furthermore, many behaviors used to cope with negative feelings that make the individual feel better in the short-run

but are detrimental in the long-run increase through a process of negative reinforcement. Such coping strategies do not help alleviate depression, they make it worse.

Behavioral activation targets inertia and avoidance, working from the "outside-in," by scheduling activities and using graded task assignments to allow the patient to slowly begin to increase their chance of having activity positively reinforced.

Patients are asked to create a hierarchy of reinforcing activities. These are then rank-ordered by difficulty. Patients track their own goals along with clinicians who reinforce success in moving through the hierarchy of activities.

Modeling. **Modeling** is a strategy used to form new behavior patterns, increase existing skills, or reduce avoidance behavior. The target behavior is broken down into a series of separate stages that are ranked in order of difficulty or distress, with the first stage being the least anxiety provoking. The patient observes a person modeling the behavior in a controlled environment. The patient then imitates the model's behavior.

In participant modeling the model and patient perform the behavior together before the patient performs it alone. For the treatment to be most effective, it is particularly important that the model selected for this treatment be credible to the patient.

Shaping. **Shaping** induces new behaviors by reinforcing those that approximate the desired behavior. Each successive approximation of the behavior is reinforced until the desired behavior is attained. Skillful use of the technique requires that the nurse carefully look, wait, and reinforce. The nurse needs to look for the desired behavior, wait until it occurs, and then reinforce it when it does occur. An example of this strategy is the nurse noticing that an aggressive child is playing cooperatively with a peer and then praising the child for this behavior.

Token Economy. A **token economy** is a form of positive reinforcement used most often on a group basis with children or patients in a psychiatric hospital. It consists of rewarding the person in various ways (e.g., tokens, passes, or points) for performing desired target behaviors. These target behaviors might include performing hygienic grooming, attending classes, or verbally expressing frustration rather than striking out at others. Tokens also may be lost for inappropriate behaviors. If tokens or points are used, they may be cashed in periodically for rewards such as free time, off-unit outings, games, or nutritious snacks.

Role Playing. **Role playing** allows patients to rehearse problematical issues and obtain feedback about their behavior. It can provide practice for decision making and exploring consequences. A related practice is role reversal, in which the patient switches roles with someone else and thus experiences the difficult situation from another point of view.

Social Skills Training. Smooth social functioning is central to most human activity, and social skills problems exist in many psychiatrically ill patients. **Social skills training** is based on the belief that skills are learned and therefore can be taught to those who do not have them. The principles of skill acquisition include the following:

- **Guidance**
- **Demonstration**
- **Practice**
- **Feedback**

These principles must be included in implementing an effective social skills training program, which is often a component of recovery support (Chapter 14). Guidance and demonstration are usually used early in the treatment, followed by practice and feedback. Treatment typically follows four stages:

1. **Describing** the new behavior to be learned
2. **Learning** the new behavior through the use of guidance and demonstration
3. **Practicing** the new behavior with feedback
4. **Transferring** the new behavior to the natural environment

The types of behaviors that are often taught in these programs include asking questions, giving compliments, making positive changes, maintaining eye contact, asking others for specific behavior changes, speaking in a clear tone of voice, and avoiding fidgeting and self-criticism. This treatment strategy is most often used with patients who lack social skills, assertiveness (assertiveness training), or impulse control (anger management), as well as with patients who exhibit antisocial behavior.

Aversion Therapy. **Aversion therapy** helps reduce unwanted but persistent maladaptive behaviors. Aversive conditioning applies an aversive or noxious stimulus when a maladaptive behavior occurs. An example is for a patient to snap a rubber band on the wrist when being bothered by an intrusive thought. Another aversive technique asks the patient to imagine scenes that pair the undesired behavior with an unpleasant consequence. By imagining aversive consequences for a behavior such as overeating, the patient gains control by providing a form of punishment for the behavior.

Contingency Contracting. **Contingency contracting** involves a formal contract between the patient and the clinician, defining what behaviors are to be changed and what consequences follow the performance of these behaviors. Included are positive consequences for desirable behaviors and negative consequences for undesirable behaviors.

ROLE OF THE NURSE

Current changes in the scope and functions of contemporary nursing practice underscore **the need for all nurses to learn behavior change and cognitive interventions.** Contemporary nursing practice includes both caring and treating activities. Nurses have always been involved with helping patients reduce anxiety, change cognitions, and learn new behaviors. As influential agents of behavioral change, nurses need to be aware of their ability to promote adaptive or maladaptive

responses and increase their skills and knowledge in effective treatment strategies.

Nurses are the front-line providers of care. They are the group called on most often to carry out selective reinforcement, modeling, skills training, shaping, and role playing. Because of their direct patient contact, nurses are best able to observe patients, assess problem areas, and recommend targets for cognitive behavioral intervention.

Psychiatric nurses provide direct patient care in both inpatient and community settings, and the value of cognitive behavioral interventions is evident throughout the continuum of care. Most treatments are ideally suited to community settings, and they can include interventions across the continuum of coping responses—from promoting health, to intervening in acute illness, to promoting recovery.

Nurses also may function as planners and coordinators of complex treatment programs; consultants; and teachers of other nurses, professionals, patients, and their families. It is clear that with the current emphasis on cost-effective treatment and documented outcomes of care, cognitive behavioral interventions will be a growing area of expertise for all nurses in the next decade.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Darcy O'Neill, RN

I first met this 13-year-old girl, when she was admitted by her mother to our combined child and adolescent psychiatric unit. Her mother reported that she was becoming increasingly oppositional, refusing to attend school, having sexual relations with multiple partners, running away from home for long periods, and exhibiting destructive outbursts when confronted.

A was admitted to our unit following a 3-day runaway. She appeared tired, disheveled, and somewhat older than her chronological age, and she was extremely angry about hospitalization. However, despite her angry demeanor, it was rapidly apparent that she was a very bright and charming young girl. I was intrigued.

During this hospitalization she continued to have unpredictable violent outbursts. At times the most benign redirection would result in verbal threats, screaming, and cursing, which would often escalate into physical attacks on staff. At other times a similar or more emphatic directive would be calmly accepted and performed. I was puzzled and rather frustrated by trying to balance this child's need to express some deeply felt anger while maintaining the safety of the milieu.

Our unit uses a token economy as part of a patient's treatment. Depending on the age and cognitive abilities, patients earn points or stickers for attending activities and participating in treatment. Points are earned as rewards and may be exchanged for special privileges. Although we specialize in short-term assessment and evaluation, many children quickly engage in this token economy and are able to address behavioral issues in a direct and timely fashion. Unfortunately, my patient was not one of these children. Her participation in the point system was as unpredictable and sporadic as her behavior.

The team began to discuss the therapeutic effectiveness of an individually designed behavioral program for her. As a new graduate nurse who knew little about the use of behavioral therapies, I balked. I felt that what she needed was more one-to-one time to process the strong emotions underlying her behavior. She and I were beginning to have regular but brief interactions in which she began to share some of her feelings. I feared that by making a more concrete program, obviously different from the program her peers experienced, we risked alienating a child who already had great difficulties with trust. I also feared that from a position of frustration we were falling into a punitive stance. Unfortunately, she was discharged to an outpatient program before the formulation of a new behavioral program. It seemed that many of my questions concerning the therapeutic value of special behavioral programs would remain unanswered.

After I had been on the unit for 6 months, she was readmitted. At this admission her mother reported an increase in the severity and frequency of the behaviors that had precipitated her first admission. In the time that had passed since her first admission, I had had quite a few opportunities to work with individually designed behavioral programs. I had begun to appreciate this therapeutic approach and to understand that for many children these programs provided a sense of security and an opportunity to address their problem behaviors more concretely.

What I had not understood at the time of her first admission was that these programs increase the amount of one-to-one interaction while helping children take more control of their own behavior. I had discovered that behavioral programs provided the framework for increased teaching and learning.

From the outset of her second admission, she was increasingly difficult to reach. She had become more physically and verbally threatening. I continued to try to engage her in the point system and had moderate success.

She also was even more unpredictable. At one minute she was willing to discuss her emotions and was open to nurturance and support, and at the next she was isolated and violent, with no tolerance of any perceived frustration. I was quickly exasperated. I truly liked this charming, bright young girl who showed me through her behavior that she was in a great deal of pain. Many times after a violent or threatening outburst she would cry inconsolably, curled in the fetal position, appearing much younger than her 13 years. I agonized along with the team members on how to help this child out of a self-destructive, downward spiral.

The team quickly returned to the discussion of a special behavioral program. With her full participation and tenuous acceptance, a preliminary program was designed and implemented. Within 3 days some minor improvements were noted, but they were buried in continually violent and impulsive

COMPETENT CARING—cont'd

A Clinical Exemplar of a Psychiatric Nurse

Darcy O'Neill, RN

behavior. Again, the team reassessed the program and decided to adopt a more concrete contract with her. She could earn immediate rewards by either exhibiting new positive behaviors or by refraining from old negative behavior. The hope was to extinguish dangerous, self-destructive behaviors while replacing them with new coping strategies. Again, the changes were subtle and erratic and were surrounded by what appeared to be setbacks.

I recall one time I was attempting to process with her after she was placed in open seclusion after threatening staff. I found myself desperately searching for positive feedback to offer her. With a little reflection, I was able to see a number of significant changes as I reviewed her behavioral contract. She had walked to seclusion independently; she needed only one directive to go to the seclusion room; and she was able to sit there without swearing at or threatening me. As soon as I realized all the changes I was witnessing, I became elated. Although she was still unable to talk with me, I continued to state how impressed I was by her ability to eliminate these behaviors. I made a point of sharing this information with passing staff, loud enough for her to hear. In time she was able to process what had happened and reintegrate into the milieu.

Through this trying, challenging experience I believe I was able to grow professionally and personally. I learned in a very deep way the therapeutic necessity of a fully functioning interdisciplinary team, as well as my integral role on that team. More important, I gained a new respect for behavioral programs and the opportunities they offer not only for patients but also for nurses. A well-designed behavioral program provides numerous opportunities for teaching, one-to-one relationship building, and a framework for continual assessment, planning, and evaluation—all essential nursing activities.

CHAPTER IN REVIEW

- Behavior change interventions apply learning theories to problems of living with the aim of helping people overcome difficulties in everyday life. Behavior change is the most powerful aspect of health care.
- Behavior is any observable, recordable, and measurable act, movement, or response. It is what is observed—not the conclusions drawn from the observation.
- Patients are more likely to engage in behavior change when providers assess patients' readiness for change and tailor interventions accordingly. There are 6 stages of change: precontemplation, contemplation, preparation, action, maintenance and termination.
- Motivation to change arises when one's values and goals conflict with one's current behavior and when the benefits of change outweigh the benefits of staying the same.
- Elements of motivational interviewing include expressing empathy, identifying discrepancies, rolling with resistance and supporting self-efficacy.
- Decisional balance exercises are specific ways that the clinician can assist the patient to explore the pros and cons of old and new behaviors for the purpose of tipping the scales toward a decision for positive change.
- Cognitive strategies are based on the thinking that it is not the events themselves that cause anxiety and maladaptive responses but rather people's expectations, appraisals, and interpretations of these events.
- The goal of cognitive interventions is to change irrational beliefs, faulty reasoning, and negative self-statements that underlie behavioral problems.
- Cognitive behavioral interventions are evidence-based, goal oriented, practical, collaborative, open and active. They use homework and measurement of problem behavior.
- Cognitive behavioral assessment includes collecting information, identifying problems, defining the problem, deciding how to measure the problem, and identifying environmental variables that influence the problem behavior.
- The *ABC*s of behavior are antecedent, behavior, and consequence.
- The *ABC*s of treatment are affective, behavioral, and cognitive.
- Cognitive behavioral treatment strategies are aimed at helping people overcome difficulties in any area of human experience. They are problem focused and goal oriented, and they deal with here-and-now issues.
- Cognitive behavioral treatment strategies include increasing activity, reducing unwanted behavior, increasing desired behavior, increasing pleasure, and enhancing social skills.
- A variety of cognitive behavioral treatment strategies may be used alone or in combination. They focus on cognitive restructuring, and learning new behavior.
- Cognitive restructuring includes monitoring thoughts and feelings, questioning the evidence, examining the alternatives, decatastrophizing, reframing and thought stopping.
- Learning new behavior includes behavioral activation, modelling, shaping, token economy, role playing, social skills training, aversive therapy and contingency contracting.
- Three basic roles for nurses involved in cognitive behavioral therapy are: (1) providing direct patient care, (2) planning treatment programs, and (3) teaching others the use of behavioral techniques. These roles may be enacted by all nurses in various practice settings.

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CHAPTER

28

Preventing and Managing Aggressive Behavior

Gail W. Stuart

Healthy children raised in decent conditions among loving people in a gentle and just society where freedom and equality are valued will rarely commit violent acts toward others.

Ramsay Clark, A Few Modest Proposals to Reduce Individual Violence in America

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Compare passive, assertive, and aggressive behavioral responses.
2. Describe theories on the development of aggressive behavior.
3. Identify factors useful in predicting aggressive behavior among psychiatric patients.
4. Assess patients for aggressive behavioral responses.
5. Analyze nursing interventions for preventing and managing aggressive behavior.
6. Develop a patient education plan to promote patients' appropriate expression of anger.
7. Describe the implementation of crisis management techniques.
8. Evaluate prevention strategies related to the workplace, including addressing lateral violence and staff education and support.

People who enter the health care system are often in great distress and may exhibit maladaptive coping responses. Nurses who work in settings such as emergency departments (EDs), critical care areas, and trauma centers often care for people who respond to events with angry and aggressive behavior that can pose a significant risk to themselves, other patients, and health care providers (Lanza et al, 2009). **Thus, preventing and managing aggressive behavior are important skills for all nurses.**

Violence against ED nurses is common, with reports of 25% to 50% of ED nurses reporting that they have experienced physical violence (Gacki-Smith et al, 2009). Psychiatric nurses also are at risk for violence as they work with patients who have inadequate coping mechanisms for dealing with stress. Patients admitted to an inpatient psychiatric unit are usually in crisis and not thinking clearly, so their coping skills are even less effective. During these times of stress, acts of physical aggression or violence can occur.

Nursing staff members on psychiatric units are likely to be involved in preventing and managing aggressive behavior and are at risk for being victims of aggressive acts by patients. Thus, it is critical that psychiatric nurses be able to assess patients at risk for violence and intervene effectively with patients before, during, and after an aggressive episode.

Critical Reasoning Members of different disciplines sometimes have different views on how to manage aggressive behavior. Talk with nurses and physicians who care for psychiatric patients about their personal experiences and clinical judgments regarding this problem.

BEHAVIORAL RESPONSES

Within each person lies the capacity for passive, assertive, and aggressive behavior. When in a threatening situation, the choices are to be:

1. **Passive** and fearful and to flee
2. **Aggressive** and angry and to fight
3. **Assertive** and self-confident and to confront the situation directly

The situation and the characteristics of the people involved determine the appropriate response.

Passive Behavior

Passive people give up their own rights to their perception of the rights of others. When passive people become angry, they try to hide it, thereby increasing their own tension. If other people notice the anger by observing nonverbal cues, passive people are unable to confront the issue, further increasing their tension. This pattern of interaction can seriously impair interpersonal growth. The following clinical example illustrates passive behavior.

CLINICAL EXAMPLE

Ms. J was a staff nurse on a busy surgical unit who enjoyed her work and liked the patients. She also placed a high value on getting along with her co-workers. Other staff members always spoke positively of her. The head nurse valued Ms. J as an employee, stating particularly, "She's not like the rest of them. She never complains."

Ms. J made it a practice never to refuse a request made by a patient or another staff member. If patients who were assigned to another nurse asked her to explain their diet or straighten their bed, she would do so, even if she was then behind in her own work. She never asked for help from others because she felt that her assignment was her responsibility. If a co-worker asked to change days off with her, Ms. J always agreed even if she had plans, rationalizing that the other person probably had more important plans.

The head nurse began to sense tenseness when she was around Ms. J. Because she could not think of any problem at work, she assumed that Ms. J must have been having a problem at home. She was concerned and asked Ms. J if she could help. To her amazement, Ms. J recited a long list of angry feelings related to the work situation. The head nurse then felt guilty when she realized that she and the other staff members had been taking advantage of Ms. J.

Although Ms. J thought that she was acting in a healthy way, she was actually ignoring her own needs and diminishing her self-respect. Her co-workers, who superficially liked her, in reality felt uncomfortable with her because they were never allowed to reciprocate her acts of kindness. The head nurse's guilty response quickly changed to anger when she realized that she had been a victim of Ms. J's passivity. If Ms. J had informed the head nurse of her feelings, she would have treated her more fairly.

Passivity can be expressed nonverbally. The person may speak softly, often in a childlike manner, and make little eye contact. The person may be slouched in posture, with arms held close to the body.

Sarcasm is another indirect expression of anger. This usually provokes anger in the person who is the target. It is different from assertive behavior because it usually infringes on the rights of the other. A sarcastic remark generally conveys the message, "You are not worthy of my respect." Sarcasm may be disguised as humor. Confrontation may then be responded to with a disclaimer such as "Can't you take a joke?" Humor that disrespects another person is hostile and is done for the purpose of self-enhancement. It tends to backfire because the joker is often revealed as insecure.

Aggressive Behavior

At the opposite end of the continuum from passivity is aggression. **Aggressive people ignore the rights of others. They think that they must fight for their own interests, and they expect the same behavior from others.** For them, life is a battle.

An aggressive approach to life may lead to physical or verbal violence. The aggressive behavior often covers a basic lack of self-confidence. Aggressive people enhance their self-esteem by overpowering others and thereby proving their superiority to themselves. The following clinical example describes aggressive behavior.

CLINICAL EXAMPLE

Suzy was a 9-year-old girl brought to the child psychiatric clinic by her mother on referral from the school nurse. She was described as a tomboy who loved active play and hated school. She was the first girl to make the neighborhood Little League baseball team and had proved her right to be there by beating up several male team members. Suzy was sent to the clinic after the teacher caught her forcing younger children to give her their lunch money.

When Suzy came to the clinic, she acted tough. She did not deny her behavior and explained it by saying that the "little kids don't need much to eat anyway. I let them keep some of the money." Suzy was saving money for a new baseball glove. When she was asked about school, she said angrily, "I'm not dumb. I could learn that junk, but who needs it? I just want to play ball."

Psychological testing revealed that Suzy's IQ was slightly below average. She attended school with a group of upper–middle-class, college-bound children. Even in fourth grade she was feeling insecure and unable to compete. She masked her insecurity with her bullying behavior, striving for acceptance in sports, where she did have ability. The medical diagnosis was conduct disorder, undersocialized, aggressive.

When Suzy's problem was explained to her parents and the school, some of the pressure for academic achievement was relieved. Her parents spent extra time helping her with her homework. Also, she was given genuine recognition for her athletic ability, demonstrated by the gift of a new baseball glove. Suzy gradually responded to the positive input from others by developing a sense of positive regard for herself. As she did so, she no longer needed to bully other children and began to grow into some real friendships.

Aggressive adults are not unlike Suzy. They try to cover up their insecurities and vulnerabilities by acting aggressively. The behavior is self-defeating because it drives people away, thus reinforcing the low self-esteem and vulnerability to rejection.

Aggressive behavior also can be communicated nonverbally. Aggressive people may invade personal space. They may speak loudly and with great emphasis. They usually maintain eye contact over a prolonged period of time so that the other person experiences it as intrusive.

Gestures may be emphatic and often seem threatening (e.g., they may point their fingers, shake their fists, stamp their feet, or make slashing motions with their hands). Posture is erect, and often aggressive people lean forward slightly toward the other person. The overall impression is one of power and dominance.

Assertive Behavior

Assertiveness is at the midpoint of a continuum that runs from passive to aggressive behavior. **Assertive behavior conveys a sense of self-assurance but also communicates respect for the other person.** Assertive people speak clearly and distinctly. They observe the norms of personal space appropriate to the situation.

Eye contact is direct but not intrusive. Gestures emphasize speech but are not distracting or threatening. Posture is erect and relaxed. The overall impression is that the person is strong but not threatening.

Assertive people feel free to refuse an unreasonable request. However, they will share their rationale with the other person. They will also base the judgment about the reasonableness of the request on their own priorities.

On the other hand, assertive people do not hesitate to make a request of others, assuming that others will let them know if their request is unreasonable. If the other person is unable to refuse, assertive people will not feel guilty about making the request.

Assertiveness involves communicating feelings directly to others. As a result, anger is not allowed to build up, and the expression of feelings is more likely to be in proportion to the situation. Assertive people remember to express love to those to whom they are close. Compliments are given when deserved. Assertion also includes acceptance of positive input from others.

Table 28-1 summarizes the major characteristics of passive, aggressive, and assertive behaviors.

> **Critical Reasoning** Do you use passive, assertive, or aggressive behaviors most often in your personal life? How does this compare with your behavior in your professional life as a nursing student?

THEORIES ON AGGRESSION

It is useful for nurses to view aggressive and violent behavior along a continuum with verbal aggression at one end and physical violence at the other. **Violence is the result of extreme anger (rage) or fear (panic).** Specific reasons for aggressive behavior vary from person to person. Nurses need to communicate with patients to understand the events that they perceive as anger provoking.

Anger usually occurs in response to a perceived threat. This may be a threat of physical injury or, more often, a threat to the self-concept. When the self is threatened, people may not be entirely aware of the source of their anger. In this case the nurse and patient need to work together to identify the nature of the threat.

A threat may be external or internal. Examples of external stressors are physical attack, loss of a significant relationship, and criticism from others. Internal stressors might include a sense of failure at work, perceived loss of love, and fear of physical illness.

Anger is only one of the possible emotional responses to these stressors. Some people might respond with depression or withdrawal. However, those reactions are usually accompanied by anger, which may be difficult for the person to express directly. Depression is sometimes viewed as anger directed toward the self, and withdrawal also may be a passive expression of anger.

Anger often seems out of proportion to the event. An insignificant stressor may be "the last straw" and result in the release of a flood of feelings that have been stored up over time. Nurses need to be aware of this and not personalize anger expressed by a patient. The nurse may seem to be

TABLE 28-1 COMPARISON OF PASSIVE, ASSERTIVE, AND AGGRESSIVE BEHAVIORS

	PASSIVE	AGGRESSIVE	ASSERTIVE
Content of Speech	*Negative* Self-derogatory "Can I?" "Will you?"	*Positive* Self-enhancing "I can" "I will"	*Exaggerated* Other-derogatory "You always" "You never"
Tone of Voice	Quiet, weak, whining	Modulated	Loud, demanding
Posture	Drooping, bowed head	Erect, relaxed	Tense, leaning forward
Personal Space	Allows invasion of space by others	Maintains a comfortable distance; claims right to own space	Invades space of others
Gestures	Minimal, weak gesturing, fidgeting	Demonstrative gestures	Threatening, expansive gestures
Eye Contact	Little or none	Intermittent, appropriate to relationship	Constant stare

a safer target than significant others with whom the patient also may be angry.

Aggressive behavior is the result of the interaction among psychological, sociocultural, and biological factors that must be considered when providing nursing care.

Psychological

The psychological view of aggressive behavior suggests the importance of predisposing developmental factors or life experiences that limit the person's ability to use nonviolent coping mechanisms. Some of these experiences are listed in Box 28-1. They may limit a person's ability to use supportive relationships, leave the person very self-centered, or make the person particularly vulnerable to a sense of injury that can easily be provoked into rage.

BOX 28-1 DEVELOPMENTAL FACTORS LIMITING USE OF NONVIOLENT COPING TECHNIQUES

- Organic brain damage, mental retardation, or learning disability, which may impair the capacity to deal effectively with frustration
- Severe emotional deprivation or overt rejection in childhood, or parental seduction, which may contribute to defects in trust and self-esteem
- Exposure to violence in formative years, either as a victim of child abuse or as an observer of family violence, which may instill a pattern of using violence as a way to cope

Figure 28-1 shows how these factors can contribute to an **intergenerational transmission of violent behavior.** Box 28-2 presents background information about the patient that also may be associated with violence.

Social learning theory proposes that **aggressive behavior is learned** internally and externally. Internal learning occurs by the reinforcement a person experiences when behaving aggressively. This may be the result of achieving a desired goal or experiencing feelings of importance, power, and control.

For example, 4-year-old Johnny wants a cookie just before dinner. When his mother refuses, Johnny has a temper tantrum. If his mother then gives him a cookie, Johnny has learned that an aggressive outburst will be rewarded and he will get what he wants. If similar situations also produce the desired response, Johnny will continue to use an aggressive approach.

External learning occurs through the observation of role models, such as parents, peers, siblings, and sports and

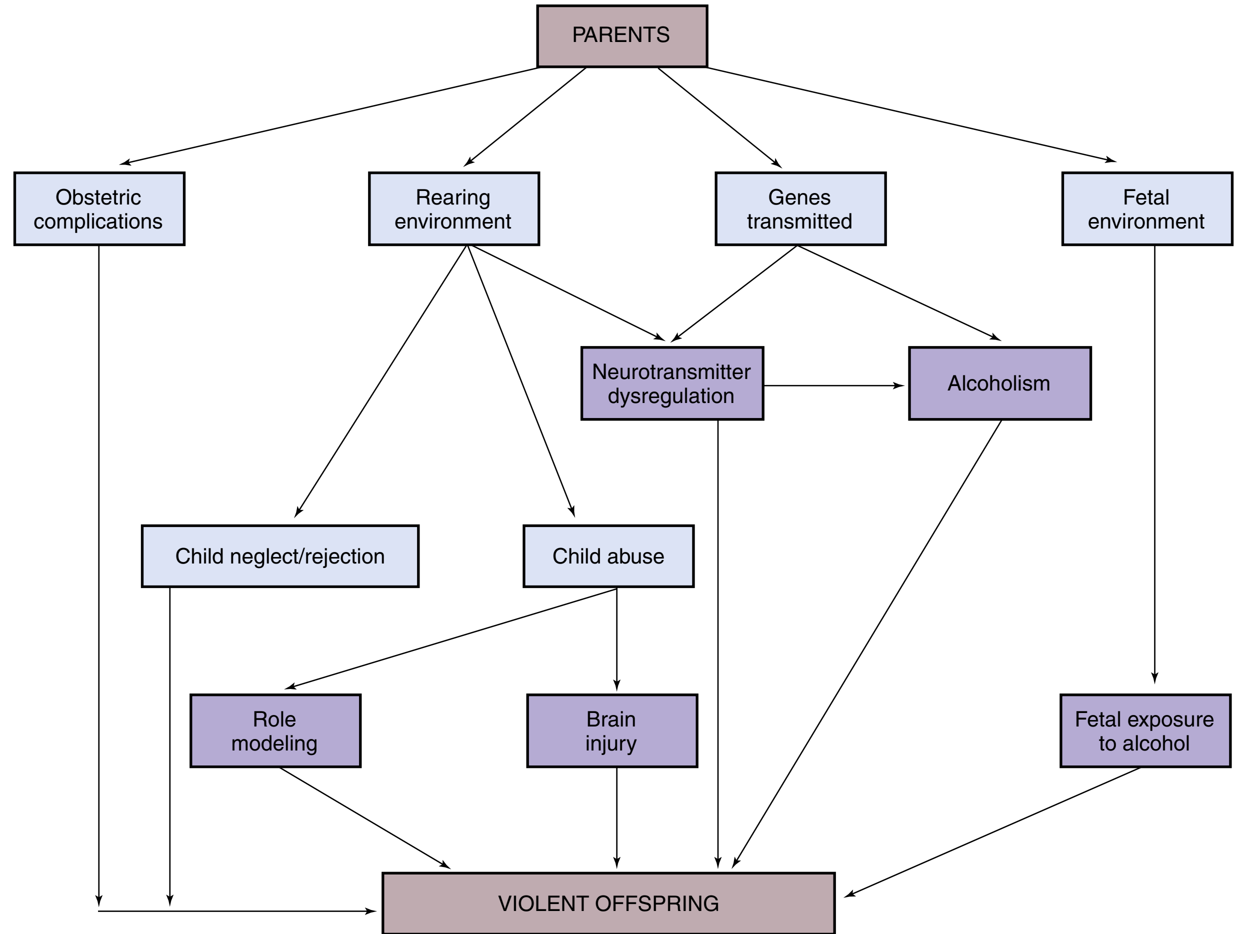

FIG 28-1 Intergenerational transmission of violence. (From Volavka J: *J Neuropsychiatry Clin Neurosci* 2:307, 1999.)

entertainment figures. Sociocultural patterns that lead to the imitation of aggressive behavior suggest that violence is an acceptable way of solving problems and achieving social status. According to this view, activities such as violent crime, aggressive sports, and other forms of violence depicted through the media or witnessed in person reinforce aggressive behavior and desensitize the viewers to the consequence of violence.

Sociocultural

Social and cultural factors influence aggressive behavior. **Cultural norms help define acceptable and unacceptable ways of expressing aggressive feelings.** Sanctions are applied to violators of the norms through the legal system. In this way, society tries to control violent behavior and maintain a safe existence for its members.

Unfortunately, this prohibition against violent behavior also may be extended to include any expression of anger. This can inhibit people from the healthy expression of angry feelings and lead to other maladaptive responses.

A cultural norm that supports verbally assertive expressions of anger will help people deal with anger in a healthy manner. A norm that reinforces violent behavior will result in physical expression of anger in destructive ways.

Physical crowding, environmental issues, and seasonal heat appear to be related to violent behavior. Other social determinants of violence are linked in a cycle and include poverty and the inability to have basic necessities of life, disruption of marriages, unemployment, and difficulty in maintaining interpersonal ties, family structure, and social control.

BOX 28-2 BACKGROUND INFORMATION ASSOCIATED WITH VIOLENT BEHAVIOR

- Childhood cruelty to animals or other children
- Fire setting or similar dangerous actions
- Recent violent behavior toward self or others
- Recent accidents, threats, or poor judgment in potentially dangerous situations
- Altered states of consciousness
- Escalating irritability, sensitivity, or hostility
- Fear of losing control
- Efforts to obtain help
- Bothering family, neighbors, or police
- History of abuse of alcohol or other disinhibiting substances

Biological

Neurobiological research has focused on three areas of the brain believed to be involved in aggression: the limbic system, the frontal lobes, and the hypothalamus (Figure 28-2). Neurotransmitters also have a role in the expression or suppression of aggressive behavior.

The limbic system is associated with the mediation of basic drives and the expression of human emotions and behaviors such as eating, aggression, and sexual response. It also is involved in the processing of information and memory. Synthesis of information to and from other areas in the brain influences emotional experience and behavior. Alterations in functioning of the limbic system may result in an increase or decrease in the potential for aggressive behavior.

In particular, the amygdala, part of the limbic system, mediates the expression of rage and fear. The surgical removal of this region makes aggressive wild rhesus monkeys docile and lethargic, unable to respond to threats to their safety. Perhaps in those prone to violence, the amygdala may be overresponsive, perceiving threats where there are none.

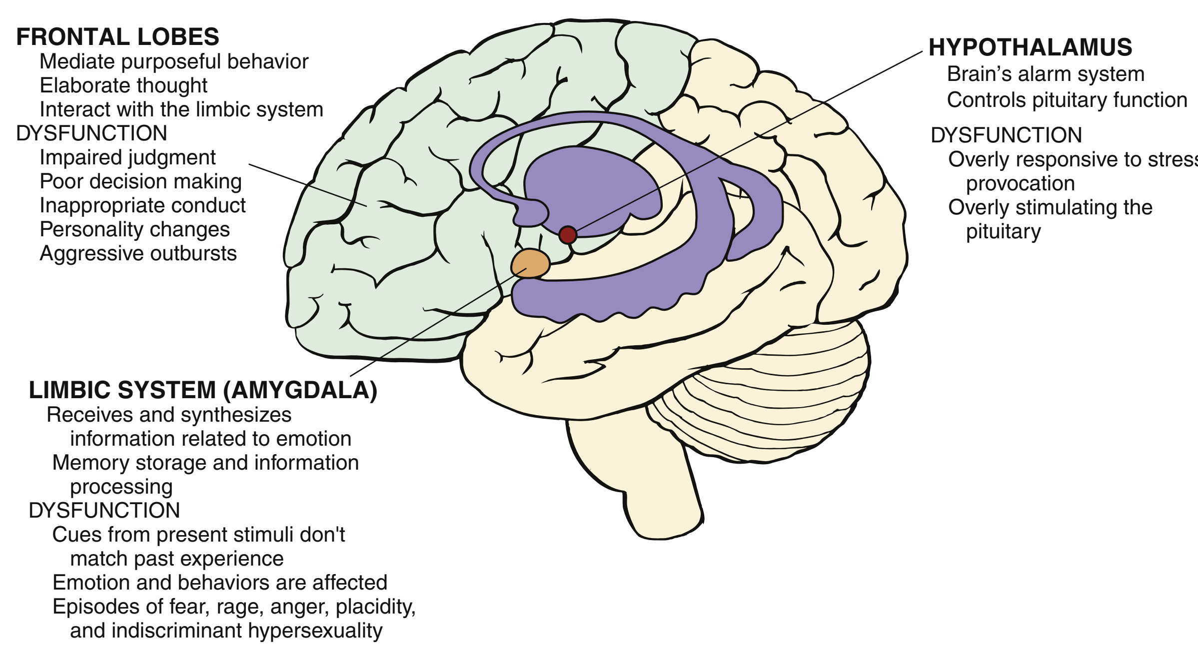

FIG 28-2 Structures of the brain that are implicated in aggression.

The frontal lobes play an important role in mediating purposeful behavior and rational thinking. They are the part of the brain where reason and emotion interact. Damage to the frontal lobes can result in impaired judgment, personality changes, problems in decision making, inappropriate conduct, and aggressive outbursts.

The hypothalamus, at the base of the brain, is the brain's alarm system. Stress raises the level of steroids, the hormones secreted by the adrenal glands. Nerve receptors for these hormones become less sensitive in an attempt to compensate, and the hypothalamus tells the pituitary gland to release more steroids. After repeated stimulation the system may respond more vigorously to all provocations. That may be one reason why traumatic stress in childhood may permanently enhance one's potential for violence.

Neurotransmitters are brain chemicals that are transmitted to and from neurons across synapses, resulting in communication between brain structures. An increase or a decrease in these substances can influence behavior. Changes in the balance of these compounds can aggravate or inhibit aggression.

Low levels of the neurotransmitter serotonin are associated with irritability, hypersensitivity to provocation, and rage. People who commit impulsive arson, suicide, and homicide have lower than average levels of 5-hydroxyindoleacetic acid (5-HIAA), the breakdown product of serotonin, in their spinal fluid.

Other neurotransmitters often associated with aggressive behaviors are dopamine, norepinephrine, acetylcholine, and the amino acid gamma-aminobutyric acid (GABA). For example, studies in animals indicate that increasing brain dopamine and norepinephrine activity significantly enhances the likelihood that the animal will respond to the environment in an impulsively violent manner.

The prefrontal cortex also may play an important role in inhibiting aggressive behavior. The specific area of the prefrontal cortex known as the orbitofrontal region appears to inhibit aggressive behavior. Stimulation of this area leads to inhibition of anger and aggression, whereas lesions lead to impulsive behavior.

Findings related to a gene associated with violent behavior are inconclusive. The evidence on whether men with high testosterone levels are more aggressive or prone to violence than those with moderate levels of testosterone is conflicting. Current understanding of the neurobiology of aggressive behavior is incomplete; more research is needed on the delicate balance of neurotransmitters and the influence of environmental forces on neurochemistry and brain function.

PREDICTING AGGRESSIVE BEHAVIOR

The best single predictor of violence is a history of violence. Mental illness is not a risk factor for violence. Psychopathic and antisocial personality traits are more predictive of violent behavior than mental illness. Demographic variables, such as age, gender, race, marital status, education, and socioeconomic level, are not useful in predicting violent behavior. However, two populations of psychiatric patients are at increased risk of violence:

- **Patients with active psychotic symptoms.** In particular, those patients who have symptoms related to a perceived threat or an overriding of internal controls, such as delusions of thought control, are at increased risk of committing violence.
- **Patients with substance abuse disorders.** The prevalence of violence is 12 times greater for those with alcohol abuse or dependence and 16 times greater for those with other drug dependence compared with those who have no psychiatric diagnosis. Co-morbid substance abuse has an added effect in increasing the risk of violence for people with major psychiatric disorders.

Situational and **environmental factors** also are important in escalating patient behavior from dangerous to violent. These factors include aspects of the physical facilities and the presence of staff and other patients (Hamrin et al, 2009). Several studies have found that the number of violent incidents is greater when patients move or gather in groups, are overcrowded, lack privacy, or are inactive.

Clinicians may intentionally or inadvertently precipitate an outbreak of violence because staff attitudes and actions have a powerful impact on patient behavior. Inexperienced staff, provocation by staff, poor milieu management, understaffing, close physical encounters, inconsistent limit setting, and a norm of violence may all negatively affect the inpatient environment (Knutzen et al, 2011).

Finally, a patient's appraisal of a situation and level of perceived stress affect one's response. When an environment is interpreted as hostile, the response is likely to be hostile in return. Those with psychiatric illness, substance abuse, past traumatic experiences, or brain damage may have distorted perceptions that can lead to aggressive responses. A model for the development of aggression in inpatient settings that incorporates these various factors is presented in Figure 28-3.

Critical Reasoning What role do you think culture plays in the expression and interpretation of aggressive behavior?

NURSING ASSESSMENT

Accurate prediction of patient violence is not possible. For this reason it is important for psychiatric nurses to be alert for symptoms of increasing agitation that could lead to violent behavior (Box 28-3).

Using a hierarchy of aggressive behaviors (Figure 28-4) in which lower levels of aggression may lead to more violent behavior is helpful in evaluating patients. Some of these early behaviors include **motor agitation,** such as pacing, inability to sit still, clenching or pounding fists, and tightening of jaw or facial muscles. **Verbal clues** also may be present, such as threats to real or imagined objects, intrusive demands for attention or swearing (Stone et al, 2011). Speech may be loud and pressured, and posture may become threatening.

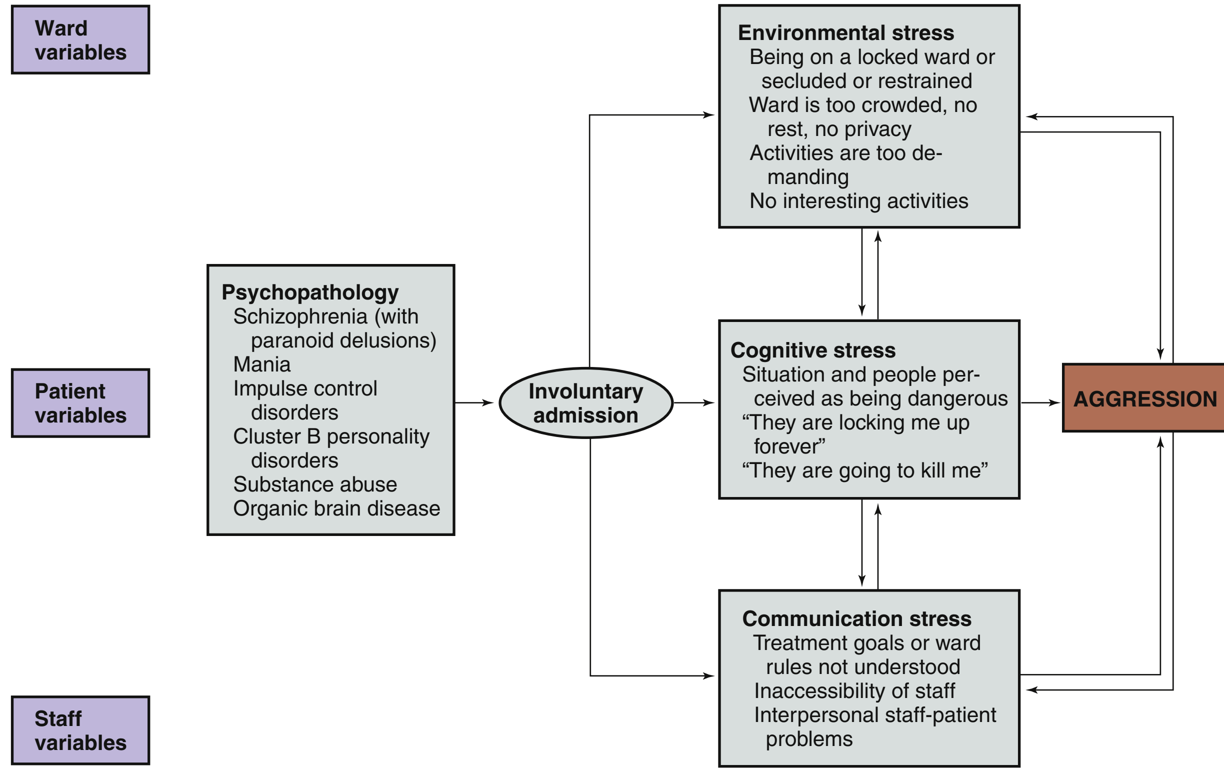

FIG 28-3 Model of inpatient aggression. (From Nijman H et al: *Psychiatr Serv* 50:832, 1999.)

BOX 28-3 BEHAVIORS ASSOCIATED WITH AGGRESSION

Motor Agitation
- Pacing
- Inability to sit still
- Clenching or pounding fists
- Jaw tightening
- Increased respirations
- Sudden cessation of motor activity (catatonia)

Verbalizations
- Verbal threats toward real or imagined objects
- Intrusive demands for attention
- Loud, pressured speech
- Evidence of delusional or paranoid thought content

Affect
- Anger
- Hostility
- Extreme anxiety
- Irritability
- Inappropriate or excessive euphoria
- Affect lability

Level of Consciousness
- Confusion
- Sudden change in mental status
- Disorientation
- Memory impairment
- Inability to be redirected

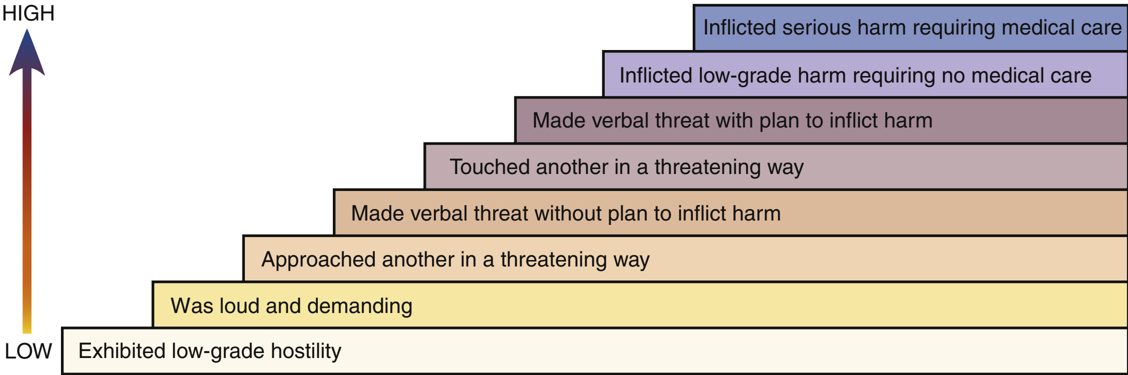

FIG 28-4 Hierarchy of aggressive and violent patient behaviors.

ASSAULT AND VIOLENCE ASSESSMENT TOOL

Description: This tool is used if a patient
a. Has a history of violence
b. Is currently threatening violence
c. Was threatening violence at the time of the referral

Directions: a. Assess each key factor.
b. Circle one (of three) descriptor for each factor that best describes the patient.
c. Add the points for each circled item to obtain the total score.

Key Factors	High Risk	Moderate Risk	No Precautions
History of Violence	Any single episode of violence with injury to others while hospitalized -OR- Multiple assaults with injury while outside hospital 2	Destruction of property without injury to others while in hospital -OR- A single assault outside the hospital resulting in injury -OR- Multiple assaults outside the hospital not resulting in injury 1	Violence only when using drugs or alcohol -OR- Destruction of property outside hospital -OR- No history of violence 0
History of Recent Aggression	Physically threatening at time of referral/admission 2	Verbally threatening at time of referral/admission 1	Nonthreatening at time of referral/admission 0
History of Aggression in Family of Origin	Victim or perpetrator of physical or sexual abuse 2	Witness of physical or sexual abuse 1	Witness or victim of verbal aggression -OR- No history of aggression in family 0
Substance Abuse Status	Recent alcohol/substance abuse actively detoxing -OR- Currently under the influence of alcohol or drugs 2	Recent substance/alcohol abuse with absence of withdrawal symptoms 1	Rehabilitated abuser -OR- No history of alcohol/substance abuse -OR- Past history (>3 months ago) of alcohol/substance abuse with no rehabilitation 0
Paranoia/Hostility	Paranoia or hostility generalized to people in the immediate environment 2	Paranoia or hostility generalized toward inaccessible people 1	No apparent paranoia No apparent hostility 0
Impulsivity	Physically impulsive 2	Verbally impulsive -OR- History of physical impulsivity 1	No apparent impulsivity 0
Agitation	Psychomotor agitation with constant pressured physical activity 2	Psychomotor agitation with intermittent bursts of hyperactivity 1	No apparent psychomotor agitation 0
Sensorium	Disoriented with impaired memory 2	Oriented with impaired memory 1	Oriented with intact memory 0

Scoring Key

9 or more	=	High-risk precautions
3-8	=	Moderate-risk precautions
0-2	=	No precautions

Total Score: ____________

Assessed by (RN): ____________

Date: ________

Time: ________

FIG 28-5 Assault and violence assessment tool.

Another critical factor in the assessment of a potentially violent patient is the **affect** associated with escalating behaviors. Anger often is seen in patients who are imminently violent. Inappropriate euphoria, irritability, and lability in affect may indicate that a patient is having difficulty in maintaining control. **Changes in level of consciousness, including confusion, disorientation, and memory impairment, also may indicate future violent behavior.**

In summary, psychiatric nurses should carefully assess all patients for their potential for violence. A screening or assessment tool can be particularly useful (Fluttert et al, 2011). One such tool is presented in Figure 28-5. Once

Preventive Strategies | Anticipatory Strategies | Containment Strategies

Self-awareness
Patient education
Assertiveness training

Communication
Environmental change
Behavioral actions
Psychopharmacology

Crisis management
Seclusion
Restraints

FIG 28-6 Continuum of nursing interventions in managing aggressive behavior.

completed, a violence assessment tool can help the nurse do the following:

- Establish a therapeutic alliance with the patient.
- Assess a patient's potential for violence.
- Develop a plan of care.
- Implement the plan of care.
- Prevent aggression and violence in the milieu.

If the patient is believed to be potentially violent following the assessment, the nurse should do the following:

- **Implement the appropriate clinical protocol to provide for patient and staff safety.**
- **Notify co-workers.**
- **Obtain additional security if needed.**
- **Assess the environment, and make necessary changes.**
- **Notify the physician and assess the need for prn medications.**

NURSING INTERVENTIONS

The nurse can implement a variety of interventions to prevent and manage aggressive behavior. These interventions can be thought of as existing on a continuum (Figure 28-6). They range from **preventive strategies,** such as self-awareness, patient education, and assertiveness training, to **anticipatory strategies,** such as verbal and nonverbal communication, environmental changes, behavioral interventions, and the use of medications. If the patient's aggressive behavior escalates despite these actions, the nurse may need to implement crisis management techniques and **containment strategies,** such as seclusion or restraints.

Self-Awareness

The most valuable resource of a nurse is the ability to use one's self to help others. To ensure the most effective use of self, it is important to be aware of personal strengths and limitations. Personal stress can interfere with one's ability to communicate therapeutically with patients.

If nurses are tired, anxious, angry, or apathetic, it will be difficult to convey an interest in the concerns and fears of the patient. If nurses lack confidence in managing aggressive behavior or are overwhelmed with personal or work problems, their effectiveness will be compromised.

When dealing with potentially aggressive patients it is important to be able to assess the situation objectively despite the positive or negative countertransference that might be present. **Countertransference** is an emotional reaction of the nurse to some aspect or behavior of the patient (Chapter 2). Both positive and negative countertransference reactions may lead to nontherapeutic responses on the part of the staff. Ongoing self-awareness and supervision can assist the nurse in ensuring that patient needs, rather than personal needs, are addressed.

Patient Education

Teaching patients about communication and the appropriate way to express anger can be one of the most successful interventions in preventing aggressive behavior (Table 28-2). Many patients have difficulty identifying their feelings, needs, and desires and even more difficulty communicating these to others. **Thus, teaching healthy anger management skills is an important area of nursing intervention.**

Teaching patients that feelings are not right or wrong or good or bad can allow them to explore feelings that may have been bottled up, ignored, or repressed. The nurse can then work with patients on ways to express their feelings and evaluate whether the responses they select are adaptive or maladaptive (Son and Choi, 2010). Providing patients with available choices in managing anger, such as those listed in Box 28-4, may be effective in reducing more restrictive interventions.

Assertiveness Training

Teaching assertive communication skills is an important nursing intervention. Interpersonal frustrations often escalate to aggressive behavior because patients have not mastered the assertive behaviors.

Assertive behavior is a basic interpersonal skill that includes the following:

- **Communicating directly with another person**
- **Saying no to unreasonable requests**
- **Being able to state complaints**
- **Expressing appreciation as appropriate**
- **Accepting compliments**

Patients with few assertive skills can learn them by participating in structured groups and programs (Lanza and Witkower,

TABLE 28-2 **PATIENT EDUCATION PLAN**

Appropriate Expression of Anger

CONTENT	INSTRUCTIONAL ACTIVITIES	EVALUATION
Help the patient identify anger.	Focus on nonverbal behavior. Role play nonverbal expression of anger. Label the feeling using the patient's preferred words.	Patient demonstrates an angry body posture and facial expression.
Give permission for angry feelings.	Describe situations in which it is normal to feel angry.	Patient describes a situation in which anger would be an appropriate response.
Practice the expression of anger.	Role play fantasized situations in which anger is an appropriate response.	Patient participates in role playing and identifies behaviors associated with expression of anger.
Apply the expression of anger to a real situation.	Help identify a real situation that makes the patient angry. Role play a confrontation with the object of the anger. Provide positive feedback for successful expression of anger.	Patient identifies a real situation that results in anger. Patient is able to role play expression of anger.
Identify alternative ways to express anger.	List several ways to express anger, with and without direct confrontation. Role play alternative behaviors. Discuss situations in which alternatives would be appropriate.	Patient participates in identifying alternatives and plans when each might be useful.
Confront a person who is a source of anger.	Provide support during confrontation if needed. Discuss experience after confrontation takes place.	Patient identifies the feeling of anger and appropriately confronts the object of the anger.

BOX 28-4 **WAYS TO MANAGE ANGER**

- Positive self-talk
- Change of environment
- Writing about your feelings
- Thinking of the consequences
- Listening to music
- Watching television
- Deep-breathing exercises
- Taking a walk
- Counting to 50
- Comfort wrap with a blanket
- Relaxation exercises
- Talking about your feelings
- Using adaptive coping skills
- Reading
- Being alone
- Medication

2010). In these settings patients can watch staff members demonstrate specific skills and then role play the skills themselves. Staff members can provide feedback to patients on the appropriateness and effectiveness of their responses. Homework also can be assigned to patients to help them generalize these skills outside the group milieu. Aggressive behaviors may diminish as the patient learns new and more effective social skills.

Critical Reasoning How can a nurse who has difficulty being assertive with peers and interdisciplinary colleagues effectively teach assertiveness skills to patients?

Communication Strategies

The psychiatric nurse often can prevent a crisis situation through the use of early verbal and nonverbal intervention. This is sometimes called "talking the patient down." Because it is much less dangerous to prevent a crisis than to respond to one, every effort should be made to carefully monitor patients who are at risk for violent behavior and intervene at the first possible sign of increasing agitation.

It is important for nurses to notice the early verbal and behavioral signs indicating that a patient is becoming increasingly agitated. By understanding where a patient may be on the continuum of escalation and the meaning of the patient's behavior, they can assess the potential danger and provide the necessary intervention to assist the patient to de-escalate. Strengthening the therapeutic alliance is an important part of this process.

Speaking in a calm, low voice can help decrease a patient's agitation. Agitated patients often speak loudly and use profanity. It is important that nurses not raise their voices in response because this can be perceived as competition and further escalate the volatile situation. The nurse should use short, simple sentences and avoid laughing or smiling inappropriately.

The nurse also can help reduce a rising level of agitation by acknowledging the patient's feelings and reassuring the patient that the staff is there to help. The importance of allowing the patient to communicate concerns without interruption and engaging the patient's participation in treatment decisions cannot be overemphasized.

Mental health consumers who are hospitalized report fear of physical violence and negative experiences they have had

with staff characterized by depersonalization, lack of fairness, arbitrary enforcement of rules, and disrespect. Other areas of distress include seclusion, restraint, having medications used as a threat or punishment, inadequate privacy, and sexual assault.

Psychiatric advance directives can provide staff members with strategies to assist a patient in the event that the patient becomes unable to participate in treatment decisions (Chapter 9). Whenever possible, collaboration with patients is important not only to minimize further trauma to the patient but also to decrease the chances that the patient may respond in an angry or aggressive manner.

It is also important that the nurse communicates expected behavior in a way that encourages the patient to maintain control of any violent impulses. At this early stage some patients, with encouragement, may be willing to remove themselves from an overstimulating environment, thus facilitating self-control.

The specific nonverbal communication used by the nurse also can greatly affect the outcome of the intervention.

- **A calm and relaxed posture with the nurse's head lower than the patient's head is supportive.** It is much less intimidating than a posture in which hands are placed on the hips and the nurse looms over the patient. Changing position so that the nurse's eyes are lower or at the same level as those of the patient allows the patient to communicate from an equal rather than inferior position.
- **The nurse's hands should be kept open and out of pockets.** Threatening, nervous, and sudden gestures should be avoided. Crossing one's arms across the chest communicates emotional distance and an unwillingness to help and should be avoided.
- **The nurse should assume a supportive stance that is at least one leg length or 3 feet from the patient and at an angle to the patient.** Violence-prone people need four times more personal space than do non–violence-prone people. Intrusion into a patient's personal space can be perceived as a threat and provoke aggression.

Finally, when approaching potentially violent patients, nurses should carefully observe their behavior. If they display clenched fists, tightening of the facial muscles, and movement away from the nurse, it may suggest that they are feeling threatened. The nurse should respond by giving these patients as much distance as possible. Communication strategies used to prevent aggressive behavior are summarized in Box 28-5.

Critical Reasoning Why do you think that standing at an angle to the patient is less threatening than directly facing the patient? Try the two stances with a friend, and describe your feelings about each one.

BOX 28-5 COMMUNICATION STRATEGIES USED TO PREVENT AGGRESSIVE BEHAVIOR

- Present a calm appearance.
- Speak softly.
- Speak in a nonprovocative and nonjudgmental manner.
- Speak in a neutral and concrete way.
- Put space between yourself and the patient.
- Show respect for the patient.
- Avoid intense direct eye contact.
- Demonstrate control over the situation without assuming an overly authoritarian stance.
- Facilitate the patient's talking.
- Listen to the patient.
- Avoid early interpretations.
- Do not make promises you cannot keep.

Environmental Strategies

Violent behavior is more likely to occur in a poorly structured milieu with undefined program rules and a great deal of unscheduled time for patients. Inpatient units that provide many productive activities reduce the chance of inappropriate patient behavior and increase adaptive social and leisure functioning (Bowers, 2009). Both the unit norms and the rewards associated with such activities may reduce the amount of disorganized patient behavior and the number of aggressive acts.

In contrast, units that are overly structured with too much stimulation and little regard for the privacy needs of patients also may increase aggressive behavior. For example, some psychiatric hospitals have patients eat in dining rooms that are crowded during mealtimes. Other hospital units restrict patients to a central day room to allow for better observation by staff and minimize patient isolation. In such situations, often only one television is provided and sometimes only one telephone is available. For patients who lose much of their privacy when they are admitted to a psychiatric unit, the lack of personal privacy and loss of control over their lives can foster anger and hostility when their ability to cope is already challenged.

Allowing those at risk to spend time in their rooms away from the hectic day room, rather than encouraging them to interact with others in a crowded milieu, may more effectively manage aggressive behavior. The environment that may have been therapeutic in the days of extended hospital stays may no longer be suitable for patients who are hospitalized on short-term, acute, inpatient units where the acuity of the patients is extremely high. Inpatient units should adapt the environment to best meet the needs of the patients they treat. The impact of the environment is seen in the following clinical example.

CLINICAL EXAMPLE

Mr. T was a 36-year-old man who was admitted for the third time to an acute care unit at a state psychiatric hospital. His medical diagnosis was bipolar disorder, manic. The nursing staff was apprehensive because the patient had a history of assaultive behavior on earlier admissions. At the time of this admission, the unit atmosphere was

tense because one of the other patients had made a suicide attempt requiring ED treatment.

Mr. T's primary nurse from his previous admission was working when the patient arrived on the unit. During the nursing assessment, the nurse discussed the nursing interventions that had seemed to be helpful in the past. He validated with Mr. T that he was usually able to maintain control of his behavior by participating in a structured physical activity when he was feeling upset. In addition, he recalled that the patient would begin to pace rapidly and sing when he was losing control. Mr. T agreed with these observations.

Mr. T responded very quickly to the tension on the unit. He began to pace up and down the hall and sing in a moderately loud tone of voice. Other patients also began to show signs of increased agitation. The nursing staff held a brief consultation. They decided that the charge nurse would gather the patients for a community meeting to discuss their feelings about the suicide attempt. Meanwhile, Mr. T's primary nurse would take him for a walk with one of the other staff members. The interventions were successful, and more intensive nursing actions were not needed.

Room Program. In an inpatient setting the use of a structured room program is an effective tool for the management of agitated patients. A **room program** limits the amount of time patients are allowed in the unit milieu. For example, patients initially may be asked to stay in their rooms for a certain length of time or, conversely, be allowed out of their rooms for a specific amount of time every hour. The amount of time in the milieu may then be increased by increments of 15 minutes as patients tolerate the environment.

Another way of implementing a room program is to allow patients to come out of their rooms during certain designated hours, such as when the unit is quiet or when other patients are off the unit. **A room program allows patients time away from situations that may increase agitation and provides a way to regulate the amount of stimulation patients receive.** Its purpose is the prevention of a crisis that could result in more serious patient complications.

Comfort rooms also may be used to reduce seclusion and restraint. These rooms are designed with comfortable furniture, soothing colors, soft lighting, quiet music, and other sensory aids to help reduce the stress level of patients and to promote a healthy, therapeutic, supportive, and safe environment (Cummings et al, 2010).

Cathartic Activities. Many clinicians support the use of cathartic activities as a way of helping patients deal with their anger and agitation. These can be of two types: physically cathartic and emotionally cathartic. The first type is based on the assumption that some physical activity can be useful in releasing aggression and can prevent more explosive or destructive forms of aggression or violence. However, aggressive behavior exists on a continuum and minor manifestations of aggression can lead to further aggressive behavior.

Research does not support the effectiveness of physically cathartic activities and calls into question some traditional nursing interventions, such as encouraging patients to release tension through the use of exercise equipment or allowing patients to pace the halls in the expectation that their tension will decrease. **Physically cathartic activities are not recommended nursing actions because they are not supported by research and may increase the patient's potential for aggressive behavior.** This is an excellent example of the way in which nursing evidence can challenge traditional nursing interventions and help psychiatric nurses base their practice on empirical data rather than on commonly held but untested assumptions.

Research does support the effectiveness of emotionally cathartic activities. Having patients write about their feelings, do deep breathing or relaxation exercise, or talk about their emotions with a supportive person can help the patient regain control and lower feelings of tension and agitation.

Behavioral Strategies

Nursing interventions include applying principles of behavior management to the aggressive patient. These are described in detail in Chapter 27. Effective limit setting is one of the most basic interventions in this area.

Limit Setting. **Limit setting** is a nonpunitive, nonmanipulative act in which the patient is told what behavior is acceptable, what is not acceptable, and the consequences of behaving unacceptably. By explaining the rationale for the limit and communicating to the patient in a calm and respectful manner, potentially aggressive behavior can be avoided. When nursing staff members communicate in an authoritarian, parental, controlling, or disrespectful way, patients are more likely to respond in an angry, aggressive manner.

The nurse does not assume responsibility for the patient's behavior, adaptive or maladaptive. It is recognized that the patient has the right to choose a behavior and understands its consequences. Limits should be clarified before negative consequences are applied.

Once a limit has been identified, the consequences must take place if the behavior occurs. Every staff member must be aware of the plan and carry it out consistently. If staff members do not do so, the patient is likely to manipulate them by acting out and then pointing out areas of inconsistent limit setting. **Clear, firm, and nonpunitive enforcement of limits is the goal.**

It also is important for nurses to understand that when limit setting is implemented, the maladaptive behavior will not immediately decrease; in fact, it may briefly increase. This is consistent with behavioral principles and testing behavior. If staff members understand the dynamics of this intervention, they will be able to implement this strategy effectively and understand that patient behavior will eventually change.

Behavioral Contracts. If a patient uses violence to win control and make personal gains, the nursing care must be planned to eliminate the rewards the patient receives while still allowing the patient to assume as much control as possible. Once the rewards are understood, nursing care can be

planned that does not reinforce aggressive and violent behavior. Behavioral contracts with the patient can be helpful in this regard. For example, head-injured patients with low impulse control can be told that staff will take them for a walk if they can refrain from using profanity for 4 hours.

To be effective, contracts require detailed information about the following:

- **Unacceptable behaviors**
- **Acceptable behaviors**
- **Consequences for both following and for breaking the contract**
- **The nurse's contribution to care**

Patients also should have input into the development of the contract to increase their sense of self-control. This negotiated process increases the mutuality of the therapeutic alliance and reduces the possibility of aggressive behavior.

Time-Out. In an inpatient setting the use of time-out can be an effective tool for the management of agitated patients. It is a strategy that can decrease the need for seclusion and restraint. **Time-out** from reinforcement is a behavioral technique in which socially inappropriate behaviors can be decreased by short-term removal of the patient from overstimulating and sometimes reinforcing situations.

Patients who appear to be escalating are prompted to enter time-out, which is usually a quiet, low-traffic area of the unit or the patient's room. Patients remain there until they have been nonaggressive for a couple of minutes.

Time-out allows the patient time away from a stimulating environment to regain control of oneself. Time-out may be initiated by the patient or by the staff. It is not considered to be seclusion and therefore is not subject to the regulations required for seclusion.

Patients are allowed out of the time-out area when they are able to remain calm. Patients determine their own readiness to leave the time-out area. If the patient is prevented from leaving the area for any reason, this intervention then becomes seclusion and is subject to the monitoring, documentation, and evaluation required of seclusion.

Token Economy. Another effective behavioral strategy is the implementation of a **token economy**. In this intervention, **identified interpersonal skills and self-care behaviors are rewarded with tokens that can be used by the patient to buy items or receive rewards or privileges.**

Behaviors to be targeted are specific to each patient. Guidelines should clearly specify desired behaviors required to receive tokens, the number of tokens to be received for each behavior, and the length of time a desired behavior must be exhibited to receive tokens. In a token economy, undesired behaviors can result in the loss of tokens.

Inpatient units that have implemented token economies have significantly fewer aggressive episodes than more traditional settings. This strategy for managing aggressive behavior is particularly useful with long-term, lower-functioning patient populations. The following clinical example describes the use of this intervention.

CLINICAL EXAMPLE

A regressed patient, Ms. S, refused to get out of bed in the morning. She would not shower, dress, or change her clothes. When encouraged to do these things, Ms. S became agitated, swore, and threatened to hit anyone who tried to help her.

Under her contract, Ms. S would receive two tokens for each of the following behaviors:

- Getting out of bed by 7:30 AM
- Showering before 8:00 AM
- Dressing before 8:00 AM
- Being at the breakfast table by 8:15 AM
- Eating 100% of the food on her breakfast tray by 8:45 AM
- Arriving at the community meeting by 9:00 AM

A token store was set up with the number of tokens required to purchase each item. Her contract also included the following penalty:

- An episode of swearing will result in the loss of four tokens.

Psychopharmacology

Pharmacological interventions are effective in the management of aggressive behavior (Hankin et al, 2011). They include a variety of therapeutic agents, all of which are discussed in greater detail in Chapter 26. Early use of medication can reduce the incidence of seclusion and restraint among high-risk patients early in their hospitalization (Goldbloom et al, 2010).

Patients should be given the option of an oral medication whenever possible. Liquid formulations are preferred because of their more rapid onset and increased ability to verify that the patient did indeed swallow the medication. Intramuscular injections may increase the risk of side effects as well as trauma to the patient.

Antianxiety and Sedative-Hypnotic Medications. Antianxiety and sedative-hypnotic drugs are effective in the management of acute agitation. Benzodiazepines, such as lorazepam, are often used during psychiatric emergencies to sedate combative patients. Lorazepam in particular is frequently used because of its quick onset and because it can be administered either orally or intramuscularly.

Antianxiety medications are not recommended for long-term use because they can result in confusion and dependency and may worsen depressive symptoms. **Most important, some patients experience a disinhibiting effect from benzodiazepines that can result in increased impulsive and aggressive behavior.**

Buspirone, an antianxiety drug that may be effective in the management of aggressive behavior associated with anxiety and depression, also has been shown to decrease aggression and agitation in patients with head injuries, dementia, and developmental disabilities.

Antidepressants. The selective serotonin reuptake inhibitors (SSRIs) appear to reduce the risk of violence associated with posttraumatic stress.

Mood Stabilizers. Valproate is effective in the treatment of aggression resulting from mania. Lithium is also useful in decreasing aggression resulting from mania and other disorders, such as mental retardation, head injuries, schizophrenia, and personality disorders, and in children with conduct disorder. In patients with temporal lobe epilepsy, lithium may actually increase the frequency of aggressive acts. Carbamazepine has been shown to be effective in managing aggressive behavior in patients with abnormal electroencephalograms (EEGs). Some evidence also indicates that carbamazepine may be effective in managing agitated behavior associated with dementia.

Antipsychotics. Antipsychotics are often used for the treatment of aggression. The most common medication strategy for managing violent patients in a psychiatric emergency is the high-potency typical antipsychotic haloperidol in combination with the benzodiazepine lorazepam. Both medications are considered effective for decreasing agitation, and both can be given by injection with a quick onset of action. Droperidol is also highly effective in decreasing agitation. It acts quickly and effectively to calm violent patients.

Patients given typical antipsychotics should be assessed for the occurrence of acute neuroleptic-induced akathisia, which can appear as worsening of agitation and acute dystonic reaction. This complication can be frightening and uncomfortable for patients.

Atypical antipsychotics also are used often to manage potentially violent behavior. These drugs are less likely to cause extrapyramidal side effects. The liquid concentrate and orally disintegrating tablets of risperidone plus lorazepam may be just as effective as intramuscular haloperidol plus lorazepam. In addition, the atypical antipsychotics olanzapine and ziprasidone are available in intramuscular formulations and are very effective in reducing acute agitation. Finally, the atypical antipsychotics clozapine and risperidone may be effective not only for patients with schizophrenia but also for people with dementia, brain injuries, and intellectual disabilities.

Other Medications. Naltrexone, an opiate antagonist, may reduce self-injurious behavior. This effect is particularly notable in patients with developmental disabilities. Beta-blockers, such as propranolol, have been shown to decrease aggressive behavior in children and adults and particularly in patients with organic mental disorder. Nurses should be aware of the side effects of beta-blockers, including hypotension, bradycardia, and, in some cases, depression.

Psychostimulants are used to treat aggressive behavior in children with attention deficit hyperactivity disorder (ADHD). Lithium and the atypical antipsychotics, such as risperidone, are more effective than stimulants in the treatment of aggression in children and adolescents with conduct disorders.

> **Critical Reasoning** How do the strategies for managing aggressive behavior relate to the theories of aggression described earlier in this chapter?

CRISIS MANAGEMENT TECHNIQUES

At times early interventions are unsuccessful and more active intervention is necessary. Experience and wisdom are needed to determine when verbal and other less restrictive interventions may be unsuccessful (Mann-Poll et al, 2011). **Physical control and restraint should be used only as a last resort.** Like medical emergencies, psychiatric emergencies require immediate action.

Team Response

Effective crisis management must be organized and should be directed by one clearly identified crisis leader (Box 28-6). Because psychiatric nurses are responsible for the management of patient care 24 hours per day, it is most appropriate that the crisis leader be a nurse. The leader may be the charge nurse, primary nurse, nurse manager, or a staff nurse; however, the person designated as the leader should be chosen in advance. Other staff members, including physicians, nurses, and counselors, can provide support.

The crisis leader must decide the intervention necessary to ensure the safety of both patients and staff. The decision can be a difficult one to make, especially when the acuity of the situation does not always allow adequate time to discuss all possible strategies with the entire treatment team.

Once the decision to intervene has been made, the crisis leader must obtain assistance to manage the crisis. **All members of the crisis team should be trained in crisis management and have experience working as a cohesive group.** The staff should be prepared to intervene under the direction of the crisis leader.

In many inpatient facilities, hospital security personnel are also notified when assistance is needed. It is the responsibility of the crisis leader to be acquainted with the security officers, give them a brief description of the situation, describe the intervention, and identify the role of security personnel in managing the crisis. Because security officers are not mental health professionals, their assistance should be used

BOX 28-6 PROCEDURE FOR MANAGING PSYCHIATRIC EMERGENCIES

- Identify crisis leader.
- Assemble crisis team.
- Notify security officers if necessary.
- Remove all other patients from area.
- Obtain restraints if appropriate.
- Devise a plan to manage crisis and inform team.
- Assign securing of patient limbs to crisis team members.
- Explain necessity of intervention to patient, and attempt to enlist cooperation.
- Restrain patient when directed by crisis leader.
- Administer medication if ordered.
- Maintain calm, consistent approach to patient.
- Review crisis management interventions with crisis team.
- Process events with other patients and staff as appropriate.
- Process event with the patient.
- Gradually reintegrate patient into milieu.

only when the patient cannot be physically managed by the nursing staff. Often there is little time for planning, and the leader must balance the need to act quickly with the need to be organized so that the safety of the patients and staff is not jeopardized.

The leader also is responsible for ensuring the safety of the other patients during a crisis. This can be accomplished by assigning a staff member to remove the other patients from the area. Quite often other patients become more acutely distressed in response to a psychiatric emergency on the unit and require extra nursing attention both during and after the crisis.

After the crisis has passed, allowing patients to verbalize their anxiety and concern about the crisis and processing it with them can be helpful. It is not appropriate to encourage this activity during a crisis intervention.

A room without furniture should always be readily available for an emergency. If restraints are necessary, they must be obtained from an easily accessible place. To protect the patient and staff, the leader must assess the situation quickly and devise a plan. This plan should include a brief explanation to the staff of the patient's behavior and the intervention necessary.

Staff members who will be directly involved in the intervention should each be assigned to secure one of the patient's limbs when directed to do so. The leader must also explain to the team what will be said to the patient and on what signal the staff should secure the patient's limbs.

As the group approaches within 6 to 8 feet of the patient, the leader should express concern for the patient's safety and the behavior demonstrated that has caused such concern. The patient should then be escorted to the appropriate room and informed of the necessary intervention. It should be emphasized that the intervention is not a punishment but is being provided to help ensure the safety of the patient and the rest of the unit.

If restraints are to be used, the patient should be asked to lie on the bed with arms at the sides. Quite often the presence of several staff members is enough to gain the patient's cooperation. If the patient is unable to cooperate, the patient should be told that the staff will be assisting.

Patients often hesitate at this point in their attempt to remain in control. If patients cannot cooperate within several seconds, they may be unable to cooperate at all, and the leader must then direct the staff to restrain the patient as planned. This can be very frightening for patients, and they may need several reminders that they will not be hurt but that the staff will protect them from their impulses.

During this time it is critically important that **the leader talk to the patient in a calm, steady voice and manner.** Any anxiety or ambivalence will be conveyed to the patient and contribute to a feeling of insecurity. A leader who is anxious will be unable to think clearly about the situation. Many patients are afraid of losing control, and they become assaultive not because they want to frighten people but because they themselves are frightened.

If the staff shows control of the situation, the patient's agitation is often defused. When crisis team members are overwhelmed by their own fears of the patient, they cannot be effective in reducing the patient's fear.

Consistency is also important so that the patient cannot bargain with or manipulate staff members. If the leader is indecisive, inconsistent, or easily manipulated, the patient will not be assured that the staff can guarantee safety by controlling the situation.

After the crisis is over, the team should discuss any concerns they may have had during the crisis because this type of intervention can be stressful for both staff and patients. The patient's behavior may have evoked feelings of guilt, anger, or aggression in the staff.

These issues should be discussed as a team so that care is consistent, interventions are therapeutic, and staff members do not become discouraged, negative, or burned out. **Ongoing reevaluation of the patient's status and gradual reintegration of the patient into the milieu are important as soon as the patient is no longer a danger to self or others.**

Seclusion and Restraints

Seclusion and restraints are the most restrictive interventions used in psychiatric facilities. They are viewed as a negative experience by staff and patients, have no therapeutic value other than as a last resort to ensure safety, and often raise ethical issues for staff, patients and families (Gelkopf et al, 2009; Lindsey, 2009; Mohr, 2010; Happell and Koehn, 2011). In addition, they may actually cause further trauma and harm to patients who have experienced significant physical and psychological trauma in the past.

- **Seclusion** is the involuntary confining of a person alone in a room from which the person is physically prevented from leaving.
- **Physical restraints** are any manual method or physical or mechanical device attached to or adjacent to the patient's body that the patient cannot easily remove and that restricts freedom of movement or normal access to one's body, material, or equipment.
- **Chemical restraints** are medications used to restrict the patient's freedom of movement or for emergency control of behavior but that are not standard treatments for the patient's medical or psychiatric condition.

Because seclusion and restraints represent restriction of patient freedom and can result in harm to both the patient and the staff who implement them, they should be used only as an emergency intervention to ensure the safety of the patient or others and only when other less restrictive interventions have been ineffective. They are a violation of patient rights if used as a means of coercion, discipline, or convenience of staff.

A rule developed by the Centers for Medicare & Medicaid Services (CMS) in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA) set forth regulations for patients' rights for health care facilities as a condition of participation in the Medicare and Medicaid programs. It has resulted in a decrease in the use of seclusion and restraints (Sees, 2009).

The requirements apply to all participating hospitals, including short-term, psychiatric, rehabilitation, long-term,

children's, and alcohol/drug treatment facilities. Under the rule the following apply:

- All hospital staff members who have direct contact with patients are required to have ongoing, rigorous education and training in the proper use of seclusion and restraints and alternative interventions to avoid the use of seclusion and restraints.
- A physician, licensed independent practitioner, registered nurse, or physician assistant must evaluate the patient's need for seclusion and restraints within 1 hour after the initiation of this intervention. Restraints can be ordered for a maximum of 4 hours for adults, 2 hours for adolescents ages 9 to 17 years, and 1 hour for children under age 9 years. Orders may be renewed for 24 hours before another face-to-face evaluation is necessary.
- There must be continual assessment, monitoring, and reevaluation of patients in restraints or seclusion. Patients who are both restrained and secluded must be constantly monitored face to face or by both audio and video equipment.
- Patients must be released from seclusion or restraints as soon as possible.
- Hospitals must provide patients and their family members with a formal notice of basic rights at the time of admission. These include care, privacy, and safety; confidentiality of records; and freedom from the use of restraints and seclusion for coercion, discipline, retaliation, or staff convenience.
- Health care facilities must report the death of a patient associated with the use of restraints and seclusion.

Nonclinical factors, such as cultural biases, staff members' role perceptions, and the attitude of hospital administration, have a great influence on rates of seclusion and restraint. Facilities that have been successful in decreasing or eliminating the use of seclusion and restraint have included top-level administrative support, involvement from consumers of mental health services, and a change in culture, staff education, data analysis, and individualized treatment (American Psychiatric Nurses Association, 2007; Lewis et al, 2009; Stewart et al, 2010; Benedictis et al, 2011; Borckardt et al, 2011).

Seclusion. Degrees of seclusion vary. They include confining a patient in a room with a closed but unlocked door or placing a patient in a locked room with a mattress but no linens and with limited opportunity for communication. Patients may be dressed in their clothes or in hospital clothing. A sheet or blanket and mattress are the minimally acceptable conditions for seclusion.

The rationale for the use of seclusion is based on three therapeutic principles:

- **Containment**
- **Isolation**
- **Decrease in sensory input**

Using the principle of **containment,** patients are restricted to a place where they are safe from harming themselves and other patients.

Isolation addresses the need for patients to distance themselves from relationships that, because of the illness, are pathologically intense. Some patients, particularly those with paranoia, distort the meaning of the interactions around them. Their distortions create such psychic pain that seclusion may provide some relief and may be the only place they feel safe from their "persecutors."

The third principle is that seclusion provides a **decrease in sensory input** for patients whose illness results in a heightened sensitivity to external stimulation. The quiet atmosphere and monotony of a seclusion room may provide some relief from the sensory overload.

Legal requirements for the care of the secluded patient vary from state to state. Good nursing care includes optimum fulfillment of basic human needs and concern for personal dignity. The nurse must help the patient meet biological needs by providing food and fluids, a comfortable environment, and the opportunity for use of the bathroom.

Frequent observation and monitoring are essential. The room must be constructed so the patient can be observed without being unnecessarily exposed to those who are not involved in care.

Staff should be able to communicate with the patient. **Careful records should include all nursing care and observation of the isolated patient.** The need for continued isolation should be assessed on a regular basis. It may be necessary for the nurse to initiate this review of the patient's condition with other health team members (Allen et al, 2009). Box 28-7 identifies nursing interventions related to seclusion from the Nursing Interventions Classification (NIC) project (Bulechek et al, 2008).

Critical Reasoning One of the best ways to understand patients' points of view is to "walk in their shoes." Arrange to spend 15 minutes alone in the seclusion room on a psychiatric unit. Dare you try on the restraints? Describe your thoughts and feelings.

Restraints. The patient in physical or mechanical restraints may be confused or delirious and will probably be frightened at the limitation of movement. The nurse should not assume that the patient understands the need for restraints.

Support and reassurance are critical (Moylan, 2009). Restraints should be applied efficiently and with care not to injure a combative patient. Padding of cuff restraints helps to prevent skin breakdown. For the same reason the patient should be positioned in anatomical alignment.

Privacy is essential. If visitors are allowed, the nurse should explain the reason for restraints or seclusion before they see the patient. This may help them accept the situation.

Face-to-face assessment within one hour after placing a patient in restraints is required. This evaluation should include physical risks of loss of life; other physical dangers and discomforts; the patient's psychological state; and legal and ethical concerns for the event (Nadler-Moodie, 2009).

Physical needs must be addressed in the nursing documentation. Vital signs should be checked, and regular

BOX 28-7 NIC INTERVENTIONS RELATED TO SECLUSION

Definition
- Solitary containment in a fully protective environment with close surveillance by nursing staff for purposes of safety or behavior management

Activities
- Obtain a physician's order, if required by institutional policy, to use a physically restrictive intervention.
- Designate one nursing staff member to communicate with the patient and to direct other staff.
- Identify for patient and significant others those behaviors that necessitated the intervention.
- Explain procedure, purpose, and time period of the intervention to patient and significant others in understandable and nonpunitive terms.
- Explain to patient and significant others the behaviors necessary for termination of the intervention.
- Contract with patient (as patient is able) to maintain control of behavior.
- Instruct on self-control methods, as appropriate.
- Assist in dressing in clothing that is safe and in removing jewelry and eyeglasses.
- Remove all items from seclusion area that patient might use to harm self or nursing staff.
- Assist with needs related to nutrition, elimination, hydration, and personal hygiene.
- Provide food and fluids in nonbreakable containers.
- Provide appropriate level of supervision/surveillance to monitor patient and to allow for therapeutic actions, as needed.
- Acknowledge your presence to patient periodically.
- Administer prn medications for anxiety or agitation.
- Provide for patient's psychological comfort, as needed.
- Monitor seclusion area for temperature, cleanliness, and safety.
- Arrange for routine cleaning of seclusion area.
- Evaluate, at regular intervals, patient's need for continued restrictive intervention.
- Involve patient, when appropriate, in making decisions to move toward a more/less restrictive intervention.
- Determine patient's need for continued seclusion.
- Document rationale for restrictive intervention, patient's response to intervention, patient's physical condition, nursing care provided throughout intervention, and rationale for terminating the intervention.
- Process with the patient and staff, on termination of the restrictive intervention, the circumstances that led to the use of the intervention, as well as any patient concerns about the intervention itself.
- Provide the next appropriate level of restrictive intervention (e.g., physical restraint or area restriction), as needed.

From Bulechek GM, Butcher HR, Dochterman JM, editors: *Nursing interventions classification (NIC),* ed 4, St Louis, 2008, Mosby.

observation of circulation in the extremities is necessary. Fluids should be offered regularly and opportunities for elimination provided. Skin care is also essential. Restraints should be released at least every 2 hours to allow exercise of the extremities. Nursing interventions related to the use of physical restraints from the NIC project are presented in Box 28-8.

Terminating the Intervention

Patients must be removed from seclusion or restraints as soon as they meet criteria for release. It is important to review with the patient the behaviors that led to the intervention and for the patient to be told which behaviors or impulses they need to control before the intervention can be discontinued. Communication and careful documentation are critical in making an accurate assessment of a patient's level of control.

Debriefing is an important part of terminating the use of seclusion or restraints. **Debriefing** is a therapeutic intervention that includes reviewing the facts related to an event and processing the response to them. It provides staff and patients with an opportunity to clarify the rationale for the seclusion, offer mutual feedback, and identify alternative methods of coping that might help the patient avoid seclusion in the future (Bonner et al, 2010; Larue et al, 2010; Needham et al, 2010).

Critical Reasoning Debriefing can be used after any stressful event. Describe how talking with your friends after an examination can be seen as a kind of debriefing.

PREVENTION

Employers have a duty to provide a work environment that is free from hazards that may cause death or serious physical harm to employees. Health care facilities are required by law to develop a plan to decrease the risk to staff who may be the targets of violence. Specifically, The Joint Commission's Environment of Care standards require health care facilities to address and maintain a written plan describing how an institution provides for the security of patients, staff, and visitors.

Lateral Violence

Nurses may be subjected to aggressive behavior and abuse from their nursing and physician colleagues. It is unprofessional and never acceptable and should not be tolerated.

Horizontal or lateral violence among nurses is a form of aggressive behavior. **Lateral violence** is nurse-on-nurse aggression and intergroup conflict. It includes a range of disruptive behaviors such as verbal abuse, intimidation, bullying, excessive criticism, denial of access to career opportunities, and withholding of information (Fornes et al, 2011).

Nurses are often exposed to these behaviors. Under these conditions job stress and emotional stress increase and quality of care suffer (Ditmer, 2010). Triggers or situations that often precipitate or make a nurse vulnerable to bullying and aggressive behavior from their peers and other health care professionals include:

- Being a student or new graduate
- Receiving a degree, promotion, or honor that others envy

BOX 28-8 NIC INTERVENTIONS RELATED TO PHYSICAL RESTRAINT

Definition

- Application, monitoring, and removal of mechanical restraining devices or manual restraints used to limit physical mobility of patient

Activities

- Obtain a physician's order, if required by institutional policy, to use a physically restrictive intervention or to reduce use.
- Provide patient with a private, yet adequately supervised, environment in situations in which a patient's sense of dignity may be diminished by the use of physical restraints.
- Provide sufficient staff to assist with safe application of physical restraining devices or manual restraints.
- Designate one nursing staff member to direct staff and communicate with the patient during the application of physical restraints.
- Use appropriate hold when manually restraining patient in emergency situations or during transport.
- Identify for patient and significant others those behaviors that necessitated the intervention.
- Explain procedure, purpose, and time period of the intervention to patient and significant others in understandable and nonpunitive terms.
- Explain to patient and significant others the behaviors necessary for termination of the intervention.
- Monitor the patient's response to procedure.
- Avoid tying restraints to side rails of bed.
- Secure restraints out of patient's reach.
- Provide appropriate level of supervision/surveillance to monitor patient and to allow for therapeutic actions, as needed.
- Provide for patient's psychological comfort, as needed.
- Provide diversional activities, (e.g., television, reading to patient, visitors), when appropriate, to facilitate patient cooperation with the intervention.
- Administer prn medications for anxiety or agitation.
- Monitor skin condition at restraint site(s).
- Monitor color, temperature, and sensation frequently in restrained extremities.
- Provide for movement and exercise, according to patient's level of self-control, condition, and abilities.
- Position patient to facilitate comfort and prevent aspiration and skin breakdown.
- Provide for movement of extremities in patient with multiple restraints by rotating the removal/reapplication of one restraint at a time (as safety permits).
- Assist with periodic changes in body position.
- Provide the dependent patient with a means of summoning help (e.g., bell or call light) when caregiver is not present.
- Assist with needs related to nutrition, elimination, hydration, and personal hygiene.
- Evaluate, at regular intervals, patient's need for continued restrictive intervention.
- Involve patient in activities to improve strength, coordination, judgment, and orientation.
- Involve patient, when appropriate, in making decisions to move toward a more/less restrictive form of intervention.
- Remove restraints gradually (i.e., one at a time if in four-point restraints), as self-control increases.
- Monitor patient's response to removal of restraints.
- Process with the patient and staff, on termination of the restrictive intervention, the circumstances that led to the use of the intervention, as well as any patient concerns about the intervention itself.
- Provide the next appropriate level of restrictive action (e.g., area restriction or seclusion), as needed.
- Implement alternatives to restraints, such as sitting in chair with table over lap, self-releasing waist belt, Geri-chair without tray table, or close observation, as appropriate.
- Teach family the risks and benefits of restraints and restraint reduction.
- Document the rationale for use of restrictive intervention, patient's response to the intervention, patient's physical condition, nursing care provided throughout the intervention, and rationale for terminating the intervention.

From Bulechek GM, Butcher HK, Dochterman JM, editors: *Nursing interventions classification (NIC),* ed 4, St Louis, 2008, Mosby.

- Pursuing higher education
- Having difficulty working with others
- Receiving special attention from others in the work setting

Steps can be taken to prevent workplace violence. Healthy workplaces establish a culture of respect. Nurses should support one another and victims of lateral violence, including reporting the incident. Education and effective nursing leadership can mediate oppressive and negative behavior, while ineffective nursing leadership can exacerbate lateral violence (Cleary et al, 2009). Recommendations for the prevention of disruptive and inappropriate behavior for all professionals are presented in Box 28-9.

Workplace Guidelines

Violence prevention guidelines help health care employers provide an environment that reduces exposure of employees

BOX 28-9 HOW TO PREVENT AGGRESSIVE WORKPLACE BEHAVIOR

- Education for staff about professional and respectful behavior
- Holding individuals accountable for behavior
- Organizational policies endorsing "zero tolerance" for intimidating or abusive behaviors and protection of those who report such behaviors
- Leadership training to ensure standards of behavior are upheld
- Surveillance and reporting systems for unprofessional behaviors
- Documentation systems for bullying behaviors
- Established code of conduct that defines acceptable and disruptive and inappropriate behaviors

to violence in the workplace (Adamson et al, 2009; Peek-Asa et al, 2009; U.S. Department of Labor, OSHA, 2011). These guidelines include the following:

- Management commitment and employee involvement
- Worksite analysis
- Prevention and control
- Safety and health training

For a workplace violence prevention program to be successful, administrators and managers must be willing to commit energy and resources to this initiative. The guidelines state that the goals and objectives related to the prevention of workplace violence be established by each facility and that a policy of zero tolerance for workplace violence be communicated.

The guidelines also recommend that a worksite analysis be completed to identify areas of potential vulnerability for workplace violence. The analysis should include the review of procedures and operations as well as prior incidents to identify trends. Input from employees is an important aspect of this analysis. Quantifying the frequency and severity of incidents is also needed so that improvement can be measured over time.

Once potential hazards are identified, physical changes may be needed to decrease the risk of violence. The installation of alarm systems or other security devices such as panic buttons can be crucial in enlisting necessary assistance in the event of a psychiatric emergency. Changes in procedures and practices also can be implemented to minimize the risk of danger to staff members who provide care for potentially violent patients (APNA, 2008).

Staff Development

Effective management of potentially dangerous patients requires highly skilled staff and attention to environmental and workplace factors (Linette and Francis, 2011). Nurses, physicians, and other support staff members, including security personnel, must be trained in emergency psychiatric care and crisis management techniques (Barton et al, 2009; Allen et al, 2011). This includes training in early detection of behaviors that can lead to violence, strategies to verbally intervene with agitated patients, the use of alternative interventions that can avoid seclusion and restraint and seclusion, nonviolent self-defense skills, and crisis management techniques (Johnson, 2010; Ray et al, 2011).

SAMHSA has a training curriculum, *Roadmap to Seclusion and Restraint Free Mental Health Services,* that gives mental health providers information on prevention strategies and alternative approaches to avoid and reduce the use of seclusion and restraint. It is organized in seven modules and emphasizes the importance of creating cultural change within organizations to effect reduction in seclusion and restraint practices. It should be an essential part of a staff education program.

Education should focus on assessment of the patient, particularly mental status, motor behavior, affect, and speech. Verbal intervention should be stressed as a way of defusing agitation, and helpful and nonhelpful responses should be reviewed.

All nursing interventions should be grounded in theory and current research, and crisis intervention in psychiatric emergencies is no exception. The theoretical basis and supporting research for various intervention strategies should be discussed as part of the training.

Pharmacological interventions should be reviewed, with particular attention given to the choice of medication, its purpose, and its potential adverse effects. Finally, the program should be evaluated for its effectiveness as related to the knowledge, attitude, and behavioral interventions used by the staff.

Ongoing practice sessions in crisis management should be required of all staff members. These sessions should include basic self-protection maneuvers and strategies for restraining assaultive patients.

Each member of the staff should be able to function as a leader in the event of a crisis, and the staff as a whole must be able to function smoothly as a cohesive emergency team. The nursing and medical care of these patients should be reviewed, as should the impact of countertransference issues.

The guidelines for preventing workplace violence also recommend the following as part of staff education:

- Knowledge of the workplace violence prevention policy
- Identification of risk factors that cause or contribute to assaults
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults
- Ways of preventing or diffusing volatile situations or aggressive behavior, managing anger, and appropriately using medications as chemical restraints
- Information on multicultural diversity to develop sensitivity to racial and ethnic issues and differences

Staff Support

Unfortunately, nurses are sometimes assaulted by patients. It is impossible to predict and prevent all episodes of violent behavior in a psychiatric setting. If a staff member is assaulted, the support and assistance of colleagues are needed (Lanza et al, 2011).

Nurses who have been assaulted may experience symptoms such as anger, anxiety, helplessness, irritability, hyperalertness, depression, shock, or disbelief that the assault occurred. It is not unusual for nurses to blame themselves for the assault or to question their competence in managing potentially violent patients.

Allowing adequate time off from work to address their physical and emotional needs can support nurses. Discussing the event in a nonblaming manner also can be helpful. **Validation from others that assaults occur despite clinical competence and appropriate interventions can help the assaulted nurse in healing.**

Another way of helping nursing staff members who have been assaulted is through a peer support group, which legitimizes staff responses and allows for the expression of feelings in a supportive setting. Developing a staff action program made up of volunteers who work with staff members in

critical incident debriefing, run support groups, and offer specialized services such as family and community meetings is another effective strategy.

A final suggestion is the implementation of a nursing consultation support service that responds to the needs of assault victims and sets the tone for institutional attitudes of nonblaming concern. All these programs have merit, and each organization should select the best way to deal with the problem of staff assault based on the environment, group process, and institutional resources.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Mary Brown, RN

When I think about aggressive behavior, I think back to an incident that could have ended badly but instead resulted in the people involved receiving the help needed. I was working for an agency that provided intensive case management for chronically mentally ill people. The event took place on a weekend. Office hours were 9 AM to 5 PM during the week, and a person was assigned to be on call after working hours and on all weekends.

I was the person on call this particular weekend. One of the agency's patients had been hospitalized and was now ready for discharge. This patient was deaf, and I was to pick him up from the hospital and see that he got settled in his home. After I left the hospital with the patient, my beeper went off indicating I needed to call the answering service.

I was close to the office, so I stopped there to use the phone. The building has two stories, and I had access only to the top floor. I climbed the stairs with the discharged deaf patient behind me, unlocked the door, walked in, and then turned around to shut the door, but a large hand kept me from doing so.

The hand belonged to a man who was over 6 feet tall, weighed approximately 250 pounds, and appeared to be psychotic. He forced his way into the building with the patient and me. I was terrified at this point. He stated, "I came to get my money," in an angry and loud tone of voice.

I then recognized him as a patient I had worked with before and could see the changes in him, which made me feel unsafe to be alone with him. I tried very hard not to let him know how frightened I was of him. I told him the office was closed and he needed to come back Monday, when the appropriate people could help him.

He shouted, "I want my money now!" I became increasingly frightened. There was no panic button to push for help. There were no other staff members to distract him to allow me to get my deaf patient and myself to safety. I was the one who needed to protect us.

In a calm voice, I told him I couldn't help him get his money. I told him I would need to go to the staff room (he was aware that patients were not allowed in this room) to call someone to help him. He followed me into the room. I firmly told him that he was not allowed in the room and to please leave. He sat down anyway.

I told him I was only at the office to return an emergency call. I called the service and the doctor who paged me was checking to see whether everything went okay with the discharged patient. I told him about the intrusion from the angry and irrational man who was insisting on staying until he got his money. The doctor said he would call the police.

While waiting for the police, I kept trying to get the patient to leave the room. He repeatedly refused. He sat at one end of the table, and I sat at the other end. The deaf patient was watching our interaction intensely.

The angry patient appeared to be responding to internal stimuli. He was looking at me and began to laugh. He stopped laughing and said, "Why won't you go out with me?" as he proceeded to my end of the table. I told him firmly that this behavior was not appropriate. I reinforced that I was his nurse, and again I asked him to leave the room. He stopped, looked at me inexplicably, and said, "I'll be back on Monday to get my money."

When I heard the door slam, I quickly locked the door. The doctor called back to say that the police were on their way and asked whether everything was okay. While shivering, I managed to say "yes." The police picked the angry patient up downstairs and found that he was carrying a screwdriver. He told them that he was at the office before I arrived and intended to break into the office to take his money.

The deaf patient who was watching all this communicated with me by writing on a piece of paper, "Are you all right? I could tell you were afraid of him." I was amazed. A layperson as well as a skilled observer can decipher nonverbal communication. I also was reminded of the value of setting firm limits and giving clear, consistent, and nonthreatening messages at all times when managing aggressive behavior.

CHAPTER IN REVIEW

- High rates of assaultive behavior have been reported in a variety of health care settings, including outpatient clinics, nursing homes, EDs, and psychiatric settings.
- Within each person lies the capacity for passive, assertive, or aggressive behavior. The situation and the characteristics of the person define the most appropriate response.
- Passive people give up their own rights to their perception of the rights of others. Passivity can be expressed nonverbally or as sarcasm.
- Aggressive people ignore the rights of others. They think that they must fight for their own interests, and they expect the same behavior from others.
- Assertive behavior conveys a sense of self-assurance but also communicates respect for the other person. Assertiveness involves communicating feelings directly to others.
- Anger usually occurs as a response to a perceived threat.
- Theories on the development of aggressive behavior include psychological, sociocultural, and biological factors.
- Psychological factors suggest the importance of an intergenerational transmission of violent behavior. Social learning theory proposes that aggressive behavior is learned.
- Cultural norms help define acceptable and unacceptable ways of expressing aggressive feelings.
- Biological research supports the involvement of three areas of the brain in aggression: the limbic system, the frontal lobes, and the hypothalamus. Neurotransmitters also play a role.
- The best single predictor of violence is a history of violence.
- Two populations of patients are at increased risk of violence: patients with active psychotic symptoms and patients with substance abuse disorders.
- Nurses need to assess all patients for their potential for violence, including their motor agitation, verbalizations, affect, and level of consciousness. A formal screening tool may be useful in this process.
- Many nursing interventions may be helpful in dealing with aggressive behavior, including self-awareness, patient education, assertiveness training, communication strategies, environmental strategies, behavioral strategies, and psychopharmacology.
- Effective crisis management must be organized and clearly directed by one team leader.
- Because seclusion and restraints represent restriction of patient freedom and can result in harm to both the patient and the staff who implement them, they should be used only as an emergency intervention to ensure the safety of the patient or others and only when other less restrictive interventions have been ineffective. They are a violation of patient rights if used as a means of coercion, discipline, or convenience of staff.
- Seclusion and restraints should be used only as a last resort.
- Employers have a duty to provide a work environment that is free from hazards that may cause death or serious physical harm to employees. Health care facilities are required by law to develop a plan to decrease the risk to staff members who are often the targets of violent patients.
- Nurses may be subjected to aggressive behavior and abuse from their nursing and physician colleagues. It is unprofessional and never acceptable and should not be tolerated.
- Horizontal or lateral violence among nurses is a form of aggressive behavior.
- Staff development issues include educating staff in crisis management techniques and working with staff members who have been assaulted.

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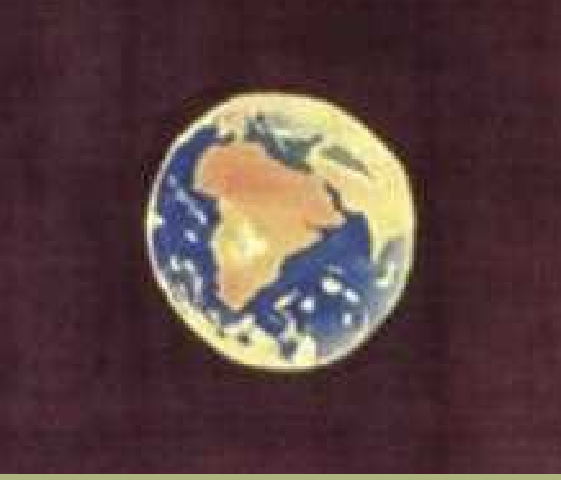
CHAPTER

29

Somatic Therapies

Carol M. Burns



Canst thou not minister to a mind diseas'd,
Pluck from the memory rooted sorrow,
Raze out the written troubles of the brain,
And with some sweet oblivious antidote
Cleanse the stuff'd bosom of the perilous stuff
Which weights upon the heart?

William Shakespeare, Macbeth, Act V

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LEARNING OBJECTIVES

1. Analyze the use, indications, mechanism of action, and adverse effects of convulsive therapies (electroconvulsive therapy [ECT] and magnetic seizure therapy) as treatment strategies for psychiatric illness.
2. Discuss the nursing care needs of the patient receiving ECT.
3. Analyze the use, indications, mechanism of action, and adverse effects of chronotherapy (phototherapy, sleep deprivation) as treatment strategies for psychiatric illness.
4. Analyze the use, indications, mechanism of action, and adverse effects of transcranial magnetic stimulation, cranial electrotherapy stimulation, and implantable brain stimulation devices as treatment strategies for psychiatric illness.
5. Analyze the use, indications, mechanism of action, and adverse effects of implantable brain stimulation devices (vagus nerve stimulation and deep brain stimulation) as treatment strategies for psychiatric illness.

Growing knowledge of neuroscience has increased interest in somatic therapies for psychiatric illness. The limitations of psychotropic medications increase in treatment-resistant psychiatric disorders, and refinement in treatment techniques has placed greater emphasis on somatic therapies.

Nurses provide care to patients receiving somatic therapies and it is essential that all nurses understand how these treatments work. This includes an understanding of nursing care that enhances their effectiveness. This chapter discusses some of the most current somatic therapies used for psychiatric illnesses (Higgins and George, 2009).

CONVULSIVE THERAPIES

Electroconvulsive therapy (ECT) was first described in 1938 as a treatment for schizophrenia, when it was believed that people with epilepsy were rarely schizophrenic, and it was thought that convulsions could cure schizophrenia. This was

not supported by later research. ECT is actually more effective for mood disorders than for schizophrenia (Payne and Prudic, 2009a).

- Electroconvulsive therapy is a treatment in which a grand mal seizure is artificially induced in an anesthetized patient by passing an electrical current through electrodes applied to the patient's head (Mankad et al, 2010).
- Magnetic seizure therapy (MST) is a newer form of treatment that uses a magnetic current instead of electricity**.** MST has been developed based on the ECT model. It uses a magnetic stimulus to produce controlled seizures in selected regions of the brain. It was developed in an effort to reduce seizure spread to medial temporal structures, thus limiting cognitive side effects (Kayser et al, 2009; Cycowicz et al, 2009). Clinical experience with MST is still limited, and current studies are exploring its antidepressant efficacy.

Traditionally electrodes in ECT have been applied **bilaterally.** Alternative electrode placements are now routinely used, including **bifrontal and unilateral.** Patients have equal effectiveness and fewer cognitive side effects with these alternative placements, including less disorientation and fewer disturbances of verbal and nonverbal memory (Sackeim et al, 2008; Peterchev et al, 2010).

Studies of a new form of unilateral ECT, called **focal electrically administered seizure therapy (FEAST)** appears to minimize cognitive effects of ECT even further (Pierce et al, 2008). Figure 29-1 illustrates the different electrode placements.

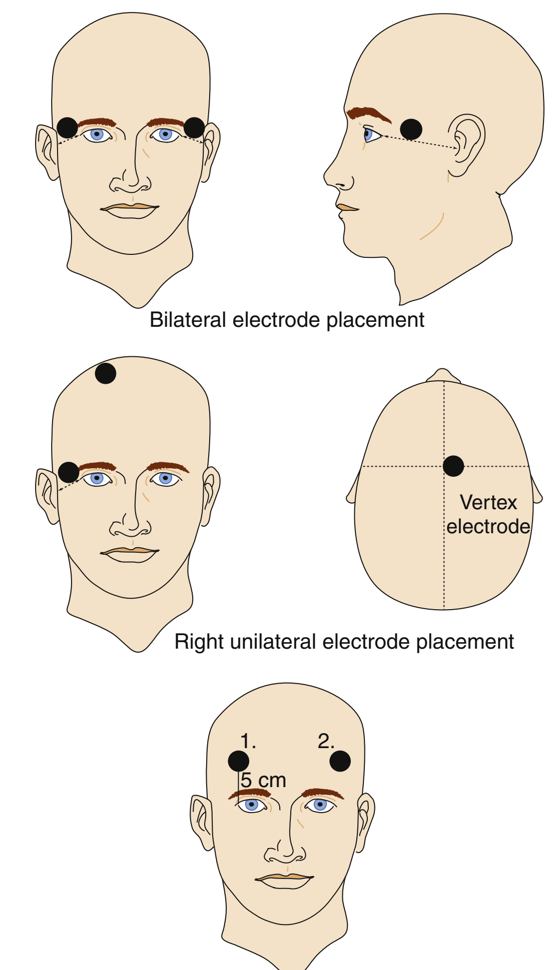


FIG 29-1 Electrode placement in electroconvulsive therapy.

For ECT to be effective, a grand mal seizure must occur. The electrical stimulus is adjusted to the minimum energy that produces a seizure. Treatments are given in a series, which varies by the patient's therapeutic response. **A usual course is 6 to 12 treatments given two or three times per week.** Patients with schizophrenia may require more.

ECT is an effective psychiatric treatment and is generally well tolerated by patients. In some cases, after a successful initial course of treatment, maintenance ECT plus antidepressant medication is recommended: weekly treatments for the first month after remission, gradually tapering to monthly (APA, 2001).

> **Critical Reasoning** ECT is sometimes called "shock therapy." Describe how use of this term stigmatizes mental illness and its treatment.

Indications

The primary indication for ECT is major depression (Weiner and Falcone, 2011). Some see it as the gold standard for treatment-resistant depression (Nahas and Anderson, 2011). ECT's response rate of 80% or more for most patients is better than response rates for antidepressant medications, and is considered to be the most effective antidepressant in use (Keltner and Boschini, 2009).

It can be used for people in most age-groups who cannot tolerate or fail to respond to treatment with medication. Box 29-1 lists the primary and secondary criteria for the use of ECT as determined by the American Psychiatric Association (APA) Task Force on Electroconvulsive Therapy.

Primary criteria in which ECT may play a life-saving role involve patients who are extremely depressed and suicidal or are so hyperactive that they are in grave danger of self-harm, such as those with acute mania and affective disorders with psychosis. ECT is considered appropriate for patients with schizophrenia in a few situations. This includes when psychotic symptoms have an abrupt or recent onset, the duration of illness is short, catatonia is present, or the patient has responded well to ECT in the past.

Finally, ECT should be an initial intervention when its anticipated side effects are considered less harmful than those associated with drug therapy in populations such as the elderly, patients with heart block, and women who are pregnant. The potential effectiveness of ECT is reduced in those with personality disorders. Box 29-2 **summarizes behaviors for which ECT is and is not effective.**

> **Critical Reasoning** Why would ECT be particularly indicated for depressed patients with heart block?

BOX 29-1 CRITERIA FOR THE USE OF ELECTROCONVULSIVE THERAPY (ECT)

Primary Use

Situations in which electroconvulsive therapy may be used before a trial of psychotropic medications include, but are not limited to, the following:

- Need for rapid, definitive response owing to the severity of a psychiatric or medical condition
- Risks of other treatments outweigh the risks of ECT
- History of poor medication response or good ECT response in one or more previous episodes of the illness
- Patient preference

Secondary Use

In other situations a trial of an alternative therapy should be considered before referral for ECT. Subsequent referral for ECT should be based on at least one of the following:

- Treatment resistance (taking into account issues such as choice of medication, dosage, duration of trial, and compliance)
- Intolerance or adverse effects with pharmacotherapy that are deemed less likely or less severe with ECT
- Deterioration of the patient's psychiatric or medical condition that creates a need for a rapid, definitive response

From American Psychiatric Association: *The practice of electroconvulsive therapy: recommendations for treatment, training, and privileging,* ed 2, Washington, DC, 2001, The Association.

BOX 29-2 TARGET BEHAVIORS FOR ELECTROCONVULSIVE THERAPY (ECT)

ECT Proved Effective

- Catatonia
- Severe psychosis with acute onset
- Life-threatening psychiatric conditions
- Rigidity of parkinsonism or neuroleptic malignant syndrome

ECT Proved Ineffective

- Severe character pathology
- Substance abuse and dependence
- Sexual identification disorders
- Psychoneurosis
- Chronic illness without obvious psychopathology

Mechanism of Action

Despite much research, the exact mechanism of action of ECT is still unknown. The most popular theories include:

- **Neurotransmitter theory** suggests that ECT acts like tricyclic antidepressants by enhancing deficient neurotransmission in monoaminergic systems. Specifically, it is thought to improve dopaminergic, serotonergic, and adrenergic neurotransmission.
- **Neurotrophic factor theory** suggests that cyclic adenosine monophosphate (AMP) is up-regulated with ECT, which increases brain-derived neurotrophic factor (BDNF). BDNF regulates neuronal cell growth and is also involved in norepinephrine and serotonin receptor expression.
- **Anticonvulsant theory** suggests that ECT treatment exerts a profound anticonvulsant effect on the brain that results in an antidepressant effect. Some support for this theory is based on the fact that a person's seizure threshold rises over the course of ECT and that some patients with epilepsy have fewer seizures after receiving ECT.

Adverse Effects

The mortality rate associated with ECT is estimated to be the same as that associated with general anesthesia in minor surgery (approximately 2 to 10 deaths per 100,000 treatments) (Payne and Prudic, 2009b). Mortality and morbidity are believed to be lower with ECT than with the administration of antidepressant medications.

Medical adverse effects can, to some extent, be anticipated and prevented. Patients with preexisting cardiac illness, compromised pulmonary status, a history of central nervous system problems, or medical complications after anesthesia are likely to be at increased risk. Thus the work-up preceding ECT should include a thorough review of the patient's history and may include a complete blood count, serum chemistry profile, chest and spinal radiographs, electrocardiography, and a computed tomography scan of the head. Adverse effects potentially can occur in the following categories:

- **Cardiovascular:** Transient cardiovascular changes are expected in ECT. Routine electrocardiograms (ECGs) are performed to rule out baseline pathology, with further work-up as indicated.
- **Systemic:** Headaches, nausea, muscle soreness, and drowsiness may occur after ECT, but usually respond to supportive management and nursing intervention.
- **Cognitive:** ECT is associated with a range of cognitive side effects, including confusion immediately after the seizure and memory disturbance during the treatment course, although a few patients report persistent deficits. The onset of cognitive side effects varies considerably among patients. Patients with preexisting cognitive impairment, those with neuropathological conditions, and those receiving psychotropic medication during ECT are at increased risk of developing side effects. **No evidence has been found to indicate that ECT causes brain damage** (McClintock and Husain, 2011).

Nursing Care

Psychiatric nurses have always had a role in assisting with the ECT procedure. This role has evolved to include independent and collaborative nursing actions.

Emotional Support and Education. Nursing care begins as soon as the patient and family are presented with ECT as a treatment option. **An essential role of the nurse is to allow the patient an opportunity to express feelings, including concerns associated with myths or fantasies involving ECT.** Patients may describe fears of pain, dying of electrocution, suffering permanent memory loss, or experiencing impaired intellectual functioning.

As the patient reveals these fears and concerns, the nurse can clarify misconceptions and emphasize the therapeutic value of the procedure. Supporting the patient and family is an essential part of nursing care before, during, and after treatment (Payne and Prudic, 2009b).

The nurse can then begin patient and family teaching, taking into consideration anxiety, readiness to learn, and ability to understand. The amount of information provided should be individualized. The nurse reviews with the patient and family the information they have received and responds to any questions.

During this assessment process the nurse also should attempt to identify specific target behaviors the family associates with the patient's illness. Any information about the family's previous experiences with ECT helps the nurse identify beliefs about the patient's illness, ECT treatment, and expected prognosis.

Open-ended questions may give the nurse the opportunity to identify and correct misinformation and address specific concerns the patient or family has about the procedure. Nursing actions may facilitate the family's ability to provide support to the patient thus further reducing the patient's anxiety.

Various media may be used to teach the patient and family about ECT, including written materials and videos individualized for each patient. A tour of the treatment suite may help familiarize the patient with the area and equipment. Encouraging the patient to talk with another patient who has benefited from ECT may be worthwhile.

Finally, facilitating flexibility in family visiting arrangements, particularly during the patient's first few treatments, may be helpful in allaying the family's anxieties and concerns about the treatment while encouraging the family to support the patient. If the family cannot or does not want to visit, the nurse should contact the family after treatments. The nurse also should encourage family members throughout the course of treatment to discuss changes they observe in the patient or concerns that arise.

Critical Reasoning Many misconceptions exist regarding ECT. Many of these are perpetuated by movies. Observe ECT in person and then watch the movies *One Flew Over the Cuckoo's Nest, Frances, Ordinary People*, and *Girl Interrupted* and critique the way in which ECT is presented.

Before ECT treatment begins, an informed consent form must be signed by the patient or, if the patient does not have the capacity to give consent, by a legally designated person (Chapter 8). This consent acknowledges the patient's rights to obtain or refuse treatment. Although it is the physician's ultimate responsibility to explain the procedure when obtaining consent, the nurse plays an important part in the consent process (Fetterman and Ying, 2011).

Informed consent is a dynamic process that is not completed with the signing of a formal document; rather, the process continues throughout the course of treatment. It is helpful if a nurse is present when ECT is discussed with the patient. It is preferred that this is a nurse who already has established a trusting and therapeutic relationship with the patient.

The nurse also can ensure that, before signing the consent form, the patient has understood fully the explanation of ECT, including its nature, purpose, and implications, and that the patient has the option to withdraw consent at any time. After the consent form has been signed but before the beginning of treatment, the nurse should again thoroughly review the information and discuss the treatment with the patient in an open and direct manner.

Certain patients pose particular challenges to the nurse when obtaining informed consent. If a patient is unable to make independent judgments and meaningful decisions about care and treatment, the nurse is responsible for acting as a patient advocate.

For example, concentration is often impaired in depressed patients, so they are less likely to comprehend and retain new information. For these patients it is essential that the nurse repeat the information at regular intervals because new knowledge is seldom fully absorbed after only one explanation. Then, throughout the patient's treatment course, the nurse should reinforce relevant information, remind the patient of anything that may have been forgotten, and answer any new questions.

Pretreatment Nursing Care. Providing quality nursing care for the patient receiving ECT includes evaluating the pretreatment protocol to ensure that it has been followed according to hospital policy. **This involves reviewing recommended consultations, noting that any abnormalities in laboratory tests have been addressed, and checking that equipment and supplies are adequate and functional.**

The treatment nurse is responsible for ensuring proper preparation of the treatment suite. Box 29-3 provides a list of standard equipment needed to provide optimal patient care. A crash cart with defibrillator should be readily available for emergency use.

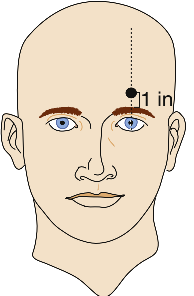
Patient preparation for ECT is similar to that for any brief surgical procedure. General anesthesia is required, so fluids should be withheld from the patient for 6 to 8 hours before treatment to prevent the potential for aspiration. The exception to this NPO status is in the case of patients who routinely receive cardiac medications, antihypertensive agents, or H_2 blockers. These drugs should be administered several hours before treatment with a small sip of water.

The patient should be encouraged to wear comfortable clothing, which can include loose-fitting street clothes, pajamas, or a hospital gown, preferably clothing that can be opened in the front to facilitate the placement of monitoring equipment.

The patient's hair should be clean and dry to facilitate optimal electrode contact. The patient should void immediately before receiving ECT to help prevent incontinence during the procedure and to minimize the potential for bladder distention or damage.

BOX 29-3 EQUIPMENT FOR ELECTROCONVULSIVE THERAPY

- Treatment device and supplies, including electrode paste and gel, gauze pads, alcohol preps, saline, electroencephalogram (EEG) electrodes, and chart paper
- Monitoring equipment, including electrocardiogram and EEG electrodes
- Blood pressure cuffs (two), peripheral nerve stimulator, and pulse oximeter
- Stethoscope
- Reflex hammer
- Intravenous and venipuncture supplies
- Bite-blocks with individual containers
- Stretchers with firm mattress and side rails and with the capability of elevating the head and feet
- Suction device
- Ventilation equipment, including tubing, masks, Ambu bags, oral airways, and intubation equipment with an oxygen delivery system capable of providing positive pressure oxygen
- Emergency and other medications as recommended by anesthesia staff
- Miscellaneous medications for medical management during ECT, such as anesthetics, beta blockers, muscle relaxants, anticholinergics, benzodiazepines, etc.



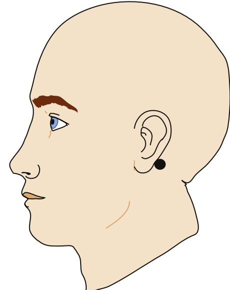


FIG 29-2 Electroencephalogram (EEG) electrode placement.

Nursing Care During the Procedure. The patient should be brought to the treatment suite either ambulatory or by wheelchair, accompanied by a nurse with whom the patient feels at ease. **The nurse should remain with the patient throughout the treatment to provide support.**

On arrival the patient should be introduced to the members of the treatment team and given a brief explanation of each person's role in the ECT procedure. The patient should then be assisted onto a stretcher and asked to remove shoes and socks. This allows for the placement of a blood pressure cuff on an ankle and clear observation of the patient's extremities during the treatment.

Once the patient is positioned comfortably on the stretcher, a member of the anesthesia staff inserts a peripheral intravenous line. One member of the treatment team should explain the procedure while it is occurring.

Electroencephalographic (EEG) monitoring consists of two or more electrodes placed on the forehead and mastoid (Figure 29-2). A set of three-lead ECGs is placed on the patient's chest. A pulse oximeter is clipped to the patient's finger to monitor oxygen saturation.

Blood pressure monitoring throughout the treatment is accomplished by either a manual or automatic cuff. A peripheral nerve stimulator helps to determine muscle relaxation.

The patient's head is then cleaned with mild soap at the sites of electrode contact. This cleansing process facilitates optimal stimulus electrode contact during treatment, thus eliminating the potential for skin burns and minimizing the amount of electrical stimulus. The areas being cleaned will be either the forehead if bilateral or bifrontal electrode placement is to be used, or the right temple and top of the head 1 inch to the right of the midline if unilateral placement is used.

Once the preparation is completed an **anticholinergic agent,** such as glycopyrrolate (0.1 to 0.4 mg) or atropine (0.3 to 0.6 mg), may be administered intravenously to decrease oral secretions and minimize cardiac bradyarrhythmias in response to the electrical stimulus.

Next an **anesthetic,** usually methohexital, or etomidate (0.15 mg/kg), is administered. When the patient is asleep the blood pressure cuff on the ankle is inflated, allowing it to serve as a tourniquet, so motor seizure activity can be visualized in that extremity.

A **muscle relaxant,** succinylcholine (usual dose approximately 0.75 mg/kg) or rapacuronium (a nondepolarizing muscle relaxant recently approved by the U.S. Food and Drug Administration [FDA]) (usual dose 1.5 mg/kg) is then administered to minimize the patient's motor response to the ECT treatment.

Progressive muscle relaxation is monitored by the nerve stimulator, as well as by observing the patient for the cessation of muscle twitching. As the muscle relaxant takes effect, the anesthesiologist provides oxygen by mask to the patient through positive pressure ventilation.

Although most muscles become completely relaxed, jaw muscles are stimulated directly by the ECT, causing the patient's teeth to clench. This creates the need for a **bite-block** to be inserted in the patient's mouth by the treatment nurse before the electrical stimulus. This device prevents tooth damage and tongue or gum laceration during the stimulus. The patient's chin is firmly supported against the bite-block during delivery of the brief electrical stimulus. After delivery of the stimulus, the bite-block may be removed.

The electrical stimulus causes a brief generalized seizure. Motor signs of the seizure can be observed in the cuffed foot. Characteristic EEG changes also may be observed. One member of the treatment team records the time elapsed during the seizure.

A seizure lasting 15 to 20 seconds is considered adequate to produce a therapeutic effect. Seizures lasting longer than 2 minutes should be terminated to prevent a prolonged postictal state. The seizure may be terminated by using a benzodiazepine, such as midazolam, or additional anesthetic given at half the induction dose.

Anesthesia staff continuously ventilate the patient with oxygen during the procedure until the patient is able to breathe spontaneously. **The nurse should monitor vital signs both before and after the ECT treatment.** Once the patient is stabilized, the anesthesiologist clears the patient for transfer to the recovery area.

Posttreatment Nursing Care. The recovery area should be adjacent to the treatment area to provide accessibility for anesthesia staff in case of an emergency. **The area should contain oxygen, suction, pulse oximeter, vital sign monitoring, and emergency equipment.** The area should be adequately staffed and provide minimal sensory stimulation.

Once the patient is in the recovery area with pulse oximeter in place, a staff member should observe the patient until awakening. When the patient awakens, a nurse should discuss the treatment and check vital signs as indicated. The nurse should provide frequent reassurance and reorientation at frequent intervals. Providing brief, distinct direction is most beneficial.

When the patient appears ready to return to the hospital room, the nurse verifies that the patient's vital signs, oxygen saturation, and mental status have returned to an acceptable level. Wheelchair transport from the recovery area is advisable.

The ECT treatment nurse provides information about the patient to the nursing staff. This includes medications that have been given to the patient, as well as any change in the procedure that may impact the patient's condition upon return to the unit. Table 29-1 identifies some common problems patients may have and the related nursing interventions.

Patients should be observed at least once every 15 minutes. If the patient is agitated, confused, or restless, one-to-one observation may be required until the patient's condition has stabilized. If the patient is awake, the level of orientation should be assessed every 30 minutes until mental status returns to baseline. If sleeping, the patient should remain undisturbed unless additional nursing intervention is needed, as sleeping may help the patient recover more quickly.

After assessing the return of the gag reflex, medications and a meal may be offered. When fully awake the patient should be on fall precautions. Any confusion or disorientation is likely to be of short duration. The patient may respond well to restricted environmental stimulation, and frequent nursing contacts focusing on reorientation are helpful. Memory loss affects primarily material that has been recently learned and any information acquired during the time of the ECT treatments.

Memory loss is distressing for the patient. **The nurse should clarify that most memory problems will pass within several weeks.** A minimal amount of difficulty with memory may last up to 6 months, and some information can never be retrieved, including the experience of the treatment itself and events that occurred just before the procedure, such as intravenous placement. In addition, events that occurred during treatment may be unclear. A summary of nursing interventions for patients receiving ECT is presented in Table 29-2.

Critical Reasoning What kind of post-ECT environment do you think would be most helpful to the patient's recovery?

Interdisciplinary Collaboration. The nurse is part of an interdisciplinary treatment team that not only administers the treatments but also collaborates to evaluate the effectiveness of ECT and recommend changes in the patient's treatment

TABLE 29-1 COMMON PATIENT PROBLEMS AND NURSING INTERVENTIONS RELATED TO ELECTROCONVULSIVE THERAPY (ECT)

PATIENT PROBLEM	NURSING INTERVENTIONS
Pretreatment with beta-blockers may cause a decrease in blood pressure, pulse, or both.	Vital signs should be monitored frequently until they return to normal.
Lengthy seizures (more than 2 minutes) may increase the duration of disorientation or confusion.	Reorientation may need to be repeated for longer periods than usual.
If given a barbiturate or benzodiazepine to terminate the seizure, the patient may be more drowsy than usual.	Patient may need more time to rest after treatment.
After effects may increase potential for falls.	Increase intensity of observation to prevent falls.
Nausea and vomiting create potential for aspiration.	Extended stay in the recovery area may be necessary to provide access to suctioning equipment.
Headache creates alteration in comfort.	After assessment for gag reflex return, an analgesic may be administered. If headache is a recurrent problem, a standing order for analgesia to be given as soon as possible after each treatment may be obtained. Change in activity schedule and environment to provide a darkened room or quiet area may be necessary. Cryotherapy, a frozen gel band, may be an alternative approach because of the different mechanisms by which it relieves pain in patients with post-ECT headache.

plan. The nurse identifies patterns of patient behavior and evaluates their implications as related to treatment response.

Adverse behaviors associated with ECT should be reported, including prolonged periods of confusion or disorientation, recurrent nausea or headaches, elevation in blood pressure that does not resolve within several hours after treatment, or an increase in the intensity or occurrence of target symptoms. Together the team evaluates length of the ECT treatment course, the need for modifications in the treatment plan, and considerations for maintenance ECT.

> **Critical Reasoning** Give specific examples of ways in which the psychiatric nurse's role in ECT has evolved from the dependent function of implementing physicians' orders to more independent and interdependent areas of psychiatric nursing practice. How have patients benefited from this change?

Nursing Staff Education. Despite recent increases in the use of ECT and its effectiveness in the treatment of certain psychiatric illnesses, the procedure continues to elicit emotional responses from the public, medical, and nursing communities. Some of these responses may be positive, but many people react negatively to ECT based on outdated ideas and procedures.

It is essential that when a patient is referred for ECT the patient and family be presented with information regarding treatment options in a balanced and unbiased manner. If a nurse has ambivalent or negative feelings about ECT, these feelings can be communicated to the patient and render the treatment course less effective. To function as patient advocates, nurses need to examine their attitudes and have as much information about the procedure as possible.

Staff and students need to be educated about the latest evidence regarding ECT. Programs should be developed that address both cognitive and attitudinal content. Programs might start by asking staff to discuss their beliefs and feelings about ECT. The content can then move to a discussion of factual information about ECT, including the rationale for the treatment, possible mechanisms of action, its efficacy relative to other treatment options, risks and side effects resulting from ECT, and current research on its indications and benefits. **All nurses should be encouraged to observe the ECT procedure as performed in their institution.**

These discussions can be supplemented with written handouts, reference articles, and teaching videos on the topic of ECT. Nursing standards of care for patients receiving ECT and a standardized nursing care protocol should be established. In addition to informing nurses who routinely care for patients undergoing ECT, the nursing community at large needs more information about ECT including those who work in geriatrics, neurology, and medicine.

> **Critical Reasoning** What stereotyped views did you have about ECT before reading this chapter? How have they changed, and how might this experience help you educate patients and colleagues about this treatment procedure?

CHRONOTHERAPY

Chronotherapy is a group of interventions that are based on how circadian rhythm changes contribute to mood

TABLE 29-2 NURSING INTERVENTIONS FOR THE PATIENT RECEIVING ELECTROCONVULSIVE THERAPY (ECT)

PRINCIPLE	RATIONALE	NURSING INTERVENTIONS
Informed participation in the procedure	A patient who understands the treatment plan will be more cooperative and have less stress than one who does not; an informed family is able to provide the patient with emotional support.	Educate regarding ECT, including the procedure and expected effects. Teach family about the treatment. Encourage expression of feelings by patient and family. Reinforce teaching after each treatment.
Biological integrity	General anesthesia and an electrically induced seizure are physiological stressors and require supportive nursing care.	Check emergency equipment before procedure. Maintain NPO status several hours before treatment. Remove potentially harmful objects, such as jewelry and dentures. Check vital signs. Maintain patent airway. Assist to ambulate. Offer analgesia or antiemetic as needed.
Dignity and self-esteem	Patients are usually fearful before ECT treatment; amnesia and confusion may lead to anxiety and distress; patient will need help to function appropriately.	Remain with the patient and offer support before and during treatment. Maintain the patient's privacy during and after treatment. Reorient the patient. Help family members understand behavior related to amnesia and confusion.

NPO, nothing by mouth.

disturbances. The interventions include phototherapy and sleep deprivation (also called "all night wake therapy").

Phototherapy exposes a patient to artificial therapeutic lighting about 5 to 20 times brighter than indoor lighting. Patients usually sit with eyes open about 3 feet away from and at eye level with a box containing a set of broad-spectrum fluorescent bulbs designed to produce the intensity and color composition of outdoor daylight. They then can engage in their usual activities, such as reading, writing, or eating (Figure 29-3).

The timing and dosage of the light vary from person to person. Bright light treatment administered in the morning simulating dawn is most effective (Termann, 2007). In addition, shorter wavelength light is more effective than longer wavelengths. The amount of light to which a person is exposed depends on the intensity of the light source and the duration of exposure.

Sleep deprivation consists of total absence of sleep, which can be for an entire single night, a partial night, or a combination of both. A single night of sleep deprivation can be an effective antidepressant treatment in up to 60% of patients. Unfortunately, the effect is short-lived, with full or partial relapse frequently occurring after napping or with sleep on the subsequent night.

Chronotherapy appears to have important positive effects. Treatment is rapid and can be repeated. Treatment can be received at home, and it need not disrupt one's daily routine, although a professional with experience and training should supervise initial therapy sessions (Benedetti et al, 2007).

Indications

Chronotherapy has a response rate above 60% in patients with well-documented, nonpsychotic winter depression or seasonal affective disorder (SAD). SAD is a cyclical mood disorder characterized by periods of depression that begin in October and subside in April (Chapter 18). It is a safe and satisfactory treatment, particularly for those with seasonal types of depression (Privitera et al, 2010). It has shown some efficacy for non-seasonal depression as well.

Chronotherapy may be of value to patients who prefer nonpharmacological treatments. Due to its rapid response, it may be even more beneficial as an adjunct to other treatments.

FIG 29-3 Broad-spectrum fluorescent lamps such as this one are used in daily therapy sessions from autumn until spring for people with seasonal affective disorder (SAD), who report feeling less depressed within 3 to 7 days after treatment begins. (Courtesy Apollo Health.)

Mechanism of Action

Chronotherapy is based on biological rhythms, particularly those related to light and darkness (Chapter 5). The exact mechanism of action of chronotherapy remains unclear; however, the most popular theory relates to "phase shift." This is defined as an abnormal phase delay in circadian rhythm.

Adverse Effects

Side effects, when they occur, are generally mild. The most common adverse effects of phototherapy are eyestrain and headache. Patients with a history of mania or hypomania should use light therapy with caution because it may precipitate those conditions.

Other adverse effects include irritability; insomnia; fatigue; nausea; and dryness of the eyes, nasal passages, and sinuses. These usually can be managed by decreasing the duration of therapy or increasing the patient's distance from the light.

The long-term effects of phototherapy, if any, are currently unknown. Light therapy should be used with caution in those with specific ophthalmic conditions.

Sleep deprivation may induce mania in some patients with bipolar disorder. Thus sleep deprivation, as with some antidepressant medications, should be used with caution in patients who are susceptible to mania or have a family history of bipolar illness.

> **Critical Reasoning** Do you think that people who experience common disturbances in body rhythms such as jet lag and shift work can be helped by phototherapy?

TRANSCRANIAL MAGNETIC STIMULATION

Transcranial magnetic stimulation (TMS) is a noninvasive procedure in which a changing magnetic field is introduced into the brain to influence the brain's activity. The field is generated by passing a large electrical current through a wire stimulation coil over a brief period.

After assessing a patient's resting motor threshold to determine dosing, an insulated coil is placed on or close to a specific area of the patient's head, allowing the magnetic field to pass through the skull and into target areas of the brain (Figure 29-4). When the magnetic stimulus is administered as a train of multiple stimuli per second, it is called **repetitive transcranial magnetic stimulation (rTMS).**

Indications

TMS has been studied for a number of indications. **The most frequently cited use for TMS in psychiatry has been in the treatment of mood disorders.** Imaging studies have found that depressed patients have reduced perfusion in the prefrontal

cortex area of the brain, especially on the left side. The results of numerous studies have suggested that rTMS, when administered daily at the left prefrontal cortex, is an effective treatment for nonpsychotic depression (Dowd et al, 2008; Demitrack, 2010b; George and Post, 2011; Hadley et al, 2011).

It may not, however, be as effective as ECT for treatment resistant depression. The FDA approval indicates that it is a first line treatment in individuals who have failed only one prior adequate antidepressant trial (Demitrack, 2010a; Rasmussen, 2011).

Some data suggest that rTMS, administered at the right prefrontal cortex, can be helpful for those with treatment-resistant depression and mania (Cohen et al, 2010), as well as those with increased anxiety. In addition, a few small studies have suggested that rTMS may be helpful for other psychiatric disorders, such as obsessive-compulsive disorder and posttraumatic stress disorder. It also has been found to be helpful for auditory hallucinations in those with schizophrenia. **Studies describing the duration of improvement with rTMS suggest that daily sessions extending over 3 weeks or more are usually required for optimal response.**

Mechanism of Action

The mechanism of action of TMS is based on the principle of *Faraday induction*. According to this principle, when an electrical current is passed through a coil a magnetic field is generated. If another conductive material, such as a neuron in the brain, is exposed to a changing magnetic field, a second electrical field is activated within that material. This activation may result in neurochemical changes based on alterations in gene expression, such as an increase in some receptor binding.

Unlike ECT, with TMS the brain is directly stimulated to produce neurochemical changes. However, as with ECT, the exact changes that make the treatment effective are still under investigation.

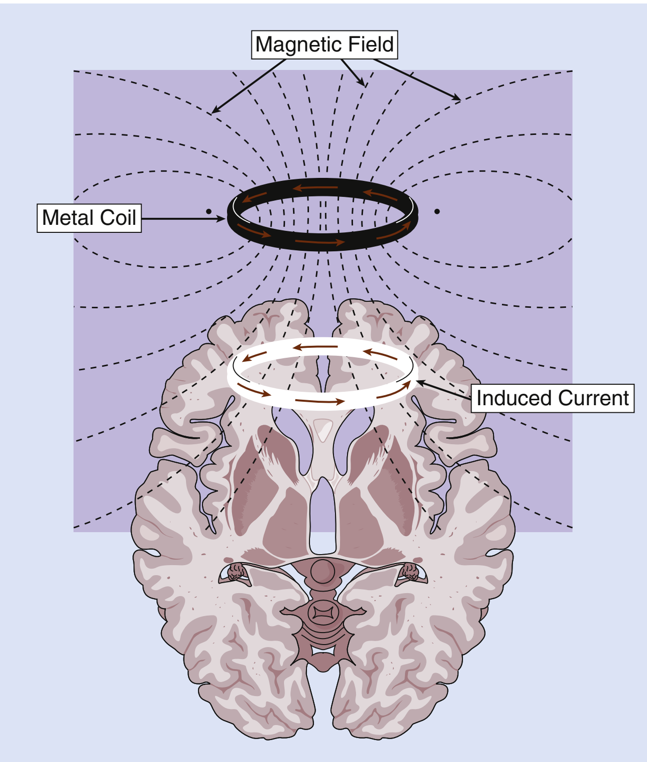


FIG 29-4 The physics of repetitive transcranial magnetic stimulation (rTMS). (From Medina J: *Psychiatric Times*, August 2001.)

Adverse Effects

The biggest concern when using rTMS is the potential for inducing seizures, even in patients with no preexisting epilepsy. Most occurred during early studies designed to test rTMS safety, and they appeared to be related to higher-frequency pulses. Recommendations for treatment parameters have now been made, which have minimized further occurrences.

The potential for tinnitus or transient hearing loss caused by the high-frequency noise produced by the treatment apparatus has prompted the routine use of earplugs for both patient and investigator, thereby minimizing the occurrence of this adverse effect.

The most common reported adverse effect from rTMS is the occurrence of headaches. The etiology appears to be contraction of scalp muscles during the stimulation. In most cases this discomfort resolves with standard analgesics.

As a result of the strong magnetic fields involved in this treatment, some patients may not be candidates. These patients include those with metal objects such as screws, plates, or shrapnel anywhere in the body unless it is known that the object will not create a problem. Patients with pacemakers or other implants that might create a low-resistance current path may not be considered for rTMS. Patients at increased risk for seizures should be considered with caution.

Critical Reasoning How would you explain to patients who have metal in their bodies why TMS is contraindicated for them?

CRANIAL ELECTROTHERAPY STIMULATION (CES)

Cranial electrotherapy stimulation (CES) is a somatic therapy in which pulsed microcurrents are delivered transcutaneously. Despite the fact that the general idea of CES predates the advent of ECT, it is only recently that interest in this therapy has had a resurgence as another intervention in the treatment of depression.

Although it remains a lesser-known intervention, its noninvasive nature and availability for home use may be appealing in some cases. Current research indicates that CES may be helpful as an adjunctive treatment in mild to moderate depression (Gunther and Phillips, 2010).

CES uses a small, portable device with currents provided by a 9 volt battery. The current is delivered via ear-clip electrodes. The small amount of current is limited to 600 microamperes. Treatment is delivered for 30 minutes 5 times per week (Gunther and Phillips, 2010).

Mechanism of Action

Although the exact mechanism of action is unknown, CES is believed to affect neurotransmitter secretion in the limbic system, reticular activating system, and, perhaps the hypothalamus. The electric currents are thought to move electrons through the brain at "harmonic resonance" frequencies, which results in this secretion.

Adverse Effects

Patients receiving CES may experience mild side effects. These include a tingling sensation at the electrode site, nausea, stinging pain, or dizziness. All of these effects are avoidable by device adjustment.

IMPLANTABLE BRAIN STIMULATION DEVICE—VAGUS NERVE STIMULATION

In the 1990s some epileptic patients receiving vagus nerve stimulation (VNS) by way of an implanted device reported improved mood. These reports stimulated interest in VNS as a treatment for depression. Results from a multicenter study showing a 40% to 50% reduction in depressive symptoms among patients receiving VNS validates its potential as an effective somatic therapy in psychiatry (Janicak and Dowd, 2009).

VNS involves surgically implanting a small (pocket watch–sized) generator into the patient's chest. An electrode is threaded subcutaneously from the generator to the vagus nerve on the left side of the patient's neck. The end of the electrode is wrapped around the nerve. Once implanted, the generator is programmed by means of a computer for the frequency and intensity of the stimulus (Figure 29-5).

Indications

VNS is used in the treatment of affective disorders, particularly treatment-resistant depression. VNS is most effective for patients with low to moderate antidepressant resistance. The best effect appears to occur over a period of months (Janicak and Dowd, 2009).

Mechanism of Action

The exact mechanism of action of VNS is unknown, but it is thought to work by way of the neurotransmitter system. The left vagus is used because it is composed of mostly afferent sensory fibers that connect to the brainstem and deep brain structures. Stimulation of these fibers changes the function of some of these structures and also affects the concentration of some neurotransmitters, such as gamma-aminobutyric acid (GABA) and glutamate (Howland, 2008).

Adverse Effects

In general, reported adverse effects of VNS have been mild and tolerable. These include hoarseness, throat pain, neck pain, headache, and shortness of breath. A few incidences of infection at the incision sites, coughing, voice alteration, vocal cord paralysis, lower facial muscle paresis, changes in heart rate, and an accumulation of fluid over the generator have been reported.

> **Critical Reasoning** A patient with a history of chronic, severe depression asks you if she would be a good candidate for a new treatment she learned of on the Internet called vagus nerve stimulation. How would you respond?

DEEP BRAIN STIMULATION

In deep brain stimulation (DBS) tiny electrodes are surgically implanted into abnormally functioning areas of the brain. Wires from them are connected to two battery-operated pulse generators implanted just below the collarbone. The electrodes emit pulses of electrical activity to block abnormal brain activity that can cause obsessions, distressing moods, and anxieties. DBS does not destroy brain tissue and is reversible. If a patient no longer wants the device it can be turned off (Sachdev and Chen, 2008).

Indications

DBS is an approved treatment for tremors and Parkinson disease. It is being studied as an option for the treatment of people with major depression, as well as those with severe obsessive-compulsive disorder (Holtzheimer and Mayberg, 2010). Research suggests that DBS is a safe and effective treatment for treatment-resistant depression (Kennedy et al, 2011).

Mechanism of Action

The exact mechanism of action of DBS is unknown. It is thought that the electrodes stimulate the target brain nuclei and may work by modulating the function of the brain circuits.

Adverse Effects

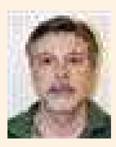
Seizures, bleeding, and infection can occur as a result of the surgery. Paresthesias, muscle contractions, and adverse effects on mood, memory, and cognition can be stimulation-related adverse effects.

FIG 29-5 Vagus nerve stimulation (VNS) implantation. (Courtesy Cyberonics, Inc.)

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Dean Olivet, RN, MS, C



One morning, I arrived at work and performed all the morning rituals that a nurse does before venturing out on the clinical floor. After having been off for several days, I learned from reading reports and listening to my co-workers that the acuity on the unit was high. Not only was the unit psychiatrically tense, but several geriatric patients had been admitted for evaluation and electroconvulsive therapy (ECT) treatment. I decided to care for a few of the older, acute patients, including Mr. J, who was 80 years old.

Mr. J was newly admitted for evaluation of medications and a possible course of ECT. Staff described him as needy, confused, and wanting constant reassurance. At my first contact, Mr. J was asleep in his bed. He was disheveled, as was his room. When he awoke, I introduced myself to him and found out immediately why he seemed to have caused the staff to be anxious. He grabbed my arm and spoke to me in a high-pitched whine.

My initial reaction was a flight response. To resist this, I began to assess his level of independence, and it became clear that he was unable to make any choices with regard to planning his morning. In organizing my care, I decided to outline the morning routine for him in small time increments and assess his ability to make decisions with regard to his basic needs.

We began with his activities of daily living. Mr. J needed help to meet these physiological needs, and his anxiety level made it necessary for me to maximize his safety and security. He told me that his daughter and son had helped him the night before. He assured me that I was too busy and they would help him the next time they visited as well.

I was puzzled about the necessity for his family to perform what seemed to be a nursing responsibility and I carried on with my care and convinced him to bathe while I cleaned up his room and made his bed. Implementing this minor intervention made me feel more comfortable in his room, and he didn't seem quite as overwhelmed.

Because his anxiety was still moderately high, I consulted with the nurse who was giving his medications and reviewed his chart. I learned that this was his second hospitalization, after many years of being free of symptoms of depression. During his first hospital stay, he had received a course of ECT that was very successful in helping him get well. I also learned that his wife and daughter were caring for him. Their treatment of choice was to medicate him until he slept.

Learning this, I sensed the need to evaluate the quality of his experience with his last course of ECT, as well as the current need for possible ECT and medication education for the family. These two educational needs became an ongoing process dependent on his and his family's readiness to learn.

My plan of care was quite simple. I would make sure that his activities of daily living were completed each morning, his environment kept orderly, and his introduction to the milieu made in short intervals. This was necessary to keep him safe from patients with less impulse control and to avoid overwhelming him or the other patients. Mr. J needed some peer contact as well, and I introduced him to other patients as appropriate.

That afternoon his family came to visit, and I met with them to assess their need for information and their readiness to learn. I outlined Mr. J's day and apologized for his insistence that they perform his activities of daily living. I thought that perhaps they might be annoyed about this issue and was relieved when they expressed their appreciation for my interest in him.

After listening to their concerns, I outlined my plan of care for Mr. J and explained that in my absence, the rest of the nursing staff would use the care plan to meet his daily needs. At this point the family became an ally to the total hospital experience, and I became a resource for the patient and the family. This brought comfort to the family, which in turn allowed Mr. J to meet his basic needs and have the security necessary for him to meet the challenge of recovering from his illness.

As nurses we all can relate to experiences in which we have cared for patients only to have family members complain about the care or lack of care their significant other received. We also can describe occasions when it was very rewarding to have a patient respond to our care and to have the family recognize this nursing effort. Given this dichotomy, which do you prefer? The answer really reflects the crux of good psychiatric nursing practice.

CHAPTER IN REVIEW

- Electroconvulsive therapy (ECT) is an effective treatment for major depression with an efficacy rate of 80% or more, which is equal to or better than response rates to antidepressant medications. It is particularly useful for people who cannot tolerate or fail to respond to treatment with medication.
- Nursing care in ECT involves providing emotional and educational support to the patient and family; assessing the pretreatment protocol and the patient's behavior, memory, and functional ability before ECT; preparing and monitoring the patient during the actual ECT procedure; and observing and interpreting patient responses to ECT with recommendations for changes in the treatment plan as appropriate.
- Chronotherapy is a group of interventions that are based on how circadian rhythm changes contribute to mood disturbances. The interventions include phototherapy and sleep deprivation.
- Phototherapy, or light therapy, consists of exposing patients to bright, artificial lighting for a specified period each day. It is an efficacious treatment option for patients with nonpsychotic winter depression or seasonal affective disorder.
- Total sleep deprivation has been reported to be effective with depressed patients; however, many become depressed again when they resume sleeping even as little as 2 hours per night.

CHAPTER IN REVIEW—cont'd

- Transcranial magnetic stimulation consists of using a magnetic field to produce changes in brain chemistry. It is a new treatment for mood disorders, especially depression, and has a relatively low side effect profile.
- Vagus nerve stimulation involves surgically implanting a nerve stimulator into the patient's chest. An electrode is threaded from the generator to the vagus nerve on the left side of the patient's neck. It is effective in relieving depressive symptoms.
- Deep brain stimulation involves surgically implanting electrodes into abnormally functioning areas of the brain where they emit pulses of electrical activity to block abnormal brain activity that can cause obsessions, distressing moods, and anxieties. It is a safe and effective treatment for treatment-resistant depression.

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CHAPTER

30

Complementary and Alternative Therapies

Therese K. Killeen

Through the like, disease is produced, and through the application of the like it is cured.

Hippocrates

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Evaluate the evidence base and ethical issues related to complementary and alternative therapies.
2. Analyze complementary and alternative therapies used to treat depression, anxiety, substance use disorders, eating disorders, attention deficit hyperactivity disorder, and dementias.
3. Discuss nursing implications for the use of complementary and alternative therapies in psychiatric care.

Complementary and alternative medicine (CAM) describes a broad range of healing philosophies, approaches, and therapies that focus on the whole person, including biopsychosocial and spiritual aspects. CAM therapies are often used alone (referred to as **alternative**), in combination with other CAM therapies, or in combination with other conventional therapies (referred to as **complementary** or **integrated**).

The National Center for Complementary and Alternative Medicine (NCCAM) defines integrative medicine as "combined mainstream medical therapies and CAM for which there is some high quality scientific evidence of safety and effectiveness." Although most CAM therapies involve healing systems outside the realm of conventional Western medical practice, many of them are becoming established in mainstream health care. **This chapter focuses on evidence-based CAM therapies.**

OVERVIEW OF COMPLEMENTARY AND ALTERNATIVE MEDICINE

People have become more active in their health care, and often seek CAM therapies. CAM therapies may be used by adults who delay conventional medical care due to worry about rising medical costs. **Anxiety and depression are the most common mental health conditions for which adults use CAM.** The 2007 Centers for Disease Control and Prevention survey found the following (Barnes et al, 2008; Nahin et al, 2009):

- 38% of adults and 12% of children in the U.S. had used some type of CAM therapy in the past 12 months.
- CAM visits were most often used by women, adults aged 30 to 69, adults with higher education, adults with higher income, adults living in the West, former smokers, and those hospitalized in the past year.

TABLE 30-1 **MAJOR DOMAINS OF COMPLEMENTARY AND ALTERNATIVE MEDICINE**

DOMAIN	DESCRIPTION	EXAMPLES
Whole medical systems	Complete systems of theory and practice that have evolved independently of, and often before, the conventional biomedical approach	Traditional Chinese medicine, *Ayurveda,* homeopathy, naturopathy
Mind-body interventions	Employ a variety of techniques designed to facilitate the mind's capacity to affect body function and symptoms	Meditation; hypnosis; prayer; yoga; guided imagery; biofeedback; art, music, and dance therapy
Biologically based therapies	Natural and biologically based practices, interventions, and products, many of which overlap with conventional medicine's use of dietary supplements	Herbal, special dietary, orthomolecular, and individual biological therapies
Manipulative and body-based methods	Methods based on manipulation and/or movement of the body	Chiropractic, massage and body work, reflexology
Energy therapies	Focus on either energy fields believed to originate within the body (biofields) or those emanating from other sources (electromagnetic fields)	Qigong, Reiki, therapeutic touch, electromagnets

- Compared to 2002, in 2007 individuals reported using more acupuncture, deep breathing, massage, meditation, naturopathy and yoga.
- In 2007, people in the United States spent nearly 34 billion out-of-pocket dollars for CAM therapies, one third of which were for visits to CAM practitioners.

With increasing CAM research, mental health clinicians are more informed about evidence-based CAM approaches to treat mental health problems. Many conventional providers are including CAM in their routine assessments and prescribing CAM therapies, patients are becoming more comfortable disclosing use of CAM to their conventional health care providers, and providers are including more questions about the use of CAM in their routine assessments.

Survey data found that among patients with a mood, anxiety or substance use disorder, 34% reported using a CAM in the past 12 months (Woodward et al, 2009). A study targeting patients with serious mental illnesses who used CAM therapies found that the primary perceived benefit was improved anxious and depressed mood. Other CAM benefits included enhanced capacity for emotional self-regulation, dealing with such negative emotions as guilt, shame and anger, and having a more positive impact on personal and spiritual growth (Russinova et al, 2009).

The National Center for Complementary and Alternative Medicine (NCCAM) has developed a classification system of four major domains of CAM, recognizing there can be some overlap (NCCAM, 2007). Table 30-1 lists the domains and gives a description of each along with specific examples of CAM therapies that fall under each classification.

Evidence-Based Practice

Research in CAM continues to increase, and studies have become more rigorous in the scientific methodology used. An evidence-based approach assumes the following:

- Adequate scientific methodology
- Treatment effects that are measured and clinically meaningful
- Application of the therapy to clinical practice

Few CAM therapies claim to cure diseases; rather they propose to have therapeutic benefits related to the reduction or relief of symptoms (sleep disturbances, anxiety, irritability, depressed mood), and the promotion of well-being. Evidence-based outcomes provide more information about efficacy, tolerability, dosage, safety, and interactions with other treatments, allowing nurses to become more active in educating consumers about the evidence supporting these therapies. This chapter describes the most common evidence-based CAM therapies that have been used for some of the major psychiatric disorders.

Ethical Issues

Ethical concerns about CAM therapies include issues of safety and effectiveness, as well as the expertise and qualifications of the practitioner. Of equal importance is the communication between CAM and conventional health care providers. **Nurses should always inquire about the use of CAM therapies in their assessments of patients.**

Care must be taken to monitor medications being combined with herbal products for potential harmful interactions. For example, ginkgo biloba may interact with aspirin or warfarin to prolong bleeding times. The herbal product, *Hypericum* (St. John's wort) lowers blood levels of protease inhibitors, thereby decreasing their effectiveness by an average of 57%. Herbal products that are metabolized by the same cytochrome enzyme system as psychotropic medications may increase or decrease the therapeutic drug levels of the psychotropic agents (Lake, 2007).

The possibility also exists that symptoms relieved by CAM therapies may mask signs of a more serious condition, thereby causing delays in seeking conventional, evidence-based treatment. **There is still a general lack of quality control for herbal products and unfounded or exaggerated claims made about their safety and effectiveness.** This is a concern because these products are accessible to many vulnerable populations, including elderly adults, youth, pregnant women, and individuals with psychiatric disorders who often may not consult or report use to a health care professional.

BOX 30-1 PATIENT GUIDELINES FOR CONSIDERING COMPLEMENTARY AND ALTERNATIVE THERAPIES

- Ask a health care provider about the safety and effectiveness of the desired therapy or treatment. Information also can be found on the National Center for Complementary and Alternative Medicine (NCCAM) website: http://nccam.nih.gov/.
- Contact a state or local regulatory agency with authority over practitioners who practice the therapy or treatment being sought. Check to see whether the practitioner is licensed to deliver the identified services.
- Talk with those who have had experience with the practitioner you are considering, both health care providers and other patients. Find out about the confidence and competence of the practitioner and whether patients have lodged any complaints.
- Talk with the practitioner in person. Ask about both conventional and unconventional education, additional training, licenses, and certifications. Find out how open the practitioner is to communicating with patients about possible side effects and potential problems.
- Visit the practitioner's office, clinic, or hospital. Ask how many patients are typically seen in a day or week and how much time is spent with each patient. Look at the conditions of the office or clinic. The primary issue here is whether the service delivery adheres to regulated standards for medical safety and care.
- Find out what several practitioners charge for the same treatment to get a better idea about the appropriateness of costs. Regulatory agencies and professional associations also may provide cost information.
- Most important, discuss all issues regarding therapies and treatments with your usual health care provider, whether your provider is a practitioner of conventional or alternative medicine. Competent health care management requires knowledge of both conventional and alternative therapies for the provider to have a complete picture of your treatment plan.

Many herbal products have not been tested in patients with severe psychiatric conditions, and prescribing such a product may be withholding evidence-based conventional therapy. Other concerns are related to effective symptom management, possible side effects, and the lack of regulation of herbal products for purity and potency.

Because of these concerns, the U.S. government has issued the "Final Rule" regulation for the manufacturers of dietary supplements. **Under the new regulations, manufacturers are required to identify the purity, strength, composition, and associated adverse events of their dietary supplements.**

Given these concerns, the nurse who refers a patient to a CAM practitioner needs to explore the evidenced-based options, as well as the health risk-benefit ratios. Local and state regulatory boards, other health regulatory agencies, and consumer affairs departments also can provide information about practitioner qualifications such as licensure, education, accreditations and complaints that may have been filed.

Box 30-1 provides patient guidelines for those considering a complementary or alternative therapy. In addition, the website www.consumerlab.com provides testing results of the authenticity of ingredients on product labels. The FDA website www.fda.gov provides consumer reports on dietary supplements.

DEPRESSION

Depression is a common condition for which people use CAM therapies. **Research supports the use of acupuncture, several herbal supplements, exercise, mindfulness meditation, light therapy and acupuncture for depression.** Although many studies showed efficacy superior to placebo, other studies showed efficacy comparable with conventional therapies, such as cognitive behavioral therapy or antidepressant medication (Thachil et al, 2007; Freeman et al, 2010).

Acupuncture

Acupuncture involves the insertion of needles into specific acupoints along body *meridians* in order to correct energy or *Qi* imbalances, which is thought to be the cause of many medical conditions. In Western cultures, the proposed mechanism of action is the activation of endogenous opioid receptors and possible involvement of the autonomic nervous system and central monoaminergic systems (Lin and Chen, 2011).

A meta-analysis of randomized controlled studies exploring the safety and effectiveness of acupuncture in depressive disorders found that acupuncture was more effective for post-stroke depression than major depressive disorder (MDD). The effectiveness of acupuncture in the MDD studies was comparable to antidepressants and there is some indication that acupuncture may accelerate the response to serotonin selective reuptake inhibitors (Zhang et al, 2010).

Another study showed acupuncture specific for depression decreased Hamilton Depression Rating Scale scores (63% reduction) significantly more that control acupuncture (37.5% reduction) or massage therapy (50% reduction) in pregnant women with a diagnosis of MDD (Manber et al, 2010). As many other studies have not been able to differentiate "real" from "sham" acupuncture effects, more research with well designed methodology is needed to conclude that acupuncture is a primary treatment for depression.

Meditation

In **mindfulness meditation** individuals focus on their "here and now" experiences. Patients are taught to be aware of sensations, thoughts, and feelings they are experiencing in the present moment. The goal is to allow oneself to observe these experiences in a purposeful, non-judgemental and accepting way in order to discover the deeper nature of these experiences (Tusaie and Edds, 2009).

There are two types of mindfulness practices: mindfulness-based stress reduction and mindfulness-based cognitive therapy. Mindfulness-based cognitive therapy integrates cognitive therapy into mindfulness practice. Maladaptive negative thoughts that are often associated with depression are recognized as transient mental events and not facts or reality. Consciously allowing oneself to be exposed to such experiences can lead to better emotional processing and thus, improved affect regulation and self management skills (Lau and Grabovac, 2009).

Meditation practices should be supervised in certain vulnerable psychiatric populations because of the potential to induce certain states of consciousness. Different meditation approaches may produce a stimulating effect, which could evoke mania in bipolar patients.

Yoga

About 6 percent of adults use yoga for health purposes (Barnes et al, 2008). Although there is limited evidence for yoga as a treatment for depression, yoga has been associated with antidepressant effects and stress reduction. **Yoga** is a physical and emotional conditioning of the body produced by engaging in a series of postures (*asanas*), stretching exercises, breath control *(pranayama),* and meditation (*dhyana*).

The breathing techniques associated with yoga may be associated with vagus nerve stimulation and balancing of the autonomic nervous system. The activity (*asanas* and stretching) associated with yoga may reduce the agitation and inactivity that some depressed patients experience when practicing dhyana alone.

Other yoga-related mechanisms of action include hypothalamic-pituitary-adrenal (HPA) axis down-regulation with resulting decrease in stress, regulating neurotransmitter systems, improving sleep efficacy, and promoting behavioral activation and adaptive thinking (Uebelacker et al, 2010).

Herbal Products

One of the most widely researched herbal products is ***Hypericum* (St. John's wort).** It is currently used throughout Europe and the United States to treat mild to moderate depression, anxiety, seasonal affective disorder, and sleep disorders.

The herb's mechanism of action may involve serotonin, dopamine, gamma-aminobutyric acid (GABA), and norepinephrine reuptake inhibition. Other reported effects of *Hypericum* include antiinflammatory, antiviral, antimicrobial, antiulcerogenic, and astringent activity.

The herb is available in tea, capsule, or tincture form, usually standardized to contain 0.3% hypericin. The higher 5% hyperforin extract may have more antidepressant effects than the 0.5% hyperforin constituent (Sarris and Kavanagh, 2009). The standard dose is 900 mg per day, taken in divided doses. Side effects include dry mouth, headache, dizziness, gastrointestinal symptoms, photosensitivity and acute mania.

Meta-analyses studies have found *Hypericum* to be superior to placebo and of comparable efficacy to conventional antidepressants, including selective serotonin reuptake inhibitors (SSRIs), in patients with major depression. Adverse events and discontinuation rates were lower in patients treated with *Hypericum* versus antidepressants (Linde et al, 2008; Rahimi et al, 2009).

However *Hypericum* has significant and potentially dangerous drug interactions. It interferes with the metabolism of many medications and should not be taken with medications that use the CYP450-3A4 pathway for metabolism, including posttransplant antirejection drugs, oral contraceptives, statin anticholesterol drugs, protease inhibitors, antineoplastics, antiretrovirals, anticonvulsants, digoxin, theophylline, triptans, SSRIs, and anticoagulants (Mischoulon, 2007).

Hypericum extracts with the higher concentrations of hyperforin are more likely to cause CYP3A induction. Since serotonin syndrome is a potential problem when *Hypericum* is administered with SSRIs, a 2-week washout period is recommended before initiating SSRI antidepressants following *Hypericum* discontinuation or vice versa (Kasper et al, 2010).

Melatonin, a hormone secreted by the pineal gland, works by synchronizing circadian rhythms. In doses of 0.3 to 3 mg, melatonin has been shown to shorten sleep latency and improve duration and quality of sleep (Brzezinski et al, 2005). Melatonin may be used as an adjunct to medications such as antidepressants and benzodiazepines and can potentially decrease the therapeutic dosages needed for these medications.

In addition, melatonin may be used to facilitate tapering off benzodiazepines. Several studies found melatonin to be effective for improving sleep in elderly depressed patients. This population is at a higher risk for adverse effects associated with use of benzodiazepines, such as cognitive impairment and increased risk for falls.

***S*-Adenosylmethionine (SAMe),** a dietary supplement, has been used for the treatment of mild to moderate depression. SAMe is a naturally occurring substance found in living cells and is involved in many biochemical reactions. Transmethylation, one reaction that affects neurotransmitter—namely, serotonin, dopamine, and norepinephrine—levels, is most likely responsible for the antidepressant action. Vitamin B_{12} and folate, which are believed to be deficient in depressed patients, are required for the synthesis of SAMe.

Only a few randomized, double-blind, placebo-controlled studies have explored the effectiveness of SAMe. **They concluded that it was more effective than placebo and comparable to several standard antidepressants for the treatment of depression** (Freeman et al, 2010). SAMe may be indicated as an adjunct to standard antidepressant therapy to enhance responsiveness and may possibly increase the onset of standard antidepressant effects (Saeed et al, 2009).

The usual oral dose of SAMe for the treatment of depressive symptoms is 800 to 1600 mg per day. Side effects are generally mild and include mostly gastrointestinal symptoms, sweating, dizziness, and nervousness. **SAMe should not be combined with other psychotropic medications unless medically supervised and should not be taken by patients with bipolar or manic disorders.**

Omega-3 essential fatty acids, a supplement found mostly in fish oils and plants, may have some efficacy in

patients with affective disorders. Although little evidence exists regarding essential fatty acids as a single therapy, several studies show that omega-3 fatty acids—namely, eicosapentaenoic acid (EPA) and EPA combined with docosahexaenoic acid (DHA)—used with conventional antidepressants and mood stabilizers, improve treatment response.

There is some evidence that the EPA or the combination of EPA and DHA are more effective than the DHA alone. One recent study compared EPA 1 gram daily to fluoxetine 20 mg and to a combination of the two. The EPA and fluoxetine groups had comparable response rates as measured by the Hamilton Depression Scale but the combination group had the highest response rates (Saeed et al, 2009).

Some evidence indicates that mood disorders are associated with low plasma omega-3 fatty acid levels (Lake, 2007). As such, the dose range for treatment response may depend on plasma levels, and there appears to be a ceiling effect on the dosage. The dose range of EPA augmentation is between 1 and 2 g per day.

> **Critical Reasoning** Conduct an informal survey of your friends and family. How many of them have taken *Hypericum* (St. John's wort)? Were they aware that in a *Los Angeles Times* survey, 3 of 10 brands of *Hypericum* had no more than half the potency listed on the labels? As a nurse, how would you advise them?

Exercise

Physical exercise in the form of muscular strength training, flexibility training, and cardiovascular aerobic endurance has been associated not only with positive medical benefits but also with improvement in mood and self-esteem, decreased tension, and a feeling of accomplishment and renewed energy. Exercise may be particularly beneficial to vulnerable populations such as the elderly, pregnant/postpartum women and youth.

Numerous studies suggest that levels of depression are lower in exercise groups compared with control groups, with some showing equivalent outcomes when compared with psychotherapy and antidepressants (Blumenthal et al, 2007; Greer and Trivedi, 2009). A large epidemiological study that spanned 10 years examined the relationship between physical activity and depression. Higher levels of physical exercise and exercise coping were associated with lower global depression scores. Physical activity served as a buffer for negative life events and medical conditions (Harris et al, 2006).

Several studies have found that a high dose/intensity of aerobic exercise (consistent with public health recommendation) may be more effective than frequency of exercising or exercise consisting of low energy expenditure (Dunn et al, 2005; Knubben et al, 2007). Since exercise may cause dehydration, which can potentially alter therapeutic blood levels of medications such as lithium, patients should be advised about taking plenty of water before, during and after exercising, particularly in warm weather.

Massage

A few studies have shown that massage therapy may be beneficial for individuals with depression. Proposed mechanisms of action include suppression of the HPA axis with reduced stress hormones and increased parasympathetic nervous system activation resulting in reduced pulse rate, relaxation and reduction in pain.

The therapeutic alliance between therapist and patient as well as the effect of therapeutic touch may also contribute to beneficial effects. A meta-analysis of randomized control trials using massage therapy for individuals with depression revealed a greater reduction in depression with massage therapy compared to comparison groups (Hou et al, 2010).

> **Critical Reasoning** How might physiological changes stimulated by massage therapy relate to one's thoughts and emotions?

Light Therapy

Exposure to bright light, or phototherapy, has been shown to be effective for the treatment of major depression with a seasonal component and seasonal affective disorder (SAD). Phase-delayed sleep brought on by the reduced sunlight in winter disrupts circadian rhythms. It has been suggested that the onset of increased melatonin levels and minimum body temperature, which peak at specific times during the sleeping hours, are delayed in SAD (Terman and Terman, 2006).

A meta-analysis exploring light therapy for depression found a large effect size for seasonal affective disorder. Light therapy has a lower side effect profile than antidepressant medication and may reduce the time to antidepressant response. Evidence is less established for light therapy as a single therapy for non-seasonal depression, but it may be effective as an adjunct to antidepressant medications. Phototherapy is discussed in Chapter 29.

Guided Imagery

Guided Imagery (GI) is a program of directed thoughts and suggestions that guide a person's imagination toward a relaxed, focused state to reduce stress and improve comfort and mood. In a European nursing study, 30 inpatients with moderate to severe depression received GI and were compared to a usual care control group. Patients listened to a guided imagery CD once nightly for 10 days. The 21-minute CD contained breathing exercises, progressive muscle relaxation and instructions to imagine a peaceful, relaxing scene and meeting someone who they could share their life experiences with. Those receiving the GI had higher levels of comfort and lower levels of depression, anxiety, and stress compared to those not receiving GI (Apostolo and Kolcaba, 2009).

ANXIETY

Anxiety disorders are one of the most common conditions for which people use CAM therapies. Anxiety disorders that have been studied using CAM therapies include generalized anxiety

disorders (GAD), social and specific phobias, panic disorder, obsessive-compulsive disorder (OCD), and posttraumatic stress disorder (PTSD). Because anxiety and depressive disorders often co-occur, many therapies used for depressive disorders are also used for anxiety disorders.

Progressive Muscle Relaxation

Relaxation techniques are often used in psychotherapy, particularly in patients with anxiety disorders. Progressive muscle relaxation (PMR) uses a process of tensing and releasing groups of muscles to gain control over anxiety-provoking thoughts and muscle tension. Relaxation techniques are discussed in detail in Chapter 27.

PMR also has been used in conjunction with imagery, breathing retraining, autogenic training, and biofeedback. In a meta-analysis of studies using relaxation training for anxiety, for those studies that used a control or comparison group there was a moderate to large effect size favoring PMR for patients with psychological and psychosomatic diseases. Length of treatment, practicing exercises at home and use of certain anxiety outcome measures moderated the effect sizes (Manzoni et al, 2008).

Energy Therapies

Energy therapies such as therapeutic touch, *Reiki, Qigong*, and distant healing involve the transfer of healing energy. **Therapeutic touch** involves the intentional exchange of energy between the practitioner and patient to promote healing and well-being. The use of the hands is the conduit for the energy exchange. This intervention is proposed to work by eliciting the relaxation response.

Therapeutic touch has been embraced by nurses in all areas of practice and is probably one of the most widely researched interventions in the nursing literature. Although less research has been done on therapeutic touch in psychiatric populations, it has been explored for possible stress reduction in nonpsychiatric populations.

> **Critical Reasoning** Why do you think that therapeutic touch has been relatively unexplored as a treatment for psychiatric patients?

Yoga and Meditation

Several types of yoga and meditation have been used for stress and anxiety disorders. In one study, 46 patients with treatment-resistant anxiety disorders (generalized anxiety disorder, panic with or without agoraphobia) were randomized to either a meditation or education program for 8 weeks. All patients were taking conventional SSRI antidepressants and alprazolam for the past 6 months. At post intervention follow-up, anxiety scores as measured by the Hamilton Anxiety Rating Scale (HAM-A), STAI, and Symptom Checklist-90 were significantly more reduced in the meditation versus the education group (Lee et al, 2007).

In another study, a 12-week yoga class was compared to a structured walking intervention to determine if the efficacy of yoga was due to the associated physical activity. Healthy subjects were recruited and outcome measures of anxiety, depression, and magnetic resonance spectroscopy were collected. There was a greater improvement in mood and reduction of anxiety in the yoga group. These improvements were also correlated with increased GABA levels in the thalamus (Streeter et al, 2010).

Ross and Thomas (2010) compared the benefits of yoga and exercise. The authors point out that there are different styles of yoga that range from meditative to power (physically active) yoga or a mix of the two. Although exercise may have greater effects on cardiovascular fitness, yoga has a greater positive impact on the HPA axis and sympathetic nervous system response to stress.

PTSD is one common anxiety disorder that occurs in about 8% of the population. A recent study investigated the effects of Sudarshan Kriya yoga (SKY) alone versus SKY plus an exposure intervention, Trauma Incident Reduction (TIR), versus a control wait list in a group of individuals who survived the Indian Ocean tsunami and had high PTSD symptoms. The SKY intervention consisted of a repetitive series of breathing patterns of different rates meant to simulate trauma-related breathing (i.e., fearful, anxious), but done in a systematic and safe context.

The proposed mechanism of action was to balance the overactive sympathetic nervous system and the underactive parasympathetic nervous system. Participants were to practice SKY on a daily basis. The TIR intervention, conducted 3 to 7 days after the SKY was initiated, consisted of three to five sessions in which the participant recalled the trauma memory to a point that they were in a state similar to the actual trauma experience. This was done in the presence of the clinician and in a safe environment.

Participants repeated this procedure until the memory was processed and no longer aversive. The SKY and the SKY plus TIR had significantly reduced PTSD symptoms and depression, and improvement in general health than the wait list control group at 6, 12, and 24 weeks postintervention (Descilo et al, 2010).

Overall, most yoga and meditation studies have been conducted in healthy and medically ill patients. More well-designed studies are needed to replicate evidence of the effectiveness of yoga and meditation in populations with anxiety and other psychiatric disorders.

Acupuncture

There is some evidence to support the use of acupuncture in certain anxiety disorders. In a pilot randomized controlled study, patients meeting DSM-IV criteria for PTSD were randomized to acupuncture, a trauma-focused group cognitive behavioral therapy (CBT), or a wait list for 12 weeks. Changes in PTSD symptoms from baseline to post treatment were significantly more improved in both the acupuncture and CBT group but not in the wait list group. At the end of treatment 63% of the acupuncture group, 36% of the CBT group and 17% of the wait list group had PTSD symptom scores that were below study entry criteria. Symptom improvement for acupuncture and CBT was maintained at 3-month follow-up (Hollifield et al, 2007).

Herbal Products

Several herbs are marketed for the relief of anxiety, but few have been empirically studied. **Kava** (*Piper methysticum*)**,** a plant found in the South Pacific, is said to have anxiolytic, sedative, and muscle relaxant properties in dosages between 60 and 300 mg containing 70% kavalactones (active ingredient). The mechanism of action for kava is probably associated with modulation of GABA, serotonin, dopamine, and glutamate systems.

In therapeutic doses, kava has a low side effect profile and does not have the adverse effects or addictive potential associated with conventional sedative-hypnotics or benzodiazepines. Use of kava combined with other central nervous system medications may increase sedating effects, and it may have addictive properties with long-term use.

In a placebo controlled trial of 28 adults with GAD, there was a significant reduction in anxiety for those receiving kava (Sarris et al, 2009). Kava also may be used to reduce anxiety and withdrawal symptoms while tapering off benzodiazepines.

In 2002, the U.S. Food and Drug Administration (FDA) issued a warning that using kava supplements was linked to a risk of severe liver damage. The liver toxicity associated with kava was likely associated with inappropriate product quality, overdose, prolonged therapy or interaction with other medication.

Kava products should use water-based extracts of peeled and dried roots and rhizomes (Sarris and Kavanagh, 2009). Long-term overuse combined with alcohol or other drugs and/or pre-existing liver conditions also may be contributing factors. Its safety in long-term use has not been established.

Another herbal product, **valerian,** has been used for insomnia, a symptom common to many anxiety disorders. The active constituent, valepotriates, may act on GABA receptor binding. Several small studies have shown valerian can improve sleep latency and sleep quality, specifically slow-wave (stages 3 and 4) restorative sleep in mild to moderate insomnia. Valerian may also lessen withdrawal symptoms from benzodiazepines while stabilizing sleep.

The dosages used are 300 to 900 mg at bedtime or 2 to 3 g of the dried root three times per day. Side effects include possible potentiation of other central nervous system depressants, blurred vision, headache, nausea, and excitability. Adverse events associated with benzodiazepines, particularly daytime psychomotor slowing and potential for developing tolerance and addiction, are not commonly seen with valerian.

SUBSTANCE USE DISORDERS

Acupuncture

One of the most widely researched CAM therapies used to treat addiction is acupuncture. The National Acupuncture Detoxification Association (NADA) has trained thousands of individuals on the standard 4- to 5-point auricular acupuncture procedure (Figure 30-1). Quantitative studies with better methodologies have questioned the efficacy of site-specific acupuncture. **Studies using acupuncture for addictions have had mixed results and more recent studies have not shown differences in efficacy between acupuncture specific for addiction and sham or placebo acupuncture** (Behere et al, 2009).

FIG 30–1 Auricular acupuncture points.

There is recent evidence that electrical stimulation of acupoints may provide more benefits than manual needle insertion. In a study using a form of acupuncture, transcutaneous electrical acupoint stimulation (TEAS), 48 inpatients with opioid addiction seeking detoxification were randomized to receive either active TEAS or placebo TEAS three times daily for up to 4 days. Both groups were receiving suboxone therapy.

At 2-week follow-up, those receiving active TEAS were less likely to begin taking opioid drugs (29% relapse) than those who had received placebo TEAS (65% relapse). The patients receiving active TEAS were also less likely to have used any other drugs and reported improvements in overall health than the patients receiving placebo TEAS. Thus, acupuncture may be more effective in reducing craving and withdrawal symptoms when used as an adjunct to conventional treatment (Meade et al, 2010).

Yoga and Meditation

Yoga and meditation have been explored in substance abusing populations for their effectiveness in reducing stress, which is a predictor of relapse to alcohol/drugs. Stressful life events are common in recovery and can precipitate cravings and thus, increase the risk for relapse. Specifically, stress involves cognitive, affective, and physiologic responses that are associated with relapse and substance use (Garland et al, 2010).

Patients recovering from addictive disorders are constantly struggling with cravings, urges, and thoughts of using. Traditional models of treatment encourage the use of distraction and avoidance or suppression of these cravings and thoughts. However, it is often difficult to disengage from cravings in response to stress. Mindfulness meditation is a practice that invites patients to experience and monitor cravings and urges in a nonevaluative, nonjudgmental manner with the goal of self-regulating thoughts, emotions, sensations, and behavior.

As opposed to craving/thought suppression, individuals practicing mindfulness attempt to increase conscious awareness of cravings. In one study, patients with alcohol dependence were randomized to either a 10-session group manualized mindfulness meditation-based intervention (MORE) or a 10-session alcohol dependence support group derived from the Matrix

treatment model (ASG). Over the 10 weeks, those receiving MORE reported larger decreases in perceived stress and thought suppression than those in the ASG (Garland et al, 2010).

The practice of yoga or a combination of yoga and meditation can also be beneficial. Early in recovery when concentration and focus may be impaired, patients may be more receptive to breathing exercises and/or yoga postures.

SKY was found to have antidepressant effects in alcohol-dependent patients who were 1 week post detoxification. SKY sessions lasted 1 hour and were delivered on alternate days for 2 weeks. Each session consisted of the practice of three distinct patterns of breathing to induce a tranquil state. At 3-week follow-up, depression scores, plasma adrenocorticotropic hormone (ACTH), and cortisol levels were significantly reduced in the SKY versus the control group (Vedamurthachar et al, 2006).

Biofeedback

Some studies have investigated the use of biofeedback for the treatment of addictions and other psychiatric disorders. Biofeedback is an intervention in which physiological responses, such as heart rate, skin conductance, skin temperature, and muscle activity, are monitored for the purpose of teaching the patient to consciously regulate these processes. Often patients engage in relaxation exercises or other cognitive behavioral techniques to decrease arousal and activation of these physiological responses.

EEG biofeedback (EFB), also known as neurotherapy or neurofeedback, is a specific biofeedback that transmits electroencephalogram (EEG) signals and provides information about neuronal activity in the cerebral cortex. Through operant conditioning or learning, patients are taught to use information about the brain to alter or enhance its function. EFB has been shown to increase abstinence rates in patients with alcoholism for as long as 1 year.

Herbal Products

Kudzu, a plant with a large root system that contains a variety of isoflavones including diadzin, daidzein, and puerarin, has been studied for its effects on alcohol. One of the isoflavones, diadzin, is a potent inhibitor of aldehyde dehydrogenase, the enzyme that metabolizes alcohol. Lucas et al (2005) found that heavy alcohol users pretreated with kudzu consumed less alcoholic drinks and, when drinking, took smaller sips of alcohol.

Kudzu may reduce the desire to drink and prevent a slip from becoming a relapse. Research investigating the effects of kudzu continues and may be an important adjunct to alcohol treatment.

EATING DISORDERS

Yoga and Meditation

A recent pilot study found that yoga twice weekly for 8 weeks added to standard treatment for eating disorders was more beneficial in reducing eating disorder symptoms than standard treatment alone. There was less preoccupation with food and eating after yoga sessions, indicating the effectiveness of yoga in redirecting focus away from pathologic obsessional thinking. Furthermore, there were no weight alterations in any of the eating disorder diagnostic groups (anorexia, bulimia, or eating disorder not otherwise specified) as a result of yoga (Carei et al, 2010).

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Although conventional treatment with psychostimulants for attention deficit hyperactivity disorder (ADHD) has been well established as evidence-based treatment, there continues to be some resistance to using psychostimulants. Particularly, many parents are unwilling to use medication to treat their children with ADHD and may turn to alternative therapies.

Neurofeedback

Neurofeedback (NF) has been most explored for the management of ADHD symptoms. Abnormal EEG rhythms associated with ADHD may account for the problems with attention, impulse control, hyperactivity, and information processing.

One study compared NF to attention skills training (AST) in 102 children diagnosed with ADHD and followed the children for 6 months post training. The superior effects in inattention and hyperactivity seen at post intervention in the NF versus the AST group were maintained at 6-month follow-up. There were also greater improvements in conduct disorder and homework problem behavior in the NF group and the authors recommend the use of NF as an adjunct to a comprehensive treatment plan (Gevensleben et al, 2010).

DEMENTIAS

Herbal Products

Gingko biloba, an extract obtained from the leaves of the *Ginkgo* (maidenhair) tree indigenous to China, is another herbal product that has been studied in psychiatric populations for its cognitive-enhancing effects, specifically in those with Alzheimer disease. It may act by dilating blood vessels and increasing blood supply, reducing blood viscosity, decreasing free radicals, and altering neurotransmitter levels.

Dosages range from 120 to 240 mg daily taken in divided doses, standardized to contain 24% to 32% flavone glycosides and 6% to 10% terpenoids (active ingredients) with results in 4 to 6 weeks. Side effects include gastrointestinal upset, skin reactions, headache, and dizziness.

Reports have indicated that gingko may interact with anticoagulants and aspirin to increase the risk of bleeding. In a meta-analysis of gingko for Alzheimer, vascular and mixed dementia, gingko showed a significant moderate effect size compared with placebo for improving cognitive function. For Alzheimer dementia, there was also improvement in activities of daily living (Weinmann et al, 2010).

Energy Therapies

Reiki, an ancient form of energy therapy involving hands-on healing, has been shown to improve mental functioning,

memory, and behavior problems in elderly patients with mild cognitive impairment or Alzheimer disease (Crawford et al, 2006). Another energy therapy, Therapeutic Touch (TT), was compared with simulated TT and a wait list control group in Alzheimer patients residing in a long-term care facility to determine the effects of TT on agitated behaviors. Patients receiving TT had a significant reduction in physical aggressive behavior compared to the other groups (Hawranik et al, 2008).

NURSING IMPLICATIONS

As more evidence supports the effectiveness of CAM, more clinicians are referring patients to CAM practitioners as either single therapy or as an adjunct to conventional therapy. CAM therapies can have an important impact on psychiatric nursing practice. Many of them are beneficial, safe, cost-effective, and easily implemented throughout psychiatric settings. CAM therapies can be prescribed and implemented by nurses.

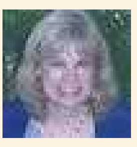
Nurses should continue to follow the research literature to track the emerging evidence regarding their effectiveness and safety. One valuable resource is the Cochrane Collaboration, which has an ongoing registry of randomized clinical trials related to CAM that can be accessed on the Internet. Other CAM information can be accessed at http://nccam.nih.gov.

Knowledge of up-to-date, evidence-based CAM enables the nurse to assist patients in making more informed decisions about use of such therapies. When offering or making referrals for CAM mental health care, nurses must take into consideration clinical judgments, patient expectations, and liability (Lake, 2007). **Patients must be informed about both the risks and benefits associated with CAM therapies, as well as implications regarding delay of conventional therapies.**

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Paula E. Johnson, MSN, RN, CS



As a psychiatric nurse who has spent 15 years working in academic medical centers and 5 years in private psychotherapy practice, I have had the opportunity to study, personally experience, and offer many therapeutic modalities that are not commonly found in traditional or conventional health care settings. I have come to appreciate the value and power of these practices commonly known as "alternative" therapies. I rarely use the term *alternative therapy;* however, because I do not see my work as precluding other forms of therapy. I believe that the most effective therapy incorporates an alternative perspective and includes rather than excludes the use of appropriate conventional treatments.

Early in my own personal quest for physical and mental wellness, I was drawn to the practices of yoga, meditation, and conscious breathing. Later in nursing school, I was given the opportunity to experience and investigate other holistic approaches to health care, including therapeutic touch and guided imagery. After graduation, my interest and excitement in alternatives continued to grow. I pursued certification in reflexology, Reiki, transformational breathing, and the self-inquiry work of Byron Katie. With each of these alternative therapies, I first experience and apply it in my own life. Eventually I bring those techniques that have a positive impact on my own health and wellness to my patients, the majority of whom enjoy similar results.

For example, after years of meditation practice, I began to incorporate the use of conscious breathing and mindfulness into my time with my patients. My intention is to pass on to them the healing effects of calmness, presence, and relaxation that I have experienced. In simple and clear ways, I talk with them about the power of conscious awareness and instruct them how to use the breath to consciously bring themselves into the present moment and to increase their realization of what they are experiencing within their bodies. I have observed that when patients grow in their personal awareness of their internal experience, they are better able to express their feelings, more likely to pay attention to early symptoms of distress and take appropriate action, and eventually become more comfortable in their bodies.

I recently worked with a woman who was experiencing marital and job-related stress and severe anxiety. I noticed that every sentence she spoke contained within it some projection into the future. "I won't be able to stand it if he doesn't change." "My boss will never appreciate what I do for him and the company." When I asked how she feels when she has these thoughts, she said she felt tremendous fear. I suggested some homework in between sessions. I simply asked her to check in with herself throughout the day, notice her breathing, and for a few minutes practice being totally present in the moment. The following week she told me that she had never before realized just how little of her time is spent fully aware in the present moment. I observed her growing attention and even excitement as she learned to acknowledge and report her internal experiences. As she continued to apply this practice more and more in her everyday life, she reported that her husband seemed to be changing, she had started to ask her boss for what she wanted, and she was feeling more in control of her own life.

Alternative therapies offer an approach to creating and maintaining health that may not be available in a conventional health care setting. Yet this growing field of practices is perhaps nothing more than the manifestation of our growing conscious awareness of ourselves and how we exist in the universe. As I see it, the greatest benefit for patient and therapist is the opportunity to experience a relationship that honors and respects, listens and hears, and is open to all possibilities.

As nurses we can begin by looking within ourselves for the answers. To believe that we have reached the pinnacle of development in health care that the physical world is all there is, or that we are separate from each other is to live in a myth. Whether it is an alternative therapy or a more conventional one, our full presence in the here and now makes the difference. This is where true healing begins.

With its holistic framework, nursing is in an ideal position to provide care incorporating many of the CAM therapies for the management of symptoms experienced by psychiatric patients. In addition, CAM therapies that empower the patient can play an important part in strengthening the nurse-patient partnership and enhancing the recovery process.

CHAPTER IN REVIEW

- Complementary and alternative medicine (CAM) is the term used to describe a broad range of nontraditional healing philosophies, approaches, and therapies. CAM can be delivered alone or in combination with conventional therapies.
- Well-designed CAM research studies in mental health and psychiatric disorders are beginning to provide empirical evidence for practice. Nurses must continue to inform themselves of research findings related to CAM because nurses play an important role in educating consumers about the evidence supporting these new therapies, as well as the dangers involved in using some of them.
- Ethical concerns include issues of safety and effectiveness, the expertise and qualifications of the practitioner, and communicating the use of CAM therapies to the traditional health care provider.
- Evidence-based CAM therapies for various psychiatric disorders include herbal products and nutrients, acupuncture, exercise, massage, light therapy, relaxation, meditation, therapeutic touch, yoga, and biofeedback.
- CAM therapies can be used by psychiatric nurses and potentially can have a significant impact on their practice.

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CHAPTER

31

Therapeutic Groups

Gail W. Stuart

Self and world are correlated, and so are individualization and participation. . . .
Participation means: being a part of something from which one is, at the same time, separated.

Paul Tillich, The Courage to Be

http://evolve.elsevier.com/Stuart/

LEARNING OBJECTIVES

1. Define a group.
2. Describe the components of a small group.
3. Compare the stages of group development.
4. Analyze small-group evaluation factors.
5. Examine the responsibilities and qualities of nurses as group leaders and the types of groups they lead.

Groups offer members a variety of relationships as they interact with each other and with the group leader. Because group members come from many backgrounds, they have the opportunity to learn from others outside their usual social circle. They are confronted with envy, anger, aggression, fear, joy, generosity, attraction, competitiveness, and many other emotions and motives expressed by others (Yalom, 2005). All this takes place within the dynamics of the group process in which, with careful leadership, members give and receive feedback about the meaning and effect of their interactions with each other.

Groups can be formed to address the needs of many different populations and can be conducted in a variety of settings. Facilitating group work is an important skill for all nurses to master, regardless of their practice setting or specialty area.

Critical Reasoning Think of some specific patient situations in which a group approach would be more effective than an individual nurse-patient encounter. Discuss the reasons for this. Describe other situations in which a group format would be less helpful.

OVERVIEW OF GROUP THERAPY

A **group** is a collection of people who have a relationship with one another, are interdependent, and may have norms in common. Therapeutic groups have a shared purpose. For example, a group's purpose may be to help members who consistently engage in destructive relationships identify and change their maladaptive behaviors.

Each group has its own structure and identity. The power of the group lies in the contributions made by each member and the leader to the shared purpose of the group. These contributions are content and process oriented.

- **Content functions** of the group are met when members share their experiences in an effort to help another. They tell their stories, relate their problems, and discuss what they did that worked or did not work to solve those problems.
- **Process functions** allow an individual to receive feedback from other members and the leader about how the member interacts with and is perceived within the group. The group can be viewed as a laboratory in which to observe, experiment, and define relationships and behaviors.

For example, a member who complains that his wife is always accusing him of being domineering may receive feedback from the group about whether others see him acting in a similarly domineering way. He then can work on changing his behavior in the group setting before risking the change in the outside world.

The group has primary and secondary tasks. The primary task is necessary for the group's survival or existence; secondary tasks may enhance the group but are not basic to its survival. An example of a primary task for a group of mothers is to improve mothering skills; a secondary task is to add to the mothers' social network. Relationships in the group may limit or enhance their willingness to share concerns about mothering.

COMPONENTS OF SMALL GROUPS

Various approaches can be used to increase the therapeutic potential of the group for its members. The components of small groups are summarized in Table 31-1.

Structure

Structure is the group's underlying order. It describes the boundaries, communication and decision-making processes, and authority relationships within the group. The structure offers the group stability and helps regulate behavioral and interactional patterns. Examples of group structure include set meeting time and place, rules regarding attendance, and rules for behavior in the group, such as no smoking while interacting with the group.

TABLE 31-1 COMPONENTS OF SMALL GROUPS

COMPONENT	CHARACTERISTICS
Structure	The group's underlying order; includes boundaries, communication and decision-making processes, and authority relationships; offers stability and helps regulate behavior and interactional patterns
Size	Preferred size: 7-10 members
Length of sessions	Optimal length of a session: 20-40 minutes for lower-functioning groups and 60-120 minutes for higher-functioning groups (divided into time for a brief warm-up, work time, and a brief wrap-up)
Communication	Feedback used to help members identify group dynamics and communication patterns
Roles	Determined by behavior and responsibilities assumed by the members of the group
Power	Ability to influence the group and other members
Norms	Standards of behavior in the group influence communication and behavior; communicated overtly or covertly
Cohesion	The strength of the members' desire to work together toward common goals; related to group's attraction and member satisfaction

Size

The preferred size of an interpersonally oriented group is 7 to 10 members. The group must have enough people to give members the opportunity to receive consensual validation and to hear different viewpoints. If the group has too many people, not all members will be given enough time to speak, and some will feel excluded. If the group has too few members, sharing and interaction can be diminished.

Length of Sessions

The ideal length of a session is 20 to 40 minutes for lower-functioning groups and 60 to 120 minutes for higher-functioning ones. For the latter groups, a few minutes are spent warming up to the task of working, most of the session is spent on group work, and the last few minutes are used to summarize and take care of any unfinished business that relates to that session. Some groups end by assigning homework, such as practicing saying *no* three times to various requests before the next group session.

Communication

A primary task of the group leader is to observe and analyze the communication patterns within the group. Using feedback, the leader helps members become aware of the group communication patterns so that they realize the significance of these patterns for the group and for themselves. The group or individual members may then experiment and change these patterns if they choose. Observable verbal and nonverbal elements of the group's communication include the following:

- Spatial and seating arrangements
- Common themes expressed by the group
- How often and to whom members communicate
- How members are listened to in the group
- What problem-solving processes occur in the group
- Facial and hand gestures that may indicate emotional content

These behaviors help the leader assess the following: resistance within the group, interpersonal conflict, the roles assumed by some members, the level of competition, and how well the members understand and are working on the task.

Roles

In studying groups it is important to observe the roles that members assume in the group. Each role has certain expected behaviors and responsibilities. The role a member takes can be determined by observing communication and behavioral patterns.

The following factors influence role selection: the member's personality, the interaction in the group, and the

TABLE 31-2 **GROUP ROLES AND FUNCTIONS**

ROLE	FUNCTION
Maintenance Roles	
Encourager	To be a positive influence on the group
Harmonizer	To make/keep peace
Compromiser	To minimize conflict by seeking alternatives
Gatekeeper	To determine level of group acceptance of individual members
Follower	To serve as an interested audience
Rule maker	To set standards for group behaviors (e.g., time, dress)
Problem solver	To solve problems to allow group to continue its work
Task Roles	
Leader	To set direction
Questioner	To clarify issues and information
Facilitator	To keep the group focused
Summarizer	To state current position of the group
Evaluator	To assess performance of the group
Initiator	To begin group discussion
Individual Roles	
Victim	To deflect responsibility from self
Monopolizer	To actively seek control by incessant talking
Seducer	To maintain distance and gain personal attention
Mute	To seek control passively through silence
Complainer	To discourage positive work and vent anger
Truant or latecomer	To invalidate significance of the group
Moralist	To serve as judge of right and wrong

member's position in the group. People can play three types of roles in groups (Benne and Sheats, 1948):

1. **Maintenance roles,** which involve group processes and functions
2. **Task roles,** which deal with completing the group's task
3. **Individual roles,** which are not related to the group's tasks or maintenance; they may be self-centered and distracting for the group

These roles are summarized in Table 31-2. A person who acts as a harmonizer and peacemaker is taking a maintenance role. A person in the task role of questioner may clarify and seek new information.

Members may experience a conflict when there is a difference between the role they seek or assume and the role given to them by the group. For example, a member may be expected to be a peacemaker because of having performed that role previously. However, this member may be under additional stress or feel angry with someone in the group and may choose to start rather than resolve conflict. The group often is confused and upset by the person assuming this new role.

Critical Reasoning Consider the last group in which you were a member. Identify the roles that were taken by each group member. Which helped and which interfered with task accomplishment? Give an example of the behavior that was associated with each role.

Power

Power **is the member's ability to influence the group as a whole and its other members individually.** The power structure in the group is usually resolved in its initial stages. To determine the power of various members, it is helpful to assess which members receive the most attention, which are listened to most, and which make decisions for the group. Power may be granted or assumed based on any number of factors, including gender, age, previous experience, length of time in the group, or willingness to speak in the group.

Resolution of the power struggle does not necessarily mean that everyone will be satisfied with the arrangement. A continual struggle for power sometimes occurs. This may be functional if the members are trying to gain new leadership that can contribute to their therapeutic goals. The power struggle can be dysfunctional when it takes the group's energy and attention away from other tasks.

Norms

Norms **are standards of behavior.** They are expectations of how the group will act in the future based on its past and present experiences. It is important to understand norms because they influence the quality of communication and interaction within the group.

The observance of norms results in conforming behavior by group members. The other group members may consider any member who does not follow the norms of the group rebellious or resistant.

Conforming to group norms is essential to being a fully accepted member. For example, if the group norm is to start meetings on time, a member who is always late to meetings is not conforming to group norms. The group decides to what extent it can tolerate nonconforming behavior.

Norms are created to do the following:

- **Facilitate accomplishment of the group's goals or tasks**
- **Control interpersonal conflict**
- **Interpret social reality**
- **Foster group interdependence**

Norms may be communicated overtly or covertly. Overt expression of norms may be written or clearly stated. For example, members may tell a new member that smoking is not allowed in the group. Covert expression of norms may be implied through members' behavior. For example, the other members may ignore a member who uses foul language.

A highly cohesive group may have appropriate or inappropriate norms. For example, a group of patients may unite to help a patient sneak a cigarette when such behavior is not

allowed because of that patient's health problems. The group also may unite to do what it can to prevent that patient from smoking.

One concern that is vitally important for a group to address is confidentiality. For a group to be most effective, members need to feel free to talk about issues that may be painful, embarrassing, or disturbing. The group members must agree that whatever is discussed in the group belongs to the group and that group content will not be discussed outside the group unless a different approach is specifically addressed beforehand and agreed to by all members. **This norm of confidentiality should be communicated directly.** Some groups may want members to sign an agreement of confidentiality.

> **Critical Reasoning** Identify and describe group norms that you have observed in a selected clinical setting and in the classroom. Did anyone deviate from a norm? How did the group respond? How did the leader respond?

Cohesion

Cohesion is the strength of the members' desire to work together toward common goals. It influences members to remain in the group and is related to each member's attraction to and satisfaction received from the group.

Cohesion is a basic aspect of any group because it affects its life span and success. Many factors contribute to the level of cohesion, including agreement of members on group goals, interpersonal attractiveness between the members, degree to which the group satisfies individual needs, similarities among members, and satisfaction of members with the leadership style.

Cohesion is such an important dimension that some group leader interventions are specifically aimed at promoting it. Activities may include encouraging members to talk directly with each other, discussing the group in "we" terms, and encouraging all members to sit within the space reserved for the group. A leader also can promote cohesion by pointing out similarities among group members, helping members listen to each other, and encouraging cooperation among the members.

The group leader continually monitors the level of cohesion in the group. Group leaders may observe how much members express interest in other members and recognize other members for their individuality. Another way to measure cohesion is to find out whether members identify with the group and whether they want to remain in the group.

GROUP DEVELOPMENT

Groups, like individuals, have the capacity for growth and development. They also have the ability to regress and resist working effectively. **Every group develops according to a series of three interpersonal stages:**

1. **Inclusion: being in or out**
2. **Control: being top or bottom**
3. **Affection: being near or far**

> **BOX 31-1 GROUP PROPOSAL GUIDELINES**
>
> List the primary and secondary group goals.
> List group leaders and their related expertise.
> List theoretical frameworks used by the leaders to meet the group goals.
> List criteria for membership.
> Describe the referral and screening process.
> Describe the structure of the group, including the following:
> - Meeting place
> - Meeting time
> - Length of each meeting
> - Number of members
> - Duration of the group
> - Expected member behaviors
> - Expected leader behaviors
>
> Describe the evaluation process for members and the group.
> Describe resources needed for the group, such as coffee, a movie projector, or audiovisual equipment.
> If pertinent, describe the expected cost and financial benefits incurred by the group.

Each stage is characterized by members expressing various aspects of the same interpersonal issue or conflict.

In group development, phases may overlap, or a group may regress to a previous phase. For example, group regression can occur when a new member is added. Phases of group development can be thought of as a path that a group takes to form and accomplish its objectives. The leader's task is to understand and assist the group as it moves along its growth path.

Pregroup Phase

An important factor to consider when starting a group is what its **goals** will be. The group's purpose greatly influences many of the leader's behaviors. The group may have more than one goal; if so, the primary goal should be clearly stated. To guarantee success, the group's goals must be understood by all people involved, including the members and sponsoring agencies. It is the leader's role to clarify the task and help the group achieve it.

After the purpose is established, the leader must be sure that the group has **administrative permission.** A written group proposal is one effective way to request this permission. Box 31-1 provides information to include in a group proposal.

To avoid possible problems, the leader should explore any administrative limitations. For example, an agency may not permit a group to meet outside its own physical facilities or may prefer that the leader not use certain techniques in the group. Any potential cost to the agency should be clearly identified.

The leader is responsible for **finding physical space in which the group can meet.** The leader identifies the room requirements of the group. For example, in a patient education group, resources such as flip charts or a DVD player may be needed. A psychotherapy group may need space for

comfortable chairs to be placed in a circle without a table. For a group that plans to use human relations exercises, a more spacious room probably will be needed.

In all cases, the group room should be comfortable, private, and quiet. The same room should be used for each meeting. Leaders often have to adapt inadequate space to fit the needs of the group. The session itself is more important than where it is conducted.

The next responsibility of the group leader is to **select members.** Selection is based on the purposes of the group, referrals to the group, and interviews with potential members. The leader or the agencies must provide information about the group to potential sources of referrals.

Information should clearly identify the group's purpose and state the criteria for membership eligibility and the time, place, and duration. The leaders' names and professional credentials should be provided.

Membership can greatly influence the group's outcome. The leader should consider group cohesion and therapeutic problem solving when selecting members. Selection criteria include problem areas, motivation, age, gender, cultural factors, educational level, socioeconomic level, ability to communicate, intelligence, and coping and defensive styles.

Homogeneous groups share preselected criteria (e.g., all members are women who suffered incest as children). Heterogeneous groups include a mixture of people, such as a group for men and women who want to build their self-esteem.

If possible, the leader should decide whether the membership of the group will be closed or open before screening members. **In a closed group, no new members are added after the group is started.** The closed group offers the advantage of consistency of leadership, norms, and expectations.

In an open group, some members leave and new members are added throughout the duration of the group. Open groups may retain their initial purpose for the duration of the group but experience a change of members and leaders. These groups usually continue indefinitely with no termination date. The open group can continually bring fresh ideas and opportunities for learning to its members.

The primary purpose of the screening interview is to determine the appropriateness of the potential member to the group. Secondary purposes include the following:

- Beginning to develop a relationship between the leader and the member
- Determining the motivation of the possible member
- Determining whether the candidate's goals are in agreement with the group goals
- Educating the candidate about the nature of the group
- Determining the type of group experience the person has had in the past
- If appropriate, beginning to review the group contract with the candidate

In addition to or instead of the screening interview, some clinicians use group intake meetings. Several new members meet in a group to learn about the group process and identify some possible treatment goals. This approach is less costly and has the same objectives as the screening interview.

A decision should be made as soon as possible about group membership. Candidates not selected should be referred to other treatment options. The reasons for not being selected should be explained to the candidate and, if appropriate, to the person who made the referral.

> **Critical Reasoning** You are asked to develop a group treatment program for victims of discrimination. What membership characteristics will you list as necessary for inclusion in the group? What will you say to the patients who are not selected for inclusion in your group?

Initial Phase

The initial phase includes meetings in which the group's members begin to settle down to work. This phase is characterized by anxiety about being accepted by the group, setting of norms, and casting of various roles.

This initial phase has been further subdivided into three stages by Yalom (2005): the **orientation, conflict,** and **cohesive** stages. These stages correspond to Tuckman's (1965) first three phases of group development: **forming, storming,** and **norming.** Table 31-3 summarizes Tuckman's and Yalom's stages of group development.

Orientation Stage. The Yalom orientation stage corresponds to Tuckman's **forming** stage. The leader is more directive and active than in other stages. The leader orients the group to its primary task and helps the group arrive at a **group contract**. Some common factors that may be included in the group contract are goals, confidentiality, meeting times, honesty, structure, and communication rules (e.g., only one person may talk at a time).

Because an important part of this phase is norm setting, the leader must ensure that the norms can help the group achieve its goals. Another task of the leader in this stage is to **foster a sense of belonging or cohesion among the members.** To accomplish this, the leader encourages interaction among members and maintains the group at a working level of anxiety.

For example, the leader could refer to the group as "our" group and suggest how members can help each other. Members can be encouraged to state what they hope to learn from the group. The leader then can reinforce realistic expectations and give examples of how the group can meet them.

During the first stage, the members are evaluating each other, the group, and the leader. They are deciding whether they are going to be a part of the group and how much they will participate.

Some common conscious or unconscious concerns of members during this stage are fear of being rejected, fear of self-disclosure, and fear of not being seen as an individual. Social behaviors are important, and the members are attempting to develop their social roles. The roles members assume during this stage are often renegotiated during other stages.

Members of groups often test their dependency needs and wishes on the leader. They look to the leader for structure,

TABLE 31-3 DEVELOPMENTAL PHASES IN SMALL GROUPS

YALOM PHASE	TUCKMAN PHASE	DEFINITION	TASK ACTIVITY	INTERPERSONAL ACTIVITY
Orientation	**Forming**	Group members concerned with orientation	To identify task and boundaries regarding it	Relationships tested; interpersonal boundaries identified; dependent relationship with leaders, other group members, or preexisting standards established
Conflict	**Storming**	Group members resistive to task and group influence	To respond emotionally to task	Intergroup conflict
Cohesive	**Norming**	Resistance to group overcome by members	To express intimate personal opinions about task	New roles adopted; new standards evolved in group feelings; cohesiveness developed
Working	**Performing**	Creative problem solving engaged; solutions emerge	To direct group energy toward completion of task	Interpersonal structure of group becomes a tool to achieve its task; roles become flexible and functional

approval, and acceptance, and they may try to please the leader with reward-seeking behaviors.

The leader is not responsible for meeting all the dependency wishes of the members but must encourage them to interact more with one another. This approach supports members in becoming more interdependent and less dependent on the leader. The dependency issue between the leader and the members may lead the group into conflict and therefore into the second stage.

Conflict Stage. The conflict stage of the group corresponds to Tuckman's **storming** stage of group development. **Issues related to control, power, and authority become primary.** Members are concerned about the pecking order or deciding who is top or bottom in control and decision making.

The dependency conflict may be openly or covertly expressed, with members being polarized between independent and dependent issues. For example, a group may be divided about whether members can telephone each other. Some members may want the leader to decide, whereas others may think that the leader's statements are irrelevant.

Subgroups usually form within the group, and hostility may be expressed. Often the hostility is directed toward the leader, but it also may be expressed toward other members.

The leader's tasks are to allow expression of negative and positive feelings, help the group understand the underlying conflict, and prevent or examine nonproductive behaviors, such as scapegoating. This phase is usually the most difficult for a new leader because some members may try to convince the leader to believe that the leader has failed the group by not living up to its unrealistic expectations.

The leader must be careful not to avoid or suppress the group members' anxiety and sometimes should encourage the expression of hostility. If hostility toward the leader is expressed indirectly, such as anger aimed at other authority figures (e.g., staff members, teachers, parents), the leader should help the group express its anger more directly. A useful technique is for the leader to give the group permission to discuss its anger by acknowledging that the group may be disappointed or angry with the leader.

By the end of the conflict stage, the leader may be dethroned, and the leader's omnipotent role with its "magical solutions" may be discarded. Slowly the leader becomes humanized.

Members learn that responsibilities for the group are shared. Members also may learn that expressions of anger and disappointment do not destroy the leader and may help the group assess its resources and limitations more accurately. The group's resources can then be used to achieve its tasks. Members may realize that conflicts need not be avoided; through discussion, open conflicts instead may increase the group's maturity and usefulness.

Cohesive Stage. Tuckman's **norming** phase is closely related to the cohesive stage. Group members, after resolving the second stage, feel a strong attraction toward one another and a strong attachment to the group. Positive feelings toward one another and the group are often expressed, but negative feelings usually are not shared.

At this stage, members feel free to give self-disclosing information and share more intimate concerns. However, the group's problem-solving ability is restricted because negative communication is usually avoided to maintain high group morale. The leader's task is to make a connection between the members' disclosures and the group's primary task.

The leader should not interfere with the group's basic cohesion but should encourage the group to use its problem-solving ability. The leader shows how a group member can have individual concerns and values and still be productive within the group. In other words, the leader demonstrates that differing and opposite opinions do not destroy the group identity.

At the resolution of this stage, members may learn that self-discoveries and differences should not be feared. They

TABLE 31-4 YALOM'S CURATIVE FACTORS

FACTOR	DEFINITION
Imparting information	Receiving didactic information and advice
Instillation of hope	Increasing hopefulness of group members
Universality	Realization that others experience similar thoughts, feelings, and problems
Altruism	Experience of sharing part of oneself to help another
Corrective reenactment	Ability of members to alter learning experience previously obtained from primary family group in their families
Development of social interaction techniques	Opportunity to increase awareness of social interactions and develop social skills
Imitative behaviors	Opportunities to increase skills by imitating behaviors of others in group
Interpersonal learning	Ability to engage in wider range of interpersonal exchanges, thereby increasing each member's understanding of responsibility and complexity of interpersonal relationships and decreasing members' interpersonal distortions
Existential factors	Ability of group to help members deal with meaning of their own existence
Catharsis	Opportunity to express feelings previously unexpressed
Group cohesion	Attraction of member for group and other members

Modified from Yalom I, Vinogradov S: *Group psychotherapy*, Washington, DC, 1989, American Psychiatric Press.

also learn that similarities and differences among the members may help the group achieve its tasks.

At the end of the cohesive stage, the group begins to see task achievement as a reality. The members gain a more realistic and honest view of their ability to work together and accomplish their primary and secondary tasks.

Critical Reasoning Compare behaviors that would indicate that a group is in the orientation stage, the conflict stage, and the cohesive stage. Give specific examples. What leader interventions would be appropriate at each stage?

Working Phase

The working phase of a group can be compared with Tuckman's **performing** stage of group development. **During this stage, the group becomes a team, directing its energy mainly toward completing its tasks.** Although everyone is hard at work, this phase is enjoyable for the leader and the members. Responsibility for the group is more equally shared, anxiety is usually decreased and tolerated better, and the group is more stable and realistic.

Yalom's therapeutic or curative factors that occur in groups are presented in Table 31-4 (Yalom and Vinogradov, 1989). Although these factors were identified in relation to therapy groups, they apply to experiences in all types of groups. Other therapeutic factors important in promoting positive change in short-term groups include self-responsibility and self-understanding.

The leader's major role is to help the group complete its tasks by maximizing effective use of its curative properties. Because the members are fully participating in the group's work, the leader's activity level decreases. The leader now acts more as a consultant to the group. The leader helps keep the group goal directed and tries to decrease the impact of anything that may cause the group to regress or slow the group.

Because this phase is the group's creative problem-solving and resolution phase, there are few or no specific guidelines for the leader. The leader's interventions are based primarily on theoretical frameworks, experiences, personality, and intuition, as well as the needs of the group and its members.

In addition to fostering group cohesion, maintaining its boundaries, and encouraging the group to work on its tasks, the leader may help the group solve specific problems. Because these problems are unique to the group, many are not predictable. Some of the more common problems are the formation of subgroups, the management of conflict, determining the optimal level of self-disclosure, and dealing with resistance.

Subgroups that conflict with the group's goals and are not acknowledged by the group can restrict its work. Other members may feel excluded, and loyalties can be divided between the subgroup and the whole group. For example, in a women's group, two of the members may become close friends, keeping secrets from the group and engaging in private conversations during the session. Other members may feel excluded from this pair and be ineffective in working with them. To decrease the negative impact of a subgroup, its consequences and the group's reactions should be openly discussed.

Conflict is unavoidable but can be used to foster growth. However, expression of conflict may need to be controlled so that the intensity does not exceed the group's tolerance. Examples of conflict are competition among members for the leader's attention and a disagreement between two members.

A leader may manage conflicts by identifying the conflict, explaining that conflicts are natural and can lead to growth and encouraging members to discuss the reasons for the conflict. Successful conflict resolution is related to the amount of group cohesion, trust, and acceptance among the members.

Self-disclosure in the group is usually related to the amount of acceptance and trust the member feels. Self-disclosure is always risky. If people give private information

too quickly, they will feel vulnerable. If people disclose too little during the working phase, they may not be able to form supportive interpersonal relationships. Their growth potential in the group may be decreased.

Resistance, or holding back the therapeutic process, can be expected in therapy groups. **Resistance to working on the therapeutic goal can occur at an individual and a group level.** Group work can initially be anxiety producing because working through interpersonal issues can be personally threatening and emotionally painful. The leader must actively structure the group to make it as nonthreatening as possible and to allow for some early successes for patients.

It is one matter to agree on goals and another to work on obtaining the actual therapeutic outcomes. Resistance by individual members may take many forms, such as avoiding discussion of a conflict, frequent or prolonged silences, attempting to become an assistant leader, absence from the group, pairing between two members, and prolonged or unusually intense expression of hostility.

Resistance by the group or most of its members may be expressed in ways similar to those used by individuals. Other examples of group resistance include shared silence among the members, unusual amounts of dependency on the leader, scapegoating, subgroup formations, and the wish for magical solutions to resolve group conflict.

Resistance to group psychotherapeutic efforts can have a demoralizing effect on the therapist. With experience, handling resistance becomes less threatening. The nurse should realize that resistance is a signal that treatment is progressing and that the therapist and the group members are getting close to crucial issues. Resistance also may occur because of increased anxiety related to conflict or change.

The management of resistance depends on the type of group, the group contract, and the therapist's theoretical framework**. Some ways of decreasing resistance are to establish trust, make observations regarding the group process or individual behaviors, offer interpretations, counteract the resistant behavior, and demonstrate more adaptive behavioral patterns.**

By the end of the second phase, members have made significant progress toward goal achievement. They have a sense of their own productivity and accomplishments. They have less need for the group. The group must then begin to deal more actively with its final task: separation.

Termination Phase

The two types of termination are termination of the group as a whole and termination of individual members. A closed group usually terminates as an entire group; in an open group, members and perhaps the leader terminate separately. Members and groups may terminate prematurely, unsuccessfully, or successfully.

Termination is a highly individual process. Members and groups terminate in unique ways. If the group has been successful, termination may be painful and involve grieving or a sense of loss. It may cause the group to experience increased anxiety, regression, but also a sense of accomplishment.

Allowing members to avoid discussing termination would deprive them of a possible growth experience. **Leadership behaviors include encouraging an evaluation of the group or its terminating members, reminiscing about important events that occurred in the group, and encouraging members to give each other feedback.**

Evaluation usually focuses on the degree to which the group's or individual's goals have been met. Leaders must be careful not to collude with members in denying termination; rather, they should encourage full discussion. Termination should be talked about several sessions before the final session to allow members time to work through issues that may surface.

Termination may lead to discussion of many related topics, such as other separations, death, aging, and the use and passage of time. If terminated successfully, members may feel a sense of resolution about the group experience and use these experiences in many other life situations.

Premature termination means that the group ends before its tasks are completed or members leave the group before their work is finished. Premature termination may occur for appropriate and inappropriate reasons. An appropriate reason is moving to another city before the group is terminated. An inappropriate reason is a member's unwillingness to discuss an issue central to the group but painful to that person.

> **Critical Reasoning** As a staff nurse, you are given the responsibility for developing a group for parents of children with cancer. Outline the points you will need to consider and the steps you would take to establish the group.

EVALUATION OF THE GROUP

Notes detailing the group sessions should be descriptive to help identify goal achievement. One format for quickly recording each group meeting is provided in Box 31-2. In most agencies, summary notes are also included in individual members' clinical records.

It is helpful to determine each member's goal attainment periodically during the course of the group. This can be done

BOX 31-2 GROUP SESSION NOTE OUTLINE

Date ____________________ Group Meeting No. __________
List members attending (state whether a new member).
List members who were late.
List absent members.
List individual members' pertinent issues or behaviors discussed in the group.
List group themes.
Identify important group process issues (e.g., developmental stage, roles, norms).
Identify any critical leadership strategy used.
List proposed future leadership strategies.
Predict member and group responses for the next session.

using subjective ratings by the group leader and by obtaining individual members' perceptions on how they are meeting their goals. For a slightly more objective evaluation, members are asked to rate their goal achievement on a Likert scale, such as one that allows members to rate their response along a continuum from 1 (low) to 5 (high). Members' goal achievement should always be evaluated at termination.

Before, during, and at the end of the group, the clinician should use behavioral rating scales to assess progress toward expected outcomes. The scales selected should be related to the expected changes in the group. For example, an anxiety scale should be administered to members attending a group whose major goal is to reduce anxiety.

It is also essential to identify specific outcomes so that the impact of nursing group interventions can be communicated to consumers and health care organizations. For example, possible short-term outcome measures for nurse-led groups may include increased knowledge of coping skills and increased insight into the members' own effective and ineffective coping behaviors. Long-term outcomes may be related to a decrease in specific symptoms, such as anxiety or depression, as measured by specific behavioral rating scales.

In contrast, a nursing staff support group may have as measurable outcomes the use of a problem-solving approach, the development of a unit communication tool, or the identification of strategies to negotiate staff conflict, seek assistance from each other when stressed, decrease patient complaints, or reduce staff turnover.

NURSES AS GROUP LEADERS

Nurses who are group leaders must be able to study the group and participate in it at the same time. The leader must constantly monitor the group and, whenever necessary, help the group achieve its goals.

The qualities of an effective nurse leader are the same qualities that are important in the therapeutic relationship (see Chapter 2). In particular, they include the responsive and active dimensions of empathy, genuineness, and confrontation.

Creativity and opportunism are helpful qualities for leaders to possess. While they are listening to members' words, leaders also must be aware of the group process. They must be alert to opportunities for the group to use themes and behaviors and see how these are related to individual issues.

Group leaders must make it safe for members to challenge their authority. In examining the interplay between the leader and the members, opportunities can be found to practice conflict management, confrontation, and assertive communication. The leader needs to accept confrontation without taking it personally.

Leaders also need assertive communication skills so that they can foster independence in the group and help the group focus on reaching its goals. Achieving this balance requires a blend of skills and judgment, which can be gained by working in groups, studying group leadership, and being supervised by an experienced group facilitator.

Leaders must be able to organize much information and identify themes for the session. Novice leaders usually need to review the group experience with a supervisor after the session so they can identify and analyze the important events.

A nurse leader also needs a sense of humor. Laughter helps reveal truth and enables participants to share and empathize when serious matters are being discussed. Laughter can lessen the high levels of tension that often accompany such discussions.

For example, in a women's co-dependent group, humor and laughter were used regularly. The group adopted this technique to talk about their rescuing and controlling behaviors. This group was composed of fragile women who grew up in abusive families. They worked hard at seeing, understanding, and changing their contributions to the destructive relationships they had developed. The members came to the weekly group sessions prepared to share examples of their "setting themselves up" behavior and laughed as they were able to find humor in recognizing behavior that was similar to their own. The humor also allowed the members to give feedback in a less confrontational manner.

Groups with Co-Leaders

For some groups, the presence of co-leaders may have advantages and disadvantages. When two clinicians share the leadership, the breadth of observation and the choice of interventions are greater than with just one leader. For example, a male-female team of leaders may represent the family and offer the group members an opportunity to deal with issues related to parents or other significant male and female figures.

A male-female team also offers group members opportunities to observe a man and a woman working together with mutual respect and without exploiting, sexualizing, or patronizing each other. When experienced co-leaders work together in learning and resolving problems, they are modeling adaptive behavior for the group. This can contribute to the group's openness and power.

Disadvantages of the leadership team are often related to difficulties between the leaders themselves. When there is competition, a major philosophical difference, or great variance in strategy or style, the group cannot work effectively. Differences in levels of experience can be handled successfully if both are comfortable with their roles of apprentice and senior leader.

Conflict between co-leaders can lead to splitting of the group or to the group developing an alliance with only one of the leaders, which can be very damaging. If the group becomes divided, or split, this dynamic must be openly interpreted in the group and dealt with by the group members and leaders.

Nurse-Led Groups

Nurses lead groups in a variety of health care settings. Some types of groups that may be led by nurses are task groups, self-help groups, teaching groups, supportive therapy groups, psychotherapy groups, and peer support groups. The type of

group intervention provided by an individual nurse is determined by the needs and goals of the patients and by the education and experience of the nurse.

Task Groups. Task groups are designed to accomplish a particular task. Nursing care–planning meetings and committees are examples of task groups. The emphasis of these groups is on decision making and problem solving. They often have specific goals to accomplish and a deadline for completion of the work.

Self-Help Groups. Groups organized around a common experience are labeled self-help groups. Examples include smoking cessation groups, Overeaters Anonymous, Alcoholics Anonymous, Parents and Friends of Lesbians and Gays, Parents Without Partners, and numerous groups related to specific health problems. They may not receive consultation from a health care provider, such as a professional nurse.

Although some self-help groups are established and organized by professionals, the groups are run by the members alone and often do not have a designated leader. Leadership evolves within the group depending on the need that arises. Nurses can support self-help groups by referring members and by offering advice and assistance if they are requested. Nurses also can promote links between the self-help group and the health care system. Self-help groups are discussed as a mental health promotion strategy in Chapter 12.

Educational Groups. The goal of educational groups is to provide information. Examples are childbirth preparation, parent education groups, medication groups, and psychoeducation groups. In-service education groups for staff are also included in this category. The nurse leader is able to educate more people more efficiently using a group format. The members themselves often become co-teachers as they share their information and experiences. **Psychoeducation groups** are designed to teach symptom identification, symptom management, and recovery planning skills. They are discussed as a recovery and rehabilitation strategy in Chapter 14.

Supportive Therapy Groups. The primary goal of supportive therapy groups is to help the members cope with life stress. The focus is on dysfunctional thoughts, feelings, and behaviors. Supportive therapy groups have value for patients of all ages and with both medical and psychiatric diagnoses.

Psychotherapy Groups. The goal of a psychotherapy group is the treatment of emotional, cognitive, or behavioral dysfunction. Group techniques and processes are used to help members learn about their behavior with other people and how it relates to core personality traits.

The intent is for the members to change their behavior, not just understand or seek support for it. Members also learn that they have responsibilities to others and can help other members achieve their goals.

Brief Therapy Groups. The purpose of brief therapy groups is to focus on the actions participants can take to improve their current situation. Far less importance is given to the causes of the patient's problems or the accompanying emotional reactions.

These groups target what can be done immediately to change a patient's problem-solving approach and help the patient implement more adaptive coping skills. Establishment of a recognized and self-sustaining group program is greatly facilitated by advance planning, well-considered structure, and clearly stated goals.

Intensive Problem-Solving Groups. Intensive problem-solving groups are designed for 6 to 10 patients, each working on resolving specific target problems with problem-solving strategies related to an individual treatment plan. They are based on cognitive, behavioral, and interpersonal therapy models implemented in a structured problem-solving format.

The goal is to identify and clarify the problem, explore alternative solutions, and commit to change. The therapist acts as a leader, teacher, and coach whose purpose is to teach group members the cognitive, behavioral, and interpersonal skills needed to solve the problems identified in their treatment plans.

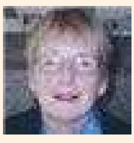
Peer Support Groups. Peer support groups are an effective way for professionals to share the stresses and problems related to their work. An example of a peer support group is a group of psychiatric nurses who meet monthly. Group purposes may include case consultation, sharing information about educational opportunities, providing information about management skills, and decreasing professional isolation. Another example is a group of nurses who work with people who have human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). They meet regularly for nursing consultation and support in coping with the continual loss associated with this disease.

> **Critical Reasoning** As a head nurse, you decide to form a staff support group. How would this differ from a therapeutic group? Discuss it in terms of the roles of the leader and the members. Are there any similarities?

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Paula M. LaSalle, CS, RNP, LCPC



As a psychiatric clinical nurse specialist, I ran a community-based group for people living with HIV/AIDS. The purpose of the group was to support the members by providing a safe, confidential, nonjudgmental, and consistent forum to help them cope with the emotional aspects of having HIV/AIDS. It was also a place where they could access medical, social services, educational, and legal resources.

The group was open, and membership changed from week to week in number and personalities. Some people came weekly for years, others came for a period after the initial diagnosis, and others came at times of crisis. Members were gay, straight, old, and young, and they were from diverse cultures and socioeconomic backgrounds. There were lawyers, former prisoners, military personnel, parents, and people from other countries. The meetings were held in a room in a nonprofit agency that served families and children.

As the leader, I was the gatekeeper who interviewed potential members briefly on the phone. There was agreement in the group that new members could bring along a friend or family member for the first couple of meetings to enable anxious members to feel supported and encouraged in the joining process. With time, it became evident that a family and significant others group was also needed, and one was begun.

Ms. M was a mother of three school-age children whose husband and brother-in-law had died of AIDS. Her husband had attended a few meetings before he died. Her greatest fears involved what would happen to her children when she died. She came every week and especially appreciated the group when she was in a physical crisis. She was generous and nurtured other members in a sweet and gentle way that members could accept.

Mr. J was a nurse who had to deal with this disease in his professional role and personal life. His lover had died quickly from a rapidly progressing infection. He came to the group to grieve his loss and was eventually able to get tested and found himself to be HIV positive. He was a great resource regarding the newest regimens available to treat HIV. He taught the other members about the medical system and how to navigate it.

Ms. B was a single mother of three children who was a master at researching and learning all of the social and medical systems to gain access to funds and social services. She was politically active and a strong advocate for herself and others, especially when she believed there were issues of discrimination.

It was the longest running group of its kind in the state. They trusted one another and me and were passionate in their efforts to live as well as possible with HIV/AIDS. The group continues to meet and receive community support.

Leading the group was rewarding and difficult. A member who became terminally ill frequently came to group to do “life review.” Although the member was frightened, the group members did their best to be there to offer support and love.

It was difficult to share the experiences of members who had been rejected by their families and friends. Some could no longer work because of illness. Others had to do battle with the legal system regarding the survivor benefits for their partners. I was allowed to share in the lives of many brave and strong people who managed their illness as best they could while continuing to raise families, earn a living, cope with recurrent bouts of illness, and sometimes prepare for death.

The group taught me to respect and trust in the group. I was the consistent person who turned on the lights. I facilitated, not controlled, the content and process of the group. This group cried, laughed, ate, sang, and prayed together. At its best, it offered a solid footing from which the members could cope and step out into their lives.

CHAPTER IN REVIEW

- A group is a collection of people who are interrelated and interdependent and may share common purposes and norms.
- Components of a small group include structure, size, length of sessions, communication, roles of members, norms, and cohesion.
- The phases of group development are pregroup; initial phase with orientation, conflict, and cohesion stages; working phase; and termination.
- Small group evaluation is based on accomplishment of individual goals and expected group outcomes.
- Careful documentation of each group session is required.
- The responsibilities and qualities of nurse group leaders include empathy, nurturance, genuineness, creativity, acceptance of confrontation, assertive communication skills, organization, and a sense of humor.
- Types of nurse-led groups include task, self-help, educational, supportive therapy, psychotherapy, brief therapy, intensive problem-solving, and peer support groups.

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CHAPTER

32

Family Interventions

Janet A. York

The family is one of nature's masterpieces.

George Santayana

http://evolve.elsevier.com/Stuart/

LEARNING OBJECTIVES

1. Discuss the context of family interventions, including the family movement, cultural competence, professional training, and a framework for working with families.
2. Analyze family assessment and planning, intervention, and outcomes.
3. Examine the research evidence for family interventions.
4. Evaluate the role of nurses in working with families.

The research on families and family interventions has dramatically expanded. Family interventions target families, couples, caregivers, and significant others and include family and couples psychotherapy, family psychoeduation, family skills building, multiple family groups, and in-home support. Working with families now includes the following:

- **Family advocacy** is a model of working with parents and family members to help them act as advocates with and on behalf of their family member with a disability.
- **Family-oriented practice** refers to specific family interventions and to a broader conceptual framework for intervention that includes family-centered treatment.
- **Family intervention science** is a well-defined area of research in changing behavior in families.

THE CONTEXT OF FAMILY INTERVENTIONS

The Family Movement

National policy reports have helped to educate professionals, policymakers, and laypersons about the needs of those with mental illness and their families and about the problems of the mental health delivery system. Organizations also have been formed to serve families of the mentally ill.

Four organizations that are committed to family support, advocacy, research, and public awareness include the National Alliance on Mental Illness (NAMI), the National Federation for Families for Children's Mental Health, Mental Health America (MHA), and the National Center on Family Homelessness. These groups offer rich resources for nurses working with families.

Family advocacy groups can be effective in raising awareness among service providers, legislators, and the public for improved services and opportunities for family members with psychiatric illness. Family members are strong partners in the new recovery movement. Box 32-1 illustrates the power of consumer grassroots activity.

Patient- and family-centered care is defined as an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. **Four core concepts**

BOX 32-1 ADVOCACY

Elsie Weyrauch is a retired psychiatric nurse. Her husband, Jerry, is a retired navy officer. Elsie and Jerry lost their daughter Terri Ann, a physician, to suicide. After that event the couple worked tirelessly for suicide prevention. They founded Suicide Prevention Advocacy Network (SPAN), a grassroots advocacy organization, in 1996 in Marietta, Georgia.

SPAN links the energy of those bereaved by suicide with the expertise of leaders in education, religion, science, business, government, and public service to significantly reduce suicide. It is a nonprofit organization dedicated to the creation and implementation of national, state, and local suicide prevention strategies.

SPAN USA (located in Washington, DC) includes survivors left behind by suicide victims, suicide attempt survivors, and community activists. SPAN activities have included holding awareness events; visiting and writing letters to legislators; advocating for the passage of congressional resolutions related to suicide; participating in public hearings; hosting suicide awareness events in Washington, DC; co-sponsoring a national suicide prevention strategy meeting, and sitting in federal advisory groups.

The story of SPAN is an inspiring testimonial to the role of family consumers as advocates and the nurse consumer as champion. Despite the tremendous progress that has been made by this organization, the Weyrauchs continued to urge local, state, federal, and international communities to never let up. In their late 70s, they exclaimed, "We can't wait. We're too old."

underlie patient- and family-centered care: dignity and respect, information sharing, participation, and collaboration. Box 32-2 describes activities for promoting dialogue and partnerships with patients and families. These activities are consistent with the tradition, roles, and practice of psychiatric nurses (see Box 32-2).

Critical Reasoning Talk to a family member of someone who is mentally ill. Ask about their experience with the mental health delivery system.

Cultural Competence

Cultural competence is essential in family interventions. The culture of the family can facilitate recovery from mental illness and can also present barriers, such as stigma. **Respecting the roles of family members and community structures, hierarchies, values, and beliefs within the patient's culture is critical**.

Specific multicultural contexts include immigration status, economics, education, ethnicity, religion, gender, age, role, minority-majority status, and geography. Nurses need to examine their own sociocultural contexts, recognize similarities and differences with those of patients and families, assess the sociocultural context of the patient and family, and include sociocultural considerations in the assessment and planning of care for the family (Chapter 7).

BOX 32-2 ACTIVITIES FOR PROMOTING PARTNERSHIPS WITH PATIENTS AND FAMILIES

- Actively respect and incorporate families' strengths, traditions, beliefs, and value systems in all aspects of care.
- Acknowledge that the word *family* is broadly defined.
- Recognize the important influence of the larger community on the patient and family.
- Encourage families' participation in care and decision making at developmentally appropriate levels and as they desire.
- Encourage families to share their observations, ideas, and suggestions for the plan of care.
- Acknowledge the expertise of families.
- Provide complete information in ways families prefer and find useful and affirming.
- Ask families about their learning goals and priorities and how they prefer to learn.
- Make written, electronic, and audiovisual resources available to enhance families' access to information and support.
- Use language that reflects an emotional connection with the family when explaining aspects of a disease or treatment.
- Help staff and families find common ground when disagreements occur.
- Offer a variety of ways for families to express satisfaction or dissatisfaction with care.
- Ask families to participate as faculty for staff orientation and education and in classes for professionals-in-training.
- Invite families to participate in formulating policy and planning and evaluating programs for the hospital.

The Office of Minority Health National Standards for Culturally and Linguistically Appropriate Standards of Care case-based nursing curriculum modules and guidelines developed for youth with emotional, behavioral, and mental disorders and their families also can be used as guides to ensure cultural competence in the delivery of mental health services to families (U.S. Department of Health and Human Services, 2007a,b).

Critical Reasoning Identify one way a nurse can demonstrate understanding and respect for a Hispanic wife of a deployed soldier whose parents insist her depression would improve if she would talk to her priest.

Professional Training

Clinical training programs in family psychotherapy are open to psychiatric nurses and other health care professionals across the United States. They vary in duration, theoretical framework, and the level of knowledge and credentials required for participation. They usually are limited to clinicians with graduate degrees in mental health.

Although the nurse generalist needs knowledge of family systems and psychoeducation in the daily clinical work with

patients, the nurse family therapist should have a graduate degree and didactic content and clinical seminars focused on family theory and intervention science and individual or group counseling related to awareness of the family of origin.

The nurse also should be supervised on an individual or group basis when doing family psychotherapy to facilitate the refinement of clinical skills and the theoretical understanding of family systems and interventions. Students can be trained in family psychotherapy by acting as co-therapists with experienced therapists or being supervised by means of recorded sessions or live observation.

The professional association for the field of marriage and family therapists is the American Association for Marriage and Family Therapy (AAMFT). The organization has defined what should constitute the education, training, and certification for family therapists, supervisors, and teachers. Licensing is also available through AAMFT. Nurses are well represented in the more than 50,000 therapists in this field.

Critical Reasoning What are the qualifications of the person providing family interventions in your psychiatric clinical setting?

Framework for Family Work

Much of the original family therapy work was defined by specific schools, approaches, or models of family therapy. No unified system of family functioning has been established. However, recognized family theories, such as developmental, gender, organizational, functional, conflict, and symbolic interaction systems; family life course development; ecology; social exchange and choice; and risk and protective factors do exist.

Theoretical approaches to intervention include cognitive behavioral, experiential, integrative, brief, systemic, narrative, psychodynamic, psychoanalytical, solution-focused, strategic, structural, and transgenerational approaches (Sadock and Sadock, 2007). Many of these family theories and interventional approaches overlap, and some have clinical evidence of effectiveness but not research evidence. During past decades, there has been a shift toward integrative family therapy.

The risk and protective factors framework has been widely used in the family movement and in mental health prevention. These factors can include individual aspects of biology, behavior, personality, psychiatric, family, and environmental studies (O'Connell et al, 2009). Box 32-3 lists family risk and protective factors impacting children and adolescents.

There is an overlap in family and environmental risk factors and an interaction effect of all risk factors with each other. Many of these family factors have been recognized by the Institute of Medicine as being associated with poorer outcome in the management of chronic medical illnesses.

Examples of family risk factors include a sibling's drug use or a lack of consistent discipline by parents. Family protective factors can include parental supervision, family cohesion, and attachment and bonding between parents and children. The risk and protective factors model is consistent with predisposing factors, precipitating stressors, and appraisal of stressors in the Stuart Stress Adaptation Model (see Chapter 3).

BOX 32-3 FAMILY RISK AND PROTECTIVE FACTORS IMPACTING CHILDREN AND ADOLESCENTS

Risk Factors

- Family behavior concerning substance abuse
  - Parental substance use and drug use modeling
  - Perceived parental permissiveness of youth's substance use
  - Siblings' drug use, particularly that of older brothers
- Poor family management and parenting practices
  - Overinvolvement of one parent and distancing by the other
  - Low parental aspirations for children's educational achievement
  - Unclear or unrealistic parental expectations for children's behavior, especially as they relate to the child's developmental level
  - Poor disciplinary techniques, such as lack of or inconsistent discipline and extremely harsh punishment
- Poor maternal-child relationships
  - Lack of maternal involvement in children's activities
  - Cold, unresponsive, underprotective mother
  - Low level of maternal attachment
  - Maternal use of guilt to control children's behavior
- Family and intrafamilial conflict
  - Criticism and blame
  - Perfectionism and rigidity
  - Physical abuse (the earlier the age of experience, the greater its negative effects)
  - Extreme poverty
  - Lack of an extrafamilial support system
  - Delayed family developmental tasks
- Psychological trauma related to diagnosis and treatment

Protective Factors

- Family cohesion, closeness, warmth, mutuality, connectedness, attachment, and bonding
- Mutually supportive family relationships
- Parental coping skills and supervision
- Clear family organization
- Interaction and communication between family subsystems
- Direct communication about illness and its management
- Formal and informal supports and resources available to the family

Critical Reasoning Think about your own family. Identify two risk factors and two protective factors from your family experience.

Family theories provide a way to examine family processes, such as hierarchy (who is in charge), boundaries (closeness without too much closeness or enmeshment and distance or

estrangement), and organization (how tasks are structured). **It is important for the family therapist and psychiatric nurse to differentiate between adaptive and maladaptive family functioning in order to appropriately identify target symptoms for interventions.** Characteristics of functional families are described in Chapter 10.

At the opposite end of the continuum are dysfunctional families. Some of the more common dysfunctional family patterns (conceptualized as *symptoms* within a pathology paradigm and maladaptive coping within the empowerment model) include the following:

- The acting-out adolescent who is a symptom bearer and whose symptoms bring the family to treatment
- The overprotective mother and distant father (distant through work, alcohol, or physical absence)
- The overfunctioning "superwife" or "superhusband" and the underfunctioning passive, dependent, and compliant spouse
- The spouse who maintains peace at any price and denies difficulties in the marriage but suddenly feels wronged and self-righteous when the mate is discovered to be in legal trouble or having an affair
- The child who exhibits evidence of poor peer relationships at school while attempting to parent younger siblings to compensate for ineffective or emotionally overwhelmed parents
- The overly close three generations of grandparent, parent, and grandchild in which lines of authority and generational identity are poorly defined and the child acts out because of a lack of effective limit setting by an agreed-on parental figure
- The family with a substance-abusing member
- The family subjected to physical, emotional, or sexual abuse by one of its members
- The child who is scapegoated by the family to diffuse marital conflict

Critical Reasoning You need a license to drive a car, fish, and hunt but not to be a parent. Do you think a parenting skills–building program should be required of all new parents?

ASSESSMENT AND PLANNING

The goals of a family assessment and subsequent intervention are as follows:

- **Reduction of psychiatric symptoms**
- **Increase in family resourcefulness or skills**
- **Improvement in individual psychological needs and family interactions**
- **Enhanced awareness of how family patterns affect the members' health and satisfaction**
- **Selection, implementation, and evaluation of treatment**

Many methods of family assessment have been identified, including measures of relationships, family history, family relational diagnoses, self-report inventories, and genograms (Chapter 10). A systems model for assessing families includes five levels: individuals, dyads, nuclear families, extended family, and community and cultural systems.

Although clinical assessment and clinical research assessment tools overlap, the gold standard in clinical assessment is the clinical interview. In family-focused clinical research the gold standard is the analysis of video- or audio-taped interviews.

One nursing model is the Calgary Family Assessment Model (CFAM) and the companion Calgary Family Intervention Model (CFIM) (Wright and Leahey, 2009). Families are assessed from structural, developmental, and functional categories to identify strengths and problems in the assessment. Interventions target change in cognitive, affective, and behavioral domains of family functioning. This model is often used to help families cope with physical or psychiatric illness in a family member.

Another family assessment model comes from child psychiatry. The American Academy of Child and Adolescent Psychiatry (2007) has recommended a comprehensive family assessment for every youth. Components of the assessment include historical and current family information and its functioning, observation of the child's interaction with caretakers, family risk factors for specific disorders, family psychiatric history, family developmental history, marital and individual parent history, family communication, structure, functioning, and beliefs.

Sources of data include interviews with caregivers and family members and observations of interactions of the child with caregivers. The clinician needs to determine the context of the youth's symptomatic behaviors and be sensitive and aware of cultural differences that affect family functioning, precipitate, predispose, or maintain clinical problems, and affect treatment decisions. These data should be documented to identify beliefs, strengths, and barriers to care.

Critical Reasoning Consider your observations of the interaction of a family and patient from your practice and how these observations have informed the treatment plan.

Family Relational Problems

Although no formal family diagnostic system exists, the nurse may find it useful to examine family relational problems in terms of categories described in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association, 2000). The *DSM-IV-TR* lists relational categories (partner, parent-child, or sibling relations; family functioning) under *Other Conditions That May Be a Focus of Clinical Attention*. Relational problems often require clinical attention to avoid further family deterioration, individual symptoms, and decreased quality of life of family members.

Many insurance and managed care companies may require a *DSM-IV-TR* psychiatric diagnosis (other than a family relational diagnosis) before authorizing family interventions. Many family interventions, such as family skills building

(a parenting intervention) are not reimbursed. Third-party payers have not been well informed about the impact of such programs in preventing dysfunctional behavior, such as substance abuse in children and families.

IMPLEMENTATION

Family interventions are aimed at engaging families and encouraging them to be active participants in treatment and recovery, thereby increasing their knowledge and improving coping skills in both patients and their families (Nathan and Gorman, 2007). The indications for family interventions are supported by research that suggests that stressful family environments predict the course of illnesses, such as mood disorders and schizophrenia.

Family interventions are included in disease-specific guidelines for mood, anxiety, eating, and psychotic disorders. New studies of family interventions in medical specialties are emerging as family therapists are joining medical specialty (e.g., geriatrics, rehabilitation, cardiology, oncology) teams to target the family needs.

Family interventions are delivered in a variety of community settings, such as schools, homes, outpatient programs, offices, inpatient units, residential treatment programs, hospitals, courts, child development centers, and churches. Many family education, support, and skills-building programs can be delivered by nurses, social workers, psychologists, or peers or consumers and community-based leaders trained in the intervention. For example, survivors of suicide can be trained as leaders of support groups for family and friend survivors of a loved one who died by suicide. This often enhances culturally competent programs.

Advanced practice nurses who are experts in family intervention can provide training, supervision, and support and can play an important role in program development, applications for funding, and dissemination of evidence-based family interventions in the community. **The delivery of family and couples psychotherapy by nurses requires advanced training and supervision.**

> **Critical Reasoning** Search for a manualized family intervention relevant to your clinical area, and consider the feasibility of its adaptation in your area.

Psychotherapy

The purpose of family psychotherapy is to improve interpersonal skills, communication, behavior, and functioning. Family psychotherapy has two principles that distinguish it from individual or group therapy and from other types of family interventions, such as skills building.

1. **The family is conceptualized as a behavior system with unique properties rather than as the sum of the characteristics of its individual members.**
2. **It is assumed that a close relationship exists between the way a family functions as a group and the emotional adaptation of its individual members.**

Situations in which family psychotherapy may be useful include the following:

- The presenting problem appears in system terms, such as marital conflicts, severe sibling conflicts, or cross-generational conflicts (e.g., parents versus offspring, parents versus grandparents).
- Various types of difficulty and conflict arise between the identified patient and other family members.
- The family is experiencing a transitional stage of the family life cycle, such as beginning a family, marriage, birth of the first child, entrance of children into adolescence, the first child leaving home, retirement, or the death of a spouse or other family member.
- Individual therapy with one family member has resulted in symptoms developing in another family member.
- No improvement occurs with adequate individual psychotherapy. Enlarging the conceptual field to include the family in psychotherapy may produce therapeutic movement.
- The person in treatment seems unable to use individual psychotherapy for personal understanding and change but rather uses therapy sessions primarily to talk about or complain about another member.

OUTCOMES IDENTIFICATION

Outcomes of family interventions include measures of individual change (e.g., medication adherence, hospitalization, relapse intervals, use of skill training, employment, global state, independent living, social functioning, school attendance). They also include changes in interactions relevant to problem behaviors or social systems (e.g., family experience, ability to cope, need for supervision, effective communication).

RESEARCH ON FAMILY INTERVENTIONS

Studies of family intervention effectiveness, also known as **family intervention science,** include basic family research, family intervention research, and family-related research. In each of these areas of research, the conceptualization, measurement, and analysis view the family as a unit or system and contribute to the knowledge of family functioning. In family-related research, the responses of individual family members or concepts related to families or family members are examined.

There is a shift to more family-oriented psychiatric practice, and evidence has increased on the effectiveness of such programs. Research in various medical specialties show that families have powerful influences on health and risk factors for illness. For example, in persons hospitalized for depression, three predictors—expressed emotion, marital distress, and the patient's perceptions of criticism from a spouse—were significantly associated with 9-month rates of relapse (Heru, 2006).

Brief family interventions can improve health and decrease the risk of relapse in cases of chronic illnesses. Research demonstrates that family interventions reduce the

rate of relapse, improve recovery, and increase family well-being. Family intervention science has included interventions for persons with mood disorders, schizophrenia, obsessive-compulsive disorder, substance abuse, personality disorders, conduct disorders, developmental disorders, substances, diabetes, nicotine dependence, anorexia, and suicidality.

Family psychotherapy is being examined in studies of psychosocial interventions in comparison with pharmacological interventions and in combinations of these treatments. For example, a large National Institute of Mental Health–funded trial (the STEP-BD) compared the impact of combining medications with either cognitive behavioral therapy or family-focused therapy (FFT) for persons with bipolar affective disorder (National Institute of Mental Health, 2007).

FFT is a behavioral family management intervention, originally developed for families of persons with schizophrenia, consisting of three modules: psychoeducation, communication enhancement training, and problem-solving skills. Persons receiving either combination treatment demonstrated greater improvement compared with those with pharmacological treatment alone. FFT demonstrated the highest positive impact on medication adherence, hospitalizations, and cost; however, these effects required 2 years of treatment.

Although almost 200 interventions have undergone systematic review by panels from the Substance Abuse and Mental Health Services Administration and there is evidence that the intervention supports mental health promotion, substance abuse prevention, and mental health and substance abuse prevention, only 16 of these interventions are family interventions. These interventions are detailed in the online registry of the National Registry for Effective Prevention Programs (NREPP) and provide valuable resources for nurses for implementation, referrals, and advocacy activities.

Youth

Much family intervention research has focused on youth. The field has moved beyond family systems and views families as building blocks for youth (Josephson, 2008). The evidence base shows the following:

- **Family interventions are effective when working with children and adolescents.**
- **Family risk and protective factors influence the onset and course of youth disorders.**
- **Family interventions should be coordinated with other interventions, including parent management training and building on family strengths.**

Youth With Conduct Disorders. The majority of evidence-based interventions for youth with conduct disorders are family interventions (Nathan and Gorman, 2007). Multisystemic therapy (MST) is a family- and community-based treatment to prevent youth out-of-home placements, such as incarceration and psychiatric hospitalization (Henggeler et al, 2009). **MST has produced long-term outcomes and is cost effective for youth with serious problems.** MST has also been used to intervene in child maltreatment and parental substance abuse and in youth diabetes (Swenson et al, 2009).

A key feature of MST is the integration of empirically based approaches, such as structural family therapy, cognitive behavioral therapy, and psychopharmacological treatment, to address a variety of risk factors across the family, peer, school, and community levels. Treatment principles are clearly identified, and the home-based therapists are actively supervised. MST has been the focus of federally funded projects with multiple replications, revisions, and adaptations, and it is included in policy recommendations for juvenile offenders.

Youth With Mood, Attention, and Behavioral Disorders. Psychoeducational Multiple Family Groups (PMFGs) for youth has been adapted from adult interventions and combines education with therapeutic factors and support for families with youth with mood disorders, attention deficit disorder, and oppositional disorder (Gearing, 2008). Five to eight families attend groups for 2 months to 2 years. Studies have demonstrated a variety of outcomes, such as decreased relapse and inpatient stays, enhanced adherence to medications, increased knowledge, and increased family support and problem solving.

Prevention of Youth Substance Abuse. In 1999 the Office of Juvenile Justice and Delinquency, in collaboration with the Center for Substance Abuse Prevention, searched for best-practice family-strengthening programs, specifically family programs that have been effective in the prevention of youth substance abuse and other dysfunctional behavior (Tolan et al, 2007). A guideline, *Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches*, was developed based on systematic review. It is based on the belief that the family is the first line of defense.

Three family-centered approaches with clinical and research evidence to support their efficacy with youth substance abuse were identified: parent and family skills building, family in-home support, and family psychotherapy. All three programs target families with multiple risk factors or a high level of exposure to one risk factor, such as divorce, parental substance abuse, or juvenile legal involvement.

Family-based prevention programs for substance-abusing youth should enhance family bonding and relationships, including parenting skills, practice in developing, discussing, and enforcing family policies on substance abuse, and drug abuse education and information. Family bonding is the core of parent-child relationships and can be strengthened through training parents in supporting and praising appropriate behavior, protecting their children, enhancing parent-child communication, and increasing parental involvement. **Parental monitoring, supervision, discipline, and rule setting also are critical for drug abuse prevention.**

Drug abuse education for parents or caregivers reinforces what children are learning about the harmful effects of drugs and opens opportunities for family discussions about the abuse of legal and illegal substances. Brief, family-focused interventions, such as education on specific drugs, can positively change specific parenting behavior, thus reducing later risks of drug abuse.

The Kumpfer **Strengthening Families Program (SFP)** is another family skills–building program. Like MST, the SFP has had more than 20 years of implementation, replication, revisions, development of adaptations for specific groups, and funded dissemination and evaluation (Strengthening Families, 2011; Centers for Disease Control and Prevention, 2009). Three components (parent, child, and family) are involved in the 14-week SFP program.

Another family skills–building program is the **Effective Black Parenting Program** developed by Alvey. It is a cognitive behavioral program designed to meet the specific needs of African-American families using African-American language and emphasizing African-American achievement and competence. Evaluation of the program demonstrated a significant decrease in parental rejection, increase in the quality of family relationships, and improvement in child behavior outcomes (Centers for Disease Control and Prevention, 2009).

A final family intervention for early prevention is **in-home support.** Trained personnel visit high-risk families in their homes in the prenatal or infancy period with the objectives of improving the home environment and family development and preventing child behavioral problems. The findings of a systematic review reported that the intervention reduced child maltreatment by 40%, the required intervention dose was 2 years, and the visitors needed to be professional visitors (the best outcomes occurred with nurse visitors) (The Community Guide, 2011).

Prevention of Youth Suicide. Suicidal youth often present in the emergency department (ED). A few family-centered interventions have been developed that may improve treatment adherence and decrease the risk of a subsequent suicide attempt. One example is an urban ED adherence program targeting Hispanic adolescents who attempted suicide. It included an orientation video for families, an on-call bilingual crisis therapist/crisis manager, and an interdisciplinary training program for ED personnel (Rotheram-Borus, 2011).

Another youth suicide prevention program trained ED staff to deliver a means restriction intervention to parents of youth at risk for suicide (Kruesi et al, 2011). Means restriction is intended to restrict access to firearms, medications, and other means of suicide. When this intervention was delivered by nurses in a rural ED, parents were significantly more likely to lock up guns and medications.

Although mental health professionals may be reluctant to discuss firearms with parents, nurses are well trained and well positioned to deliver this intervention because of their training in responding to sensitive issues and culturally competent care. Box 32-4 provides the three-step interventions for means restriction education with parents.

Critical Reasoning Do you think nursing staff in emergency rooms are prepared to care for suicidal youth? What additional training in family-centered care do you think they would need to enhance the care they now provide to this group of patients?

BOX 32-4 THREE-STEP INTERVENTIONS: 10 MINUTES OF YOUR TIME CAN MEAN A LIFETIME FOR AN ADOLESCENT

Program Description

The goal of this intervention is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Education takes place in emergency departments and is conducted by department staff. Emergency department staff members are trained to provide education to parents of children who are assessed to be at risk for suicide. Lethal means covered include firearms, medications (over-the-counter and prescribed), and alcohol. To help with the safe disposal of firearms, collaboration with local law enforcement or other appropriate organizations is advised.

Program Content

The content of parent instruction includes the following:

1. Informing parents, apart from the child, that the child is at increased risk for suicide and why the staff believed this
2. Informing parents that they can reduce risk by limiting access to lethal means, especially firearms
3. Educating parents and problem solving with them about how to limit access to lethal means

From Kruesi M et al: Emergency department means restriction education, Registry of Evidence-based Suicide Prevention Programs, Suicide Prevention Resource Center. Accessed November 2011 at www.sprc.org/featured_resources/bpr/ebpp.asp.

Family Psychoeducation

Family psychoeducation is an evidence-based practice (see Chapter 10). Some overlap exists between family psychoeducation and family psychotherapy. Psychoeducation is often combined with marital and family therapy. Both psychoeducation and psychotherapy focus on problem-solving and communication therapy. Outcomes of these interventions have demonstrated decreases in feelings of rejection by family members, decreases in patient relapse and rehospitalization, improvement in family communication and patient functioning, recovery, and medication adherence.

A well-recognized psychoeducation intervention was developed by the National Alliance on Mental Illness (NAMI). In the Family-to-Family program, families teach other families about the illnesses experienced by adult family members, methods of coping, and support resources. Participants have underscored the significance of information coming from other families in the education and support component of the program (Dixon et al, 2011).

Psychoeducation for families that includes persons with severe disorders, such as schizophrenia, major depression, and bipolar disorder, is typically combined with pharmacotherapy. It has been shown to improve global and symptomatic functioning and family rejection and burden. Nurses are often involved in psychoeducation.

Couples Therapy

Relationships have implications for health. Persons in healthy marriages and satisfying relationships have better health, healthier lifestyles, greater work productivity, and better coping with stress compared with persons who are divorced or never married. They also detect physical problems earlier and have a reduced likelihood of developing physical illness. Marital distress increases the risk for developing psychiatric disorders and health problems, in part because of immunological suppression.

The variability in the types of happy marriages is great. Wallerstein and Blakeslee's (1995) classic study of functional couples identified nine tasks of building a good marriage:

1. To separate emotionally from the family of one's childhood and invest fully in the marriage and, at the same time, to redefine the lines of connection with both families of origin
2. To build togetherness by creating the intimacy that supports it while carving out each partner's autonomy
3. To embrace the daunting roles of being parents and to absorb the impact of a baby's dramatic entrance while working to protect their own privacy
4. To confront and master the inevitable crises of life, maintaining the strength of the bond in the face of adversity
5. To create a safe haven for the expression of differences, anger, and conflict
6. To establish a rich and pleasurable sexual relationship and protect it from the intrusions of the workplace and family obligations
7. To use laughter and humor to keep things in perspective and to avoid boredom by sharing fun, interests, and friends
8. To provide nurturance and comfort to each other, satisfying each partner's needs for dependency and offering continuing encouragement and support
9. To keep alive the early romantic, idealized images of falling in love while facing the sober realities of the changes wrought by time

Marital therapy is the treatment of the distress in a committed relationship or the education of a couple in regard to what makes healthy relationships, such as good communication skills. It has been used in the treatment of depression, substance abuse, sexual dysfunction, divorce, stepfamily conflict, and trauma.

Therapy typically is brief (12 to 20 sessions) and includes enhancing communication skills, increasing caring activities, and linking current family issues to family of origin experiences. Contraindications for marital therapy include ongoing marital affairs, intense anxiety, a potential for violence, a lack of commitment to the relationship, and an inexperienced therapist.

The six types of martial therapy include behavioral, emotion-focused, cognitive behavioral, integrative, strategic, and insight-oriented. Behavioral marital therapy is a very successful and well-researched approach, based on the premise that distress in a couple results from efforts to get positive reinforcement that fails.

Empirical validation also exists for emotion-focused therapy that focuses on a maladaptive emotional response in which a person fears intimacy because of learning that closeness or touch can be dangerous and thus reacts with fear or anger.

THE ROLE OF THE NURSE

Nurses have many opportunities to encourage healthy family relationships through psychoeducation, reinforcement of strengths, supportive counseling, and referrals for therapy and support. Nurses are well prepared to enhance family functioning in traditional clinical settings and nontraditional settings.

The knowledge, skills, creativity, and therapeutic alliance of nurses and families improve the likelihood of completion of family interventions. Nurses at generalist and specialist levels of preparation can contribute to the implementation of family-oriented practice, interventions, research, and advocacy. However, these endeavors must be based on the available evidence, not on tradition, rich as it is.

Nurses should integrate family-based theory and family intervention science into clinical programs, deliver and promote evidence-based family interventions, and advocate for families and third-party reimbursement for family interventions. Proactive strategies can have a significant impact on strengthening families and helping people become competent parents and family members. The expanded knowledge related to medical illnesses and family risk and protective factors and family oriented-practice and interventions provides new opportunities for nursing expertise and practice.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Julie Carbray, DNSc, APN, BC

One of the pleasures of being a psychiatric nurse is enjoying the positive transformation of families that can occur through your guidance. I participated in such a transformation with a family I saw professionally in our outpatient child psychiatry setting.

J was a 9-year-old, white boy, the oldest child of two professional parents, who had been hospitalized for a suicidal gesture. During a family conflict, he had threatened to take his life in a letter he wrote to his parents. After he was stabilized in the hospital and started on antidepressant medication, he was discharged with a referral to my care for his medication management and family therapy.

In a preliminary family session, it became clear that each family member was stressed and that the family had a pattern of highly expressed emotion that typically fueled their conflicts. The mother, father, patient, and his younger sister each felt victimized by the anger in the home, and all agreed that the family did more criticizing than supporting. We discussed J's illness and how his own symptoms—irritability, low self-esteem, and aggression—always were preceded by one of these high conflict states at home.

The parents were educated about how depression manifests in children: that it was almost as if J were more sensitive because of the depression and that the conflict prompted him to respond or to withdraw. His aggression and suicidality were frequently the result of his feeling unable to control the situation at home.

The family had a strong extended family history of mood disorders and alcoholism, and both parents were raised in families where conflict and expressed emotion were high. As children, they had done their best to avoid these situations or "grew tough skin" to protect themselves. Their son's extreme sensitivity and reactivity appeared out of proportion to what they had experienced in their own childhoods.

As part of the treatment plan, the parents agreed to try to empathize with their son because his hurting himself would be one of the worst scenarios they could imagine. His mother started by noting how she felt a need to nag others at home to help out more because she felt things should be orderly and because this behavior took care of "my control issues."

The father shared his own struggles and the frustration he felt because of not having time with his wife, feeling as if everything he did was not enough for her, and feeling that the family did very little together. These feelings contributed to a sense of isolation he felt at home, and he frequently attempted to rescue his children from his wife when she was disciplining them. They had grown accustomed to a good guy–bad guy style of parenting that resulted in more conflict rather than less.

The family also was encouraged to discuss similarities and strengths. They all enjoyed joking with one another, enjoyed sports, and liked watching movies together. I used their sense of humor as a means of bringing them together and getting them to talk about difficult issues while at the same time reinforcing their affection for one another.

CHAPTER IN REVIEW

- Family therapy refers to both specific family interventions and a broader conceptual framework for intervention that includes family-centered treatment, family and couples psychotherapy, family skills building, multiple family groups, and in-home support.
- Family advocacy refers to the mutual support, time, energy, and resources needed to advocate for improved services and opportunities for family members with psychiatric illness.
- Cultural competence is essential in family interventions.
- It is important for the family therapist and psychiatric nurse to differentiate between adaptive and maladaptive family functioning to appropriately identify target symptoms for interventions.
- The goals of a family assessment and subsequent intervention are appraisal; reduction of psychiatric symptoms; increase in family resourcefulness or skills; improvement in individual psychological needs and family interactions; enhanced family awareness of how family patterns affect the health and satisfaction of their members; and the selection, implementation, and evaluation of treatment.
- Family interventions are aimed at engaging families and encouraging them to be active participants in treatment and recovery, thereby increasing knowledge and improving coping skills in patients and their families.
- Family interventions supported by research exist in the areas of youth, couples therapy, family psychoeducation, and parent and family skills building.

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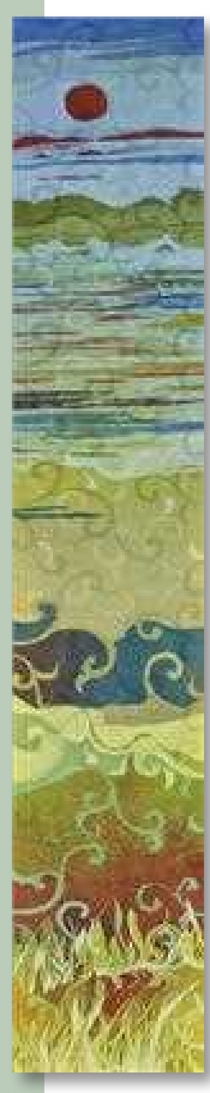
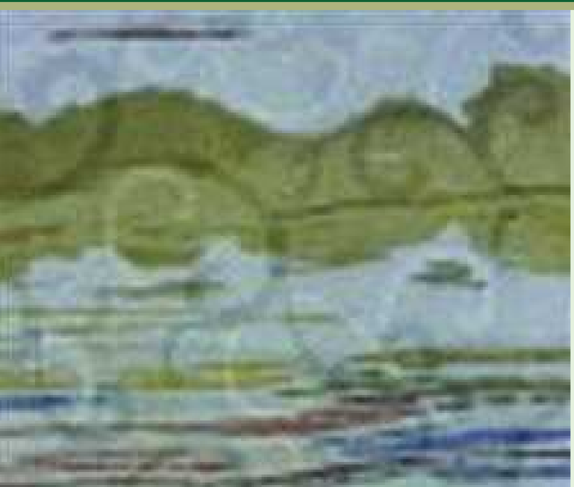
UNIT 5

Treatment Settings





CHAPTER

33

Hospital-Based Psychiatric Nursing Care

Elizabeth G. Maree

"We're all mad here. I'm mad. You're mad."
"How do you know I'm mad?" said Alice.
"You must be," said the Cat, "or you wouldn't have come here."
Alice didn't think that proved it at all.

Lewis Carroll, Alice's Adventures in Wonderland

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe recent changes in hospital-based psychiatric care.
2. Examine the components of the therapeutic milieu and its application to hospital-based psychiatric nursing practice.
3. Discuss the caregiving activities of the psychiatric nurse in structured treatment settings.
4. Analyze the psychiatric nurse's role in integrating and coordinating hospital-based care.

The treatment of mentally ill people has always reflected social values and public policy. Contemporary mental health services have been transformed by economic forces, scientific advances, and advocacy movements. Despite national policy that focuses on a shift from hospital to community-based services, critical demand for acute inpatient services continues. Increases in hospital admissions, days of care, and occupancy rates underscore the need for this level of care (National Association of Psychiatric Health Systems, 2011).

Inpatient psychiatric units are developed and maintained primarily in response to community need. Although not always profitable, successful programs generate steady patient volumes. Changes in mental health policy and financing have resulted in significant reductions in reimbursement and psychiatric inpatient capacity (Marks et al, 2011). Some of the issues impacting the delivery of inpatient psychiatric services include mental health parity legislation, health care reform, state mental health budget cuts, shortened length of stay, workforce issues, recovery model philosophy, and stigma.

Psychiatric nurses are in a unique position to implement strategies to address these challenges and improve the system of care for persons with mental illness. News headlines remind society of the need for psychiatric intervention and the danger of ignoring behaviors associated with mental illness (Pickert and Cloud, 2011). Hospital-based programs play a vital role in the system of care addressing these needs.

INPATIENT PSYCHIATRIC CARE

General hospitals are the largest providers of inpatient psychiatric services in the United States, accounting for almost 60% of all admissions. Negative financial margins often make clinical services in general hospitals unprofitable and vulnerable to downsizing or closure. As a result, psychiatric patients

BOX 33-1 INDICATIONS AND TREATMENT OBJECTIVES FOR PSYCHIATRIC HOSPITALIZATION

Indications for Inpatient Hospitalization
- Prevention of harm to self or others
- Stabilization to allow treatment at a less restrictive level of care
- Initiation of a treatment process for patients with safety risks who must be monitored by specially trained personnel
- Management of severe symptoms such as significant confusion, disorganization, and inability to care for self
- Need for a rapid, multidisciplinary diagnostic evaluation that requires frequent observation and monitoring by specially trained personnel

Treatment Objectives
- Rapid evaluation and diagnosis
- Decreasing behavior that is dangerous to self or others
- Stabilization of symptoms allowing for treatment at a less restrictive level of care
- Preparing the patient and caregivers to manage the patient's care in a less restrictive setting
- Arranging for effective aftercare to ensure continued improvement in the patient's condition and functional level

are increasingly being cared for in emergency departments and medical-surgical beds, referred to as *scatter beds*.

These trends illustrate some of the unintended consequences of policy and funding decisions. Behavioral health spending must be evaluated broadly to include the need for and access to treatment in addition to dollars spent (Mark et al, 2010; Glick et al, 2011). **Indications for inpatient psychiatric hospitalization and treatment objectives are listed in Box 33-1.**

The focus of psychiatric care has moved away from extended care in inpatient settings toward shorter lengths of inpatient stays with transfer to less intensive settings in the continuum of care. **The average length of stay (ALOS) in most psychiatric inpatient settings is 5 to 10 days** (Figure 33-1). Specific treatment interventions include detoxification from substances, intervening with support systems, initiation or modification of pharmacological treatment, and follow-up planning.

Crisis stabilization units were designed as an alternative to traditional inpatient services as a way to decrease inpatient hospitalization stays and reduce costs. **Crisis stabilization units provide brief, intensive emergency care for an acute crisis, usually for 2 to 3 days, with immediate linkage to community-based services.**

The major psychiatric diagnoses of patients discharged from short-stay hospitals are listed in Table 33-1. In previous years most patients with maladaptive coping responses entered the psychiatric hospital in the **acute treatment stage** and were able to stay in the hospital until the goal of symptom **remission** was attained. Currently, most patients are admitted to hospitals in the **crisis stage,** with the treatment goal of **stabilization** rather than symptom remission.

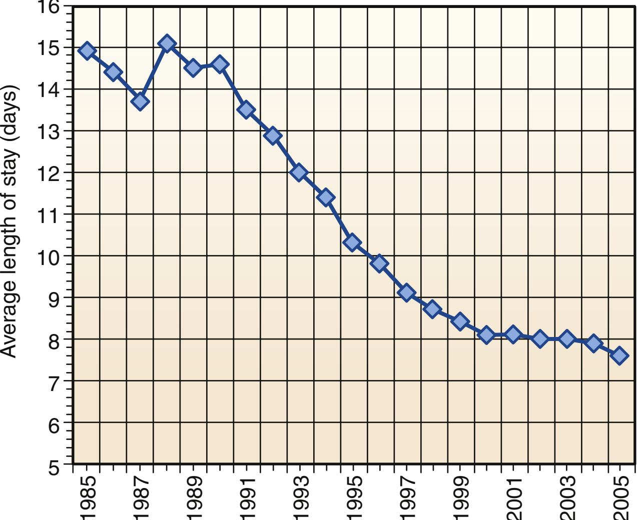


FIG 33-1 Hospital stays for psychiatric patients. (From DeFrances CJ, Hall MJ: *2005 National hospital discharge summary*. Advance data from vital and health statistics, No. 385, Hyattsville, Md, 2007, National Center for Health Statistics.)

TABLE 33-1 FIRST-LISTED DIAGNOSIS FOR PATIENTS DISCHARGED FROM SHORT-STAY HOSPITALS

DIAGNOSIS	PERCENTAGE
Mood disorders	44
Substance use disorders	24
Schizophrenic disorders	14
Anxiety disorders	4
Nonorganic psychosis	4
Organic mental disorders	3
Adjustment reactions	2
Other	5

From Hall MJ et al: *National hospital discharge survey: 2007 summary.* Advance data from vital health and statistics, No 29, Hyattsville, Md, 2010, National Center for Health and Statistics.

Critical Reasoning Does your community have any crisis beds? If so, how often are they used and by what type of patient?

State Hospitals

Changes in hospital-based psychiatric care are most evident in the changes that have taken place in state mental hospitals across the United States. **The number of state hospital beds has declined by 90% over the past 50 years while the number of people with mental illness has increased** (National Association of Psychiatric Health Systems, 2011).

The first data collected on state hospitals from 1831 reported 150 patients in four state hospitals. The number steadily rose until 1955, when it peaked at 559,000 patients in 352 state hospitals (Manderscheid et al, 2009). These institutions provided custodial care to patients believed to be unable

to safely function in the community or those thought to be a threat to society.

The 1950s brought new trends in treatment, including psychotropic medication and changing philosophies regarding the best location of treatment for persons with severe mental illness. A shift occurred in favor of community-based services. One driving force for this change was concern about **institutionalism,** or the tendency of long-term hospital patients to demonstrate passive dependent behavior and become resistant to discharge. Advocates for the mentally ill expressed a strong belief that community-based treatment models integrating family and social living were better than institutionalization.

Deinstitutionalization moved patients out of state hospitals into community-based treatment facilities. Hospital funding was reallocated to advancing treatment, especially psychopharmacological and outpatient services. The period from 1955 to 2003 produced a steady decline in the numbers and size of state hospitals, with a peak of closures in the 1990s. In 2004 there were 57,302 state and county psychiatric hospital beds, which is about 10% of the beds that existed in 1955. As a result of this drastic reduction in beds, there are major concerns about the outcomes of deinstitutionalization and the lack of adequate community resources.

Because there are so few beds available, individuals with severe psychiatric disorders who need to be hospitalized are often unable to get admitted. Those who are admitted are often discharged prematurely and without a treatment plan. The consequences of this reduction in psychiatric hospital beds include the following (Treatment Advocacy Center, 2011):

- **Homelessness:** A 2005 federal survey estimated that approximately 500,000 single men and women are homeless in the United States at any given time, and multiple studies have reported that one third have a serious mental illness.
- **Jails and prisons as psychiatric hospitals:** Since the reduction in public psychiatric hospital beds occurred, there has been a significant increase in severely mentally persons in jails and prisons. Estimates have placed the number at 7% to 10% of all inmates, but some studies have put the figure at 20% or higher.
- **Hospital emergency room overflow:** Emergency rooms are often used as waiting rooms for people in need of a psychiatric bed. This backs up the entire hospital system and compromises other medical care.
- **Violent crime:** Studies have shown that between 5% and 10% of seriously mentally ill persons who are not receiving treatment will commit a violent act each year, accounting for 5% of all homicides.

The state hospital of the twenty-first century must focus on the needs and characteristics of the specific patient populations it serves, including patients with criminal justice histories, forensic patients, sexually dangerous persons, and the difficult-to-discharge patient with complex ongoing care needs. Research is needed to address the unique treatment and rehabilitative challenges for these populations and to inform future policy decisions (Fisher et al, 2009).

Despite advancements, some patients continue to require long-term, highly structured care on a 24-hour basis. Safety of the patient and society, inconsistent availability of appropriate services in the community, and preventing the mentally ill from becoming homeless or incarcerated are a few of the challenges that must be faced to meet the needs of the most severely mentally ill.

Critical Reasoning Some say that state psychiatric hospitals have created a two-tiered (insured and indigent) system of mental health care that does not exist in general health care settings. How do you respond to this?

Partial Hospitalization Programs

Partial hospitalization programs (PHP) are an important part of the continuum of care for mental health and chemical dependency treatment. A PHP is designed to prevent relapse and avoid hospital admission or to provide active treatment for serious mental disorders with reasonable expectation of improvement. PHPs use crisis stabilization and recovery-oriented approaches (Khawaja and Westermeyer, 2010).

- **Crisis stabilization** approaches assist patients to identify personal and environmental triggers, understand the crisis, and develop healthy patterns of problem solving and coping.
- **Recovery-oriented** approaches focus on patient improvements through engagement in their treatment plan, choosing options, and establishing realistic goals in a respectful environment that emphasizes hope and quality of life.

PHP patients usually receive 4 to 6 hours of services per day for 4 to 5 days per week (National Association of Psychiatric Health Systems, 2011). Typically, the patient receives the maximum service for the first 1 to 2 weeks after discharge from an inpatient unit. As the crisis stabilizes and the patient's level of functioning improves, participation in the program is reduced, allowing for transition back to home, work, or school.

The PHP team is multidisciplinary and usually includes a psychiatrist, psychiatric nurse, social worker, and activity therapist. Some programs also include occupational therapists and vocational counselors. PHP patients typically are seen by the psychiatrist weekly, and the psychiatric nurse assumes the primary responsibility for assessing and identifying biological issues that may be contributing to the patient's psychiatric condition. Studies of PHPs have raised questions about their clinical effectiveness and whether they promote the recovery model of psychiatric care (Yanos et al, 2009; Lariviere et al, 2010).

Critical Reasoning How do you think the changes in hospital-based psychiatric care affect the families and support systems of the mentally ill? How can nurses help them with the problems they face?

The Role of the Nurse

Most psychiatric nurses work in inpatient and PHP psychiatric settings. **Psychiatric nurses are the only group of mental**

health professionals who are responsible for meeting the needs of inpatients 24 hours per day, 365 days per year. To deliver cost-effective, high-quality inpatient or PHP care, psychiatric nurses must manage the nurse-patient relationship within a complex social and organizational environment. The scope of contemporary hospital-based psychiatric nursing practice requires knowledge and expertise in three broad areas:

- **Managing the therapeutic milieu**
- **Implementing caregiving activities**
- **Integrating and coordinating care delivery**

This chapter is organized around these areas because they represent the structure and the process of hospital-based psychiatric nursing care.

MANAGING THE MILIEU

A basic difference among care settings is the structured environment, or milieu, in which treatment occurs. Hospital-based treatment provides physical and emotional shelter. It gives patients an opportunity to stabilize while being protected from factors that can interfere with treatment. PHP treatment provides structure and intensive support on a more limited basis while promoting development of a more home-like environment that supports the patient's progress. **The goal of managing the milieu is to provide patients with a safe, stable, and consistent social environment that facilitates the development and implementation of an individualized treatment plan.**

The Therapeutic Community

In the 1950s, Maxwell Jones described the inpatient environment as a **therapeutic community** with cultural norms for behaviors, values, and activity (Jones, 1953). He viewed patients' social interactions with peers and health care workers as treatment opportunities and proposed that clinical staff share community governance with the patient group on an equal basis. He emphasized the benefit of patient's participation in each other's treatment, predominantly through sharing information and giving feedback in group settings.

The concept of the inpatient therapeutic community is less relevant to today's inpatient environment. It was developed when patients spent months or years in the hospital, which is very different from the current short-term stays. Democracy and equality among patients and clinical staff is not compatible with the medical model of current inpatient settings.

> **Critical Reasoning** The therapeutic community is an example of the social model of psychiatric care. Discuss how it differs from the medical model in the roles of patient and clinician and the therapeutic process.

The Therapeutic Milieu

In the late 1960s, the idea of the **therapeutic milieu** emerged (Abroms, 1969). It had two main purposes:

- **To set limits on disturbing and maladaptive behavior**
- **To teach psychosocial skills**

Five categories of disturbing behaviors and interventions that can help patients keep maladaptive behaviors under control and allow treatment to progress are listed in Table 33-2. After maladaptive behaviors are limited, the therapeutic milieu can be used to develop the following four important psychosocial skills in mentally ill patients:

1. **Orientation.** Orientation is the patient's knowledge and understanding of time, place, person, and purpose. Awareness of these elements can be reinforced through patient interactions and activities. For example, introducing oneself, one's role, and the rationale for an interaction helps disoriented patients attend to their surroundings. Other interventions include large unit postings identifying the day, date, and schedule of the day's activities; patient room white boards identifying important specific information for the patient, including the name of their nurse and physician; community meetings to explain unit structure and answer patient questions in a group setting; and discussions of current events.
2. **Assertion.** The ability to express oneself appropriately can be role-modeled and exercised in a variety of ways in the treatment setting. Supporting patients in expressing themselves effectively and in a socially acceptable manner on a specific topic or issue is the overall goal. Sample interventions include assertiveness training, anger management groups, and focus groups for lower-functioning patients.
3. **Occupation.** Patients can feel a sense of confidence and accomplishment through industrious activity. Many therapeutic opportunities are provided through completion of individual or group hands-on activities. Spending time working with patients on something as simple as a jigsaw puzzle can provide purposeful activity, physical skill development, and the added benefit of practiced social interaction.
4. **Recreation.** The ability to engage in and enjoy leisure time is a beneficial outlet for pleasure and relaxation. Providing a variety of recreational opportunities helps patients apply many of the skills they have learned, including orientation, assertion, social interaction, and physical dexterity. Examples include group and individual games, exercise groups, brief walks outdoors, and participation in a healing garden.

These are useful and practical ideas related to therapeutic environments that continue to have value in inpatient and PHP settings. They support the use of some of the multidisciplinary therapies that patients receive in structured settings, such as occupational and recreational therapy. Collaboration between nursing and these specialties enhances overall unit programming and individual care plans.

> **Critical Reasoning** How do you respond to a patient's wife who asks you why her husband is spending time in an exercise group or a current events discussion when he has only 5 days of insurance to pay for his hospitalization for severe depression?

One of the most important contributions to the idea of the therapeutic milieu came when Gunderson (1978) described

TABLE 33-2 MANAGING DISTURBING BEHAVIORS IN THE MILIEU

DISTURBING BEHAVIOR	DEFINITION	INTERVENTIONS
Destructiveness	Physically destructive behavior that is a response to a variety of feelings, such as fear or anger	In working with destructive behavior, the goal is to control or set limits on the maladaptive response but support the feeling underlying the behavior. Validation is essential to help the patient recognize the feeling and ultimately regain control of maladaptive behavior.
Disorganization	Distorted or unusual behavior a psychotic patient may exhibit as symptomatic of the illness may be triggered by elevated anxiety, profound depression, or organic dysfunctions.	Reassure and help the patient while reducing the degree to which these behaviors inhibit therapeutic processes.
Deviancy	Behaviors often described as acting out are the result of the patient expressing conflicts overtly in the environment. It is often difficult to determine precisely what acting-out behavior is or what is justifiable or even tolerable, because much of it may be influenced by sociocultural factors.	The therapeutic goal in working with deviancy is to analyze how the behavior affects the milieu and how it inhibits the patient's progress. Examining the behavior with the patient and identifying consequences and alternatives are useful approaches.
Dysphoria	Patients with mood alterations may be dysphoric, which is evident in maladaptive responses, such as withdrawal from the environment, obsessional behaviors, intrusiveness, or hyperreligiosity.	Establishing a therapeutic alliance is the first task. From there, the nurse and patient can explore feelings and dysfunctional thoughts and begin to modify behavioral responses.
Dependence	Behavior is evidenced by patients who do not identify and meet their own needs despite being able to do so; the avoidant nature of dependency interferes with therapeutic progress.	The initial therapeutic goal is to work with the patient to draw on any remaining areas of independence and strength. Then situations can be identified in which the patient can apply these independent behaviors successfully.

five specific functions of a therapeutic milieu: **containment, support, structure, involvement,** and **validation.** These functions are often used to measure the therapeutic effectiveness of the treatment environment.

Containment. **Containment refers to providing for the physical well-being of patients.** It includes provision of food, shelter, and medical attention, as well as taking the steps necessary to prevent the patient from harming self or others. It includes a continuum of interventions, with the use of seclusion and restraints being the most extreme.

Reduction of seclusion and restraint use is a high priority in inpatient settings. Inpatient nurses have focused on the issue of seclusion and restraint for the past two decades and regulations are related to concern for the physical and emotional safety of patients and staff (Allen et al, 2009; Scanlan, 2009; Delaney and Shattel, 2010; Johnson, 2010; Larue et al, 2010). **Seclusion and restraint is to be used only in situations of imminent harm** (Chapter 28).

Containment interventions should be evaluated using the philosophy of least-restrictive measures required to ensure safety. A focus on prevention and alternatives is carried out through development of a personal safety plan preferably with patient and family input on admission. Appropriate use of therapeutic containment strategies provide safety and foster trust.

Examples of therapeutic containment include the use of consistent, nonpunitive limit setting, specified observation periods, and special precautions as defined by regulatory standards and hospital policy. Nurses should engage in self-evaluation and constructive feedback with peers to be sure that containment strategies are based on response to patient behaviors and not staff needs or frustration.

Planning for containment in PHP settings poses additional challenges. The nurse must attend to the structured therapeutic milieu of the treatment program and consider the patient's environment outside program hours.

Support. **Support refers to the staff's conscious efforts to help patients feel better and enhance their self-esteem.** It involves providing sanctuary and unconditional acceptance of the patient. The function of support is to help patients feel more secure and less anxious.

Support can be communicated by being available, appropriately offering encouragement and reassurance, giving helpful direction and explanations, offering food or beverages, and taking time to engage patients in therapeutic conversation and activities. Some units have devoted space to specially designed *comfort rooms* (Cummings et al, 2010), and supportive unit designs ideally offer patients access to safe outdoor areas.

Structure. **Structure refers to all aspects of a milieu that provide a predictable organization of time, place, and person.** Dependability of the environment helps patients feel safe and control maladaptive behaviors. Providing a daily schedule for groups, rounds, meals, and medications, as well as fostering an expectation of participation are examples of structure.

The individualized treatment plan should guide staff response if the patient is unwilling or unable to participate in aspects of unit structure. For PHPs, this involves working with the patient to create a realistic plan that addresses the need for structure outside the hospital.

Involvement. **Involvement refers to processes that help patients actively attend to their social environment and interact with it.** The purpose is to modify maladaptive interpersonal patterns. Programs that emphasize involvement encourage the use of cooperation, compromise, and confrontation.

Examples of involvement include patient inclusion in treatment team rounds, focus groups, choosing from options for group topics and activities, and peer-led activities. Progressively demanding skill-building opportunities builds patient confidence.

Validation. **Validation refers to the recognition of the individuality and value of each patient.** It affirms a person's unique world view. The psychiatric nurse communicates this through individual attention, empathy, and nonjudgmental acceptance of the patient's thoughts, feelings, and perspective. Examples of validating interventions include individualized treatment planning and showing respect for a patient's rights.

> **Critical Reasoning** Visit an inpatient psychiatric unit. Which of the five components of a therapeutic milieu did you observe? Which ones were missing? What barriers prevented the unit from fully implementing this concept?

Nursing Implications

One of the earliest advocates of the importance of the environment for nursing care was Florence Nightingale. She believed that the essential responsibilities of nursing included the provision of pure air and water, efficient drainage, cleanliness, and light. The "prudent" nurse also prevented unnecessary noise and attended to the nutritional value of food and the comfort of bedding (Nightingale, 1960).

Although there is major focus on biomedical treatment during an acute inpatient admission, the milieu has been shown to be an important part of the experience of illness and recovery, with great power for healing or destruction (Thibeault et al, 2010). Psychiatric nursing has a rich history associated with the therapeutic milieu. However, to be relevant to contemporary psychiatric inpatient practice, the idea of the milieu must be adapted. One example of modifying the therapeutic milieu for current realities broadens the concept from a unit-based to a system-wide environment of healing, which incorporates patient-centered care, safety, and provider cooperation as system priorities (Mahoney et al, 2009).

Milieu management is an important activity of the psychiatric nurse and requires a deliberate decision-making process. It is essential that psychiatric nurses working in structured settings realize the potential positive or negative impacts that the environment can have on the patient (Shattell et al, 2008).

The psychiatric nurse should first assess patient needs within the context of the needs of the larger patient group. Weighing individual needs against group needs can be difficult, but it is necessary for the successful implementation of a therapeutic milieu. The nurse can then engage aspects of the therapeutic milieu to meet these needs by providing the following:

- **Physical safety and well-being without barriers to interaction (containment)**
- **Education about the patient's individualized treatment and safety plan (support)**
- **Therapeutic and predictable activity schedules that reduce boredom (structure)**
- **Opportunities for social interaction to prevent isolation (involvement)**
- **Acknowledgment of the patient's feelings to foster respect and trust (validation)**

Activities related to each part of the therapeutic milieu should be incorporated into the treatment plan to maximize the therapeutic effect of the environment.

Nurses face the challenge of better articulating the nursing component of the inpatient treatment program and what specifically they contribute to improving patient outcomes (Delaney and Johnson, 2007b). **The key processes of inpatient psychiatric nursing care should be focused on outcomes related to ensuring the patient's safety, stabilizing acute symptoms, restoring functioning, establishing a system of support, and developing a plan for ongoing symptom management.**

Safety, structure, support, and symptom management are clinical functions that help organize nursing practice. Table 33-3 outlines how a nurse may think about outcomes of inpatient care in relation to the nursing process and these clinical functions.

> **Critical Reasoning** Compare the components of the therapeutic milieu with the responsive and action dimensions of the therapeutic nurse-patient relationship described in Chapter 2.

IMPLEMENTING CAREGIVING ACTIVITIES

Hospital-based psychiatric nurses must have clinical knowledge and skills and apply them for the benefit of patients and their families. The atmosphere created by the psychiatric nurse should provide patients with activities and interactions designed to meet their needs.

Patient Safety and Risk Reduction

One of the most important aspects of psychiatric nursing practice is ensuring safety and reducing risk for the patient and others. Psychiatric nurses are the largest licensed professional workforce on psychiatric units, and they assume 24-hour accountability for patient care and safety. **Safety is a central priority of the nursing profession.**

TABLE 33-3 SIX PROCESSES AND OUTCOMES OF INPATIENT PSYCHIATRIC TREATMENT

OUTCOME	BASIC PROCESS LABEL	CLINICAL FUNCTION
Do no harm	Provide physically and psychologically safe milieu Handle milieu tensions proactively Use least restrictive methods in handling dyscontrol Develop collaborative relationship with patient	Safety
Thorough assessment	Diagnostic interviews and testing completed in a timely manner	Symptom management
Mutual goal setting	Identify patient's perceptions of illness and treatment Identify patient's goals Determine what inpatient treatment can realistically provide	Support
Normalize	Restore sleep pattern Ensure adequate nutrition Reengage in socialization	Structure
Resolve crisis	Increase patient's perception of control Increase supports to patient's system Decrease patient's symptom acuity	Safety, support, and symptom management
Patient understands medications, cognitive behavioral strategies, and reasons for referrals	Outpatient treatment planning Guide patient and family through logic of basic cognitive/behavioral approaches Pharmacological recommendations and potentials of service agency referrals	Symptom management

Modified from Delaney K et al: *J Psychosoc Nurs Ment Health Serv* 38:7, 2000.

Inpatient safety has traditionally been defined by adverse events such as medication errors, falls, and noncompliance with regulatory standards (Estrin et al, 2009; Hanrahan et al, 2010a; The Joint Commission, 2011). However, a broader view of what makes a unit safe and contributes to patients and staff feeling safe is needed to adequately evaluate quality of care (Borckardt et al, 2007; Jones et al, 2010; Manna, 2010).

Psychiatric inpatient unit safety is based on complex interactions of multiple factors, including unit philosophy, physical structure, and staff and patient characteristics (Delaney and Johnson, 2008). More research is needed to fully describe and evaluate quality of care, work environments, burnout, and adverse outcomes in inpatient psychiatric units (Hanrahan and Aiken, 2008; Hanrahan et al, 2010b; Seed et al, 2010).

Ensuring patient safety and risk reduction begins with a thorough risk assessment on admission and throughout the course of treatment. **Common areas of safety risk for psychiatric inpatients include potential for aggression or violence, suicide attempts, adverse medication reactions, elopement, seizures, falls, allergic reactions, and communicable diseases.**

Effective management strategies that can be used to keep units safe include knowing each patient, noticing the beginning of an episode, regularly documenting risk assessments, and awareness of the climate and tensions within the unit. Examples of staff maintaining awareness of what is happening on the unit are focusing on meeting patient needs, responding to patient requests, adding structure to the unit schedule, and increasing staff presence in the milieu (Delaney and Johnson, 2007a).

The nurse in collaboration with the treatment team is responsible for implementing appropriate safety precautions and treatment protocols to minimize risks. Implementation includes enacting the prescribed nursing care and explaining the assessed risk and precautions to the patient and other caregivers so that everyone is working together to keep the patient safe.

Another example of assuring patient safety is the implementation of a behavioral emergency response team (BERT). This team is used to proactively de-escalate potentially volatile situations when psychiatric patients are hospitalized on nonbehavioral health units in general hospitals (Loucks et al, 2010).

Meeting Physical Needs

Physical illness often goes undetected in the psychiatric patient population. However, the high rate of medical co-morbidities and the reduced life span of persons with severe mental illness make this is an issue of high priority for psychiatric nurses. Physical illness may have several effects:

- Cause a patient's presumed psychiatric illness
- Exacerbate a psychiatric illness
- Have no direct relationship to the psychiatric illness, but still require medical and nursing intervention for the patient's well-being

The increase in medical and psychiatric co-morbidity among psychiatric patients emphasizes the need for psychiatric nurses to stay current with their physical assessment and medical-surgical nursing skills. **Completion of a physical assessment on admission and monitoring the patient's physical status throughout the hospitalization are essential functions of the psychiatric nurse** (Chapter 5). Many patients in psychiatric programs require oxygen, intravenous therapy, tube feedings, wound care, dressing changes, or dialysis.

Equipment and supplies necessary in the management of medical co-morbidity on an inpatient psychiatric unit may present significant dangers. Nurses must be vigilant in the ongoing assessment and management of environmental risks

to all patients in the milieu to prevent adverse outcomes. Patients at risk for self-harm and aggression require special monitoring considerations when they also are being treated for medical illnesses.

Patient and Family Education

The education of patients and significant others is an essential nursing activity. The process of education begins with an assessment of the patient's strengths, readiness, and barriers to learning. Such barriers may include lack of insight or denial related to the illness, low level of literacy, sensory deficits such as visual or hearing impairments, limited concentration and attention span, confusion, or impaired memory.

After barriers have been identified, strategies can be incorporated into the teaching plan to help the patient retain and use the information. Repetition, presenting information in ways that engage multiple sensory avenues, and providing opportunities for practice and feedback promote learning for psychiatric patients. Common topics for education include symptom recognition and management, medication education, relapse prevention, and discharge plans.

Almost every interaction provides an opportunity for informal education. For example, meal selection provides an opportunity to learn about nutrition and to practice decision-making and communication skills. Conflicts between patients provide opportunities to learn problem solving, anger management, negotiation, and assertive communication.

Critical Reasoning Given that patients are admitted to psychiatric units in acute distress, how should nurses structure their approach to make patient education most effective?

Activities, Groups, and Programs

Therapeutic activities, groups, and programs provide opportunities for the nurse to influence the patient's progress toward treatment goals throughout the hospital stay. The challenge is to plan these events in a way that integrates patients' interests and abilities with desired patient outcomes.

Structured activities can accomplish several goals at the same time. Encouraging a cognitively impaired patient to play a common table game allows the nurse to assess the patient's concentration, orientation, memory, and abstract thinking. Based on these observations, the nurse can better understand the patient's learning needs and incorporate them into the plan of care. This same activity can help the socially withdrawn patient try out new social skills, experience role-modeling by the nurse, and receive supportive feedback and coaching.

Therapeutic groups and programs provide a cost-effective way to implement psychiatric nursing care. Group interventions allow one or two nurses to work with many patients at the same time. Consideration of patient characteristics, and the size and goals of the group is essential (Chapter 31).

Patients are encouraged to participate as they show readiness to tolerate the intervention especially in the acute care setting. Assessment of the patient before, during, and after group experiences offers important information for diagnosis and treatment planning. Care should be taken to make sure that the group is appropriate for each patient to prevent confusion, frustration, and isolation. Some examples of psychiatric nursing groups are described in Box 33-2.

Equally important are the nursing activities directed toward involving the family in the treatment plan as early as possible, and providing programs that address family needs, including education about community supports and responding to problem behaviors (Chapter 10). Shorter lengths of inpatient stay have increased the caregiver's burden and challenges. Family-focused educational programs provide necessary preparation to assume these additional and often complex responsibilities. **Promoting family involvement is a priority in hospital-based psychiatric nursing care.**

Critical Reasoning Ask an inpatient psychiatric nurse whether you can shadow her or him for a day. Group the nursing functions you see performed as dependent, independent, or interdependent. Did this experience change your perception of the inpatient psychiatric nursing role?

Discharge Planning

Discharge planning is a process that begins on admission. The nurse must assess the patient's environment and identify potential needs and resources. After the nurse has assessed

BOX 33-2 EXAMPLES OF NURSING GROUPS OR PROGRAMS

Medication Education Groups
Basic concepts about medication can be discussed; common problems from taking psychotropic medication can be reviewed, and ways to deal with them can be shared.

Community Resource Groups
These groups can be ongoing with rotating topics. Topics should be selected based on the learning readiness, needs, and abilities of the group members and their ability to share their knowledge and experiences. These groups are often more relevant in the context of discharge planning from acute care or in the partial hospital program (PHP) environment.

Nutrition Groups
These groups teach patients the importance of healthy lifestyles related to food and nutrition. How to recognize and prepare healthful and appetizing meals, food ingredients, shopping strategies and the importance of exercise can be topics for discussion.

Sleep Improvement Programs
Psychiatric patients often need ways to improve sleep habits. Relaxation techniques such as progressive muscle relaxation may be helpful. Group members can be encouraged to share their sleep-inducing secrets, such as spending time in a soothing bath, sipping warm milk, or reading with a soft light. Behaviors and influences that inhibit sleep also may be discussed.

what knowledge and skills can help the patient adapt successfully on discharge, planning begins for education and skill development. Information about medications and supportive resources should be provided to patients and their families to decrease the chances of relapse.

Psychiatric discharge planning is part of the recovery model of care (Chapter 14). A discharge checklist can be used as an interdisciplinary tool to review the patient's discharge needs, including the patient in every step of the planning process. **Areas of discharge planning include medications, activities of daily living, ongoing comprehensive health care, housing, and financial assistance.**

Transitional care services for mentally ill patients leaving the hospital are often inadequate. Some suggest that only half of all discharged psychiatric patients successfully transition to outpatient services leaving them at high risk for poor outcomes (Dixon et al, 2009). Strong communication linkages between hospital-based and community-based providers are essential to ensure continuity of care, maximize the value of hospital-based services, and minimize readmission.

INTEGRATING CARE DELIVERY

Psychiatric nurses are essential for ensuring the coordination of hospital-based patient care. This includes managing nursing resources; balancing costs and outcomes of decision-making; evaluating nursing care delivery modalities; ensuring compliance with professional and regulatory standards; and facilitating communication, participative problem-solving, and conflict resolution among team members. The clinical practice of the nurse also involves ongoing implementation of new ideas and approaches for improving quality and decreasing costs.

Teamwork and Coordinated Care

Almost all programs use a multidisciplinary team to deliver treatment. To integrate and coordinate patient care, the psychiatric nurse must collaborate with professionals from other disciplines and manage a group of nursing care providers (Horsfall et al, 2010). For good therapeutic outcomes, team members must work together to address targeted behaviors and treatment goals. **Team communication must be open and active, and the contribution of each team member must be valued and respected.**

Nurses can enhance continuity of care by organizing clinical data obtained from their 24-hour patient involvement. Nursing shift reports should be focused and include updates on nursing assessments, medical information, specific nursing interventions, and the short-term and long-term goals of treatment.

The degree of cooperation and cohesion among disciplines may vary widely. Interdisciplinary problems that may interfere with the quality of psychiatric care include poor communication, professional self-doubt, role confusion, and conflict. All of these problems are increased by work-related stress.

Whenever people with unique perspectives are working together, the potential for conflict always exists. Handling conflict productively is an ongoing challenge for the psychiatric nurse. When poorly handled or avoided, conflict can interfere with the continuity of patient care and the management of a therapeutic milieu. However, effective management of conflict can promote stronger professional working relationships, model positive communication skills for patients, and contribute to the nurse's professional development.

> **Critical Reasoning** Observe an interdisciplinary treatment team in the inpatient psychiatric setting. Did you see any areas of team conflict, role blurring, or turf struggles? If so, how did the team handle these issues?

Resource Allocation

Psychiatric nurses must be able to justify the type and level of nursing personnel needed to provide high-quality nursing care. Inpatient unit staffing decisions should be based on timely and accurate information regarding requirements for quality treatment, including psychiatric and medical acuity, patient turnover, and skill mix. Staffing should not be based solely on staffing ratios (Delaney and Johnson, 2007b). Attention to the most appropriate and efficient use of personnel and other resources is an important part of the psychiatric nurse's role. National benchmarks such as the National Database of Nursing Quality Indicators (NDNQI) are helpful external resources to guide and evaluate nursing resource allocation decisions (Montalvo, 2007).

The assignment of nursing resources must be based on identified patient care needs, clinical competencies, and available resources. This requires that all nurses become actively involved in examining patient needs, assessing the strengths and weaknesses of available nursing personnel, and evaluating outcomes of care. Nurse practice councils and staffing committees that engage and empower staff nurses to work with leadership and co-workers in making staffing decisions are important components of professional nursing practice.

> **Critical Reasoning** You report to work one evening and discover that only you and one other staff member have been assigned to cover the 20-bed psychiatric unit. You know that the hospital has been reducing costs, but you believe that this assignment amounts to unsafe staffing. How would you present your case for more staff to nursing and hospital administration?

Professional, Regulatory, and Accreditation Standards

Professional standards of the **American Nurses Association** (ANA) for psychiatric–mental health clinical practice provide a basis for evaluating nursing care. In addition to the *Psychiatric–Mental Health Nursing: Scope and Standards of Practice* (Chapter 11), other ANA standards are available to guide nursing activities in administrative and educational areas.

The Magnet Recognition Program of the American Nurse Credentialing Center uses a system of evaluation to

identify excellence in nursing practice. Based on forces of magnetism identified 25 years ago, the program provides a framework that can be used by hospital-based psychiatric nurses to develop innovative models of care that incorporate principles of recovery into an interpersonal nursing foundation (Delaney and Lynch, 2008).

Regulatory and accreditation standards must be considered by the hospital-based psychiatric nurse. They include state laws and regulations governing nursing practice and facility licensure, laws and regulations determining the payment of federal and state insurance funds (Medicaid and Medicare), and standards set forth by accrediting bodies. A health care facility may be required to show how any of these standards are met, including those pertaining to the condition of the physical facility, credentialing and training of employees, or documentation of patient care. Requirements vary depending on the type of facility, state regulations, and scope of services provided.

The Joint Commission has become a leading accrediting agency for many different types of health care facilities. Their standards have served as a benchmark for many other regulatory agencies and are a helpful and comprehensive guide for all aspects of health care delivery in the United States (The Joint Commission, 2011). Surveyors use patient tracer methodology to track and assess care delivered throughout the patient's stay. One way hospital-based psychiatric nurses assist in evaluating the quality of care in their workplace is through participation in continuous survey readiness activities, such as conducting internal tracers on their units.

The Joint Commission released the **Behavioral Healthcare Performance Measurement System** in 2008. These quality indicators focus on initial screening, hours of physical restraint and seclusion use, discharge on multiple antipsychotic medications, creation of a continuing care plan, and transmission of the plan to the next level of care provider. These indicators provide additional benchmark data for hospital-based service evaluation.

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees the spending of Medicare and Medicaid funds. Each state has an identified agency that implements CMS policies locally. For the facility to be reimbursed by Medicare or Medicaid, specific regulations must be met. These standards are similar to those of other regulatory and credentialing bodies and include the safety and sanitation of the facility, staffing and competency of personnel, appropriateness of the care delivered, and documentation.

Critical Reasoning Determine the bed charge for 1 day of care in your psychiatric inpatient unit. How does that compare with the bed charge in a medical-surgical unit? How much of that charge is related to nursing services?

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Simmy Palecko, MSN, RN

One of the true rewards of psychiatric nursing is that many patients get better and return to functional lives in which they can again experience pleasure and increased self-esteem. It is unbelievably fulfilling to see patients regain a sense of independence and renewed control over their own destinies.

Ms. M is an example of how an intensive short-term psychiatric hospitalization can remarkably improve the quality of a patient's life. She was a 72-year-old woman who was admitted to our adult unit with an electrolyte imbalance. She was psychotic and delusional, refusing to eat or drink, not sleeping, highly anxious, and refusing to perform her activities of daily living (ADLs). She believed that her body was rotting away.

She was also extremely paranoid, insisting that the patients in the group home where she lived were plotting to kill her and that the staff were laughing and talking about her outside her door during the night. She complained of auditory hallucinations and how she felt tortured. Ms. M was extremely irritable and argumentative, as well as physically and verbally threatening. She refused to get out of bed or ambulate. She insisted that we leave her alone so that she could die.

Ms. M was a recurrent patient on our unit. Her diagnoses were Axis I, bipolar affective disorder; Axis III, colon cancer status postresection, hypertension, degenerative joint disease, peptic ulcer disease, neurogenic bladder, and recurrent urinary tract infections. She was a particular challenge to the nursing staff that we were more than willing to undertake.

We were able to use our medical-surgical skills while drawing blood repeatedly, placing intraveous lines, obtaining electrocardiograms, performing urinary catheterizations for residual volumes, making accurate intake and output calculations, and carrying out range-of-motion activities. Safety and emotional support were also a major focus of our patient care. Ms. M was placed on fall precautions with continued teaching and reinforcement, even though she was minimally receptive.

Within a few days of admission, her physical condition stabilized, and she was scheduled for electroconvulsive therapy (ECT), which had been successful for her in the past. The staff impatiently waited for Ms. M's mood to improve, her appetite to increase, her nighttime sleeping to improve, her interest in her ADLs to increase, and her auditory hallucinations, negativism, and anxiety to decrease. After the fourth ECT treatment, the staff began to see Ms. M's return to her baseline. She was smiling more, and her humor was returning. She no longer stated that her body was rotting. She even began to joke with the nursing staff.

Ms. M was discharged to the group home approximately 10 days after her admission. The change in the patient's mental and physical condition was remarkable, and I was again reminded of the intrinsic rewards of psychiatric nursing.

CHAPTER IN REVIEW

- Treatment goals, processes, expected outcomes, and lengths of stay related to hospital-based psychiatric care are changing. The average length of stay in most psychiatric hospitals is 5 to 10 days.
- Crisis stabilization units were developed as an alternative to traditional inpatient hospitalization and as a way to decrease inpatient hospitalization and reduce costs.
- The number of state hospital beds has declined by 90% over the last 50 years, whereas the number of people with mental illness has increased.
- Deinstitutionalization moved patients out of state hospitals into the community, although often without adequate community resources.
- PHPs focus on providing specific treatments, such as medication and individual, group, and family therapy in a highly organized, structured program. They use crisis stabilization and recovery-oriented approaches.
- The aim of the therapeutic milieu is to provide patients with a safe, stable, and consistent social environment that facilitates the development and implementation of an individualized treatment plan.
- The therapeutic milieu sets limits on disturbing and maladaptive behavior and teaches social skills such as orientation, assertion, occupation, and recreation.
- Functions of the therapeutic milieu include containment, support, structure, involvement, and validation.
- *Containment* refers to providing for the physical well-being of patients.
- *Support* refers to the staff's conscious efforts to help patients feel better and enhance their self-esteem.
- *Structure* refers to all aspects of a milieu that provide a predictable organization of time, place, and person.
- *Involvement* refers to processes that help patients actively attend to their social environment and interact with it.
- *Validation* refers to the recognition of the individuality and value of each patient.
- The key processes of inpatient psychiatric nursing care should be focused on outcomes related to ensuring the patient's safety, stabilizing acute symptoms, restoring functioning, establishing a system of support, and developing a plan for ongoing symptom management.
- Safety is a nursing priority. Common areas of safety risk for psychiatric inpatients include the potential for aggression or violence, suicide attempts, adverse medication reactions, elopement, seizures, falls, allergic reactions, and communicable diseases.
- Completion of a physical assessment on admission and monitoring the patient's physical status throughout the hospitalization are essential functions of the psychiatric nurse.
- The education of patients and significant others is an essential nursing activity.
- Therapeutic groups and programs provide a cost-effective way to implement psychiatric nursing care.
- Discharge planning is a process that begins on admission and includes medications, activities of daily living, ongoing comprehensive health care, housing, and financial assistance.
- The integrative function of the hospital-based psychiatric nurse includes all activities involved in the coordination of patient care, such as facilitating teamwork and coordinating care, managing nursing resources, and ensuring compliance with professional and regulatory standards.

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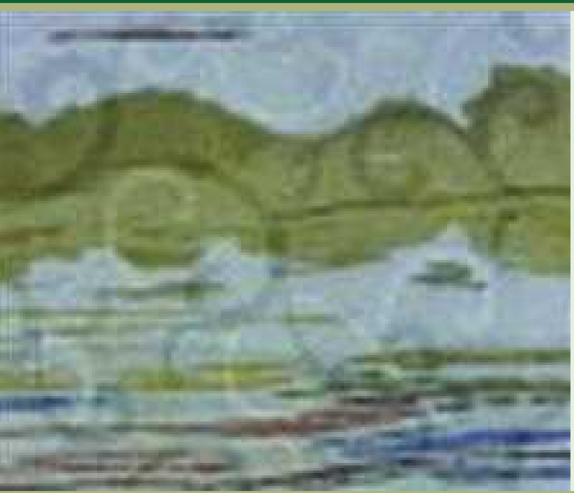


CHAPTER 34

Community-Based Psychiatric Nursing Care

Gail W. Stuart

"What life have you if you have not life together?
There is no life that is not in community.

T.S. Eliot, Choruses from the Rock

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe community-based psychiatric treatment settings.
2. Compare and contrast models of community-based psychiatric care and the role of the nurse.
3. Assess the needs of vulnerable psychiatric populations living in the community.

People live, love, and learn in communities, and most mental health care is provided in the community. The goal of the health care delivery system is to create competent and mentally healthy communities and to help people who have experienced a psychiatric illness live successful and productive lives in the community.

Psychiatric nurses work in community-based settings, where they assume a broad range of responsibilities. In these settings, they work with interprofessional teams and focus on prevention, care management, and recovery. Nurses at the basic and advanced levels of education practice in the community, where they engage with consumers and family members, empowering them to make decisions about their care.

Critical Reasoning What factors do you think influence whether a psychiatric nurse works in a hospital-based or community-based setting?

TREATMENT SETTINGS

Primary Care Settings

Most people seek help for their mental health problems from their primary care provider. Primary care settings may be the most important point of contact between patients with psychiatric problems and the health care system. The role of the primary care provider is even more important for older adults and patients from racial and ethnic minorities (Lyness et al, 2009). **The three most common problems seen in primary care are depression, anxiety, and substance abuse.**

Many patients with mental health problems are not treated effectively in the primary care setting. About 50% of mental health problems are not identified or treated in primary care, and about two thirds of primary care providers reported that they could not get outpatient mental health services for their patients (Cunningham, 2009; Ong and Rubenstein, 2009; Machado and Tomlinson, 2011). Federally funded community health centers have increased their

specialty mental health offerings, but this is not sufficient to meet the need (Wells et al, 2010).

The other side of the problem is equally compelling. People with serious mental illness have more difficulty in obtaining a primary care provider and experience greater barriers to medical care than the general population. The result is that they die 25 years earlier than the general population (Bradford et al, 2008; Green et al, 2010).

These system problems have given rise to discussions about the integration of behavioral health care in the primary care setting, and general medical care in the behavioral health care setting. The goal of integrated services is improved health outcomes and decreased costs. Nurses could play a prominent role in an integrated primary care setting (Weiss et al, 2009).

Truly integrated care needs to be a two-way street that includes the following:

- **People in primary care settings who have behavioral health problems are identified and treated in primary care settings if possible.**
- **People in behavioral health care settings who need routine primary care are identified and treated in the behavioral health setting if possible.**

Behavioral health service delivery in the primary care setting can reach many people who otherwise would not receive behavioral health intervention. It also provides a level of expertise regarding diagnosis and intervention for problems not generally seen in the medical setting, resulting in increased knowledge and skill in detection and treatment of behavioral health problems within the medical community. Primary care services for those who are mentally ill also can result in better quality of care for these patients (Canters for Disease Control and Prevention, 2011; Kilbourne et al, 2011).

An important step in addressing this issue is the use of effective screening measures in primary care (Neushotz and Fitzpatrick, 2008; Oleski et al, 2010). The U.S. Preventive Services Task Force (2010) recommends the following:

- **Screening adults for depression** in clinical practices that have systems in place to ensure accurate diagnosis, effective treatment, and follow-up
- **Screening and behavioral counseling interventions to reduce alcohol misuse** by adults, including pregnant women in primary care settings

Research has shown that one- or two-item screening tools are effective in identifying those at risk for substance use or depressive disorders (Table 34-1). Because these questions can be answered in seconds, they can be asked during routine visits. A variety of screening tools can be used in primary care (Gilbody et al, 2007; Bernstein et al, 2009; Gaynes et al, 2010; Katzelnick et al, 2011). Nurses should incorporate these screening tools in their practice.

Other important aspects of care in the primary care setting involve improving patients' self-management skills through medication management, psychoeducation, supporting clinicians' decision making through the use of practice guidelines, and facilitating access to specialty mental health care.

Many studies have assessed strategies to improve the delivery of mental health care in primary care settings. Much of this work has been done in the area of depression because it is one of the most common disorders seen in the general medical setting and because effective treatments are available for depression. **The most promising intervention is the implementation of collaborative care programs.**

A framework that nurses can use for behavioral counseling in primary care is the *Five A*'s:

- **Assess:** Ask about a person's behavioral health risk and factors affecting his or her choice of future goals.
- **Advise:** Give clear, specific, and personalized behavioral change advice, including information about personal health harms and benefits.
- **Agree:** Collaboratively select appropriate treatment goals based on the patient's interest in and willingness to change the behavior.
- **Assist:** Help the person achieve agreed-on goals by acquiring the skills, confidence, and support for change.
- **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing support, including referral to a specialist if needed.

Although mental health and physical conditions are highly interconnected, mental health and physical care delivery

TABLE 34-1 BRIEF SCREENING TOOLS

PROBLEM	QUESTIONS	POSSIBLE RESPONSES	POSITIVE SCREEN
Alcohol	When was the last time you had more than four (for women) or five (for men) drinks in 1 day?	1. Never 2. In the past 3 months 3. More than 3 months ago	In the past 3 months
Alcohol or drugs	In the last year: 1. Have you ever drunk alcohol or used drugs more than you meant to? 2. Have you felt you wanted or needed to cut down on your drinking or drug use?	Yes or no	Yes to either question
Depression	During the past 2 weeks: 1. Have you often been bothered by feeling down, depressed, or hopeless? 2. Have you often been bothered by little interest or pleasure in doing things?	Yes or no	Yes to either question

systems are separated in many ways that block the delivery of the most effective care. **Nurses can play a pivotal role in integrating the mental health and physical care of patients in primary care settings.**

> **Critical Reasoning** Nurses in primary care settings can be seen as untapped resources for promoting the mental health of patients. How would you go about better using their skills to address this unmet patient need?

Emergency Department Psychiatric Care

The use of emergency department (ED) services in general hospitals by psychiatric patients has reached crisis levels. Because EDs cannot deny treatment, they have become a safety net for patients who do not have access to care or the resources to go to another type of facility. Time constraints, training, risk, and legal concerns contribute to most psychiatric ED visits resulting in an inpatient admission. With substance use disorders and mental illness contributing to many other illnesses, EDs have seen an increasing number of patients who require interventions for these problems.

About 2 million people visit EDs for mental disorders each year, with an additional 1.3 million ED visits related to alcohol and drug problems. Estimates of the number of ED patients with alcohol problems range from 15% to more than 40%. These estimates do not include visits that result from diseases and injuries related to substance use or mental health problems, nor do they reflect the number of ED patients who are affected by these health problems.

Patients who have attempted suicide are most often seen in the ED. Unfortunately, many of these patients and their families often feel punished or stigmatized by the ED staff. Many homeless people and patients with chronic mental illness also use the ED as a primary source of health care because they do not have access to other resources.

Providing safe and effective care for psychiatric patients in EDs can be challenging. Overcrowding, noise levels, and chaotic conditions may trigger a worsening of the patient's condition. Another safety concern is access to dangerous items. A study conducted by the Emergency Nurses Association (ENA) found that only 19% of EDs had space dedicated to mental health care (Howard, 2006).

Patients also present to the ED for medical clearance before psychiatric admission. There are no standard protocols for medical clearance, and demands for this service can be the source of conflict between emergency and psychiatric providers (Reeves et al, 2010). The gaps between psychiatric and emergency care in the current health care system create serious problems for patients and staff alike.

Boarding is the practice of maintaining patients in the ED while waiting for psychiatric services to be available. Significant psychiatric bed shortages, increasing demand for psychiatric services, and lack of adequate funding for psychiatric services create the need for this unfortunate practice. Boarding frequently lasts more than 24 hours and sometimes days. It may result in safety and quality issues for all ED patients and can have a negative impact on staff workload and morale. Providing psychiatric consultants, having a separated area within the ED, and creating a separate psychiatric ED are suggested improvement strategies (Bender et al, 2008; Alakeson et al, 2010).

Some acute care hospitals have dedicated psychiatric services available in the ED. These services have evolved from crisis intervention to diagnostic and treatment services, often with on-site treatment and referral to community services. However, nurses and other clinicians working in EDs tend to focus less on behavioral health problems than on physical illnesses and injuries. The reasons for this include time constraints, lack of knowledge about how to screen and intervene effectively, reimbursement issues, and bias and stigma about psychiatric care (Nadler-Moodie, 2010).

Despite these issues, screening and interventions specifically tailored to the ED are emerging and can be used by nurses working in that setting. For example, screening and brief intervention for alcohol problems in the ED have been demonstrated to be effective in decreasing consumption in hazardous and harmful drinkers and in treatment engagement in dependent drinkers. EDs are, therefore, a prime setting for nurses to intervene to address the behavioral health problems of patients.

> **Critical Reasoning** Talk to the ED staff about their experience with psychiatric patients. Ask the nursing staff about their preparation for handling such problems and what might help them intervene more effectively.

Employee Assistance Programs

Employee assistance programs (EAPs) are worksite-based programs designed to help identify and resolve behavioral, health, and productivity problems that may affect employees' well-being or job performance. Their focus is wide ranging, covering alcohol and other drug abuse; physical and emotional health; and marital, family, financial, legal, and other personal concerns. As such, they are important points of access to behavioral health care.

EAPs have developed from being primarily alcoholism assessment and referral centers to being specialized behavioral health programs. Many cost-effectiveness studies document the value of EAPs in providing workplace education, skill development, and policy and environmental changes. Comprehensive EAPs have six major components:

- Identification of problems based on job performance
- Consultation with supervisors
- Constructive confrontation
- Evaluation and referral
- Liaison with treatment providers
- Substance abuse expertise

EAPs are a rich community-based setting on which other services may be added to promote access to mental health and substance abuse treatment.

Home Psychiatric Care

Psychiatric home care programs are changing rapidly in response to the increased number of people with psychiatric

BOX 34-1 BENEFICIARIES OF IN-HOME PSYCHIATRIC NURSING SERVICES

- Patients with repeated inpatient or crisis unit admissions
- Patients with a history of medication or treatment plan noncompliance or lack of follow-through with aftercare plans
- Patients with combined diagnoses of a medical and psychiatric nature (e.g., elderly, HIV-positive patients)
- Patients with combined substance abuse and psychiatric diagnoses
- Patients receiving injectable medications who are homebound or do not follow through with scheduled outpatient appointments
- Patients in need of laboratory monitoring who are homebound or do not follow through with outpatient laboratory appointments
- Patients who are depressed and are struggling with self-care
- Patients who experience anxiety or panic and have difficulty leaving the home

HIV, Human immunodeficiency virus.

illnesses living in the community and the competitive health care market. Although changes in Medicare home health reimbursement have limited the growth of psychiatric home care, these programs have proven to be effective in meeting the needs of the psychiatric patient in a cost-effective manner. Psychiatric home care is a natural fit for the psychiatric nurse.

Perhaps the best reason to advocate for psychiatric home care is that it is a humane and compassionate way to deliver health care and supportive services. **Home care reinforces and supplements the care provided by family members and friends and maintains the recipient's dignity and independence—qualities that are all too often lost in even the best institutions.**

Psychiatric home care programs receive and refer patients from the entire community's general medical and mental health care services (Box 34-1). Psychiatric home care ranges from serving as an alternative to hospitalization, to functioning as a single home visit for the purposes of evaluating a specific issue, to providing treatment in the home. The advantages of psychiatric home care is that it can provide the following:

- A way to provide care that removes the need for patient travel
- A way to assess and treat in the patient's own living setting
- An alternative to hospitalization by maintaining a patient in the community
- A facilitator of an impending hospital admission through preadmission assessment
- An enhancement of inpatient treatment through integration of home issues in the inpatient treatment plan
- A way to shorten inpatient stays while keeping the patient engaged in active treatment
- A part of the discharge planning process by assessing potential problems and issues

BOX 34-2 HOME VISITING AND MATERNAL DEPRESSION

Undetected and untreated parental depression places millions of children in the United States at risk each day. Parental depression can be especially damaging for the growth and healthy development of very young children, who depend heavily on their parents for nurture and care. Treating parental depression and addressing its negative effects early in a child's life can improve that child's development. Several safe and effective depression treatments are available, but the delivery of these services, especially to low-income families, requires new and innovative approaches.

One promising approach is using home visiting programs to identify depressed mothers and connect them and their families to services. Home visiting programs involve regular visits to pregnant women and mothers of young children over several months to several years by a nurse with goals that may include enhanced parenting skills, better maternal and child health, achievement of maternal education and employment goals, postponement of subsequent births, and enhanced child development. Researchers have identified different home visiting programs that are backed by solid evidence of improved results and new funding to expand the programs is included in the Patient Protection and Affordable Care Act (ACA).

From Golder O et al: *Home visiting and maternal depression,* Washington, DC, 2011, Urban Institute.

Examples of other advantages include its outreach capacity and emphasis on patient participation, responsibility, autonomy, and satisfaction. An excellent example of psychiatric home care is the Nurse Home-Visiting Program for mothers with depression (Box 34-2).

Critical Reasoning What specific kind of patients do you think would benefit most from psychiatric home care?

Psychiatric homebound status is different from medical homebound status. **Medicare guidelines require that the patient meet all of the following criteria:**

- **Be homebound**
- **Have a diagnosed psychiatric disorder**
- **Require the skills of a psychiatric nurse**

In determining psychiatric homebound status, a useful definition is a patient who is unable to independently and consistently access psychiatric follow-up. This definition is broad enough to include a person who is physically healthy and mobile but too depressed to get out of bed. It also includes patients with agoraphobia and patients with psychotic thinking processes who are vulnerable in the community. Box 34-3 lists some conditions that may make a patient psychiatrically homebound.

Psychiatric home care is a subspecialty that calls for a nurse with certain kinds of skills, education, and experience. Box 34-4 outlines Medicare requirements for psychiatric nurses practicing in the home setting.

Critical Reasoning Any nurse can be hired to work in an inpatient psychiatric unit, but Medicare has specific requirements for a psychiatric home care nurse. Discuss the implications of this from the point of view of the patient, the nurse, and the employing health care organization.

BOX 34-3 CONDITIONS THAT MIGHT MAKE A PATIENT PSYCHIATRICALLY HOMEBOUND

- Confusion, disorientation, poor judgment
- Immobilizing depression
- Severe anxiety that interferes with independence
- Agoraphobia with or without panic attacks
- Vulnerability in the community
- Psychosis or paranoid delusions that interfere with safety
- Need for 24-hour supervision

BOX 34-4 MEDICARE REQUIREMENTS FOR PSYCHIATRIC NURSES IN HOME CARE

- A registered nurse with a master's degree in psychiatric or community mental health nursing
- A registered nurse with a bachelor's of science in nursing (BSN) degree and 1 year of related work experience in an active treatment program for adult or geriatric patients in a psychiatric health care setting
- A registered nurse with a diploma or associate degree and 2 years of related work experience in an active treatment program for adult or geriatric patients in a psychiatric health care setting
- American Nurses Association (ANA) certification in psychiatric or community health nursing
- Other qualifications may be considered on an individual basis.

Psychiatric home care nursing provides unique challenges and opportunities for the nurse. In an inpatient clinic or office setting, the provider has the control and power that come with ownership. The patient is a guest, and the nurse is the host. In the home setting, the nurse is the guest and the patient sets the rules. This raises issues of cultural competence and safety for the nurse.

Cultural Competence. Awareness of the patient's ethnic and cultural background is critical to effective care in all settings, but nowhere is it more critical to treatment outcome than in the home care setting. The nurse is exposed to the patient's culture, and the patient will observe the nurse's reaction in these surroundings.

Ways of addressing members of the family, views of health and mental illness, the role of the nurse and health care providers in general, and the importance of alternative therapies are a few of the issues that vary across cultures. All these differences must be considered by the nurse planning care with the patient in the home. **Recognition and use of the patient's cultural beliefs in delivery of nursing care can positively influence the patient's participation in recovery.**

It is important that the nurse have an understanding of his or her own cultural background and the possible prejudices related to socioeconomic status, gender, family structure, and ways of dealing with emotion emanating from that background. Self-awareness gives the nurse the ability to step back from a judgmental stance and ask whether a certain behavior, opinion, or way of coping stands in the way of the patient's ultimate health.

Closely related to cultural issues are the differences in boundary issues. In the home setting, it may be appropriate for the nurse to sit and share a cup of tea with the patient or eat a piece of cake. If the patient's culture is one that sees hospitality as connected closely to the sharing of food and refusal of food is thought of as an affront, being willing to share in this ritual can build trust in the relationship between the nurse and patient.

Critical Reasoning Imagine yourself providing psychiatric home care to an individual with a cultural background very different from your own. How would this affect your assessment of the patient's biopsychosocial needs and your related nursing interventions? What resources would you draw on to provide culturally competent nursing care?

Safety. In general, psychiatric home care patients are not at greater risk for violence than the general home care patient population. However, the assessment of the environment should include issues of safety for the patient and the nurse. Strategies must be identified for dealing with suicidal or aggressive behavior. In this way, home health nursing does have its limitations.

The nurse and patient must work together to develop an acceptable plan. If the situation becomes unsafe, the nurse must leave the home. Patients' families, caregivers, and other community resources should be urged to notify the police or take the patient to the hospital for an evaluation if the patient becomes dangerous.

Nursing Activities. Nursing interventions in the home include assessment, teaching, medication management, administration of parenteral injections, venipuncture for laboratory analysis, and skilled management of the care plan. All these interventions are recognized as reimbursable skilled nursing services by Medicare.

Psychiatric home care nurses provide many other skilled nursing services. They act as case managers, coordinating an array of services, including physical therapy, occupational therapy, social work, and community services, such as home-delivered meals, home visitors, and home health aides. They collaborate with all the patient's health care providers and often facilitate communication among members of the multidisciplinary team.

CLINICAL EXAMPLE

Sonia, a 49-year-old woman, was referred by a managed care company to psychiatric home care after a 2-week inpatient stay at a local psychiatric hospital. She had a long history of psychiatric admissions for stabilization of her schizophrenia. Most hospitalizations were preceded by the patient's noncompliance with her medication schedule and follow-up care at the mental health center.

Sonia lived with her sister and elderly mother in a small row house in the Hispanic section of a large city. The family's native language was Spanish; they spoke English as a second language and understood some written English. Sonia's sister was the family's caregiver. She cared for their bedridden mother and helped with Sonia's care.

Sonia's sister could not understand why Sonia would be all right for long periods and then become "crazy" and not listen. Sonia agreed to psychiatric nursing visits but initially would not agree to treatment at the mental health center. Paranoia was a major component of her illness. Other barriers were financial concerns, a lack of knowledge about her illness, and cultural and language issues.

The psychiatric nurse's plan of care included educating the patient and her sister on the disease process, signs and symptoms of relapse, the importance of continued medical care, medication actions and side effects, and correct administration of the prescribed medication. As her care progressed and Sonia became stable, the nurse helped the patient and her sister make and attend a follow-up appointment at the mental health center. Sonia was discharged from home care and agreed to go to the mental health clinic for her follow-up medical care.

Psychiatric home care nurses make appropriate referrals to community agencies and help their patients access community resources independently. They educate families and patients, provide supportive counseling and brief psychotherapy, promote health and prevent illness, and document everything in detail so that their agency can be reimbursed for the services they provide.

Critical Reasoning How can the use of a laptop computer or iPad facilitate more concise and timely documentation in the home health setting?

Virtual Mental Health Care

Mental health care need not be limited to a geographic location. Technology, including computers and mobile phones, have opened up a world of possibilities for expanding place-bound caregiving opportunities.

E-therapy is the use of electronic media and information technologies to provide services for participants in different locations. E-therapy can be used to provide education, assessment, diagnosis, treatment engagement, direct treatment, and aftercare services. Providers can give and receive training and supervision using electronic forms of communication (Cleary et al, 2008; Center for Substance Abuse Treatment, 2009). This includes graduate programs in psychiatric nursing (Delaney et al, 2011).

In terms of access to services, online counseling may benefit people who are isolated in rural areas and underserved. Treatment providers can make themselves more available to those in need compared with providers administering face-to-face treatment. For example, e-therapy services can be found in rural clinics, military programs, correctional facilities, community mental health centers, nursing homes, home health care settings, and hospitals (Dwight-Johnson et al, 2011).

E-therapy can be one solution to the shortage of mental health providers for children and adolescents (Ellington and McGuinness, 2011). Text messaging, which is popular among youth, can provide other opportunities (Box 34-5).

E-therapy can be text-based or non–text-based communication. Each form of communication has its advantages and disadvantages, which should be taken into account when determining the best methods for the targeted population.

- Text-based forms of communication include e-mail, chat rooms, text messaging, and listservs.
- Non–text-based forms include telephone and videoconferencing.

Telepsychiatry connects people by audiovisual communication and is one means of providing expert health care services to patients distant from a source of care. It is suggested for the diagnosis and treatment of patients in remote locations or where psychiatric expertise is scarce. Research suggests that psychiatric consultation and short-term follow-up can be as effective when delivered by telepsychiatry as when provided face to face (García-Lizana and Muñoz-Mayorga, 2010).

When used with established ethical guidelines, computers offer a reliable, inexpensive, accessible, and time-efficient way of assessing psychiatric symptoms, implementing treatment guidelines, and providing care (Borzekowski et al, 2009).

BOX 34-5 TXT 4 HELP

National Safe Place has a Txt 4 Help program. It is a 24-hour text support service for youth in crisis, hoping to make it easier for them to get help. Youth in trouble can text the word *safe* and their current location to the number **69866**. They receive the closest Safe Place site where they can go for help and a contact number for a local youth shelter. If these are not available in the young persons' community, they will receive the number for the national hotline.

A network of thousands of businesses and other public locations across the country extend the doors of local youth serving agencies by displaying Safe Place's recognizable yellow and black diamond-shaped logo.

National Safe Place statistics as of July 27, 2011, include the following:

- 129,854 youth have been connected to immediate help and safety at Safe Place locations
- 18,276 Safe Place sites are available across the country
- 137,974 youth have received counseling by phone as a result of Safe Place school outreach
- 40 Safe Place states
- 9,365,917 students learned about Safe Place through classroom presentations

Computer-administered versions of clinician-administered rating scales are available for the assessment of a number of psychiatric illnesses, including depression, anxiety, obsessive-compulsive disorder, and social phobia.

Patient reaction has been positive, with patients usually being more honest with their responses and often expressing a preference for the computer-administered assessments of sensitive areas such as suicide, alcohol and drug use, sexual behavior, or human immunodeficiency virus (HIV)–related symptoms (Lieberman and Huang, 2008; Wolford et al, 2008).

> **Critical Reasoning** Do you think you would be more honest responding to a computer screening tool or answering similar questions to a provider in person?

Several studies also have shown that delivering cognitive behavioral therapy and psychoeducation using the Internet is effective in reducing symptoms of depression and anxiety and is cost effective (Stuhlmiller and Tolchard, 2009). Telenursing interventions have been shown to increase medication adherence (Beebe et al, 2008).

Benefits associated with e-therapy include greater accessibility for hard-to-reach and underserved populations, lower costs compared with face-to-face therapy, and the ability to maintain continuity of care when patients relocate or travel. However, additional research is needed on issues of quality and outcome (Kiluk et al, 2011).

Challenges associated with e-therapy include patient-practitioner confidentiality and the *digital divide.* This term is used to describe disparities in access to computers and the Internet, as well as those who are uncomfortable or fearful of technology.

An important use of this technology is in the development of an **electronic decision support system** that could provide information and supports to patients and providers. This would facilitate shared decision making, allow patients to build their own care plans, and encourage collaborative management of their overall health status (Drake et al, 2010; Woltmann et al, 2011).

MODELS OF CARE

The different models of community-based psychiatric care vary according to the target population and range of services offered. Ideally, a model should provide a comprehensive system of care, coordinating needed services in an integrated model of service delivery.

Patient-Centered Health Care Homes

A patient-centered health care home, or patient-centered medical home, is not a place but a model of primary care that delivers the core functions of primary health care. In 2011 the National Committee for Quality Assurance (NCQA) added the requirement that all patients in patient-centered health care homes receive assessments for mental health and substance abuse (National Council for Community Behavioral Healthcare, 2009, 2010).

The home is designed to expand available services to include a focus on the health, housing, and social and personal supports needed to achieve and maintain health for a whole person, not just a patient. These health care homes need to work closely with other community partners such as social service agencies, schools, child care centers, family resource centers, and public health departments.

Health care homes shift the focus from episodic care to managing the health of populations, especially those living with chronic conditions. The core of the home is team-based care that provides integrated care management and supports individuals in their health goals (Collins et al, 2010).

The core elements of the patient-centered health care home include:

- **Access to care**
- **Accountability**
- **Comprehensive whole-person care**
- **Continuity**
- **Coordination and integration**
- **Person and family-centered care**

The health care home model holds promise as a way to improve health care in North America by transforming how primary care is organized and delivered. The characteristics of the health care home are described in Box 34-6.

Accountable care organizations (ACOs) are being designed to serve as the organizing infrastructure to help health care homes coordinate care with specialists, hospitals, and other parts of the health care delivery system. These organizations also can help to manage new payment models, including bundled payments for hospital care and models that incentivize prevention, early intervention, and supports for people with chronic health conditions.

The use of ACOs is seen as a tool to improve performance. For many Americans, especially those with behavioral health disorders, this effort will require coordination with community partners.

> **Critical Reasoning** Find out if your community has a patient-centered health care home. Ask about the services it provides and the role of the nurse.

Collaborative Care and Care Management

Collaborative care is a structured approach to care based on principles of chronic disease management. It is a more recent model of care and has two key elements.

- **Systematic care management is most often done by a nurse** to facilitate case identification, coordination of a treatment plan, patient education, close follow-up, and monitoring of progress. This can be done in the primary care setting or by telephone.
- **Consultation** occurs among the primary care provider, care manager, and a mental health specialist.

It can be designed with varying levels of intensity. Collaborative care models for depression and bipolar disorder improve clinical outcomes, employment rates, functioning, and quality of life and are cost-effective (Gilbody et al, 2006;

BOX 34-6 ELEMENTS OF PATIENT-CENTERED HEALTH CARE HOMES

- **Increased access to care:** Delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care.
- **Patient and family-centered care:** Primary health care that is relationship based with an orientation toward the whole person, understanding and respecting each patient's unique needs, culture, values, and preferences. Ensures that patients and families are core members of the care team and fully informed partners in developing care plans.
- **Comprehensive care:** Accountable for meeting most of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. The health care team may include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators.
- **Coordinated and integrated care:** Coordinates care across all aspects of the health care system, including specialty care, hospitals, home health care, and community services and supports. Coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital.
- **Continuous quality improvement:** Uses evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engages in performance measurement and improvement, measures and responds to patient experiences and patient satisfaction, and practices population health management.

Adapted from the Patient-Centered Medical Home Resource Center. Accessed November 2011 at http://pcmh.ahrq.gov/portal/server.pt?open=514&objID=18011&parentname=CommunityPage&parentid=27&mode=2&in_hi_userid=11787&cached=true.

Bauer et al, 2009; van Orden et al, 2009; Katon et al, 2010; Bauer et al, 2011).

Care management is a core element of patient-centered health care homes and of new approaches designed to improve chronic illness care. **It is team-based care that helps individuals in their self-management goals.** It coordinates care to reduce fragmentation and unnecessary use of services, prevent avoidable conditions and promote independence and self-care (Druss et al, 2010).

Care management often includes nurse counseling, pharmacy review, utilization management, and specific disease management programs. The care manager has several clinical functions:

- Develop and maintain rapport with patient and provider
- Educate the patient and the family
- Monitor symptoms and communicate findings to provider
- Develop and maintain a self-care action plan
- Maximize adherence to the treatment plan through negotiation of solutions to treatment-emergent problems

Case Management

Case management involves linking the service system to the consumer and coordinating the service components so that the consumer can achieve successful community living. It is an older model of care and is different from care management.

- ***Case management* focuses on coordinating service systems.**
- ***Care management* focuses on the patient's chronic care needs and helps individuals achieve their health care goals.**

Components of case management include patient identification and outreach, mental health treatment, crisis response services, health and dental care, housing, income support and entitlement, peer support, family and community support, rehabilitation services, and protection and advocacy (Figure 34-1).

Case management focuses on problem solving to provide continuity of services and overcome problems of rigid systems, fragmented services, poor use of resources, and problems of inaccessibility. **The six activities of case management are as follows:**

1. **Identification and outreach**
2. **Assessment**
3. **Service planning**
4. **Linkage with needed services**
5. **Monitoring service delivery**
6. **Advocacy**

Core aspects and specific interventions related to clinical case management are listed in Table 34-2.

Critical Reasoning Which interventions of clinical case management listed in Table 34-2 do you think should be provided by a mental health professional, and which ones, if any, can be carried out by a layperson?

Case management has come to reflect two basic but often contradictory goals: increasing access to services and limiting costs. In the public sector, case management is intended to increase access to care and make more services available to those eligible and underserved. In the private sector, case management has become seen as gate keeping, and the emphasis is placed on cost control and limitation of resource use. Case management will continue to be a part of mental health care as attempts are made to balance cost, access, and effectiveness.

CLINICAL EXAMPLE

Jane M is single and 33 years old, with a history of multiple psychiatric admissions. She was referred to the community mental health center case management unit on discharge from a 6-month stay at the state hospital. She had a diagnosis of undifferentiated schizophrenia in remission and was discharged to the care of her family taking 4 mg of risperidone daily. Jane has occasional auditory hallucinations, is

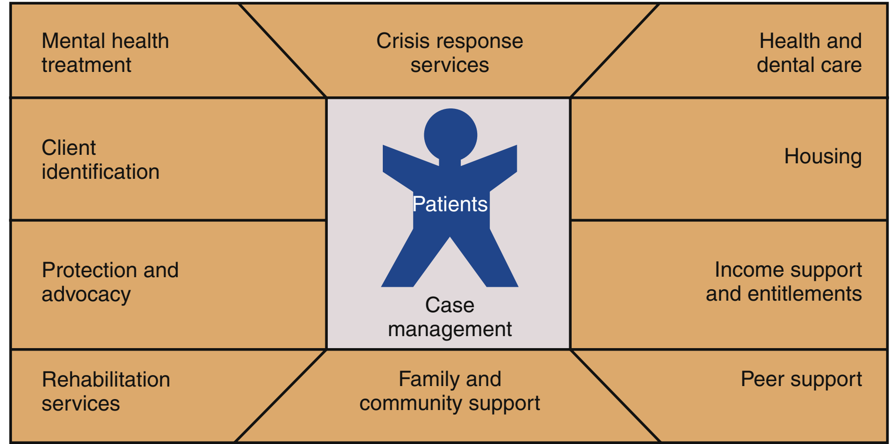


FIG 34-1 Components of a community support system.

somewhat suspicious, and has a long history of disruptive family relationships and noncompliance with medications.

The psychiatric nurse case manager volunteered to take the case and made an appointment with the family for a home visit. When she arrived, the family was visibly upset and said that in the week since Jane had been home, she slept much of the day and roamed around the house during the night, taking long showers, slamming kitchen cabinet doors, and playing loud rock music. When she was awake during the day, she disappeared for hours at a time, causing great anxiety for the family.

The mother was tearful and wringing her hands in an agitated manner while the father sat on the sofa with his head bowed. Jane sprawled in a chair and intermittently swore at her mother as the mother described these events.

The nurse recognized that Jane's illness dominated the household, essentially putting her in control of the rest of the family. The nurse worked intensely with this family to restore generational boundaries by supporting the parents in making mutually agreed-on rules about behavior that would be tolerated in their household.

She helped the family identify ways to support Jane while setting limits that would promote adaptive family functioning. The family found this to be very helpful, and they asked the nurse to provide them with ongoing information on Jane's illness. The nurse also evaluated the impact of the medication on Jane's behavior and her compliance with taking it.

Over the next few weeks, Jane began to sleep at night. With continued support from the nurse, the parents became skilled and comfortable in presenting a united front. Although Jane initially resisted, she adapted rather quickly to the new norms in the house, and a family crisis that might have resulted in Jane's readmission to the hospital was averted.

Assertive Community Treatment

Assertive community treatment (ACT) is designed to provide intensive community supports to individuals who have serious mental illnesses. **The goal of ACT is to prevent hospitalization and support the individual in achieving the highest possible level of functioning by providing a full range of medical, psychosocial, and rehabilitative services.**

TABLE 34-2 ASPECTS AND INTERVENTIONS OF CLINICAL CASE MANAGEMENT

ASPECT	INTERVENTIONS
Initial phase	Engagement Assessment Planning
Environmental interventions	Linkages with community resources Consultation with families and caregivers Maintenance and expansion of social networks Collaboration with physicians and hospitals Advocacy
Patient interventions	Individual psychotherapy Training in independent living skills Psychoeducation
Patient-environment intervention	Crisis intervention Monitoring

A multidisciplinary team is used, including nurses, social workers, case managers, employment counselors, addictions counselors, and a psychiatrist. Some ACT teams include a consumer to enhance outreach efforts (Wright-Berryman et al, 2011). ACT provides 24-hour, 7 days per week staff coverage, comprehensive treatment planning, ongoing responsibility, continuity of staff, and small, shared caseloads.

The services provided by ACT treatment team members are listed in Box 34-7. Psychiatric nurses are integral members of the ACT treatment team. **Nurses are particularly valuable in recognizing physical health care needs and integrating mental and physical health within the ACT program** (Shattell et al, 2011; Weinstein et al, 2011).

The ACT teams function as continuous care teams who work with patients with serious mental illness and their families over time to improve their quality of life (Padgett and Henwood, 2011). **ACT programs function as**

BOX 34-7 SERVICES PROVIDED BY ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM MEMBERS

Rehabilitative Approach to Daily Living Skills
- Grocery shopping and cooking
- Purchase and care of clothing
- Use of transportation
- Help with social and family relationships

Family Involvement
- Crisis management
- Counseling and psychoeducation with family and extended family
- Coordination with family service agencies

Work Opportunities
- Help to find volunteer and vocational opportunities
- Provide liaison with and educate employers
- Serve as job coach for consumers

Entitlements
- Assist with documentation
- Accompany consumers to entitlement offices
- Manage food stamps
- Assist with predetermination of benefits

Health Promotion
- Provide preventive health education
- Conduct medical screening
- Schedule maintenance visits
- Provide liaison for acute medical care
- Provide reproductive counseling and sex education

Medication Support
- Order medications from pharmacy
- Deliver medications to consumers
- Provide education about medication
- Monitor medication compliance and side effects

Housing Assistance
- Find suitable shelter
- Secure leases and pay rent
- Purchase and repair household items
- Develop relationships with landlords
- Improve housekeeping skills

Financial Management
- Plan budget
- Troubleshoot financial problems (e.g., disability payments)
- Assist with bills
- Increase independence in money management

Counseling
- Use problem-oriented approach
- Integrate counseling into continuous work
- Ensure that goals are addressed by all team members
- Promote communication skills development
- Provide counseling as part of comprehensive rehabilitative approach

a community-based "hospital without walls," providing a high-intensity program of clinical support and treatment.

Assertive community treatment is an evidence-based practice for psychiatric recovery support. Much research has been conducted with a wide range of people with severe mental illness, including patients with schizophrenia, veterans, dually diagnosed patients, and homeless people (Stull et al, 2010). These studies found that patients spent less time in hospitals and more in independent community housing. Their symptoms were reduced, their treatment compliance was increased, and ACT costs were usually lower. However, successful implementation requires committed leadership, allocation of sufficient resources, and careful hiring procedures (Mancini et al, 2009).

Critical Reasoning See if an ACT program is being used in your community, and determine the impact it may be having on vulnerable populations where you live.

VULNERABLE POPULATIONS IN THE COMMUNITY

Deinstitutionalization

Deinstitutionalization refers to the release of a psychiatric patient hospitalized for extended periods of time into the community. It was started in the 1960s with the hope that psychiatric treatment in community centers, combined with living arrangements provided by family or board and care homes, would allow these people to live more humane lives in their own communities. However, policymakers seriously miscalculated the service needs of this population and the ability of communities to accommodate the large numbers of people with mental illness who had been discharged from the state.

The results have often been tragic and inhumane for those living with serious mental illness. Some of the unintended consequences of deinstitutionalization include (Nasrallah, 2008):

- **Homelessness:** It has risen dramatically since the closure of state hospitals.
- **Incarceration:** Jails and prisons are overburdened with the mentally ill who are now labeled *criminals* rather than *ill.*
- **Poverty:** Most seriously mentally ill live at the poverty level and are barely able to meet essential needs.
- **Substance abuse:** It has grown among the mentally ill creating a more severe form of illness called *dual diagnosis.*
- **Poor access to primary care:** Most people with serious mental illness do not have a primary care provider and do not receive basic medical care.
- **Early mortality:** The seriously mentally ill die on average 25 years earlier than others.

BOX 34-8 REFLECTING ON HOMELESSNESS BY TYRONE GARRETT

Looking back on the twisted journey of my life, I am aware of how my history of homelessness was probably one of the main reasons that I'd languished so long outside mainstream society. I remember being shuttled from facility to facility with little access to effective services. The daily uncertainty of matters such as where I was going to eat and sleep contributed to my deteriorating psychiatric condition. Unable to form healthy relationships or achieve healthy pursuits, many of us homeless at times feel a little less than human.

When I was homeless the only place I had to store my belongings was a flimsy 3′ × 5′ locker. I was told when and where to sleep, and I usually stood in a long, sometimes fragrant line for an insufficient meal of questionable quality. Most of the real world has no knowledge of the subculture of homeless people—the violence and degradation.

Recovery from mental illness is a difficult undertaking, especially because it requires people to act contrary to what may seem natural when they are sick. Being suspicious of people who are trying to help may seem natural to a sick person, but it is an obstacle to recovery, which requires honesty and trusting relationships.

If we, as a society, have the knowledge and means to remove homelessness as an obstacle to recovery, we have a moral obligation to do so. If we stood tall in the face of 9/11, why can't we provide homes for our unfortunates during normally distressing times?

From *New York City Voices*, vol VII, No. 4, September-October 2002.

- **Social isolation:** Most seriously mentally ill are isolated from others and have difficulty making and maintaining friendships.
- **Social and vocational disability:** Few programs exist to prepare the serious mentally ill for gainful employment.

The needs of some of these most vulnerable populations are addressed in the following sections.

Critical Reasoning How would you and your family feel about a group home for people with mental illness being built in your neighborhood?

Homeless People With Mental Illness

Homeless people are a presence in U.S. society, where they live in subway tunnels, in abandoned doorways, and on park benches, and they die in cardboard boxes on windswept corners in communities throughout the United States. People who are mentally ill and homeless reflect the tension between a mental health system that views housing as a social welfare problem and public housing agencies that believe that this population needs specialized residential programs provided by mental health agencies. The needs of this population are underserved because services are fragmented and inaccessible (Box 34-8).

About one third of the estimated 600,000 homeless people in the United States have a severe mental illness. However, only 1 in 20 persons with a severe mental illness is homeless. Among homeless persons with a mental illness, only 5% to 7% need to be institutionalized. **Most can live in the community with appropriate, supportive housing** (Poulin et al, 2010).

Critical Reasoning Should people be allowed to choose to be homeless if they are not dangerous to themselves or others?

When homeless people with mental illnesses are given the opportunity to participate in treatment programs that address their needs for services in areas such as housing, health care, substance abuse, income support, and social support, many can be helped to find homes and achieve substantial improvements in their lives.

Mental health professionals are using new approaches to providing treatment, rehabilitation services, and housing to homeless people with mental illness—a population who often avoid contact with traditional mental health programs because of past difficulty in gaining access to care, demands from clinicians for treatment compliance, or past involuntary hospitalization (Gilmer et al, 2009).

Key elements of effective treatment approaches for the homeless include the following:

- Frequent and consistent staff contact through assertive outreach
- Meeting the patient where the patient is geographically and interpersonally
- Help with immediate survival needs, such as food, emergency shelter, and clothing
- Gradual treatment through the development of trust
- An emphasis on patient strengths
- Patient choice of services and the right to refuse treatment
- The delivery of comprehensive services, including mental health and substance abuse treatment, medical care, housing, social and vocational services, and help in obtaining entitlements

Brief, focused interventions at the time of transition from one treatment setting (inpatient) to another (group homes, community care) can enhance the long-term supports for persons with severe mental illness who are living in the community. These interventions can strengthen their ties to services, family and friends, and provide emotional and practical support during the transition period, preventing homelessness (Herman et al, 2011).

CLINICAL EXAMPLE

Neighbors reported that an unkempt, dirty, and bedraggled woman had taken to sleeping in a local park. She appeared to be physically unwell, with a cough and severe sunburn, and she was scavenging food from garbage cans. She appeared frightened when approached and refused help. Several complaints had been made about her by a nearby school.

Various health services were contacted, and it appeared that she had been diagnosed 5 years earlier with paranoid

schizophrenia, had come from another state, and had begun traveling around the area. She had a history of trauma and abuse, was noncompliant with treatment, and consistently eloped from hospitals if admitted.

A psychiatric nurse from the local community mental health center did a brief psychosocial assessment of the woman in the park. She was interviewed from about 10 feet away, which was as close as she would allow. Food, soap, towels, a small amount of money, and a warm blanket were left with her. She appeared frightened, thought disordered, and underweight.

She did agree to the nurse visiting her on a regular basis to provide food. She was seen most days for 2 weeks, during which she became more comfortable with the nurse. One day, she allowed the nurse to briefly examine her in the park toilets. She soon agreed to a 1-week hospital admission on a voluntary basis.

Rural People With Mental Illness

Rural America makes up 90% of the U.S. landmass, which is home to 25% of the population. Although the incidence and prevalence of mental illness among adults and serious emotional disturbances in children are similar in rural and urban areas, the issues related to the rural mentally ill population are different in important ways.

Particularly in the more remote, rustic areas that exist in 25 states and represent 45% of the landmass of the United States, barriers to mental health care are significant. Barriers include insufficient access to crisis services, mental health and general medical clinics, hospitals, and innovative treatments.

Rural residents also may face greater social stigma in regard to seeking mental health care, and basic community services such as transportation, electricity, water, and telephones that are important to providing health care may not be available.

Rural residents are at significant risk for substance use disorders, mental illness, and suicide. Symptoms related to mood and anxiety disorders, trauma, and cognitive, developmental, and psychotic disorders appear to be as common among rural residents as among city dwellers, and rural suicide rates have surpassed urban suicide rates over the past 20 years.

For these reasons, mental health issues are among the most prominent health concerns being faced in rural areas. The following statements are true about residents with mental health needs:

- **They enter care later in the course of their disease than their urban peers**.
- **They enter care with more serious, persistent, and disabling symptoms**.
- **They require more expensive and intensive treatment response**.

Rural areas experience three additional problems. The first is the lack of mental health professionals, including culturally competent or bilingual providers, in these medically underserved areas. Advanced practice psychiatric nurses have a great potential to be a solution to the rural mental health workforce shortage. However, they must increase in numbers, and barriers to their practice must be removed (Hanrahan and Hartley, 2008).

Second, people in the rural United States have lower family incomes and are less likely to have health insurance benefits for mental health care. Rural residents have longer periods without insurance and are less likely to seek mental health care for which they cannot pay.

Third, ethical dilemmas arise when practicing in the community, and some of these are unique to the rural setting. When numbers of providers in isolated settings are limited, problems may arise because of overlapping social and professional relationships, altered therapeutic boundaries, challenges in protecting patient confidentiality, and different cultural dimensions of mental health care. Ways to combat these dilemmas include the development of clinical treatment and support networks through electronic communications, telemedicine, attention to clinical ethics, and regular peer supervision or consultation.

Critical Reasoning What role do you think alternative and complementary therapies play in rural health care settings?

Incarcerated People With Mental Illness

About 80,000 patients are in psychiatric hospitals in the United States. In contrast, about 283,800 incarcerated persons are identified as having a mental illness (Table 34-3). **The mentally ill segment represents 16% of the inmate populations of state and local jails, or more than three times the number of people in psychiatric hospitals throughout the United States.**

Six in 10 mentally ill persons in state and federal prisons and 4 in 10 persons in jails receive some form of mental health care, most commonly prescription medication. Of all mentally ill populations, white female inmates are the most likely to receive care.

Women in jails and prisons have the highest rates of mental illness—almost twice that of male inmates (Steadman et al, 2009). Almost 40% of white female inmates 24 years old

TABLE 34-3 STATE PRISON INMATES IDENTIFIED AS MENTALLY ILL

INMATE STATUS	PERCENTAGE OF INMATES IN STATE PRISON
Reported a mental or emotional condition	10.1
Admitted to a hospital overnight*	16.2
Taken a prescribed medication*	23.9
Received professional counseling or therapy*	29.7
Received other mental health services*	30.2

*Because of a mental or emotional problem.

or younger report being mentally ill. Many of these women have children, often younger than age 5, and have experienced partner abuse. Many women are caught in a cycle of multiple arrests and violence that has a significant impact on their offspring (Kelly et al, 2010).

A result of the effect of prison life on inmates is the alarmingly high rate of suicides. **Suicide is the leading cause of death among inmates, accounting for more than one half of the deaths occurring while inmates are in custody.** Almost all who attempt suicide have a major psychiatric disorder. More than one half of the victims were experiencing hallucinations at the time of the attempt.

The presence of severely mentally ill persons in jails and prisons is an urgent problem. These individuals are often poor, uninsured, disproportionately members of minority groups, and living with co-occurring substance abuse and mental disorders. More treatment resources are needed to meet their needs (National Leadership Forum on Behavioral Health/Criminal Justice Services, 2009; Bradley-Engen et al, 2010).

Some programs are attempting to deal with this problem (Ryan et al, 2010). For example, integrating discharge planning, community mental health providers and jails can facilitate treatment engagement, limit incarceration, and improve well-being (Kubiak et al, 2011).

A community model for services (Figure 34-2) has been developed that includes methods for preventing incarceration of people with mental illness and intervening effectively when such a person is jailed. This model is based on the formation of a community board and includes preventive and postrelease interventions.

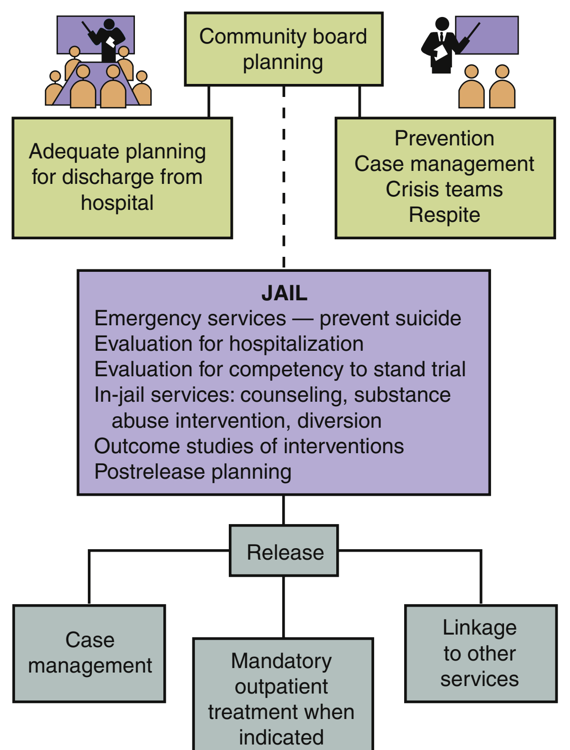


FIG 34-2 Community model for services. (From Laben J, Blum J: Persons with mental illness in jail. In Worley N, editor: *Mental health nursing in the community*, St Louis, 1997, Mosby.)

Mental health courts are being created across the United States to divert individuals away from jails and into the mental health system to receive appropriate care (Hiday and Ray, 2010) (see Chapter 9). Forensic ACT is a model for preventing arrest and incarceration of adults with severe mental illness who have substantial histories of involvement with the criminal justice system. Additional approaches will be needed, however, to fully address this growing problem and meet the needs of this vulnerable population.

The federal district courts have identified six components of a minimally adequate mental health treatment program:

1. A systematic screening procedure
2. Treatment that entails more than segregation and supervision
3. Treatment that involves a sufficient number of mental health professionals to adequately provide services to all prisoners with serious mental disorders
4. Maintenance of adequate and confidential clinical records
5. A program for identifying and treating suicidal inmates
6. A ban on prescribing potentially dangerous medications without adequate monitoring

Programs designed to fulfill these criteria can help to ensure that people already within the criminal justice system receive the help they require. However, additional resources must be channeled back into community mental health services so that mentally ill people can get the help they need.

Critical Reasoning Have jails become today's substitute for yesterday's state hospitals for people with mental illness? If so, what should be done to address this problem?

Forensic Psychiatric Nursing. **Forensic psychiatric nursing is a subspecialty of nursing that has as its objective assisting the mental health and legal systems in serving individuals who have come to the attention of both.** It is gaining momentum nationally and internationally (Kent-Wilkinson, 2010). Forensic psychiatric nursing has two very different and sometimes conflicting goals:

- The goal of providing individualized patient care
- The goal of providing custody and protection for the community

The forensic focus for nursing is the therapeutic targeting of any aspect of the patient's behavior that links the offending activity and psychiatric symptoms. The forensic nurse functions as a patient advocate, a trusted counselor, an agent of control, and a provider of primary, secondary, and tertiary health care interventions to this vulnerable population. **Interventions include risk assessment, crisis intervention, rehabilitation, suicide prevention, behavior management, sex-offender treatment, substance abuse treatment, and discharge planning.**

Most forensic psychiatric nurses work in the public sector under state departments of mental health or in psychiatric

units in jails, prisons, and juvenile detention centers. However, forensic nurses are also found working in the following areas (International Association of Forensic Nurses, 2011):

- Interpersonal violence
- Public health and safety
- Emergency/trauma nursing
- Patient care facilities
- Police and corrections, including custody and abuse

The scope of responsibility of forensic nurses can be quite broad, depending on the area of practice. Forensic nurses can practice in the ED, critical care setting, coroner's office, or correctional facility. **One specific role is that of the sexual assault nurse examiner (SANE), a nurse who has received special training to provide care to the victim of sexual assault.**

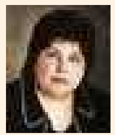
Nursing is the backbone of correctional health care, and nurses are the major providers of physical and mental health services (Prebble et al, 2011). With the need for improved mental health services and health outcomes, the role of forensic psychiatric nursing is likely to expand in the future.

Critical Reasoning Describe an innovative psychiatric nursing service that you could provide to people with mental health or substance use problems in your community.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Suzanne Smith, MSN, APRN



An experience I'll always remember involved a patient, R, who was being discharged from the state psychiatric hospital. I had previously interviewed this patient for admission into an intensive case management program. R had been in and out of the state hospital for 3 years with the diagnosis of chronic schizophrenia. His frequent readmissions were related to the system's inability to place him in the community, in part because of his history of setting fires. Before this admission, he had attempted to burn down his residence during a psychotic episode. However, his psychosis had resolved quickly after he was admitted to the hospital and started on a regimen of neuroleptic medications.

R was admitted into the intensive case management program, and his first 6 months had been very busy. He had been placed in an apartment with a roommate and became responsible for managing the apartment, cooking his own food, balancing his checkbook, and paying his bills. His adjustment to life in the community was progressing well. I was able to work with R on almost a daily basis, and all was going well.

One day, I had called R to let him know that I would be coming to take him to the bank. We discussed his checking account balance and financial obligations for that month. When I arrived at his home, R's roommate told me that R had gone to the store to get a cup of coffee. While waiting, I walked into the hallway to check on a problem thermostat.

As I glanced into R's room, I noticed that something was wrong. There were several cigarette burns in the carpet. On the bed there were a number of cigarette lighters. Propped on the pillows were cover photos from several women's magazines. The mouths on the models had been enlarged and a cigarette had been placed through the hole. In the bedside table, I found several more cigarette lighters. I noted all of these things, as well as the fact that R did not smoke.

On his return, we discussed some problems R was having with his roommate. His conversation was calm and rational. I then talked with him about what I had seen in his bedroom. Initially, he was silent and refused to discuss the matter. I realized that one of his greatest fears was returning to the state hospital, so I assured him that if something was wrong and he needed to go back to the hospital, it would be for a short-term hospitalization.

At that point he began to explain that he had not taken his medication in a week and that recently he drank a six pack of beer with several other patients in the program. Since then, he had been hearing messages from God in which she told him to smoke cigarettes because carbon monoxide was needed to clear all the pollution on the earth.

After a consultation phone call, I told R that I thought he was becoming ill again and needed a brief time in the hospital. He agreed, and we left in my car for an admission assessment at a local hospital. On the way, we stopped at the bank and R completed his banking business.

When we arrived, the staff were surprised that I had let R ride in my car and go to the bank when he was obviously experiencing psychotic symptoms. They said that they would have called for backup from the office or the mobile crisis unit. I explained to them that I had assessed R and felt that this decision would not endanger him or me. My decision was based on my skills as a psychiatric nurse, my experience in working with psychotic patients for a number of years, and my evaluation of R, with whom I had worked closely for 6 months.

I realize that this experience captured some of the critical essence of psychiatric nursing decision making. I believe that it is calculated thinking woven into a fabric of clinical experience that guides psychiatric nursing practice. For R, it was also a nursing act that expressed caring for and caring about. After 5 days in the hospital, R was stabilized again and returned to the life he so wanted to live.

CHAPTER IN REVIEW

- Transforming the mental health service delivery system rests on two principles: Services and treatments must be consumer and family centered, and care must focus on increasing consumers' ability to successfully cope with life's challenges, facilitating recovery, and building resilience.
- Most people seek help for their mental health problems from their primary care provider; however, most patients with mental illness are not treated effectively in the primary care setting. People with serious mental illness have more difficulty in obtaining a primary care provider and experience greater barriers to medical care than the general population.
- These system problems have given rise to discussions about the integration of primary and behavioral health care in the primary care setting. This must be a two-way street. Behavioral health problems should be treated in primary care and physical health problems should be treated in behavioral health settings.
- Important aspects of integrated care include screening and diagnosis; improving patients' self-management skills through psychoeducation; supporting clinicians' decision making through the use of practice guidelines; facilitating access to specialty mental health care; and engaging in collaborative care models of practice.
- The use of ED services in general hospitals by psychiatric patients has reached crisis levels. Because EDs cannot deny treatment, they have become a safety net for patients who do not have access to care or the resources to go to another type of facility. With substance use disorders and mental illness contributing to many other illnesses, EDs have seen an increasing number of patients who require interventions for these problems.
- EAPs are worksite-based programs designed to help identify and resolve behavioral, health, and productivity problems that may affect employees' well-being or job performance.
- Psychiatric home care ranges from serving as an alternative to hospitalization to functioning as a single home visit for the purpose of evaluating a specific issue. Key issues for the psychiatric home care nurse are nurse qualifications, cultural competence, and safety.
- E-therapy is the use of electronic media and information technologies to provide services for participants in different locations. E-therapy can be used to provide education, assessment and diagnosis, treatment engagement, direct treatment, and aftercare services.
- Components of a community support system include patient identification and outreach, mental health treatment, crisis response services, health and dental care, housing, income support and entitlement, peer support, family and community support, rehabilitation services, and protection and advocacy.
- A patient-centered health care home, or patient-centered medical home, is not a place but a model of primary care that delivers the core functions of primary health care.
- Health care homes shift the focus from episodic care to managing the health of populations, especially those living with chronic conditions.
- Collaborative care is a structured approach to care based on principles of chronic disease management. Key elements include systematic care management most often done by a nurse and consultation among the primary care provider, case manager, and a mental health specialist.
- Care management is a core element of patient-centered health care homes and of new approaches designed to improve chronic illness care.
- Case management includes patient identification and outreach, individual assessment and service planning, case management, advocacy and community organization, community information, and education and support.
- The goal of ACT is to prevent hospitalization and support the individual with serious mental illness in achieving the highest possible level of functioning by providing a full range of medical, psychosocial, and rehabilitative services.
- Deinstitutionalization of the mentally ill has resulted in problems with homelessness, incarceration, poverty, substance abuse, poor access to primary care, early mortality, social isolation, and social and vocational disability.
- About one third of the estimated 600,000 homeless people in the United States have a severe mental illness, although only 5% to 7% of these need to be institutionalized. Most can live in the community with appropriate, supportive housing.
- Mental health issues are among the most prominent health concerns faced in rural areas. Residents with mental health needs enter care later in the course of their disease than their urban peers; enter care with more serious, persistent, and disabling symptoms; and require more expensive and intensive treatment response.
- The rate of serious mental illness in the incarcerated population is about three to four times that of the general U.S. population. Additional approaches are needed to fully address this growing problem of the mentally ill population in jails.
- Forensic nursing is a subspecialty of nursing that has as its objective to assist the mental health and legal systems in serving individuals who have come to the attention of both. Forensic nurses work in interpersonal violence, public health and safety, emergency or trauma nursing, patient care facilities, and police and corrections.

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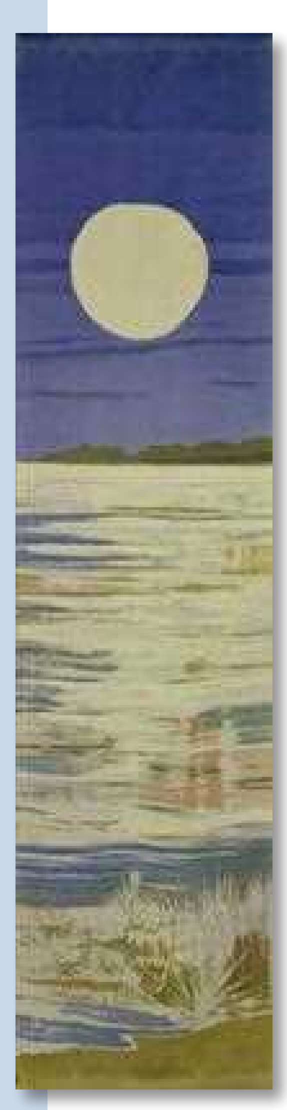
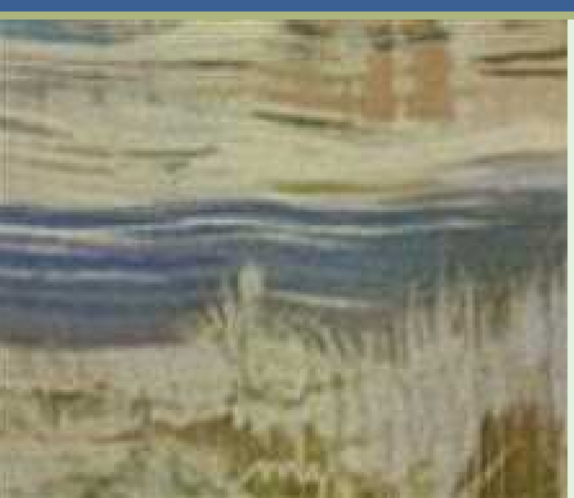
UNIT 6

Special Populations in Psychiatry





CHAPTER

35

Child Psychiatric Nursing

Sally Raphel

Nobody can go back and start a new beginning, but anyone can start today and make a new ending.

Maria Robinson, *Child Development from Birth to Eight: A Journey Through the Early Years*

http://evolve.elsevier.com/Stuart/

LEARNING OBJECTIVES

1. Discuss issues related to psychiatric illness in children, including a framework for child psychiatric nursing practice.
2. Identify the major clinical areas and ego competency skills that should be included when assessing children.
3. Analyze psychiatric and nursing diagnoses and plan interventions related to psychiatric illness in children.
4. Implement therapeutic treatment modalities with children, and evaluate their effectiveness.

Although one of five children has a clinically significant psychiatric disorder, only one third of them receive treatment. The ratio of dollars saved in later life to each dollar spent treating children early is 28 to 1 (Kluger, 2010). The Global Burden of Disease Study indicates that by the year 2020, childhood neuropsychiatric disorders will increase by more than 50% internationally to become one of the five most common causes of morbidity, mortality, and disability among children in the world (Murray and Lopez, 1996; Mental Health America, 2011).

CHILD PSYCHIATRIC CARE

Children and youth with mental health problems have lower educational achievement, greater involvement with the criminal justice system, and fewer stable and long-term placements in the child welfare system than children with other disabilities. **Research shows that one half of all lifetime cases of mental illness begin by age 14** (Kessler et al, 2009).

When treated, children with mental health problems do better at home, at school, and in their communities. The statistics regarding child mental health are alarming.

- Every 33 seconds, a child is abused or neglected.
- Every 36 seconds, a child is born without health insurance.
- Every 39 seconds, a child has a child.
- Every 3 hours, a child is killed by firearms.
- Children and youth in elementary school with mental health problems are more likely to be unhappy at school, absent, suspended, or expelled.
- Fifty percent of children in the child welfare system have mental health problems.
- Seventy percent of youth in the juvenile justice system have a diagnosable mental disorder.
- Alcohol and drug use begins by 8 years of age in some children and can be a significant problem by age 12

years. Among eighth graders, 41% have had at least one drink of alcohol, 20% of them report having been drunk, 25% have smoked cigarettes, and 16% have used marijuana (Carter Center, 2008).

Adding to these concerns is the increase in school-related shootings and other violent behavior displayed by young children in family and community settings.

Another disturbing issue is the prognosis of a child who has been diagnosed with a psychiatric illness. **Mental illness that develops before age 6 years can interfere with critical aspects of a child's emotional, cognitive, and physical development.** For example, there is an association between conduct disorder in a child and the development of antisocial personality disorder later in life. Prior anxiety, behavior, and mood disorders all increase the likelihood of the child having psychiatric problems as an adult.

Prevention, early identification, and treatment of children at risk is essential to reduce the risk for psychiatric disorders reaching into their adult lives. Although the number of children receiving care has significantly increased in the past decade, youth and families continue to suffer because of missed opportunities for prevention of psychiatric disorders and early interventions in behavioral problems.

Causative Factors

Genetic factors (nature) and childhood environment (nurture) are predisposing and precipitating causes for the development of a psychiatric illness. For example, traumatic events can have a profound impact on children (Sadock and Sadock, 2007). The symptoms of posttraumatic stress disorder (PTSD) in children are those of increased arousal, including hypervigilance, irritability, anxiety, physiological hyperactivity, impulsivity, and sleep difficulty. These symptoms are often misdiagnosed as attention deficit hyperactivity disorder (ADHD), conduct disorder, anxiety disorder, and mood disorder.

After traumatic events, many factors influence the intensity of symptoms, including the nature of the trauma, whether body integrity was threatened, the threat posed to the child's self-system and security, and the nature of the family support system (Copeland et al, 2010).

The type of symptoms a child experiences is often related to the family history. Specifically, if a family member has a history of anxiety disorder, the child may experience symptoms that are more anxious in appearance. However, if family members have a strong history of alcoholism and sociopathy, symptoms may be more related to a conduct disorder. **A genetic predisposition to certain symptoms is inherited, and these symptoms can be stimulated as a response to a stressful event in the environment.**

The neurophysiology activated during acute stress is usually rapid and reversible. The brain has mechanisms that down-regulate the stress reaction after the threat has passed, returning the brain to its prior level of functioning. However, if the stress is prolonged, severe, or repetitive, the resulting increases in neurotransmitter activity are often not reversible. This process has a significant impact on the development of the child's brain.

A trauma-induced brain response can result in abnormal patterns, time, and intensity of catecholamine activity in the developing brain. **Young children who are exposed to a high rate of stress-induced trauma are at risk for developing permanent changes in neuronal organization, making it more difficult for them to learn and to control their behavior.**

Other psychiatric disorders, such as ADHD, also show the interaction of genetics and environment. Children with ADHD usually exhibit excessive activity and have difficulty paying attention. These behaviors are often tolerated by a family, but when the children begin school, it can be problematic if these behaviors interfere with academic performance and peer relationships. As in PTSD, children with ADHD often have a range of symptoms, including symptoms that overlap with anxiety disorders, mood disorders, oppositional defiant disorder, and conduct disorder.

Although the exact cause of ADHD is unclear, it is believed that environmental factors, such as lead ingestion, prenatal and perinatal complications, socioeconomic factors, genetic factors, and brain dysfunction resulting from brain damage, may contribute to the development of the illness. Although no single finding explains the cause of this disorder, there is agreement that it has a neurobiological basis. By the time a child and family seek treatment, the child may have developed secondary mental health problems, such as **low self-esteem** and **poor socialization** (Van Cleave, 2008).

> **Critical Reasoning** What influence did your social and physical environment have on your current outlook on life?

Resilience

A child's individual characteristics and early life experiences, as well as protective factors in the social and physical environment, contribute to **resilience,** the child's ability to withstand stress. Resilient children are active, affectionate, and good natured. They are also humorous, confident, competent, realistic, flexible, and assured of their own inner resources and support from outside sources.

Resilient children have a strong sense of personal control, take age-appropriate responsibility, and exercise self-discipline. When faced with stressors, they show the capacity to recover quickly from temporary collapse and attempt to master stress rather than retreat or defend against problems.

Although developmental consequences of living in chaotic and stressful environments can be devastating for some children, not all children are harmed or develop psychiatric disorders (Coker et al, 2009; Vericker et al, 2010; Yoo et al, 2010). **It has been estimated that 80% of children exposed to powerful stressors do not have developmental damage.** Children from similar family and community environments can have the same negative experience (e.g., poverty, parental psychiatric and substance abuse disorders, violence, war, dislocation) but not experience the same degree of emotional or physical problems.

Specific **protective factors** make some children more resilient than others (National Research Council, 2009). A

sense of autonomy is one resiliency factor. Another is **adaptive distancing,** which occurs when a child is able to distance oneself from too close involvement with a dysfunctional family, transcend a difficult past, and select healthy alternatives as they become available. **Other protective factors include the following:**

- **Clear thinking skills**
- **Functional language**
- **Understanding the emotions of self and others**
- **Experiences of self-efficacy resulting in self-confidence**
- **Making friends and getting along with peers**
- **Temperament that elicits positive responses from others**
- **Caregiving that is responsive, protective, stable and affectionate**
- **Parenting that fosters competence**
- **Experience of being respected**
- **Positive self-esteem**
- **Supportive adults who foster trust and act as gatekeepers**
- **Opportunities in major life transitions that allow competencies to be reinforced and rewarded**

Resilient children have parents who model resilience, care for them in a routine and stable way, and are available to them with reassurance and encouragement during times of trouble. These support persons help children understand and process stress and trauma. Resilient children have the ability to make sense of threatening situations and understand what is happening in their environment, which then helps them cope with stress.

Critical Reasoning Resiliency is fostered by children having a supportive and caring adult in their life. How can nurses help access to community support persons for young people?

A FRAMEWORK FOR NURSING PRACTICE

To be effective in the psychiatric care of children, nurses must have knowledge of child growth and development. Nursing interventions should be based on meeting the developmental needs of the child and not on parental, societal, or academic standards. Nurses should identify realistic, well-defined goals, respond to the social needs of the child, advocate for the child, and develop a comprehensive treatment plan that identifies and integrates the child's needs and family resources. **This must be done with the realization that the behavior of children is largely culturally based and must be viewed from a sociocultural perspective.**

Organizing child psychiatric nursing care around **ego competency skills** is an effective and culturally sensitive way of planning and implementing nursing interventions for children regardless of psychiatric diagnosis or setting. The nine skills that all children need to become competent adults include the following (Strayhorn, 1989):

1. **Establishing closeness and trusting relationships**
2. **Handling separation and independent decision making**
3. **Negotiating joint decisions and interpersonal conflict**
4. **Dealing with frustration and unfavorable events**
5. **Celebrating good feelings and experiencing pleasure**
6. **Working for delayed gratification**
7. **Relaxing and playing**
8. **Cognitive processing through words, symbols, and images**
9. **Establishing an adaptive sense of direction and purpose**

BOX 35-1 STRATEGIES FOR COMMUNICATING WITH CHILDREN

- Develop an understanding of age-related norms of development.
- Convey respect and authenticity.
- Assess and use familiar vocabulary at the child's level of understanding.
- Assess the child's needs in relation to the immediate situation.
- Assess the child's capacity to cope successfully with change.
- Use nonverbal communication and alternatives to verbalization (e.g., eye contact, reassuring facial expressions).
- Work to develop trust through honesty and consistency.
- Interpret the child's nonverbal cues back to the child verbally.
- Use humor and active listening to foster the relationship.
- Increase coping skills by providing opportunities for creative, unstructured play.
- Use indirect age-appropriate communication techniques (e.g., storytelling, picture drawing, creative writing).
- Use alternative, supplementary communication devices for children with specialized needs (e.g., sign language, computer-enhanced communication programs).

Modified from Arnold EA, Boggs KU: *Interpersonal relationships: professional communication skills for nurses*, ed 6, St Louis, 2011, Elsevier.

Communication

The first goal of the nurse is to establish a therapeutic alliance with the child and the parents. If the child's verbal communications are vague or unclear, the nurse needs to ask for additional explanation. A child often does not respond to a problem-centered line of communication. In this case, the nurse should start with discussing more general aspects of the child's life, such as family members, school, or friends. Strategies for communicating with children are identified in Box 35-1.

Children with internalizing disorders, such as depression or anxiety, are often the best informants about their affective states. Children with externalizing disorders, such as ADHD or conduct disorder, are typically poor informants and usually less cooperative in an interview. They tend to blame others, thereby requiring reports from parents, teachers, day care, or school personnel to obtain information about problems and progress.

Critical Reasoning What indicates to you that a child does or does not trust you?

Cultural Competence

Cultural competence is essential to the delivery of mental health services to children and their families. **Cultural issues and communication among the child, family members, and clinician are a critical part of the care provided and the success of the child's outcomes.** Culturally relevant clinical standards and implementation guidelines have been developed (U.S. Department of Health and Human Services, 2000). They help mental health professionals working with African Americans, Hispanics, American Indians/Alaskan Natives, and Asian/Pacific Island Americans.

To ensure cultural competence, the nurse must understand the child's background, communicate effectively across cultures, and formulate treatment plans in partnership with the child and family. The nurse must develop knowledge, understanding, skills, and informed attitudes about differences related to the following:

- Type and intensity of symptoms
- Explanations for mental illness (religious, supernatural)
- Role of spiritual tradition, values, and practice beliefs in health and illness
- Perceived stigma for child and family
- Triggers of psychiatric and emotional distress
- Verbal and nonverbal language, speech patterns, and degree of English literacy
- Culturally acceptable help-seeking behavior for children
- Culturally related side effects of medications

ASSESSMENT

Assessment of the child requires a biopsychosocial approach that includes biological development, medical illness, cognitive and personality characteristics, cultural context, and the child's family, school, and social environment. The goals of assessment are to determine the child's emotional, cognitive, social, and linguistic development and to identify the nature of relationships with family, school, and social milieu. The parts of a psychiatric assessment are shown in Box 35-2.

Multiple sources of information can be used when forming an assessment, including family (e.g., parents, caregivers), school and day care personnel (e.g., teachers, parents, counselors, principals), sitters, after-school program staff, athletic coaches, scout leaders, and bus drivers. An understanding of the child's competencies related to the child's stage of development is critical to forming a well-grounded diagnosis.

Key Areas

Establishing a therapeutic alliance with the child begins during assessment. Playing with or watching the child play with age-appropriate toys or games is an effective way to observe interactions with parents, caregivers, or others. Several key areas of assessment merit further discussion.

- **Developmental history** includes demographic information, a description of the presenting problem, identification of recent stressors in the family or home, and a history of the child's prenatal, neonatal, and first year of life, including developmental milestones. The child's general behavior, sexual behavior, and past and present personality traits should be recorded. Whether a child is seen as shy, timid, unfriendly, aggressive, risk taking, fearful, or morose is important.
- **Family history** involves collecting information about all members of the child's family. This will add to understanding the context of the child's current problems. Data about family members' psychiatric diagnoses and psychological and social functioning can be key to determining the child's resources. A family genogram can be a useful tool in gaining an understanding of family issues that span multiple generations (see Chapter 10).
- **Stress and trauma history** is significant to the child's current situation when there has been caretaker absence, abandonment, or neglect; physical, sexual, or emotional abuse; placement in a foster home; or parental divorce or separation.
- **Strengths of the child** relate to the ability to cope and adapt, resilience, and ego strengths. These can enhance the

BOX 35-2 CHILD PSYCHIATRIC ASSESSMENT

Family Interview

Define the problem(s), developmental and family history (genogram), parental mental and physical health, family interactions.

Interview With the Child

Mental state: Does the child have a problem? Ask about worries, fears, mood (including tears and suicidal ideas), expression of anger, sleep, appetite, habits, obsessions, sexual and physical abuse, auditory hallucinations, and delusional ideas.

Assess development of conscience and values, interests, hobbies, talents.

Supplement the interview by play and drawing (ask the child to draw a person/family/dream).

Perform physical examination, including assessment of handedness, motor coordination, or clumsiness.

Other Investigations

School: Assess school experiences, friendship, play, teasing, bullying and academic levels of functioning.

Psychological tests (e.g., IQ profile): When there are learning problems, delayed or uneven development, or cognitive or perceptual disturbances.

Laboratory tests (e.g., chromosome analysis): When there is the possibility of an associated biological problem, such as fragile X syndrome or thyroid disease.

Neuroimaging and electroencephalogram: When there may be an associated neurological disorder, such as epilepsy.

possible treatment outcomes. A strength-based assessment identifies the resources the child has available internally and externally. It focuses on prior and current achievements, no matter how small. These resources can then be reinforced by the nurse and treatment team.

A **mental status examination** (MSE) should be completed. A standard format is followed with regard to appearance, orientation, general interaction, speech and language, motor ability, intelligence, and memory (see Chapter 6). The nurse also must assess cognitive, reading, and writing abilities; social relatedness; judgment; and insight.

For each area of the child MSE, the differences as compared with the adult version are significant. For example, it is critical to observe the child from a developmental perspective (e.g., depression may be confused with shyness). Social relatedness also is important (e.g., observation of personal boundaries and the child's view of the emotional state of others), particularly behaviors when separating from a parent. Alertness is significant because sleepiness could be a medication side effect or a symptom of depressive disorder.

Perceptions and hallucinations, if expressed, must be evaluated along with the child's level of concrete thinking. For example, a child may report seeing something the interviewer does not see, which with clarification, is a picture on the wall behind the interviewer. An evaluation of thought content may reveal suicidal or homicidal tendencies, delusions, or unusual preoccupations. Mood should be explored for sadness or anxiety.

Ego Competency Skills

The nursing assessment focuses on the specific skills that all children need to become competent adults. Regardless of the psychiatric diagnosis, a child should be assessed for mastery of the following nine ego competency skills.

Establishing Closeness and Trusting Relationships. A basic skill for positive growth and development is the child's ability to establish close and trusting relationships with others. Children with the psychiatric diagnosis of generalized anxiety disorder may have difficulty establishing trusting relationships because they do not feel personally competent. The following questions are used to evaluate this skill:

- Does the child enjoy making friends?
- Does the child often feel picked on by other people?
- Does the child not know what to say when getting to know someone?

Handling Separation and Independent Decision Making. Children who have separation anxiety have great difficulty separating from their mother or home. However, individuation is an important mental health process. Being able to identify and express feelings and make independent decisions is critical to becoming a competent individual. The following questions are used to evaluate this skill:

- Does the child get upset or worry when away from the mother?
- Does the child get upset or worry about thinking someone does not like him or her?
- When upset, is there something the child can do to feel better?

Handling Joint Decision Making and Interpersonal Conflict. Children who have not been allowed to participate in joint decision making or who have not been rewarded for cooperating may be deficient in this skill. A child with oppositional defiant disorder may use aggression instead of negotiation to respond to interpersonal conflict. However, learning the skill of joint decision making is critical for success in interpersonal relationships. The following questions are used to evaluate this skill:

- When the child has a problem, can the child usually think of several solutions?
- Does the child get angry about not getting one's own way?
- Do other people make the child agitated or easily upset?

> **Critical Reasoning** Games can be useful in teaching cooperation and compromise to children. What games can you identify that would be particularly helpful in teaching children this important skill?

Dealing With Frustration and Unfavorable Events. Tolerating frustration, although difficult, is critical to becoming a competent adult. Children with conduct disorders often have difficulty understanding a situation from another's perspective. The following questions are used to evaluate this skill:

- Does the child feel bad if he or she has hurt someone's feelings?
- If someone disagrees with the child, does it make the child angry?
- Does the child not like playing a game if unable to win?

> **Critical Reasoning** Do you think that a child's ability to handle frustration and stressful events is influenced by biological makeup? If so, does biology excuse people from being responsible for their actions?

Celebrating Good Feelings and Feeling Pleasure. Healthy children raised in a nurturing environment naturally experience good feelings and pleasure. However, children who are depressed or anxious many not be able to celebrate good feelings or experience spontaneous pleasure. In a maladaptive environment, shame is often used to control children's behavior, and they feel guilty for having angry or unacceptable thoughts. Consequently, they may lose the ability to celebrate life and feel pleasure. The following questions are used to evaluate this skill:

- Does the child worry about the future a lot?
- Does the child not like it when people say good things about the child?
- Does the child feel good about the things the child does well?

> **Critical Reasoning** How often and in what ways did your family celebrate good feelings and experience pleasure when you were growing up? How do you incorporate this in your life today?

Working for Delayed Gratification. As children grow, they are expected to delay needed gratification by following rules and waiting their turn. This skill is often difficult for impulsive children with ADHD, bipolar disorder, or conduct disorder to achieve. The following questions are used to evaluate this skill:

- Does the child believe that most rules are reasonable, and does the child not mind following them?
- Does the child find it difficult to be honest and think that lying is the only thing to do?
- Does the child get angry if the adult doesn't give what the child wants?

Relaxing and Playing. Given the stressful environment of current family life, many children may have little opportunity to learn the skill of relaxing and playing. For children with mood, anxiety, or behavior disorders, learning to relax and play is an important skill. The following questions are used to evaluate this skill:

- Are there some things the child really enjoys doing?
- Can the child have lots of fun?
- Does the child enjoy sitting around and thinking about things?

Cognitive Processing Through Words, Symbols, and Images. Children with psychiatric illnesses may not have developed the important skill of cognitive processing. The following questions are used to evaluate this skill:

- Is it difficult for the child to describe feelings?
- Does the child feel unable to ever know how something is going to turn out?
- Can the child identify personal strengths?

Adaptive Sense of Direction and Purpose. Children who experience symptoms of mental illness may feel hopeless about their life. As they view adult life from watching those around them, they begin to draw conclusions about themselves in the world. The following questions are used to evaluate this skill:

- Does the child feel that life is going to get better?
- Is the child confused about growing up, and does the child not know what to do about it?
- Does the child believe that school is important and see it as his or her job in life at present?

> **Critical Reasoning** Many people believe that youth today lack a sense of hope, direction, and purpose in life. Do you agree with this, and if so, what sociocultural factors might influence the learning of this skill?

Brain Imaging

Brain imaging can be used to track neuronal maturation of the child. **Through brain imaging, physiological and developmental brain abnormalities can be identified.** The main findings of neuroimaging studies were that brain abnormality locations fell into three groups of psychiatric diagnoses: (1) affective disorders associated with frontal-limbic changes; (2) psychiatric disorders with cognitive changes associated with cortex changes; and (3) psychomotor disorders associated with basal ganglia abnormalities (Mana et al, 2010).

A neuroradiologist can describe the degree of myelinization of an infant or toddler, the relative size of the ventricles, or the presence of atrophy visualized in routine brain magnetic resonance imaging (MRI) protocols. These techniques are being used in the study of ADHD, schizophrenia, anorexia nervosa, obsessive-compulsive disorders, autism, affective disorders, and Tourette syndrome (Shaw, 2010). Techniques used with proper release signed by a parent include MRI, functional MRI, magnetic resonance spectroscopy, magnetoencephalography, positron emission tomography (PET), and single-photon emission computed tomography (SPECT) (see Chapter 5).

Scientists have found that ADHD, childhood onset of bipolar disorder, and lead intoxication may have many similarities in presentation, and neurobiological tests cannot always give accurate classification of their important differences. These techniques may provide powerful tools for clinicians to use in following the course and treatment effects and predicting outcomes for children with neurodevelopmental conditions and disorders, such as autism and depression. This is supported by the major progress seen in the research on autism spectrum disorder since 2000 (Guttman-Steinmetz et al, 2009; Lichtenstein et al, 2010; McGuinness and Lewis, 2010).

DIAGNOSIS

Psychiatric Diagnoses

Children with psychiatric illness experience disabling symptoms that are responses to biological alterations, traumatizing situations, or maladaptive learning. The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association, 2000) classifies disorders usually first evident in infancy, childhood, or adolescence. Children also can experience a number of psychiatric illnesses common to adults.

The most common psychiatric disorders seen in children are ADHD, depression/bipolar disorder, anxiety, conduct disorder, and autism. Table 35-1 summarizes the symptoms, assessment, developmental factors, and nursing implications for each of these disorders and other psychiatric disorders of children.

A range of efficacious psychosocial and pharmacological treatments with consistent monitoring and caregiver education can be offered for these disorders. Empirically validated treatments for ADHD and conduct disorder in children are summarized in Table 35-2 (Nathan and Gorman, 2007).

TABLE 35-1 **PSYCHIATRIC DISORDERS OF CHILDREN**

DISORDER	DESCRIPTION	ASSESSMENT	DEVELOPMENTAL FACTORS	NURSING IMPLICATIONS
Mental retardation (MR)	Beginning before age 18 years, MR involves low intelligence and resulting difficulties requiring special help for child in coping with life.	Based on intelligence quotient (IQ): *Mild:* 55-70 *Moderate:* 40-55 *Severe:* 25-40 *Profound:* less than 25 Many causes detected through laboratory studies	Tools to measure IQ and developmental quotient (DQ) vary. A child with associated physical features is diagnosed earlier. Denver and Bayley scales for ages 1-42 months are helpful.	Safety needs must be closely monitored. Self-esteem is usually low and requires frequent reevaluation and enhancement. Higher-functioning child usually has a sense of humor, and some have a rich fantasy life.
Pervasive developmental disorders (PDDs): Autism Rett disorder Childhood disintegrative disorder Asperger disorder PDD NOS	Development is slow, sometimes never comes. Inability to socialize, communicate, and control motor movements.	Aspects of these disorders overlap many others. Neurological disorders must be explored with careful attention to gross and fine motor coordination.	The degree of disability varies, but the effects on child and family are profound and permanent.	The child may use language inappropriately and ask personal questions that require redirection.
Learning disorders: Reading Mathematics Written expression Academic problem Learning disorder NOS	Child is found to be substantially below expected skill level and has more difficulty than normal in learning specific academic skills. Consideration is given to intelligence level, age, and experience with appropriate education.	Often some history points to the problem and correct diagnosis. An interview with a child experiencing reading difficulty is also used to examine for accompanying disorders (e.g., ADHD, communication disorder).	Unlikely to be evident until school age.	Take time and support child from a strength-based perspective to assist self-esteem issues. Build on child's achieved communication skills, and consult with educational specialist for specific methods.
Motor skills disorders: Developmental coordination disorder	A child whose motor coordination is seriously below expectation for intelligence and age. Very young child may have delayed milestones or older child may have fine motor difficulty in sports or handiwork. Cause is unknown.	Rule out physiological, genetic, neurological, or other contributors. Criteria for pervasive developmental disorder do not fit symptoms.	The target symptoms are not from medical condition such as cerebral palsy or muscular dystrophy.	Fit play interventions to age and development. Observation in varied activities gives data to build a care plan.
Communication disorders: Expressive language Mixed receptive/expressive Phonological Stuttering Selective mutism Communication disorder NOS	Impair a child's ability to communicate with others. Most are not commonly known and often go unrecognized.	Encourage child to talk uninterrupted for prolonged periods to get samples of speech rate, repetition, dropped sounds, lack of prosody. Use story telling or have child recount an event as a nonthreatening subject.	Mild case may be missed until teens. Younger child with MRELD can appear deaf; older child shows confusion. Stuttering begins in early childhood, and self-esteem issues are important.	Need a clear sense of use of symbols and ability to comprehend and follow commands given without gestures.

Continued

TABLE 35-1 **PSYCHIATRIC DISORDERS OF CHILDREN—cont'd**

DISORDER	DESCRIPTION	ASSESSMENT	DEVELOPMENTAL FACTORS	NURSING IMPLICATIONS
Movement and tic disorders: Developmental coordination Transient tic Chronic motor or vocal tic disorder Tourette disorder Stereotypic movement disorder Tic disorder NOS	Tics can be motor or vocal, simple or complex. Simple motor—grimaces, eye muscle twitches, abdominal tensing, or jerking of shoulder, head, or distal extremities. Simple vocal—barks, coughs, throat clearing, sniffs, or single syllables called out. Complex vocals have more organized patterns.	Usually suppressed during sleep; increase in intensity or frequency at times of stress, fatigue, or illness. Present a wide range of symptoms on a continuum from occasional eye blinking to severe motor and vocal tics so severe they preclude normal classroom participation.	Motor tics appear as young as 2 years and usually involve the upper part of the face; vocal occur somewhat later. Prognosis for transient tics is better; chronic motor or vocal tics wane within a few years and rarely last into adulthood.	Child with a tic feels out of control of own body. With Tourette disorder, the child has multiple motor tics in addition to vocal ones and may use socially inappropriate, vulgar language (coprolalia). Nursing plan incorporates empathetic care, self-esteem enhancement, supportive environment to improve social relationships, and medication monitoring and teaching.
Disorders of intake and elimination: Pica Rumination Feeding disorder of infancy or early childhood Enuresis Encopresis Other eating disorders—anorexia nervosa or bulimia nervosa	Intake: Child eats nonnutrient substances (e.g., dirt, paper), regurgitates and rechews food, or fails to eat adequately. Elimination: Urinating on clothes or bed after age 5 years. Repeated passage of feces in inappropriate places after age 4 years. Enuresis is most often viewed as physiological condition with physical symptoms, not necessarily mental disorder. It does have emotional sequelae similar to obesity.	Symptoms of elimination disorders may be embarrassing. Assess for pain, sensation of need to void. A few years of maturation can separate the pathological situation from the developmental issue.	Normal toddlers put everything in their mouths. Pica should not be considered unless inappropriate eating lasts longer than 1 month in a child developmentally past the toddler stage. Focus on the involuntary nature of the elimination problem, as well as the child's hope for improvement. Build a therapeutic alliance by using child's own words for body functions and anatomy.	For eating disorders, direct observation of child and parents at mealtime may help. Most information will come in verbal reports from parent. Watch for other oral behaviors, nail biting, and thumb sucking.
Attention deficit and disruptive behavior disorders: ADHD, ADHD NOS Conduct disorder Oppositional defiant behavior Child antisocial behavior Disruptive behavior NOS	ADHD: Child's behavior comprises either attention deficits or hyperactivity and impulsivity. Develops as a failure of brain mechanisms for self-control and inhibition of impulses or frontal lobe executive functions. Conduct disorder: For 12 months or more, child has repeatedly violated rules, age-appropriate societal norms, or rights of others.	Explore problems of inattention, trouble keeping attention on task or play, listening ability, how child responds to and follows instructions, help needed organizing, is easily distracted, and avoids tasks requiring mental effort. Appears "on the go," has trouble sitting quietly, talks excessively, consistently squirms or fidgets, inappropriate running or climbing. Greater emphasis placed on parent and teacher reports of child's behaviors. Conduct disorder: Before age 10 years, at least one problem of conduct.	Can be difficult to sort from normal toddler and preschool inattentiveness. Older child may report an inner restlessness.	It is important that the nursing plan of care be based on multiple sources of data and reference resources. Talking with child and parent separately is sometimes helpful. Negativistic behaviors are always challenging.

TABLE 35-1 **PSYCHIATRIC DISORDERS OF CHILDREN—cont'd**

DISORDER	DESCRIPTION	ASSESSMENT	DEVELOPMENTAL FACTORS	NURSING IMPLICATIONS
Mood disorders: Major depressive disorder Bipolar I or II Dysthymic Mixed episode Hypomanic episode Mood disorder caused by medical condition Substance-induced mood disorder	A pattern of illness caused by abnormal mood. Episode refers to any period of time the child is abnormally happy or sad or has uncontrollable mood swings.	Use of thorough Mental Status Exam to explore current level of functioning. Explore family, particularly parental, history of mood disorder. Environmental precipitants or traumatic events in young child. Recurrence or rehospitalization within 2 years.	Very young child expresses depression through irritability, somatic complaints, or refusal to go to school. Manic symptoms are often misread for hyperactivity of ADHD. School age may have somatic complaints (headache, stomachache, abdominal pain). Delusional content depends on developmental stage. Because child has grown up with the disorder, child may not voluntarily discuss symptoms with parents or teacher.	Full assessment for self-harm and contract for safety. Establish safe environment. Monitor sleeping, eating pattern, and medications. Educate child about effects of compliance. Work with parents to foster support for child.
Anxiety disorders: Panic disorder Agoraphobia Specific phobia Social phobia Obsessive-compulsive disorder Posttraumatic stress disorder Acute stress disorder Generalized anxiety disorder Anxiety caused by medical condition Substance-induced anxiety disorder Anxiety disorder NOS	Child presents with prominent anxiety symptoms. Symptoms produce disability or distress. Co-morbidity is the rule. Anxiety symptoms can be found in a child with almost any other Axis I disorder (e.g., as part of mood disorder or in response to separation).	Fears are common in children, but in 2%-3% they cause a clinical level of distress. Children usually only relive the traumatic incident in dreams (e.g., monsters or frightening images). Children exhibit compulsions more frequently than obsessions. Although equally affected, boys' symptoms begin at an earlier age than girls'.	Children often lack the insight that they feel anxious and express symptoms by clinging, crying, or freezing in position. Important to remember that anxiety is a normal, even useful, emotion that will change from one developmental stage to the next. Young children are especially apt to experience PTSD symptoms by talking less and acting out their anxieties.	Be specific when interacting with a child, "Are there things that frighten you? What do you worry about most?" The fears can extend to include situations for parents, friends, siblings, or pets. Avoidance and vigilant behaviors may be noted. This child does not volunteer a lot of information about thoughts or feelings.
Disorders of relationship: Separation anxiety Reactive attachment of infancy or early childhood Parent-child relational problem Sibling relational problem Problems related to abuse or neglect	Inappropriate and excessive anxiety about separation from home or significant person. Parent-child diagnosis (PCD) is relevant when clinically important symptoms or negative effects on functioning are linked with the way a child and parent interact.	Examine family history for duration and intensity of current problem. Is the interaction difficulty only with one adult (mother, father) and not all adults? All family members involved should be interviewed. A most common occurrence in child mental health practice.	This area of problem behavior is not considered a mental illness but can become the focus of clinical attention. Developmental stage and norms are key to understanding the family or interpersonal dynamics.	When attention span and activity levels are within normal range, ADHD and disruptive disorders can be ruled out. Assess anger, spite, or loss of temper in exchanges with significant others.

Attention Deficit Hyperactivity Disorder. ADHD has received considerable attention and study, but controversy exists regarding the exact nature and extent of this disorder. **It is estimated that 5% to 10% of children have ADHD but that 50% of children with the disorder have never been diagnosed** (National Institute of Mental Health, 2011a). It is more common in boys than girls. A history of difficult and uneven development from infancy is usually discovered.

It is likely that ADHD has a neurobiological basis that is complicated by social interactions and the consequences

TABLE 35-2 SUMMARIZING THE EVIDENCE ON ATTENTION DEFICIT HYPERACTIVITY DISORDER AND CONDUCT DISORDER

DISORDER	TREATMENT
Attention deficit hyperactivity disorder (ADHD)	Systematic combination of direct contingency management plus clinical behavioral therapy yields significant improvement in behavior and academic performance. Psychostimulants—a group of ethylamines including methylphenidate and amphetamine—are highly effective in reducing core symptoms of ADHD in preschoolers, school-age children, adolescents, and adults. Short-term efficacy is more pronounced for behavioral rather than cognitive and learning abnormalities associated with ADHD.
Conduct disorder in children	Effective therapies include parent management therapy, multisystemic therapy, multidimensional foster care model, cognitive problem-solving skills training, and anger control training.

From Nathan P, Gorman J: *A guide to treatments that work*, ed 3, New York, 2007, Oxford University Press.

of related learning problems (Shaw, 2010). The Children's Mental Health Fact Sheet (National Institute of Mental Health, 2011a) summarizes facts and resources for systems of care. Another area of controversy is related to medications. Questions have been raised about whether children are being overdiagnosed and overmedicated to ease problematical school behaviors and about the safety of available medications (Evans et al, 2008; McGuinness, 2008).

The National Institute of Mental Health's 3-year follow-up study, Multimodal Treatment of Children with Attention Deficit Hyperactivity Disorder (MTA), showed that medication can make a long-term difference for some children if it is continued with optimal intensity and not started or added too late in a child's clinical course. Most children treated in a variety of ways for ADHD showed sustained improvement after 3 years, but increased risk for behavioral problems, including delinquency and substance use, remained higher than normal (Jensen et al, 2007).

Family factors and treatment modalities are the focus of multiple studies, publications, and media attention (Dos Reis et al, 2010; CHADD Live, 2011). The American Academy of Child and Adolescent Psychiatry has ADHD practice parameters for all health professionals using best practices for evaluating and treating children. These guidelines stress ADHD as a medical condition similar to diabetes or asthma (American Academy of Child and Adolescent Psychiatry, 2007; Van Cleave and Leslie, 2008). The American Academy of Pediatrics (2011) also has issued new guidelines for the diagnosis and treatment of ADHD that includes younger, preschool children and adolescents.

Evidence suggests that the young person does not always grow out of the problem. Symptoms tend to persist, although adolescents usually become more goal-directed and less impulsive, channeling activity into sports or work if the opportunity is possible. The outcome is less favorable for those who have an associated conduct disorder or untreated depression. In these cases the risk of substance use, mental, personality, behavioral, delinquency, or social adjustment problems is increased. However, improvement following treatment has been sustained in some areas (Ferguson-Noyes and Wilkinson, 2008; Van Cleave, 2008).

The comprehensive treatment of children with ADHD is a long-term process because they typically present with a variety of social deficits, learning disabilities, behavior problems, and depression. **The approach after a thorough and careful evaluation must be multimodal with the goal of assisting the child to cope with ADHD and the difficulties it brings to family, school, and social functioning.** The nursing implications are great and public and caregiver knowledge and attitudes have a major role in successful outcomes and access to services (Albury, 2009; Worley and McGuinness, 2010b).

Depression. **As many as 1 in 33 children may have clinical depression** (National Institute of Mental Health, 2011a). It occurs in children and becomes more common after puberty. Up to 14% of children will experience an episode of major depression before age 15 years. It seriously affects social, emotional, and educational development and is the most important predictor of suicidal behavior in young people aged 15 to 24 years (Luby, 2009; Paul, 2010).

Although the symptoms of depression in children are similar to those seen in adults, children also usually have irritable mood, may fail to make expected weight gain, and tend to keep secret their depressive thoughts and crying.

Depression can precede the diagnosis of bipolar disorder in children and can occur in combination with another disorder, such as anxiety, conduct disorder, or ADHD. The prognosis is good when the depression is secondary to a life stress and responds to psychological treatment.

Suicide is difficult to predict, but it does occur in children as young as 8 years. **Assessment for suicidal ideation, plans, and attempts is essential.** In 2011 suicide was the third leading cause of death among 10 to 24 year olds (Centers for Disease Control and Prevention, 2011a). Almost 3 million youths aged 12 to 17 years thought about or attempted suicide during the previous year, and more than one third made an actual suicide attempt. The top three methods were hanging/suffocation, poisoning, and firearms. Risk factors for childhood suicide include depression, sexual abuse, prior suicide ideation or plan, being bullied (Schreier et al, 2009), substance abuse, impulsive or aggressive behavior, and access to firearms.

The suicidal child is not likely to self-refer or seek help, and early identification of at-risk youth is critical. Screening

approaches should be carefully considered, especially in instances of comorbidity and a history of suicide in the child's family. A thorough nursing assessment of a child's mood is the first line of prevention of youth depression and suicide.

> **Critical Reasoning** Do you think a child as young as age 7 years can be suicidal? What symptoms would you look for, and where would you seek help in a community setting?

Bipolar Disorder. Bipolar disorder (BPD) is a debilitating psychiatric illness. **Children with bipolar disorder have a high rate of suicidality, psychosis and functional impairment.** Adults with BPD report 59% to 65% experienced their first symptoms in childhood. The diagnosis is a history of one or more episodes of mania. Childhood onset BPD consists of long-duration episodes of sustained impulse control or conduct problems, often with rapid cycling and mixed mania.

Almost one third of 6- to 12-year-old children diagnosed with major depressive disorder will develop bipolar disorder in a few years (Mental Health America, 2011). The controversial nature and the frequency of co-morbid condition make it hard to treat so it is important for clinicians to recognize symptoms and address the disorder as early as possible. A detailed health history is necessary and there are several tools for assessment (Maniscalco and Humphries, 2008; Carbray and McGuinness, 2009; Kowatch et al, 2011).

Chronic irritability may be the first symptom in children. BPD may co-occur with ADHD, conduct disorder, anxiety disorders, PTSD, and oppositional disorder. A major differential problem is with ADHD because of overlap in the areas of pressured speech, movement, and distractibility.

Manic symptoms of euphoric mood, grandiosity, decreased need for sleep, racing thoughts, flight of ideas, and hypersexuality are strong indicators for BPD. It is critical for clinicians to consistently reassess the suicide risk, because children with impulsivity, psychosis, self-injurious behaviors, or impaired judgment and those with prior hospitalization for BPD are at increased risk for suicide attempt.

After the diagnosis is made and medications are initiated, follow-up involvement of family-focused help through cognitive-behavioral therapies, family support and psychoeducation are important. Atypical antipsychotics are proposed as first-line medication therapy before mood stabilizers, but caution must be taken with the potentially serious side effects. These treatments must be consistently monitored and managed (Kowatch et al, 2009a; Dusetzina et al, 2011).

Anxiety Disorders. **The most common sign of anxiety in children is fear of being separated from parents and home and refusal to attend school**. The prevalence of anxiety is highest at times of transition: moving from preschool to primary school and from primary to secondary school. Children who refuse to attend school are usually capable but self-critical students, and most have separation anxiety, being frightened to leave home. The prognosis is good with treatment, but persistent anxiety disorder predicts the development of panic disorder in adulthood (Rapee et al, 2010).

An overlooked condition in this category is PTSD. The past 2 decades have seen an increasing awareness of clinical presentation of PTSD in children. Assessment tools have been developed and interventions exist for this disorder (Lubit and Pataki, 2010). Because there are developmental and often co-morbidity issues, early detection and intervention are important. Child maltreatment, witnessing violence to others, or natural disasters have far-reaching consequences for the child.

Conduct Disorder. **Serious and persistent patterns of disturbed conduct and antisocial behavior predominantly affect boys and make up the largest group of childhood psychiatric disorders.** Conduct disturbance may begin early in childhood as oppositional, aggressive, and defiant behavior, becoming established during the primary school years and increasing after puberty (Kim-Cohn et al, 2009).

Conduct disorder occurs in about 16% of boys and 9% of girls. It develops from a mix of family, biological, and psychosocial factors. The presence of other psychological disorders is common in these children, with about 30% showing ADHD and learning problems. Clinical depression is also found in about 20% of young people with conduct disorder (Lapalme and Dery, 2009).

Conduct disorder is characterized by a long-standing pattern of violation of rules. Other features are aggression toward people or animals, theft, vandalism, running away from home, destruction of property, and lying. The child does not appreciate the importance of the welfare of another and has little guilt or remorse about harming others. Affective aggression (impulsive, uncontrolled, unplanned, or overt) or predatory aggression (goal oriented, controlled, planned, or hidden) is seen in children with conduct disorder (Cohn, 2011).

Predatory aggression has a strong basis in bullying behaviors. Approximately 10% of all children attending school are being bullied, and 20% have experienced at least one incident of bullying (Governo and Siewers, 2008; Warren, 2011). **The consequences of growing up a bully or a victim can be severe, with resulting anxiety, depression, self-esteem problems, and deficits in concentration, school achievement and suicidal behaviors.**

Young victims of bullying were twice as likely to report suicidal thoughts and three times more likely to report suicidal behavior than nonbullied youth (Centers for Disease Control and Prevention, 2011a). The risk of having psychotic symptoms was two to four times higher among children who were victims of chronic or severe bullying at ages 8 or 10 years (Neblett, 2009; Schreier et al, 2009; Centers for Disease Control and Prevention, 2011b).

Childhood conduct disorder requires vigorous early intervention, assessment, and management (Puckering, 2009; Reading, 2007). Although about one third of children make a reasonable adjustment, evidence shows that at least one half of the young people with serious conduct disorder will

continue to experience mental health and psychosocial problems in adult life, such as personality disorder, criminality, and alcoholism. **As many as 40% of children with conduct disorder may grow into adults with antisocial personality disorder.**

Critical to the treatment process will be the clinician's attitude toward the conduct-disordered child or youth. Clinicians and researchers must evaluate multiple risk factors related to parent, family, school, peers and community domains. Expanded parent and family interventions are especially needed for child-specific positive outcomes reflected in this question: Will the child be viewed as hopeless or a diamond in the rough?

> **Critical Reasoning** How would you teach parents to deal with a child who is bullying another child at school? What coping skills would you teach a child who is being bullied?

Autism. The prevalence of autism spectrum disorders (ASDs) among children in the United States is 2 to 7 cases per 1000 children, or approximately 560,000 children with ASD. It occurs three to four times more often in boys than girls, and children with autism are predominately white.

Research has established the basic elements of ASD as a polygenetic developmental neurobiological disorder *not* related to vaccinations (McGuinness and Lewis, 2010). It is a disorder of the association cortex and of connectivity in the brain. The cause remains unknown; however, brain changes are evident (Lichtenstein et al, 2010; State, 2010). Children with ASD have a normal head circumference at birth, but many develop macroencephaly in childhood. Scientists have found abnormal neuronal migration and a decrease in the size of the cerebellum as early as the first trimester.

The three areas of impairment for the child are communication, social skills, and overregulated or repetitive behavior patterns. Controlled medication trials show evolving treatment approaches (Rizzolo and Cerciello, 2009). Most children have average intelligence and function in mainstream society but need individualized educational and health services.

Mental health needs are often related to co-occurring depression or anxiety disorders. Informed nurses working with these children can provide quality interventions and advocate against barriers to care.

Tourette Disorder. **Tourette disorder is a chronic neurologic condition with multiple motor and vocal tics.** These occur many times a day for more than a year. Tics are described as brief, rapid movements or vocalizations that begin in childhood and peak in adolescence. This disorder causes distress and impairment in many areas of functioning.

It is not caused by a substance or general medical condition, but there is evidence of dopamine system involvement. Medicines that antagonize dopamine (Haldol, Orap, Prolixin) suppress tics, whereas those that increase dopaminergic activity (Ritalin, amphetamines, Cylert) tend to increase tics (Sadock and Sadock, 2007).

Psychopharmacology is only recommended for severe and disabling symptoms. Antipsychotic medications are usually the first line medications for moderate to severe tics, but they can have serious adverse effects. A comprehensive behavioral intervention may result in symptom improvement (Piacentini et al, 2010).

Untreated Tourette disorder is a chronic, lifelong disorder. It is associated with serious emotional problems and major depressive disorder resulting from negative social, academic, and vocational consequences. In some cases the child's despair leads to suicide attempts.

Whether tics will disappear spontaneously, progress, or become chronic is unknown at the start of treatment. Nurses should work with the family to ignore tic behaviors if possible, and effective treatment depends on comprehensive pediatric neurological and psychiatric evaluations.

Nursing Diagnoses

Regardless of the child's medical diagnosis, nursing care must focus on the child's response to illness, with nursing interventions designed to teach and model to the child and family more adaptive coping responses and improved methods of functioning. On completing the assessment, the nurse synthesizes data gathered, decides on the child's needs, and prioritizes a problem list for the child. This list should start with the target symptoms or behaviors that are posing the most problems for the child.

Target symptoms such as inattention, distractibility, affective instability, anxious behaviors, impulsivity, thought disorganization, and aggression are common. More complex areas, such as problems with social skills, problem solving, school performance, behavioral inhibition, and communication, require ongoing data gathering. The strengths, coping abilities, and resilience of the child also should be identified.

Nursing diagnoses can be identified for each child with a psychiatric disorder and related behavioral problem. **Risk for self-directed violence is always assigned the highest priority.** Other nursing diagnoses commonly used in working with children include **Chronic or situational low self-esteem, Ineffective coping, Anxiety, Risk for other-directed violence,** and **Readiness for enhanced family processes.**

> **Critical Reasoning** Many people believe that families are in crisis in the United States. Describe the evidence for this conclusion, and give specific ways to address these problems.

Risk for Self-Directed Violence. A suicidal child requires the same safety precautions one would take with an adult. Interventions include establishing a risk-free environment, close observation, assisting parents to maintain safety if the child is not hospitalized, pharmacotherapy, and supportive coping and problem-solving interventions based on the child's cognitive abilities.

Chronic or Situational Low Self-Esteem. Children with a psychiatric disorder or behavioral problem often have low

self-esteem. It may be expressed by lack of eye contact, poor motivation, withdrawal, self-deprecating statements, or the use of negative behavior to seek attention. Specific therapeutic activities can be planned to improve a child's self-esteem.

Accomplishment of a goal, no matter how small, is very rewarding, and incremental goal setting can be effective in providing opportunities for success. The nurse also can provide information and guidance to parents to help them enhance their child's self-esteem (Table 35-3).

Ineffective Coping. A child's coping is directly related to resilience and prevention of further trauma. A child with a mood disorder or a psychosis may have disturbed thinking with hallucinations, delusions, and disorganized speech and behavior. Anxious or depressed children often have difficulty thinking, identifying options, and making decisions. Although psychotic episodes are rare, they may occur in children.

It is important that the psychiatric nurse discriminate between normal and abnormal thought processes in children. Healthy preschool and school-age children typically have vivid imaginations, and their normal fears can become quite intense; however, this should not be confused with psychotic delusions or hallucinations.

Psychotic episodes are distinguished by their level of intensity, distress, and duration. They are terrifying and should be treated as psychiatric emergencies. The nurse intervenes by helping the child process information from the environment, administering medication, and using behavioral strategies to help with activities of daily living.

Interventions for ineffective coping also include psychoeducation, problem solving, strengthening self-control mechanisms, and exploration of options and choices. Reviewing past or hypothetical situations that are threatening can help the child explore alternatives. Through practice and decision making in nonstressful situations, the child is able to identify and enact adaptive responses. Behavioral management with use of play, rehearsal, role playing, and group experiences is an excellent tool.

TABLE 35-3 ENHANCING A CHILD'S SELF-ESTEEM

TARGETED AREA	STRATEGY
Caregiver expectations	Describe expectations for the child. Assess anticipated developmental milestones. Review family patterns and influences.
Personal value	Communicate confidence in the child. Structure situations to promote success of the child. Implement effective ways of praising the child. Role model self-value.
Communication	Listen attentively. Obtain child's perspective on events affecting the child. Encourage openness to feelings. Avoid using judgmental statements. Elicit different points of view.
Discipline	Use effective methods of limit setting. Discuss and implement appropriate consequences. Review problem-solving techniques. Teach that physical punishment should not be used.
Guidance	Encourage open exchanges with the child. Know the child's activities away from home. Plan family time and activities together. Express interest in school events. Become familiar with the child's friends.
Autonomy	Demonstrate respect for the child. Promote the child's responsible decision making. Expect reciprocal respect.

Anxiety. High levels of anxiety block learning and social development. Young children can be taught stress management techniques such a deep breathing, setting small goals and exercise. Cognitive and behavior change strategies (see Chapter 27) can help children who have anxiety. The overall prognosis is good with treatment; however, some untreated and persistent anxiety disorders can evolve into the development of more severe anxiety disorders in adulthood.

Risk for Other-Directed Violence. Being able to handle conflict without becoming aggressive toward oneself or others is an important lesson for children to learn. In contemporary society, violence is widespread, and children may see it as an acceptable way of dealing with conflict. With extensive media and television coverage of violent events, children may become numb to feelings related to violence.

Alternatives such as anger management must be taught so that a child will have other solutions to use in conflict situations (see Chapter 28). A brief time-out period may be effective in interrupting behavior that is escalating or becoming out of control. During these periods of being alone, it may be helpful for a child to read a story about a similar conflict or for an older child to write thoughts and feelings in a journal.

Another strategy is to establish a contract with a child who is capable of understanding, writing, and adhering to it. This contract would identify the consequences that the child would face, based on the specific behavior, allow the child to play an active role in the treatment process, and provide immediate and constructive feedback about the child's actions.

> **Critical Reasoning** What sociocultural changes could be made to curtail the growing violence among youth today?

Readiness for Enhanced Family Processes. Every family has a history that has shaped the development of each family member. This collective family history has a powerful

BOX 35-3 STRATEGIES FOR BEHAVIOR MANAGEMENT OF CHILDREN

- Respond warmly to a child's positive behaviors.
- Communicate approval by facial expression, tone of voice, and touch.
- Express excitement regarding a child's accomplishments.
- Ignore negative behavior whenever appropriate.
- Refrain from giving unnecessary commands.
- Respond calmly but effectively to negative behaviors (e.g., "No yelling," stated in a calm tone of voice).
- Use time-outs when necessary and appropriate (30 to 60 seconds per year of a child's age). This should be done in a nonpunitive manner and presented as a way to help the child gain control or use problem-solving techniques.
- Avoid making unrealistic demands of a child.
- Avoid negative remarks about the child.
- Communicate often, using the following techniques:
  - Parent or staff member should tell about personal experiences.
  - Parent or staff member should listen, paraphrase, and ask follow-up questions.
  - Do a nightly review of positive behaviors noted during the day that the parent wants to be repeated. (Negative behaviors should not be mentioned at this time.)

influence on a child's prognosis for learning, practicing, and applying new skills. The family's willingness to participate in the therapeutic process and interest in making change should guide the nursing intervention for the child.

During parent education a nurse models the effective use of reinforcement, communication, and behavior management techniques identified in Box 35-3. The parents are then expected to practice these techniques with their child during the course of treatment. Preventive interventions in the first 5 years of life may be the most cost-effective strategies for reducing children's mental health problems (National Research Council, 2009).

Critical Reasoning Do you think the strategies for behavior management of children described in Box 35-3 are culture bound or culture free? Defend your position.

PLANNING

The plan of care may include medications, psychosocial supports (e.g., after-school programs, big brother mentoring), psychoeducational interventions (e.g., coping skills, problem-solving exercises, role playing), and individual or group therapy. The nurse should ask the child's perspective on the problem and solutions and then discuss the skills that need further development. Strategies used to teach these skills can be explained to the parents, which allows them to become active participants in the planning of nursing care.

Children will be more motivated to cooperate if they are encouraged to sign a copy of their care plan after it has been explained to them. Even if they cannot write, a mark that represents their name can indicate their participation in the process.

Nursing interventions can then be designed to improve the maladaptive responses and teach the accompanying skill. Helping children take full advantage of their resilient coping ability is a primary intervention for child psychiatric nurses (Delaney, 2006a,b).

Effective coping behaviors may include the following:

- **Withdrawing from the stressful situations**
- **Postponing an immediate response**
- **Finding a more manageable situation**
- **Restructuring (manipulating or shaping) the environment**
- **Accepting both good and bad as part of everyday life**
- **Working toward maintaining optimal conditions of adjustment, security, and comfort**

The child's resilience and ability to make sense of stressors need to be the foundation for designing and implementing interventions. **The nurse's task is to find ways to enhance resilience and promote healthy development.**

Settings

Various setting are available for the delivery of child mental health care. They range from inpatient hospitalization, which is the most restrictive and expensive, to the least restrictive settings of community programs or foster care treatment. These various treatment options are described in Table 35-4.

Although much focus is placed on children in inpatient settings, this is a limited resource. **To ensure that the mental health needs of children are met, increased focus must be placed on a multisystemic, wraparound, seamless continuum of care** (Kataoka et al, 2009; McGuinness, 2009; World Health Organization, 2008). Strengthening community-based programming also is necessary and nurses play an important role in service care innovations and social ecological interventions.

IMPLEMENTATION

After a thorough assessment has been completed and nursing diagnoses have been formulated, the nurse can implement individualized interventions that are effective in treating maladaptive responses. Nursing interventions also can be identified for each ego competency skill deficit and developmental stage as summarized in Table 35-5.

Treatment usually involves a combination of the following:

- **Medication to improve brain functioning**
- **Social skills training to improve socialization**
- **Behavior management to learn impulse control**
- **Cognitive therapy to practice problem solving and communication**
- **Parent education to integrate the new behaviors and skills into the child's life**

Therapeutic Play

Because play is normal and fun for children, it is a good tool for nurses to use. Interventions that are enjoyable, arouse

TABLE 35-4 **TREATMENT OPTIONS FOR CHILDREN AND ADOLESCENTS**

TREATMENT OPTION	GOAL	USUAL LENGTH OF TREATMENT	COST	CHARACTERISTICS
Outpatient treatment	For child and family to receive treatment once or twice per week	Can be short term (4-6 weeks) or long term (1-3 years)	One of the least expensive options	Least disruptive to family unit Allows clinician to address ongoing problems related to family and school Keeps child or adolescent in contact with peer group
In-home treatment	To provide brief, intensive mental health services in a specific crisis	Used mainly for specific periods of crisis or stress	One of the least expensive options	May be slightly disruptive to family life because all members will be asked to attend therapy at specific times Allows clinician to observe how all family members are responding to the crisis
Special education program	To provide the child or adolescent with a positive learning experience with specially trained teachers and to provide an on-site mental health clinician	Long term (2-5 years)	One of the least expensive options	More intensive than simple outpatient treatment Disrupts normal school environment and possibly peer relationships
Day treatment or partial hospitalization	To provide the child or adolescent with treatment in a structured environment for a portion of the day	Short term (few months) or long term (couple of years)	Moderately expensive; may be offset by insurance	More intensive than simple outpatient treatment Allows child or adolescent to maintain family and peer group contact Can be an after-school program or combined with a special education program May be associated with some stigmatization
Respite care	To provide the parents or caretakers with time off	Short term (2 weeks–2 months)	Moderately expensive	Provides a break for child or adolescent and parents or caretakers Provides clinician with an opportunity to use intensive individual therapy with the child or adolescent
Foster care	To remove the child or adolescent from a dysfunctional home and to place the child with foster parents who have been specially trained to work with children	Short term (few months during crisis times) or long term (years)	Moderately expensive	Removal from even the most dysfunctional home can result in a major disruption in the child's life Child or adolescent can continue to attend regular or similar school, or if necessary, a special education program can be incorporated into care Provides the child or adolescent with a more normal, predictable family atmosphere Professional mental health clinicians available to support the foster parents and reduce burnout
Group home care	To place the child with 10-12 other children who live in a structured, supervised residence	Long term (several years)	Moderately expensive	Separation from family and peers can result in a major disruption in the child's or adolescent's life Less homelike than foster care Child or adolescent must adapt to group home norms and follow rules established in the home Most group homes have a treatment philosophy, such as behavior modification Usually operated by a child care agency that is responsible for training the house parents, providing supervision, and providing a full range of mental health services as needed by the children or adolescents

TABLE 35-4 TREATMENT OPTIONS FOR CHILDREN AND ADOLESCENTS—cont'd

TREATMENT OPTION	GOAL	USUAL LENGTH OF TREATMENT	COST	CHARACTERISTICS
Residential treatment center	To place the child in a center that functions like a therapeutic community in a campus-like, multiple-residence setting	Long term (several years)	Moderately to very expensive	Separation from family and peers can result in a major disruption in the child's or adolescent's life Less homelike than other options House parents and multidisciplinary teams available 24 hours Most centers use therapeutic milieu and behavior modification techniques to influence changes in behavior Children or adolescents placed in these centers usually have failed at other levels of treatment intervention and have long-term and multiple mental health problems; they are usually known to social services, mental health agencies, or juvenile justice agencies
Inpatient hospitalization	To provide safe mental health care under direct medical and nursing supervision in a secure setting	Short term (few days to a couple weeks; stabilization for inpatient crisis treatment or evaluation)	Most expensive; may be offset by insurance	Results in the most direct disruption of the child's life Many units are locked or geographically very distant from the family Schooling is on-site and is usually a special education program Regimented schedule of daily activities assists in providing a structured environment Usual treatment philosophy is a traditional medical model with behavior modification and therapeutic milieu techniques incorporated Children placed in these settings when they are considered a potential harm to themselves or others Contact with family members structured and monitored

curiosity, and stimulate the imagination will capture the child's attention and interest. Many children with psychiatric problems may have lost interest in play or may have never experienced the joy of spontaneous play. Learning to play is critical not only to a child's development but also to mental health. **Therapeutic aspects of play and their beneficial outcomes are listed in Table 35-6.**

The first step is for the nurse to develop a therapeutic alliance and trust with the child so that life can be perceived from the child's perspective and the child's concerns can be anticipated. When a child feels understood and safe, participation in therapeutic play with the nurse is common.

Care must be taken to ensure that the child does not fail at the activity because the developmental level is too advanced or because of the severity of the child's symptoms. Children will become easily frustrated with play that is too difficult and feel a sense of failure when their self-esteem is already compromised.

Toys that are age appropriate and imaginative should be offered to a child. These may include blocks, a playhouse, family characters, soldiers, trucks, and rescue vehicles. The child is then encouraged to begin play without specific direction from the nurse. The nurse may ask the following clarifying questions:

- What is this person doing?
- How does this little boy feel?
- What is happening now?

The nurse can follow-up with some clarifying and validating statements, such as "This little girl looks afraid." The nurse should not guide the play or make unnecessary remarks or interpretations that may link the play to the child's life experience.

The play should continue for the allotted time. The nurse can then evaluate the play intervention by considering the following questions:

- What did the play activity communicate about the child's developmental level?
- What emotions and behavioral responses were demonstrated while at play?
- What information can be added to the child's assessment or treatment plan based on observations made during play therapy?

TABLE 35-5 EGO COMPETENCY SKILLS SUMMARY

COMPETENCY SKILL	DEVELOPMENTAL STAGE	DEVELOPMENTAL TASKS	NURSING CARE FOR SKILL DEFICIT
Trusting, closeness, relationship building	Infancy	Trust Attachment Learning to walk, talk, and feed self	Encourage interaction. Use face-to-face positioning. Use touch (when appropriate) and nurturance. Offer food and transitional objects. Be attentive without being unnecessarily intrusive. Offer nurturance to the child's mother. Make attempts to connect family to child. Take time to develop relationship through play.
Handling separation and independence	Toddlers	Autonomy Separation Toilet training Learning right from wrong	Offer frequent exercise and motor activities. Allow child opportunities to make choices. Offer transitional object. Take control if child is out of control; otherwise, let child have some control. Set limits and boundaries to help the child feel secure.
Handling joint decisions and interpersonal conflicts	Preschoolers	Initiative Tolerance of others Sexual identity Socialization Developing a conscience	Set up opportunities for problem solving and cooperative thinking. Help child identify fears through books, art, and play. Shape appropriate socialization using reinforcement. Become model for conflict resolution.
Dealing with frustration and unfavorable events	Middle childhood	Industry	Help the child cope with frustration using stories and plays.
Celebrating good things, feeling pleasure	Middle childhood	Physical skill development Peer relationships Learning to read, write, and calculate Development of morality and values	Model cooperation, and reinforce cooperative behavior. Do not use shame or humiliation to gain control. Have fun with the child. Use community meetings for peer support and modeling. Use positive reinforcement for child's strengths and abilities.
Working for delayed gratification	Early adolescence	Identity Role acceptance	Use daily expectations and games to teach delayed gratification. Encourage self-reinforcement.
Relaxing and playing	Early adolescence	New relations with peers of both genders	Encourage playfulness at appropriate times.
Cognitive processing	Later adolescence	Emotional and economic independence from parents	Offer games that use cognitive processing. Discuss abstractions, such as the moral of stories or movies.
Adaptive sense of direction and purpose	Later adolescence	Preparation for occupation Civic responsibility	Actively listen to and encourage the expression of needs and goals. In community meetings, discuss relevant issues and life events. Help the child realistically assess ability and potential.

Critical Reasoning What do you think is meant by the phrase "play is the work of children"?

Pharmacotherapy

Medication is one tool for treating children with psychiatric disorders, and it requires consistent monitoring. **Children metabolize and eliminate medications more rapidly than adults.** Although initial doses may be low, doses can ultimately be as high as those given to adults, requiring frequent clinical and laboratory follow-up.

Pharmacotherapy is increasingly being prescribed for children and some reports indicate significant benefit, but studies of these drugs in children are still relatively few. Only limited indications for their use with children have been approved by the U.S. Food and Drug Administration (FDA).

Psychiatric disorders are recognized in the pediatric population, and evidence exists of substantial use of psychotropic medications in this age-group, including those of preschool age. Anxiolytics, antidepressants, mood stabilizers, and antipsychotics are all used to treat psychiatric disorders in children (Kowatch, 2009b; Stahl, 2009; Rajapakse and Pringsheim, 2010; National Institute of Mental Health, 2011b).

Without awareness of the reality of childhood psychiatric illness and the impact it can have on normal growth and development, a myth persists that psychotropic drugs should

TABLE 35-6 THERAPEUTIC ASPECTS OF PLAY

THERAPEUTIC FACTOR	BENEFICIAL OUTCOME
Overcoming resistance	Working alliance
Communication	Understanding
Competence	Self-esteem
Creative thinking	Problem solving
Catharsis	Emotional release
Abreaction	Perspective on traumatic event
Role playing	Learning new behaviors
Fantasy	Compensation and sublimation
Teaching through metaphors	Insight
Relationship enhancement	Trust in others
Mastering developmental fears	Growth and development
Game play	Socialization

Modified from Schaefer C: *The therapeutic powers of play*, Northvale, NJ, 1995, Jason Aronson.

not be used in treating children. This misperception may do harm by delaying parents and professionals from making informed treatment choices for children.

There are significant regional, professional, and demographic variations in actual prescribing patterns and practices. Stimulants and antidepressants are the most commonly prescribed psychotropic medications. The most dramatic increase has been in stimulants prescribed primarily for children with ADHD (Learner and Wigal, 2008; Carlat, 2010).

Psychotropic medications are currently approved for specific syndromes (e.g., conduct disorder, ADHD, major depression, bipolar disorder) rather than for nonspecific symptoms (e.g., anxiety, depression, psychosis, aggression). Although the debate about black box child medications and at what age children should be prescribed psychotropic medications continues, science has no clear answers (Zito, 2007; Masi et al, 2009; Panagiotopoulos et al, 2010). A major psychopharmacology challenge is to better define the effectiveness and safety of these medications for the child population.

The psychiatric nurse should consult child psychopharmacology resources for guidance on the safe and effective administration of these medications. Psychiatric nurses must be knowledgeable about these medications and must develop interventions to monitor, educate, and evaluate medication effects and compliance of children and their families.

Nurses also should be aware that promoting a child's knowledge of medications can have a positive effect on self-esteem and feelings of control and self-worth, as well as enhance compliance. **Many therapeutic outcomes can be achieved by effective medication teaching and monitoring** (Worley and McGuinness, 2010a,b).

Expressive Therapies

The term expressive therapy applies to **using the child's creative process to facilitate self-expression and self-awareness.** Any medium can be used, such as painting, singing, dance, movement, or writing. The goal is the process, not the product. This area allows for many creative nursing interventions. A variety of puppet, art, graphics, and audiovisual materials can be used to successfully teach and prepare children for managing their medications and their illness.

Peer group participation is particularly effective in helping children describe common experiences, decrease their sense of isolation, and enhance their responses to the teaching materials. Through imaginative but goal-directed nursing interventions, children can learn important information and experience greater control over the treatment of their illness and their future mental health.

Art is particularly useful in assessing a child's therapeutic needs. Drawing is a valuable tool for children to use in describing an event or expressing a feeling. Children often do not have the vocabulary to express themselves, and they feel pressured to answer questions they do not understand. Through drawings, a child can provide information about behavior and developmental maturity that the nurse can then use to help the child in preparing for future change.

Children may find that a nondirected art activity helps with stress reduction. With some encouragement they will usually produce an interesting and often revealing picture. The nurse may ask the child what is happening in the picture or to name the people in it.

The nurse should make notes after the intervention about whatever the child reports the people are saying or thinking. This process can be continued over several separate encounters. In evaluating the effectiveness of this intervention, the nurse should consider the following:

- What was learned about the child's experience, view of the world, and perceptions from this intervention?
- Is there any distortion between the child's perception of personal experience and what was depicted in the exercise?

Bibliotherapy

Bibliotherapy **is the use of literature to help children identify and express feelings within the structure and safety of the nurse-patient relationship**. Because children actively engage in imaginary thinking, they can easily identify with the fictional characters in a story, be encouraged to rewrite the ending, and gain insight into their own lives.

The child's age, developmental level, and attention span are important in selecting the reading material. To be effective, the story should have illustrations and content that explore how to cope with everyday problems. The nurse also should think about the child's situation and try to select a book that describes a situation or issue relevant to the child's life situation.

While reading the story, the nurse should be sensitive to the child's response. If the text is wordy, the child may become bored or distracted. If this occurs, paraphrasing the story or asking what the child thinks is happening to the characters may be helpful. In this way the child's imagination becomes engaged, and the experience will have value. It

is also important to give the child an opportunity to reflect on the story and discuss any thoughts or feelings about the characters, because it is often easier for a child to talk about the feelings of the characters than about personal feelings.

After reading the story the nurse should evaluate the usefulness of the intervention and assess the following:

- Was the story appropriate to the child's developmental age?
- Was the child engaged with the story?
- Did the child enjoy the experience?
- What was learned by the child and about the child as a result of this intervention?

Critical Reasoning Traditional fairy tales are based on and include many gender stereotypes. Do you think this is a problem, and how would you deal with this issue in working with children?

Games

Children with behavioral disorders often have difficulty with motor control. These children can be helped by playing games that teach motor control, including Simon Says, Red Light, Musical Chairs, and many others. Games also can be used to increase a child's concentration and frustration tolerance. Games such as Candy Land, Hide and Seek, Connect Four, and Find the Button can be played with gradually increasing difficulty to teach these skills.

The nurse should consider the child's motor development and level of anxiety and choose among games that engage large or small muscle groups. Thought also should be given to the child's tolerance for frustration and competition. Games may then be modified to meet the specific therapeutic needs of the child.

Games also can be played in a way that requires the child to use increasing levels of concentration and cognitive processing; however, it is important to stop playing a game when it appears to be too difficult or stressful for a child. The nurse should consider the following questions at the completion of the game:

- Was the game developmentally appropriate for the child?
- Was playing the game a pleasurable experience? If not, why not?
- Was the nurse's therapeutic goal met?
- How should the game be modified in the future to further the child's skill development and adaptive coping responses?

Storytelling

The therapeutic use of storytelling for relieving distress and teaching new coping skills is a valuable intervention. Because at some ages children do not separate imaginary experiences from real experiences, stories that teach appropriate problem-solving skills can serve as models for real situations.

Initially, the nurse must identify a social skill that the child needs to learn, such as assertiveness. The nurse may make up a story about a character who needs that particular skill, giving the hero or heroine characteristics similar to those of the child. It is important to select an ending to the story that will guide the child in learning the skill.

The story should be told using animated facial expressions and expressive voice inflections, and the child should be actively involved in the story as much as possible. The child may choose to have the nurse write it down in a journal to revisit later. At the end of the story the nurse should ask the child about the story and how it made the child feel. This may then lead to a broader discussion of other aspects of the child's life.

In evaluating the outcome of the intervention, the nurse should consider the following questions:

- Could this character be used to teach this child other skills through other stories?
- Could the child add to the story or make up one of his or her own?
- What was the moral of the story, and how did it apply to the child?
- Could the story be used in other creative ways, such as by having the child enact the story or by including others?

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) attempts to correct cognitive distortions, particularly negative conceptions of self (see Chapter 27). It can enhance a child's sense of self-control and begin to nurture healthy problem-solving skills (Association for Behavioral and Cognitive Therapies, 2010).

Nurses can use cognitive techniques to determine the basis for faulty assumptions, cognitive distortions, or errors in reasoning. For example, a child may describe details of a situation that is taken out of context, perceptions of being inappropriately blamed for a particular event (personalization), or reveal dichotomous, black or white thinking that does not allow for a middle ground.

CBT helps the child test dysfunctional thoughts and change behavior using homework assignments such as structuring time, increasing certain activities, or carrying out exercises related to specific situations. For young children, the nurse can use methods of "the smart thoughts girl" or the "bad thoughts monster" to work with distorted perceptions about competence, appearance, or depression.

Direct contingency management is a behavioral strategy that has had a positive effect on behavior and academic performance. It involves the use of a variety of systematic reward and punishment procedures.

Milieu Management

An important role of the child psychiatric nurse is the organization, management, and integration of multiple treatment interventions with the child throughout the continuum of care, such as in the inpatient setting, day treatment program, or intensive in-home intervention. The developmental needs of children in a psychiatric milieu are complex and dynamic.

The design of the unit and treatment philosophy should provide treatment within a safe, caring environment (Delaney and Hardy, 2008; Dean et al, 2010). A planned program of activities is essential for safe milieu management. Family participation and support from the staff are also essential for successful treatment outcomes.

With escalating aggression among children, the management of a therapeutic milieu in any of these settings is very challenging. The child's day must be organized into manageable time units that are age appropriate, with specific but varied activities being assigned to each time unit. For example, younger children's development requires that they be assigned shorter time units, and large motor activities should be scheduled to follow periods of sitting or after therapy sessions that might produce anxiety.

Whenever possible, children should be assigned to a small group with specific staff members. A schedule should be set up in advance that is predictable from one day to the next. Staff consistency and predictability are very important.

Transitioning from one activity to the next is often difficult for children; a transitional object, such as a reward sheet of stickers that is carried from one activity to the next, can be helpful. Before leaving one activity, the child should be prepared for the next activity. Helping children anticipate what is expected of them in the next time period helps them better manage their anxiety.

Anxiety and aggression in any setting can be contagious and can escalate quickly. Nurses should be prepared to act decisively if a child becomes aggressive. The child who is aggressive or anxious should be temporarily separated from children who are in control of their behavior. With nursing interventions, aggressive behavior will begin to deescalate, the child can be helped to regain control, and the process of learning about why this occurred can begin.

A carefully planned milieu schedule anticipates problems, creates solutions, and capitalizes on the strengths and energy of the children. **Keeping the milieu safe and therapeutic is a high priority for child psychiatric nursing intervention.**

Ongoing clinical supervision and peer review improve communication and collaboration among staff members. These activities allow staff members to evaluate and refine their therapeutic skills and facilitate goal-directed interactions with children.

OUTCOMES EVALUATION

Evaluation of outcomes is accomplished through the child's self-report, the nurse's observation, reports from family, the school, and significant others and the use of behavioral rating scales. Compliance issues can be supported through formal psychoeducation of the child and parents or caregiver. These sessions include aspects of care such as expected and unexpected responses to the treatment, how to access help for unusual responses or concerns, and when symptomatic improvement should be seen.

Nurses should realize that systems of effective care for children with psychiatric illness do exist but that not enough resources are available to meet the existing need. Child psychiatric nurses must continue to carry the advocacy banner for the mental health of children.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Edilma L. Yearwood, PhD, RN, PMHCNS, BC, FAAN

Stacy was a 12-year-old girl in the sixth grade who came to the School-Based Health Center (SBHC) during the fifth week of school. She transferred to this new school 3 weeks earlier after she and her family moved from another state. Reports from her previous school indicated that Stacy was well liked by her peers and teachers and that she was active on the girl's baseball team, serving as their captain and chief fundraiser to help with obtaining uniforms and needed equipment. Although Stacy struggled in several subjects, including math, science, and history, she never failed a subject, and she used whatever resources were available for extra help. She excelled in English, art, music, and computer science.

Her developmental and medical history was unremarkable, with no major illnesses and with menses beginning at age 10. She was 5 feet, 2 inches tall and weighed 108 pounds. The family consisted of her adoptive parents (both age 47), an adoptive brother (age 10), and the biological child of the parents, a girl who was age 14. Stacy was adopted at the age of 6 months from Costa Rica, and her brother was adopted at 14 months of age from Mexico. There was no medical or psychiatric history for either set of birth parents. The parents reported that the siblings got along but experienced the usual sibling arguments and rivalry for parental attention. They said that during the summer before the sixth grade and their move, Stacy was more irritable and argumentative and that she had more difficulty sleeping.

In the 3 weeks since she attended the new school, Stacy had been late for school five times, had not turned in several required classroom assignments, and had been involved in verbal incidents with her peers. Her teachers reported that she appeared tired and distracted in class and that she often talked about having excelled in her previous school because "the people there knew what they were doing."

The homeroom teacher contacted her parents to report that Stacy's speech was more pressured and that she was distractible, increasingly irritable with teachers and peers, and had been observed engaging in sexually provocative behaviors with several male peers. The teacher requested consent from the parents and Stacy, who reluctantly agreed to a referral for an assessment by a mental health advanced practice nurse (APN) at the SBHC.

COMPETENT CARING—cont'd

A Clinical Exemplar of a Psychiatric Nurse

Edilma L. Yearwood, PhD, RN, PMHCNS, BC, FAAN

The APN evaluated Stacy and then met with her parents separately. Stacy's assessment included a physical exam, laboratory blood and urine testing to rule out substance use and medical concerns such as hyperthyroidism or presence of a sexually transmitted infection, and a neurological examination including an electroencephalogram to rule out head trauma, seizures, tumors or other concerns. All medical tests were negative.

The APN conducted a comprehensive clinical interview of behavioral and emotional symptoms and completed a mental status exam. Results of the self-administered screening tests and clinical interview indicated that Stacy was experiencing symptoms consistent with pediatric bipolar disorder.

The parents were interviewed about her developmental and behavioral history. They recalled several times during the past two years when Stacy had talked about feeling sadder than usual but these episodes resolved fairly quickly and were followed by periods of increased energy, irritability and difficulty sleeping.

The APRN recommended, and both Stacy and her parents agreed to a medication trial on a small dose of carbamazepine (Tegretol) and twice weekly individual sessions with the APN focused on coping strategies. Stacy and her parents were educated about the potential side effects from the medication and the importance of reporting if they should occur. Stacy made progress over the course of the year, her illness was controlled with medication, and she returned to her previous level of success in school.

CHAPTER IN REVIEW

- Today, 20% of children have some type of psychiatric disorder, but only about one third of them receive treatment. One half of all lifetime cases of mental illness begin by age 14.
- Prevention, early identification and treatment of children at risk is essential to reduce the risk for psychiatric disorders reaching into their adult lives.
- Genetic factors (nature) and childhood environment (nurture) are recognized as predisposing and precipitating causes for the development of a psychiatric illness.
- A child's individual characteristics and early life experiences, as well as protective factors in the social and physical environment, contribute to resilience, the child's ability to withstand stress.
- Organizing child psychiatric nursing care around ego competency skills is an effective and culturally sensitive way of planning and implementing nursing interventions for children regardless of psychiatric diagnosis or setting.
- Psychiatric services are offered to children in a wide variety of settings. Nurses function in these settings by assessing a child's mental status and ego competency skills and providing interventions to assist the child with needed skills.
- Assessment of the child requires a biopsychosocial approach with a focus on the nine ego competency skills that all children need to become competent adults.
- The most common medical diagnoses of childhood are ADHD, depression, bipolar disorder, anxiety, conduct disorders, autism, and Tourette disorder. Nursing diagnoses relate to each diagnosis.
- Psychiatric nurses implement a variety of therapeutic treatment modalities when caring for children, including therapeutic play, pharmacotherapy, expressive therapies, bibliotherapy, games, storytelling, cognitive behavioral therapy, and milieu management.

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CHAPTER

36

Adolescent Psychiatric Nursing

Audrey Redston-Iselin

I'm so mixed up and lonely.
Can't even make friends with my brain.
I'm too young to be where I'm going.
But I'm too old to go back again.

John Prine, Rocky Mountain Time

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Identify the developmental tasks of adolescence.
2. Describe the biological view of adolescence.
3. Discuss the major areas that should be included when assessing adolescents.
4. Examine maladaptive responses evident in adolescence.
5. Analyze nursing interventions useful in working with adolescents.
6. Evaluate nursing care provided for adolescents.

Adolescence is a time of transition—an age when the person is not yet an adult but is no longer a child. Psychiatric nurses treating adolescents focus on their movement toward adulthood, considering social, emotional, and physical aspects of their adjustment in their family, school, and peer groups. **Many mental health disorders begin in adolescence, and if they are not diagnosed and treated, they continue into adulthood, often becoming chronic illnesses.**

DEVELOPMENTAL STAGE

Adolescence is a unique stage of development that occurs between the ages of 11 and 20 years, when a shift in growth and learning occurs. The adolescent must cope with physical, cognitive, and emotional changes that can be stressful and lead to behaviors that are uniquely adolescent. Different views of adolescence are described in Table 36-1. **Tasks that should be accomplished during adolescence include the following:**

- **Achieving more mature relationships with peers of both genders**
- **Achieving masculine or feminine social roles**
- **Accepting physical build and using the body effectively**
- **Achieving emotional independence from parents and other adults**
- **Preparing for marriage and family life**
- **Preparing for a career**
- **Acquiring a set of values and an ethical system as a guide to behavior**

BIOLOGICAL VIEW OF ADOLESCENCE

One of the fundamental features of adolescence is the series of biological changes known as **puberty.** These changes transform the young person physically from a child into a reproductively mature adult. This process is so basic to adolescent development that many people identify puberty as the beginning of adolescence. Puberty involves a set of biological events that produce changes throughout the body. **The biological changes fall into two categories: hormonal and brain development.**

TABLE 36-1 **THEORETICAL VIEWS OF ADOLESCENCE**

THEORY	DESCRIPTION
Biological	Emphasis is on physical growth, behavior, and the environment, which influence feelings, thoughts and actions.
Psychoanalytical	Puberty is called the genital stage, in which sexual interest is awakened. Biological changes upset the balance between the ego and id, and new solutions must be negotiated.
Psychosocial	Adolescents attempt to establish an identity within the social environment. They try to coordinate self-security, intimacy, and sexual satisfaction in their relationships.
Cognitive	Adolescence is an advanced stage of cognition in which the ability to reason goes beyond the concrete to more abstract thinking, described as formal operational thought.
Cultural	Views adolescence as a time when a person believes that adult privileges are deserved but withheld. This stage ends when society gives the adolescent the full power and status of an adult.
Moral	Adolescents' moral development is how teens approach moral conflicts. Boys generally seek direct resolution and girls avoid conflicts to maintain a relationship.

In both genders, increases in hormone production lead to the development of reproductive capability and a mature physical appearance. Physical changes include pubic hair growth, breast development, and menarche in girls and genital development, pubic hair growth, voice change, and the emergence of facial hair in boys. A spurt in height and weight occurs in both genders. Although all adolescents experience the changes of puberty, there are large individual differences in the timing of these changes and the pace at which they take place. Hormone levels can influence the behavior of teens and result in emotional extremes such as mood swings and emotional outbursts.

Brain growth continues in adolescence. Although the number of neurons does not increase, the support cells that brace and nourish the neurons begin to proliferate. Growth of the myelin sheath around nerve cell axons continues at least until puberty, enabling faster neural processing. Simultaneously, the number of interconnections between adjacent neurons decreases, probably reflecting the disappearance of redundant or inappropriate neural connections. This fine-tuning of the neural system coincides with the development of formal operational thought, described by Piaget as adult cognitive thinking. Physical response to stress in teens occurs more rapidly than in adults because the prefrontal cortex, the area of the brain that calmly assesses danger and calls off a stress response, is not fully developed.

BOX 36-1 **COMPONENTS OF AN ADOLESCENT ASSESSMENT**

- Present problems and symptoms
- Appearance
- Growth and development (including developmental milestones)
- Parent and family health and psychiatric histories
- Biophysical status (illnesses, accidents, disabilities)
- Emotional status (relatedness, affect, and mental status, including mood and evidence of thought disorder and suicidal or homicidal ideation)
- Cultural, religious, and socioeconomic background
- Performance of activities of daily living (home, school, work)
- Patterns of coping (ego defenses such as denial, acting out, withdrawal)
- Interaction patterns (family, peers, society)
- Sexual behaviors (nature, frequency, preference, sexually transmitted diseases)
- Use of drugs, alcohol, and other addictive substances (tobacco, caffeine)
- Adolescent's perception and satisfaction with health (functional problems or complaints)
- Adolescent's health goals (short and long term)
- Environment (physical, emotional, ecological)
- Available human and material resources (friends and school and community involvement)

ASSESSING THE ADOLESCENT

Nursing care of adolescents begins with a thorough assessment of their health status. Data collection by the nurse is based on current and previous functioning in all aspects of an adolescent's life (American Academy of Child and Adolescent Psychiatry, 2005). A variety of approaches and tools may be used, but data collection should include the information listed in Box 36-1. These data are collected from adolescents and significant others through interviews, examinations, observations, and reports. The nurse also may ask the following questions of the adolescent's family:

- What concerns you about your adolescent?
- When did these problems start?
- What changes have you noticed?
- Have the problems been noticed in school as well as at home?
- What makes the behavior better or worse?
- How have these problems affected your adolescent's relationship with you, siblings, peers, and teachers?
- Has your adolescent's school performance changed?

One outcome of the nursing assessment should be the identification of teenagers at high risk for problems. Nurses need to understand the difference between constructive and age-appropriate exploration and engagement in activities

BOX 36-2 2009 NATIONAL YOUTH RISK BEHAVIOR SURVEY OVERVIEW

- 10% of students had driven a car or other vehicle one or more times when they had been drinking alcohol during the 30 days before the survey.
- 17% of students had carried a weapon (e.g., gun, knife, or club) on at least 1 day during the 30 days before the survey.
- 31% of students had been in a physical fight one or more times during the 12 months before the survey.
- 20% of students had been bullied on school property during the 12 months before the survey.
- 14% of students had seriously considered attempting suicide, and 6.3% of students had attempted suicide one or more times during the 12 months before the survey.
- 19% of students smoked cigarettes on at least 1 day during the 30 days before the survey.
- 42% of students had had at least one drink of alcohol on at least 1 day during the 30 days before the survey.
- 21% of students had used marijuana one or more times during the 30 days before the survey.
- 46% of students had ever had sexual intercourse.
- Among the 34% of currently sexually active students, 61% reported that either they or their partner had used a condom during last sexual intercourse, and 23% reported that they or their partner had used birth control pills or Depo-Provera to prevent pregnancy before last intercourse.
- 12% of students were obese, and 16% of students were overweight.
- 11% of students went without eating for 24 or more hours to lose weight or to keep from gaining weight during the 30 days before the survey.
- 5% of students took diet pills, powders, or liquids to lose weight or keep from gaining weight during the 30 days before the survey.
- 4% of students vomited or took laxatives to lose weight or to keep from gaining weight during the 30 days before the survey.

FIG 36-1 Profile of the high-risk adolescent.

that are potentially dangerous and threaten the adolescent's physical and emotional well-being. Focus should be on how the teenager is functioning in all areas of their lives. The Youth Risk Behavior Surveillance System (Centers for Disease Control and Prevention, 2010) conducted a national school-based survey of students in grades 9 to 12. The data reveal many threats to the health and well-being of teenagers, as seen in Box 36-2.

A profile of the high-risk adolescent is presented in Figure 36-1. Teenage behaviors that contribute to death and injury include smoking, poor diet, lack of physical activities, alcohol and drug abuse, unprotected sex, violence, suicide, homicide, and automobile crashes. Several high-risk behaviors, including substance use, delinquency, risky sexual behavior, and self-injury among adolescents, have been linked to victimization involving interpersonal violence. This includes experiencing

sexual or physical assault and witnessing domestic or community violence (Danielson et al, 2006).

A number of other factors combine to impact adolescent risk-taking behavior, including age, socioeconomic status, education, race, gender, self-esteem, autonomy, social adaptation, vulnerability, impulsivity, and thrill-seeking activity. The issues of body image, identity, independence, social role, and sexual behavior can produce adaptive or maladaptive responses as the adolescent attempts to cope with the developmental tasks at hand.

Nurses who work in schools and community settings can engage in screening and early nursing intervention with high-risk teenagers to promote adaptive responses and prevent the development of future problems (Gance-Cleveland and Mays, 2008). They can teach coping skills that can promote healthy adaptation and integrated adult functioning.

Critical Reasoning Many nursing students are adolescents themselves. How can this situation positively and negatively affect their work with adolescent patients?

Body Image

Physical growth is uneven and sudden, rather than smooth and gradual, and it causes a change in body image. Chronological age is not a true guide for physical maturation because growth often occurs in spurts and individual differences exist. Because school classes and extracurricular activities are usually grouped by age, the adolescent must face being with others who vary greatly in physical development and interests. This explains why adolescents often imitate behavior to fit in with one's peers. The greater a person's difference from the rest of the group, the greater is the adolescent's anxiety.

Adolescents continuously reevaluate themselves in light of these physical changes, particularly the onset of primary and secondary sex characteristics that are so pronounced. They tend to compare themselves and their physical development with their peers. They are very concerned about the normality of their physical status. **The physical changes of puberty cause adolescents to be self-conscious about their changing bodies.** They may even be reluctant to have medical examinations because they fear abnormalities will be found.

Identity

In response to the physical changes of puberty, adolescents experience heightened periods of excitement and tension. They use defenses against these feelings that were helpful in childhood and experiment with new, more adult-like attempts at mastery. Thus in their attempt to cope, adolescents sometimes act like adults and at other times behave like children.

For example, adolescents can show behavior marked with experimentation and test the self by going to extremes. This can be useful in establishing self-identity. The rebelliousness or negativism of the adolescent shows a movement toward individuation and autonomy that is more complex but similar to the 2-year-old child's "no." Adolescents also may assert themselves by acting in a negative or contrary manner when relating to parents and other authority figures whom they believe are not allowing them to be separate and unique. This is seen in the following clinical example.

CLINICAL EXAMPLE

Scottie, an avid football fan for several years, suddenly switched his interest to basketball. He quit his local football team despite his father's urgings to continue. His father, also a football fan, could not understand Scottie's sudden negative attitude toward football and newfound interest in basketball.

Adolescents often use the peer group to separate themselves from their parents and form their own identity. Exploratory behavior allows the adolescent to try on new roles and find what fits. The peer group is often used as a means to try these new roles in the safety of the group. Parenting styles that encourage individuality and relatedness to families are associated with support of adolescent identity exploration.

Adolescents expressing high levels of identity exploration have parents who express mutuality and separateness, encourage family member differences, and are aware of clear boundaries between themselves and their teenagers. These adolescents also are more likely to have positive approaches to peer and social relationships and more developed skills in initiating, diversifying, sustaining, and deepening peer friendships.

Independence

Adolescents have an unconscious desire to give in to their dependency needs, but adolescence also is a time of movement toward independence. Adolescents may show this ambivalence by responding to petty annoyances and irritations with intense outbursts. They see the process of gaining independence as being free of parental control. They do not see gaining independence as a gradual learning process but as an emancipation accomplished by acting differently.

They believe that acting like an adult equals being an adult. They expose themselves to situations beyond their capabilities and then become overwhelmed and frightened. They seek reassurance in an attempt to reduce their anxiety by returning to childlike ways and being dependent on those with whom they feel most secure, usually their parents. This accounts for the inconsistency of adolescent behavior.

Well-adjusted adults usually use a problem-solving approach and do not feel threatened when inexperience requires dependency on others. Teens, however, often feel threatened as if they are regressing into childhood. They therefore deny their need for their parents. They sometimes criticize their parents for treating them as children, but at other times, they complain that their parents are not helpful enough.

The interaction between adolescent changes in autonomy and family relationships is important. Three parenting styles have been described in relation to whether they help or hinder independent functioning in adolescence:

- **Traditional parents** tend to value a sense of continuity and order. They accept the value judgments that come from previous generations. Adolescents from these families

tend to be more attached to their parents, conforming, and achievement oriented. Often they avoid major conflicts in their teenage years.

- **Authoritarian parents** are oriented toward shaping, controlling, and restricting the adolescent to fixed standards. Obedience is seen as a virtue. Power and responsibility are not shared with the adolescent. Harsh discipline is used to curb autonomous strivings that are viewed as willfulness. The approach here is often punitive, and it can result in problems with the adolescent's development of autonomy.
- **Democratic parents** do not believe that their standards are always right. They tend to be supportive and respond to the specific situation with solutions that promote the adolescent's autonomy. They foster stimulation and challenge. This parenting style combines limit setting with negotiation, encouraging the teenager's participation in the disciplinary process. It is shown to predict greater independent functioning in adolescents.

Critical Reasoning Did your parents have a traditional, authoritarian, or democratic parenting style, and what would you do differently in raising your own children?

Social Role

Adolescents respond intensely to people and events. They may be totally invested in one interest and then suddenly change to something else. They are easily hurt and disappointed by others. They have a tendency toward hero worship and crushes, but with little evaluation of the people to whom these feelings are directed. They often mimic each other's dress, speech, language, and thoughts. These relationships help in the development of self-identity and establishment of a social role by allowing for exploration.

The peer group is very important because within the security of the peer group, adolescents can attempt to resolve conflicts. With peers they can test out their thoughts and ideas and, through mutual sharing, they can try to find answers. The peer group also can explore other ways of dealing with problems and offer its members companionship, protection, and security. In the peer group, adolescents can accept dependency, not as a child but as one of the group, testing ideas and trying new values. Within the safety of the peer group, they can observe, comment on, and evaluate the activities of others. Adolescents usually are very loyal to their friends. Group security is sometimes so important that it is pursued at all costs, even if it involves destructive behavior.

Adolescents react to many stimuli and drain off the tension created by new drives and impulses by investment in many interests. They do this with great intensity, which is why adolescents are susceptible to fads. This is often seen in their dress, music, or hobbies. Close relationships with the opposite gender provide adolescents with security (often by "going steady") and a person with whom to discuss problems and evaluate solutions. This reciprocal relationship enhances self-esteem by demonstrating sexual attractiveness and indicates that one is lovable.

Critical Reasoning Think about a current television program that is a favorite among adolescents, and describe why it is popular, based on adolescent norms and developmental tasks.

Sexual Behavior

Adolescents use **fantasy** to discharge sexual tension. However, they may feel guilt and shame about sexual feelings or fantasies. Fantasies usually are an attempt to find solutions and evaluate consequences. Masturbation is another way in which adolescents discharge sexual tension. The value of masturbation may be lessened if shame and guilt accompany it. Male adolescents often fear discovery of evidence of ejaculation, and females often fear changes in their genitalia as a result of masturbation. Mutual masturbation can help to dispel anxieties about sexuality by assuring adolescents that they are sexually adequate.

More teens are engaged in sexual activity, including intercourse and oral sex, than ever before and at an earlier age. Some believe that this is a result of media and music influences, inattentive parents, and early pubescence. Society gives very mixed messages to adolescents about sex, encouraging teens to wait to have sex or at least to be safe from disease or pregnancy with condom use. Whatever the cause, there is rising concern about the emotional and physical consequences of early sexual activity.

Although 5% to 10% of U.S. youth acknowledge homosexual experiences and 5% feel that they could be gay, **homosexual experimentation** is common during late childhood and early adolescence. Experimentation may include mutual masturbation and fondling of the genitalia and does not by itself cause or lead to adult homosexuality. Specifically, nurses need to be aware of the following:

- Not all homosexual adolescents are sexually active.
- Many homosexual adolescents are heterosexually active.
- Many heterosexual adolescents are homosexually active.
- The relationship between sexual identity and sexual behavior is variable during adolescence.
- Sexual issues produce stress and anxiety for adolescents of all sexual orientations.

Societal acceptance of homosexuality varies among cultures. Destructive attitudes toward homosexuality can result in homosexual adolescents repressing their desires by withdrawing and becoming asexual. The developmental process of identity formation can be jeopardized and healthy emotional adjustment inhibited. Sexuality and sexual identity are discussed in detail in Chapter 25.

MALADAPTIVE RESPONSES

Behaviors that impede growth and development may require nursing intervention. The nurse should consider the nature of the adolescent's maladaptive responses and the harm resulting from them. If the difficulty is significant and ongoing,

intervention is needed. **It has been found that early adolescent problem behavior is associated with a high risk for adult pathology** (National Research Council, 2009).

Adolescents are diagnosed with the various *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* psychiatric illnesses described in Chapters 15 through 25 of this text. The nursing interventions described in these chapters can be implemented with adolescents, along with the various treatment modalities described in Chapters 26 through 32. Evidence-based treatment strategies for adolescents have been identified that take into account the particular developmental issues and the unique challenges of establishing a therapeutic alliance with an adolescent (Evans et al, 2005).

Approximately one in every four or five youth in the U.S. meets criteria for a mental disorder with severe impairment across their lifetime. A national survey found that anxiety disorders were the most common condition (31.9%), followed by behavior disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%). The median age of onset was earliest for anxiety (6 years old), followed by 11 years for behavior disorders, 13 years for mood, and 15 years for substance use (Merikangas et al, 2010).

Inappropriate Sexual Activity

Sexual behaviors can be the cause of many teenage problems. Some of the negative outcomes as a result are described in Box 36-3 (Centers for Disease Control and Prevention, 2009). Sexual activity is often not as much an outlet for sexual passion as an attempt to achieve closeness with another person. Adolescents tend to use their sexuality to sublimate other needs, such as those for love and security and personal anxiety about sexual adequacy. Peer group pressure also may lead to the adolescent to inappropriate sexual relations.

Some adolescents engage in sexual relations as a means of punishing themselves. Their promiscuity elicits external control and criticism from others. Others have poor self-esteem and assume promiscuity makes them popular. Some have had poor role models and imitate destructive adult sexual acting out behaviors as seen in the following clinical example.

BOX 36-3 ADOLESCENT NEGATIVE SEXUAL HEALTH OUTCOMES

- About 1 million adolescents and young adults age 10 to 24 years were reported to have chlamydia, gonorrhea, or syphilis in 2006.
- About one fourth of females age 15 to 19 years and 45% of those age 20 to 24 years had a human papillomavirus (HPV) infection between 2003 and 2004.
- There were approximately 745,000 pregnancies among U.S. females under age 20 years in 2004.
- In 2006, most new HIV diagnoses among adolescents and young adults age 10 to 24 years occurred among those age 20 to 24 and among males.
- Approximately 100,000 females age 10 to 24 years visited a hospital emergency department for a nonfatal sexual assault injury between 2004 and 2006.

CLINICAL EXAMPLE

Isabel, a 14-year-old girl, had been sexually active since she was 12 years old. She was brought to the clinic by her parents when a neighbor told them Isabel had bragged of her sexual ventures. Two years before referral, her parents had placed her in a more controlled parochial school because they were concerned she was "acting wild."

It became apparent that Isabel wanted her parents to know about and put limits on her behavior. She admitted to not enjoying sexual intercourse very much. She seemed to be trying desperately to get approval from her distant mother. She described her father, who was a policeman, as "a hopeless case," secretly wishing that he would be a better policeman for her.

The additional risk of sexually transmitted diseases, including human immunodeficiency virus (HIV), makes sexual experimentation more problematic because of its potential short-term and long-term effects. **Adolescents' needs for exploration and sexual gratification, as well as their feelings of invincibility, put them at great risk for HIV infection and other sexually transmitted diseases.**

Despite educational efforts, many adolescents are misinformed about the transmission of these illnesses and effective preventive strategies. Some believe "it can't happen to me" or think that having only one partner ensures their safety. Unprotected sex is the area of highest risk. Oral, anal, and vaginal contacts all pose a risk because they involve the transfer of body fluids that can contain viruses. Alcohol and drug use increases the risk potential of adolescents because they are more likely to have unplanned and unprotected sex. This may be a result of these substances reducing their inhibitions.

Teen Pregnancy

Pregnancy in adolescence is a complex issue. Some adolescent girls have low self-esteem and fears of inadequacy. To ease these fears, they may become pregnant. Occasionally, an emotionally deprived adolescent hopes to give her child what she believes she has never received. More often, she may hope to receive from the child what she has not been given.

Some teens see pregnancy as a way to change their circumstances, become independent from parents, or escape a dysfunctional family situation. Sometimes being pregnant is an effort to force the parents to agree to a marriage that may be inappropriate, as shown in the following clinical example.

CLINICAL EXAMPLE

Susie, a 15-year-old girl, had run away for the second time, only to return home to the same chaos. She had tried to run away with her boyfriend. Her alcoholic mother and angry 19-year-old brother were making life unbearable. Her mother was surprised to learn about 3 months after her return that Susie was pregnant. Susie was delighted because she had hopes that she could get out of the house, knowing her mother would approve of marriage to her boyfriend.

Pregnancy in adolescence can occur accidentally after sexual exploration. The adolescent may be unaware of

contraceptive methods or may have delayed obtaining contraceptives. Research suggests that most teenage girls delay seeking contraceptives and become pregnant because they are unwilling or unable to make conscious decisions about their sexual and contraceptive behavior.

Regular contraceptive use among sexually active adolescents requires that they believe that they can become pregnant and that using contraceptives is safe and the only way to prevent pregnancy. They also must have access to reliable, affordable contraceptives and must have a positive self-concept that allows them to make conscious decisions about their sexual and contraceptive behavior. They must want to postpone childbearing. **Nurses are in an ideal position to educate teens about contraception and abstinence.**

If pregnancy for unmarried adolescents is associated with sexual promiscuity, the girl may be ostracized. Pregnancy sometimes occurs within a close, caring relationship. Peer groups can be supportive of a girl who becomes pregnant as a result of a meaningful relationship but intolerant of one whose pregnancy is the result of promiscuity. The circumstances and the adolescent's level of maturity need to be assessed. In some cultures, out-of-wedlock pregnancies are an accepted part of adolescence.

The most influential factor that discourages teens from having early intercourse is their connection to a parent, especially the mother. **Mothers who are clear about their values and communicate them to their teenagers in a nonpunitive way have the most influence on teens postponing intercourse.**

Decisions involving abortion, placement of the baby, and marriage are difficult to make. Attitudes and laws influencing these decisions are diverse. Forcing the adolescent to have the baby or have an abortion can be traumatic. Some families include the baby as another sibling. Negotiating school, social life, and baby care is a difficult challenge.

Marriage is another alternative. Forcing adolescents to marry to avoid societal stigma usually adds to their problems. However, if the couple is mature, they may do well in marriage. All the alternatives should be presented to the adolescent, with the consequences clearly stated. The adolescent should make her decision with the aid and support of her partner, her family, the nurse, and other involved health care professionals.

Teenage mothers who choose to have the baby may be at risk for posttraumatic stress disorder due to the birth experience. Vulnerable teens need to be assessed for past traumas. Nurses are in the position of minimizing the potential trauma of the birth experience by providing an educational program specifically directed toward teens that includes knowledge about labor and delivery, pain management, and postpartum care. This can help make the experience a less frightening one. Involvement of a positive caregiver and of the father can result in more positive outcomes for the teens and their babies (Anderson and McGuinness, 2008).

Critical Reasoning Pregnancy among adolescents is increasing in the United States. Why is this, and what, if anything, should be done about it?

Mood Disorders

Depression. **Adolescent depression is the most common mental health disorder, and it can be fatal** (Box 36-4). The symptoms of depression in adolescence listed in Box 36-5 differ somewhat from those seen in adults (American Academy of Child and Adolescent Psychiatry, 2008). Adolescents have difficulty describing their emotional or mood states. Young teenagers often do not complain about the way they feel and instead act moody and irritable. **Youth who develop depression between ages 14 and 16 years are at greater risk for major depression later in life.**

Teens who are depressed have negative perceptions of their current lives and their future. These thoughts result in

BOX 36-4 FACTS ABOUT DEPRESSION IN ADOLESCENTS

- Major depression affects approximately 4% to 8% of adolescents.
- Within 5 years of the onset of major depression, 70% of depressed youths will experience a recurrence.
- Depression in young people often co-occurs with other mental disorders, most often anxiety, disruptive behavior, or substance use disorders.
- Longitudinal follow-up studies estimate that 20% to 25% of depressed adolescents will develop a substance use disorder.
- As many as 5% to 10% of adolescents will complete suicide within 15 years of their initial episode of major depression.
- Although adolescent depression is twice as common among girls as boys, between the ages of 15 and 19 years, the male suicide rate is five times that of the female rate.

BOX 36-5 SYMPTOMS OF ADOLESCENT DEPRESSION

- Frequent, nonspecific physical complaints
- Absences from school
- Poor school performance and problems concentrating
- Talk or actions of running away
- Boredom or lethargy
- Outbursts of crying or moody behavior
- Irritable, angry, or hostile demeanor
- Lack of interest in friends
- Alcohol or drug use
- Decreased interaction and communication
- Fears of death
- Lack of interest in usual hobbies, sports, or recreational activities
- Sensitivity to rejection or failure
- Reckless, risk-taking behavior
- Relationship problems
- Changes in eating and sleep patterns
- Sense of hopelessness
- Feeling overwhelmed easily and often
- Thoughts or expression of suicide or self destructive behavior

low self-esteem, a sense of hopelessness, and cognitive distortions that interfere with appropriate problem solving. **Adolescents at greatest risk are those with a family history of depression.**

Between the ages of 11 and 15 years, the rate of depression in girls rises rapidly, whereas only a slight increase in rate occurs in boys. Girls worry more than boys, feeling that they have less control over their environment and what is happening in their lives. Boys tend to focus more externally on their actions and activities. For both groups, however, symptoms of depression in adolescence strongly predict an episode of major depression in adulthood.

Interventions for depression in adolescence are similar to those for adults. **Cognitive behavioral therapy (CBT) is an effective intervention for adolescents who are depressed.** It identifies and modifies negative cognitions or thoughts that underlie depression (see Chapter 27). It also focuses on coping strategies to deal with situations that trigger emotional problems (Nelson and Tusaie, 2011).

Adolescents respond differently to medication because they do not show evidence of hypercortisolemia (excessive production of cortisol) as adults often do. Research shows that depressed adolescents do not respond well to the tricyclic antidepressants. Among the selective serotonin reuptake inhibitors (SSRIs), only fluoxetine is approved for adolescent depression, with care to monitor for suicidal ideation.

The mechanism of suicidal ideation with SSRI use is unknown. It is thought that serotonergic transmission includes behavioral activation in some teens, causing irritability, agitation, and impulsiveness. This resulted in black box warnings for the use of SSRIs with adolescents in 2004, which was revised in 2007 to include young adults up to age 24.

Depression in teens is a serious mental health issue that can result in suicide if not treated. **A combination of CBT and medication produces the best results** (Vitiello and Pearson, 2008). Adding CBT can enhance the effects of antidepressants by providing coping skills for managing conflicts and stressful events and by providing alternative constructive ways to deal with anger, frustration and loss. Coping skills, if used successfully, can promote healthy adaptation. Safety plans should be established and maintained. Reducing access to firearms and prescription and over-the-counter drugs and working on improving communication in the family can improve outcomes.

Bipolar Disorder. Originally thought to be rare, bipolar illness in teens is receiving more attention. Interventions for bipolar disorder in teens need to consider the level of development, ensuring that interventions are age appropriate. The risks and benefits of medication need to be carefully explained. Education distinguishing normal outbursts from extreme moodiness should be presented to parents, and the differences between adult and adolescent bipolar behavior must be clarified.

Adolescents have more frequent mood fluctuations that are less episodic in nature than adults. They also express their feelings differently, which must be understood in the context of their development if interventions by the nurse are to be successful. Consideration should be given to the fact that parental depression may interfere with interventions for teens with mood disorders.

Psychopharmacological treatment of teens with bipolar disorder is similar to adults in the use of mood stabilizers (e.g., lithium, divalproex, lamotrigine) and atypical antipsychotics (e.g., olanzapine, risperidone). They sometimes can be used together providing a synergistic effect.

Suicide

Approximately 12 youth suicides occur each day. Most suicides occur after school hours and in the adolescent's home. Within a typical high school classroom, it is likely that three students have made a suicide attempt in the past year. One in 12 college students have made a suicide plan, and 1000 suicides occur on college campuses each year.

Suicide in those between the ages 15 and 24 years once accounted for 5% of all suicides, but it now accounts for 14%. **This makes suicide the third leading cause of death among U.S. adolescents** (American Association of Suicidology, 2011). Males between 15 and 19 years are almost five times more likely to kill themselves than females in the same age group, although female adolescents attempt suicide two to three times more often than their male counterparts.

Most suicides in adolescents are associated with drug and alcohol use, recent deaths in the family, trouble in school, legal problems, and relationship breakups (Ash, 2008). Almost one half of those who commit suicide have experienced a recent personal loss, humiliation, or rejection.

Adolescents who successfully commit suicide use firearms, hanging, jumping, carbon monoxide, and drug overdose. **Firearms are the most commonly used suicide method among youth.** They account for 45% of all completed suicides. Access to and the availability of firearms are significant factors in observed increases in rates of youth suicides (American Association of Suicidology, 2011).

Depression is significantly related to suicidal behavior, along with diagnoses of conduct disorder, bipolar disorder, and substance abuse. As adolescents move away from parental dependency, they increase their isolation and reduce their supervision. Peer problems often add to their sense of distress and alienation. The pressures to deal with intimate relationships, body changes, and an unstable sense of self can be overwhelming and lead to hopelessness and helplessness. One of the most common factors in adolescent suicide is lack of or loss of a meaningful relationship.

Suicidal attempts and completion rates are higher among gay, lesbian, and bisexual youth. The cause may be the stress and loneliness they experience related to their sexual orientation. Stigma, parental rejection, and social lack of acceptance are other possible reasons their suicide rate may be high.

Risk factors for adolescent suicide are summarized in Box 36-6. Suicidal ideation in adolescence is a sign of severe distress and is a predictor of poor overall functioning later in life (Reinherz et al, 2006). **Suicide is a call for help that must be recognized and acted on.** Subtle references and attempts

BOX 36-6 RISK FACTORS FOR ADOLESCENT SUICIDE

Psychological Factors
- Changes in personality
- Depression
- Drug and alcohol abuse
- Aggressive-impulsive behavior
- Hopelessness
- Pessimism
- Conduct disorder (male)
- Panic disorder (female)

Family and Genetic Factors
- Family history of suicidal behavior
- Parental depression
- Family conflict or dysfunction

Environmental Factors
- Trouble with a girlfriend or boyfriend
- Withdrawal from usual friends
- Lack of parental support
- Parent-child conflict
- Problems in school
- Losses and other negative life events
- History of sexual or physical abuse
- Suicide contagion among peer group
- Firearm availability

Biological Factors
- Somatic complaints (headache, stomach ache)
- High 5-hydroxytryptamine (5-HT) receptor expression in prefrontal cortex and hippocampus
- Serotonergic dysfunction

Previous Suicidal Behavior
- Previous suicide attempt
- Giving away prized possessions
- Talk of suicide
- Writing notes or poems about death

Sexual Orientation
- Same-gender orientation
- Sexual identify issues

should always be taken seriously and explored. Adolescents should be asked directly whether they are depressed or thinking of suicide. These questions assure the teen that someone cares and gives them the opportunity to talk about their problems.

It is often difficult to distinguish among risk-taking behaviors, accidents, and suicidal gestures, and careful nursing assessment is needed. Suicidal gestures are seen more often in girls; boys often express their depression by acts of bravado that result in accidents, as in the following clinical example.

CLINICAL EXAMPLE

John, a 12-year-old, depressed adolescent, had just gotten a dirt bike. Six months earlier, John's grandfather, his only friend, had died. John's father died when he was 2 years old, after which he lived with his mother and grandparents. John, feeling hopeless, had ridden his bike into a car. After medical treatment for his broken arm and rib and multiple bruises, John began to receive therapy. He described feeling helpless and lonely, especially without his grandfather.

Parent-adolescent relationships can influence suicidal behavior. For example, the adolescent may be prevented from acting on suicidal feelings by parental concern and the establishment of new relationships. **The nurse must make it clear to the adolescent that suicidal behavior is not confidential and that parents must be told.** Family involvement is essential if angry, hostile, and hopeless feelings of abandonment are to be dealt with and an atmosphere of support and caring is to be fostered.

In working with suicidal adolescents, the nurse should explore the following areas:

- Seriousness of the attempt
- Mental status of the adolescent
- Extent of environmental stress, especially family problems
- Adolescent's wider social environment and the strength of support systems (social isolation, school performance, parental loss, disruption of friendship, or romantic alliance)
- Likelihood of repeated suicidal attempts, especially if conditions remain the same

Nursing interventions related to depression are described in Chapter 18, and interventions related to suicide are described in Chapter 19. School-based prevention programs can help decrease suicidal behavior. A rapid response delivered on an outpatient basis can reduce hospitalization while increasing functioning and decreasing suicidal behaviors. The next two clinical examples illustrate suicide attempts by adolescents.

CLINICAL EXAMPLE

Maria, a 15-year-old girl, was referred to her local community mental health center from the neighborhood emergency room after ingesting pills. Maria had taken five of her mother's "arthritis pills" after an argument with her father about her 17-year-old boyfriend, José. Her father, who came home only on weekends, told her to stay away from him. After he left, the other family members noticed that Maria became sleepy while playing cards in the living room. Maria admitted to taking the pills and was rushed by her mother to the emergency room.

She had performed poorly in school in the year since her father had left the family. Maria had always been her father's favorite. When she reached puberty at age 13 years, that relationship changed. Maria's position as her father's favorite was delegated to a younger female sibling, causing Maria to feel angry and rejected. Her father left the family a year later and returned only for weekend

visits, during which he mainly disciplined the children. Maria's attempt to get close to José as a replacement for her father was sabotaged by her father. She thought her only recourse was to elicit her father's caring and concern through a suicide attempt.

CLINICAL EXAMPLE

Donald, age 13 years, was brought to the emergency department after cutting his wrists one evening when he thought his family was asleep. His mother had awakened and found him bleeding. She rushed him to the local emergency room, where he received medical treatment. It was then revealed that this was Donald's second suicide attempt. The first attempt had occurred 1 year earlier, when he had ingested pills. Donald had received therapy for about 1 month. It was discontinued when the family moved to a new location, despite recommendations that he continue with a new therapist.

Donald was always an isolated child. He was never very close with anyone but had had two friends. After the move, he became even more withdrawn. He had done well in school in the past but now appeared to have given up and was failing almost every subject. As the youngest of nine children, Donald had little contact with his siblings, who were not at home much. Donald's parents, both approaching old age, seemed not to notice that he had become increasingly withdrawn and upset. Donald was hospitalized because the risk of attempting suicide again was high.

Self-Injury

Deliberately destroying body tissue to change the way one is feeling occurs among adolescents. Forms of self-injury include carving, scratching, burning, cutting, tattooing, excessive body piercing, and picking and pulling at skin. Some adolescents hurt themselves to take risks, assert their individuality, rebel, or be accepted by their peer group. Others self-mutilate to express their feelings of hopelessness, anger, low self-esteem, or need for attention.

Teens who have difficulty verbalizing their feelings may show their emotional pain, physical discomfort, or sense of low self-worth by releasing their perceived psychological distress in the act of self-mutilation. Often teens hide their scars and bruises, fearing ridicule, rejection, and criticism (Williams and Bydalek, 2007).

Nurses can help adolescents who mutilate themselves by encouraging them to identify and verbalize their feelings rather than acting them out; use distraction techniques when destructive feelings arise (e.g., deep breathing, positive imagery, applying ice to the skin, snapping a rubber band on the wrist); engage in stress management techniques that reduce impulsivity (e.g., counting to 10, reevaluation, thought stopping); and develop enhanced social skills. If suicidal ideation is evident, emergency interventions are necessary.

Conduct Disorder

Adolescents with conduct disorders display behavior that violates the basic rights of others or societal norms and rules. Examples include fighting, cruelty, lying, truancy, and destroying property. Other behaviors may consist of aggression toward people and animals, bullying and threatening behavior, stealing, forced sexual acts, use of weapons, destruction of property, fire setting, running away, and staying out late.

Adolescents with conduct disorders often have poor relationships with their parents. Antisocial acts allow the adolescent to express anger toward parents, who may be punished for the adolescent's acts. Children are socialized mainly by their parents and, it is hoped, learn from their parents' acceptable behaviors that become part of their internalized self or conscience. A good relationship between parent and child facilitates this process.

However, adolescents learn from people other than their parents. School and peer groups are influencing factors. The self-destructive behaviors seen in conduct-disordered adolescents may indicate the need for punishment, anger at the family, peer group pressure, depression, feelings of self-defeat, a search for opportunities to take what they feel emotionally deprived of, and testing omnipotence through exciting experiences. Alignment with delinquents gives a defeated adolescent a feeling of self-respect and companionship through a sense of belonging to a subculture.

CLINICAL EXAMPLE

Levar, age 13 years, was referred by the juvenile court for therapy because he had been picked up for the second time after breaking into a store with another boy. Levar's parents became separated 2 years earlier, when his father was incarcerated in jail for possession of drugs. Levar was extremely upset when his parents separated, and he rarely saw his father. His antisocial acts caused his father to become more involved with him because his father claimed he did not want his son to go through what he had experienced in prison. Levar gained his father's attention during these times, even though his father was angry. His delinquent actions enabled Levar to express his anger about his father's leaving and to fantasize about having his father return.

This clinical example illustrates the many factors that may lead to adolescent **delinquency,** including lying, stealing, and other social offenses. Adolescents may not differentiate between their stealing and their parent's business dealings. Stealing also may be an effective way to rebel against parents. Adolescents may perpetuate childhood by indulging in immediate gratification through stealing rather than working for things.

Adolescents may drop out of school for a variety of reasons. The adolescent may be part of a peer group that denounces school attendance and involvement. Parents may overtly or covertly discourage education. This is conveyed through lack of support and approval for education or by their making it difficult for the adolescent to follow through with school expectations, as illustrated by the following clinical example.

BOX 36-7 TAKING THE BARK OUT OF BULLIES

Bullying should not be tolerated as a normal rite of passage in adolescence. It is abusive behavior that creates emotional and social problems during the teen years and later in life for the victim and the aggressor. Adults can help in several ways.

Speak up after a teen tells you about being bullied at school or elsewhere. Take his or her concerns seriously. Go to the school and talk to the teachers, coaches, and principal. Speak to the parents or adults in charge if a teen is harassed by a peer or social clique.

Observe your own behavior. Adolescents look to adults for cues about how to act. Practice being caring and empathetic and controlling your aggressions. Avoid engaging in physical violence, harsh criticism, vendettas, and vicious emotional outbursts.

Advocate for policies and programs concerning bullying in the schools and the community. Anti-bullying policies have been adopted by state boards in North Carolina, Oregon, California, New York, Florida, and Louisiana.

From McNeely C, Blanchard J: The teen years explained: a guide to healthy adolescent development. In *Adolescents: by the book, 2010*. Accessed November 2010 at www.jhsph.edu/adolescenthealth/.

CLINICAL EXAMPLE

Debbie, a 15-year-old girl, dropped out of school after several years of poor school performance and truancy. She occasionally went shopping with her mother on a school day. Her mother never knew the names of her teachers or guidance counselor and did not provide her with a place or time to study.

Bullying

Bullying has negative effects on teens that can extend into adulthood. Bullying occurs when a person repeatedly tries to harm someone weaker or more vulnerable. Bullies are more common among younger teens than older ones. As adolescents become older, they are less likely to bully or be the subject of bullying.

Most common reasons for bullying are appearance and social status. However, a teen's sexual orientation, race, religion, or merely being shy and withdrawn can trigger bullying. Bullying can be physical (more common among boys), with hitting, teasing, name calling, sexual remarks or attacks, stealing, or damaging of belongings. Attacks can also be indirect (more common among girls), such as spreading rumors or isolating a person from a social group. Bullies often have high social status based on the fact that others tolerate their intimidating behaviors. **Bullies usually are reproducing behaviors they have seen at home or have observed in adults.**

Teens who are bullied often suffer from depression and suicidal ideation, and they have decreased functioning. Those who are the bullies are more likely to have other delinquent behaviors in early adulthood. Box 36-7 reviews how to deal with bullies.

New technologies such as texting, instant messaging, social networking sites, and online videos have resulted in **cyber-bullying** (Williams and Godfrey, 2011). These bullies send messages that are intimidating, post private information on a public site, pretend to be someone else with the intent of humiliating them, or exclude someone from a chat room.

A cyber-attack can escalate into a "flame war" when attacks are sent back and forth online. It is meant to embarrass and drive a person from the site. Research shows that girls and boys equally engage in cyber-bullying. **Instant messaging (IM) is the most common means of cyber-bullying.** This differs from traditional bullying in that it is more difficult to escape, can occur at any time, and is more public and anonymous. Ways to protect teens from cyber-bullies are presented in Box 36-8.

BOX 36-8 WAYS ADULTS CAN PROTECT TEENS FROM CYBER-BULLIES

- Stress to teens what is not safe to do on the Web and information they should not reveal to people they do not know, including their full name, address, cell phone number, specific places they hang out, financial information, ethnic background, school, or anything else that would help someone locate them.
- Although it is important to protect young people's privacy, it may be necessary to review a teen's social networking site to make sure they do not reveal too much personal information.
- Emphasize that in cyberspace, there is no such thing as an erase button—messages, photos, rants, and musings stay in cyberspace forever. Information that may seem harmless to a teen can be used against them at any time, such as in the future when applying to college or looking for a job. Photos posted on the sites should not reveal too much personal information about the teen.
- Other specific actions also can be taken.
  - Shut down a website or blog if the adolescent is subjected to bullying or flaming. If necessary, get a new e-mail address and instant messaging identity.
  - Make clear to young people what kinds of messages are harmful and inappropriate. Enforce clear consequences if young people engage in those behaviors.
  - Encourage teens not to respond to cyber-bullying. The decision whether to erase messages is difficult. It is not good for teens to revisit them, but they may need to be saved as evidence if the bullying becomes persistent.
  - Keep all computers out of teens' bedrooms so that computer activity can be monitored better.

Data from Kowalski RM, Limber SP: Electronic bullying among middle school students. *J Adolesc Health* 41,S22, 2007; Wolak J, Finkelhor D, Mitchell K, Ybarra M: Online "predators" and their victims: myths, realities, and implications for prevention and treatment, *Am Psychologist* 63:111, 2008.

Violence

Violence among youth in the United States is on the rise. **Homicide is the second leading cause of death in teens 10 to 19 years old, and 82% of those who died by homicide were killed with guns.** One third of high school students reported being in a physical fight in the last year, with 4% needing

BOX 36-9 BEHAVIOR CHECKLIST FOR POTENTIALLY VIOLENT YOUTH

- History of tantrums and uncontrollable angry outbursts
- Often resorts to name calling, cursing, and abusive language
- Habitually makes violent threats when angry
- Previously brought a weapon to school
- Background of serious disciplinary problems at school and in the community
- History of drug, alcohol, or other substance abuse or dependency
- Is on the fringe of his or her peer group, with few or no close friends
- Is preoccupied with weapons, explosives, or other incendiary devices
- Previously been truant, suspended, or expelled from school
- Displays cruelty to animals
- Little or no supervision and support from parents or a caring adult
- Witnessed or been a victim of abuse or neglect in the home
- Been bullied or bullies or intimidates peers or younger children
- Tends to blame others for difficulties and problems caused by self
- Prefers television shows, movies, or music expressing violent themes and acts
- Prefers reading materials dealing with violence
- Reflects anger, frustration, and the dark side of life in school essays or writing projects
- Involved with a gang or antisocial group on the fringe of peer acceptance
- Often depressed or has significant mood swings
- Has threatened or attempted suicide

From National School Safety Center, Westlake Village, CA 91362. Accessed November 2011 at http://www.schoolsafety.us/.

medical attention. Six percent of high school teens report carrying a weapon to school in the last 30 days (Centers for Disease Control and Prevention, 2010).

Violence may be a learned response to achieve an end, or it may be a habitual way of dealing with a stressful environment. **Most adolescents displaying aggression have experienced frustration and have had violent role models during their childhood.** Aggression is a human impulse that must be channeled constructively by a learned process occurring within a supportive, loving relationship. Under favorable conditions, a child learns the healthy expression of aggression by involvement in activities that result in pleasure and active problem-solving attempts.

Risk factors for adolescent violence include weak bonding with others, ineffective parenting (including excessive or inconsistent punishment and inadequate supervision), exposure to violent acts at home or in the community, and social factors (including poverty and an environment that supports aggression). Guns represent the third leading cause of death in 10- to 14-year-old children and the second most common cause of death in teens 15 to 24 years old. Drug abuse, antisocial behavior, and exposure to violent media all promote violence as a way of resolving conflicts.

The National School Safety Center has identified the behaviors listed in Box 36-9 that could indicate a youth's potential for violent behavior. Parents can ask themselves the following questions:

- Do you know your children's friends?
- How are they spending their time?
- What movies, videos, and Internet sites are they watching?
- What music are they listening to?
- Who are their role models and why?
- How are they doing in academics and usual school activities?
- Have they made any threats about hurting another person?

Some adolescents worry that they will not be able to stop their aggressive thoughts from becoming actions. These very real fears must be acknowledged by a trusted adult, and the adolescents should be reassured that external limits are in place. Pointing out to adolescents the need to assume self-responsibility and control is very important. Their defenses against aggressive outbursts should be reinforced and supported. The focus of discussion should be on the behavior and feared loss of control, not on the roots of the anger. The following clinical example illustrates the management of a violent adolescent.

CLINICAL EXAMPLE

Ricky was a 14-year-old boy referred for treatment because of violent outbursts at home. When frustrated, he broke and destroyed objects in his path. Ricky was an only child, adopted shortly after birth by a couple in their forties who were unable to have children. Ricky's parents, who were about 55 years old, became increasingly frightened by his aggressive outbursts. They also felt powerless to deal with his childhood temper tantrums and had consistently responded to his outbursts by attempting to limit frustrating situations. They felt guilty and inadequate about his being an adopted child and continually made attempts to reassure Ricky of their love for him. They consequently reinforced his lack of control by assuming that these outbursts were results of his fear of being unloved, and they offered gifts and rewards to make peace. Ricky assumed he was omnipotent, successfully controlling his parents, but was afraid that he could not control his anger.

Acknowledging Ricky's fear of loss of control, applying external controls, and pointing out Ricky's ability to behave responsibly and assume control of aggressive behavior resulted in a gradual decrease in outbursts.

Adolescents who have committed extreme acts of violence or homicide are often from families in which violence is condoned in some form. These adolescents might have experienced physical or sexual abuse, as described in Chapter 38, or they might have witnessed violence between their parents. Often these adolescents are encouraged to be violent by the easy access to guns in the home and by family members

who praise the virtues of war, hunting, aggressive activities, or resolving conflict through violence.

Parents sometimes can predict the adolescent's ability to injure or kill. Often the adolescent has a history of dangerous assaults on family members and pets. Other predictors of potentially violent behavior include drug abuse, poor school performance, and a history of fighting. Severely violent adolescents may show calmness and lack of sorrow or guilt after committing violent acts, or they may claim that outside forces provoked them.

Many homicidal adolescents freely discuss their violent plans or fears. These ideas should be explored, and homicidal intent should be evaluated. Does the adolescent have a victim, weapons, or a plan? Along with the history, this information suggests the level of success or failure the adolescent has experienced in controlling feelings and delaying gratification.

Critical Reasoning What do you think society can do to decrease gang violence among adolescents in the United States?

Substance Use

Nationwide, substance use and abuse are significant problems for adolescents. Drug taking may be occasional or repetitive. **Substance use carries serious consequences, causing 50% of the deaths in youth age 15 to 24 years.** Use of alcohol and drugs also contributes to assaults and rapes by adolescents.

Substance use results from the interaction of environment and inherited vulnerable traits. Even though there is no addictive gene, heredity plays a role in drug dependency. For example, children of alcoholics are at increased risk of developing alcoholism. Genetic variables also affect variations in absorption of drugs, neuronal response, metabolism, and excretion.

Chemical dependency comprises neuronal involvement that produces addictive behavior. Teens are particularly vulnerable; although the reward system in their brains is fully developed, the areas involving judgment and critical decision making and the ability to delay reward and gratification are not. The subsequent dysregulation of the reward center produces loss of control, impaired pleasure seeking, and the cravings of addiction.

An understanding of drug dependency and addiction in teens is influenced by constitutional and environmental factors as well as the choice of drug used. All drugs with dependency capacity activate brain reward centers, which can be shown by an elevated dopamine level in the nucleus accumbens. Dopamine is the main player, but other neuronal systems are also involved. The rapidity of absorption is determined by the method in which the drug is taken into the body (smoked, swallowed, or injected), which determines the rate of absorption into the brain.

Alcohol is the most commonly used and abused substance by youth. Most high school seniors report some experience with alcohol. Teens who drink before age 15 are four times more likely to become alcohol dependant than those who wait until age 21 (Grant et al, 2006). Although not all youth who drink have a drinking problem, about one third of high school seniors report being intoxicated in the past 30 days. **Higher levels of adolescent alcohol use are associated with the three most common forms of mortality among adolescents: accidental deaths, homicides, and suicides**. Almost 9 of 10 teenage automobile accidents involve the use of alcohol.

Alcohol is a sedative that is accessible because it is legal after age 21 years. Alcohol impacts teens differently from adults. Teens are more vulnerable to having alcohol affect the hippocampus, the area of the brain that affects memory and learning, resulting in poor academic functioning. Adolescents are less sensitive to alcohol's sedative effects than adults, and the sedation response that protects the body from continued drinking by passing out or falling asleep does not apply. Teens stay awake longer, allowing them to drink more and resulting in cognitive impairment or brain damage from alcoholic poisoning (McNeely and Blanchard, 2010).

Binge drinking (five or more drinks in a single sitting) is a problem among youth, especially on college campuses. College drinking has its own culture, possibly because of unstructured time, easy access, and the influence of fraternities and sororities. Each year, a number of college students die from alcohol overdose.

Marijuana is the illegal drug most commonly abused by teens. Its main ingredient, tetrahydrocannabinol (THC), accumulates in the body and brain tissues and is released slowly from these tissues back into the blood. It can take 30 days or more to be completely eliminated, making urine testing useful for past abuse. Other abused drugs are cocaine, ecstasy, inhalants, methamphetamine, stimulants, and hallucinogens.

Drugs such as cocaine and amphetamines target dopamine receptor neurons in the brain. Damage to these neurons affect teen brain development for life in areas of impulse control and the ability to experience reward. Other effects include delay in developing executive functions, such as planning and completing tasks; meeting goals; and overblown and immature emotional responses to situations.

The onset of drug use before age 20 years predicts more sustained use over time. From 70% to 90% of males and 50% to 60% of females who abused drugs in adolescence continue to do so in adult life. Chemical dependency is the result of a gradual process. Table 36-2 presents the stages of adolescent substance abuse. It is important for the nurse to remember that not all adolescents progress through these stages, but the younger the user, the greater the risk for chemical dependency. First use of alcohol between the age of 11 and 14 years greatly increases the risk of the development of an alcohol disorder. Substance-related disorders are discussed in detail in Chapter 23.

The meaning of drug use in adolescence is complex. The adolescent's motivation must be explored. It may be an expression of rebelliousness supported by a peer group and a way of obtaining gratification. It may indicate an effort to come to grips with feelings of vulnerability, victimization,

TABLE 36-2 THE FIVE STAGES OF ADOLESCENT SUBSTANCE ABUSE

STAGE	SOURCES	FREQUENCY	FEELINGS	BEHAVIOR	TREATMENT
Curiosity	Available but not used	None	Curiosity	Risk taking, desire for acceptance	Anticipatory guidance to develop good coping skills and strong self-esteem, clear family guidelines on drug and alcohol use, drug education
Experimentation	House supply, friends, siblings	Weekend use for recreational purposes	Excitement, pleasure, few consequences; learning how easy it is to feel good	Lying, little change	Drug education; attention to societal messages; reduction of supply; strict, loving rules at home; establishment of drug-free alternative activities
Regular use	Buying	Progresses to midweek use; purpose is to get high	Excitement followed by guilt	Mood swings, poor school performance, truancy, changing peer groups	Drug-free self-help groups (Alcoholics Anonymous or Narcotics Anonymous), family involvement, psychiatric counseling
Psychological or physical dependency	Selling to support the habit, possibly stealing or prostitution in exchange for drugs	Daily	Euphoric highs followed by depression, shame, guilt, and perhaps suicidal thoughts	Pathological lying; school failure; family fights; involvement with the law over curfew, truancy, vandalism, shoplifting, driving under the influence, breaking and entering, violence	Inpatient programs that require family involvement and provide aftercare
Using drugs to feel normal	Any way possible	All day	Euphoria rare and harder to achieve; chronic depression	Drifting, with repeated failures and psychological symptoms of paranoia and aggression; frequent overdosing, blackouts, amnesia; chronic cough, fatigue	Inpatient programs that require family involvement and provide aftercare

and emptiness. Repeated and regular use of drugs for recreational purposes can lead to problems of anxiety and depression. Some teenagers use substances to decrease their anxiety, especially when socializing.

Adolescents often report a wish for closeness that is satisfied by sharing a drug experience with friends. Drug users can experience an illusion of closeness because drugs decrease anxiety and they can share anticipation of drug use. Some adolescents fill the void of isolated loneliness with drugs and would otherwise feel suicidally depressed. Drugs can be crippling and delay healthy maturity by promoting the avoidance of developing an adult identity in a real world, as illustrated in the following clinical example.

CLINICAL EXAMPLE

Sixteen-year-old Carlos has been school phobic since he was 10 years old. He has received home instruction since then. Each year he was referred for a yearly assessment, which was required to obtain approval for continuation of home instruction services. During the assessment, Carlos proudly spoke of his drug episodes. He and his small group of friends were close and had many exciting experiences induced by various hallucinogens and amphetamines. Carlos had little support in the real world because he had been isolated at home, and he had developed relationships with people outside the home primarily through his involvement in obtaining drugs and experiencing their effects.

Tobacco use has decreased among adults from 40% in 1965 to 25% in 2011, but adolescent smoking has increased. More than 3000 youth start smoking each year. **Adolescents account for 85% to 90% of first-time smokers.** Smoking usually begins in the sixth to ninth grades, and addiction typically occurs before age 20 years. It has been estimated that 25% of high school students are current tobacco smokers (Centers for Disease Control and Prevention, 2010).

Peers, genetic traits, and personality factors influence abuse of tobacco. Smoking starts as an unpleasant experience; without peer support or reinforcement by adult smokers, adolescents are less likely to begin smoking. Smoking

adolescents develop damage in the hippocampus, where memory is stored. Nicotine causes cell damage and loss in all smokers; but teens have more episodes of depression and are more likely to become quickly dependent.

Much work remains to be done in regard to this health issue, because only 3% of adolescents who attempt to quit are successful 12 months later. Identifying factors that predict adolescents' tendency to smoke could be helpful in developing prevention programs. **Nurses are in a good position to educate teens on the health risks of smoking.**

> **Critical Reasoning** You are concerned about your best friend's increasing use of drugs, but she denies that it is a problem. How can you best help her?

Weight and Body Image Problems

Eating disorders are another group of problems often seen in adolescence. They include **anorexia, bulimia,** and **obesity.** The emphasis on thinness, athletics, and physical attractiveness suggests that these are highly valued achievements for young women. These traits demonstrate self-control and social success and are culturally rewarded. The result is that fear of fat, restrained eating, binge eating, and body image distortion are common problems among teenage girls. Obesity often results in social isolation and ostracism.

Treatments for eating disorders are similar to those for adults; however, involvement of the family in treatment is unique to adolescence. Healthy eating and exercise are health education strategies available to nurses. Treatment for anorexia in adolescents is best if it is family treatment or multiple-family group treatment. Pharmacological treatment is complicated because use of antidepressants is minimally effective. Malnutrition may interfere with its beneficial action. Atypical antipsychotics (e.g., olanzapine) are sometimes used because they can produce weight gain.

Interventions for bulimia consist of cognitive behavioral therapy, which is time limited, problem oriented, and structured. Another intervention is interpersonal therapy, which does not deal with eating symptoms but deals with concerns about interpersonal issues. Pharmacological treatment may include the use of SSRI antidepressants.

Eating disorders are discussed in detail in Chapter 24. **Special issues related to teens with eating disorders include the following:**

- **Motivation:** If an adolescent is not motivated, prognosis is less optimistic.
- **Cognitive skills:** Skills of abstract thinking and consequences of actions are less developed in teens.
- **Interpersonal skills:** The ability for teens to communicate with others is often difficult.

Parenting that provides structure and reinforces limits with consistency and warmth is an important intervention for teens with eating disorders. As success is achieved, greater autonomy is given to the adolescent.

Eating disorders in adolescents are related to many causes. Psychosocial factors, family characteristics, physiology, and biochemical interactions all play a part in the development and treatment of these disorders. The following clinical example illustrates the development of anorexia nervosa in a young girl.

CLINICAL EXAMPLE

Janet, age 15 years, was admitted to the hospital because it was feared that her extreme weight loss was endangering her life. Exploration revealed that Janet was afraid of her sexual feelings and the response of others to her budding sexuality. Her father, provocative and teasing toward Janet, was continually kidding her about her oncoming sexual attractiveness and implied that he really preferred her to her mother. This created panic, and Janet refused to eat in reaction to this. She liked her thinness, which was a protection from sexual desires. In the hospital, the area of concentration was not the behavior of not eating but rather the underlying feelings about her sexuality and her relationship with her father. This provided freedom for normal sexual growth and development.

Boys also have body image problems. They respond to society's pressure to be muscular and virile, and many adolescent boys are ostracized from social groups for being short, overweight, too thin, or lacking muscles. Boys also may evaluate their self-worth by the qualities of their bodies. **Body dysmorphic disorder** is a psychiatric illness common in male adolescents in which they are obsessively preoccupied with flaws they perceive in their appearance. Symptoms include continually checking mirrors; attempts to hide perceived, imaginary imperfections; and excessive working out. The average age at onset is 15 years.

WORKING WITH ADOLESCENTS

Knowledge of normal adolescent development is necessary to differentiate between age-expected behavior and maladaptive responses. When working with an adolescent, it is best if the nurse's initial contact is a one-to-one meeting directly with the adolescent. Many adolescents are concerned that the nurse is aligned with their parents and not interested in their perspective. Other adolescents take a passive role, preferring to let the adults take responsibility for "straightening things out." By initiating contact with the adolescent, the nurse is able to align with the patient's independent, mature aspects. Parents asking for advice on how to approach the adolescent about seeking treatment should be advised to be honest, stating the true nature of the visit and their reasons for requesting it.

Health Education

The psychiatric nurse is in an excellent position to educate the adolescent, the parents, and the community. Basic health information can be given in areas such as smoking, drugs, sex and contraception, suicide prevention, and anger management. Adolescents want information about what activities are healthy and unhealthy, including facts about exercise, nutrition, dealing with anger, sexuality, conflict resolution, and where they can access help (Garcia, 2010).

BOX 36-10 STRESS MANAGEMENT SKILLS FOR ADOLESCENTS

- Talk about problems with others.
- Take deep breaths, accompanied by thinking or saying aloud, "I can handle this."
- Perform progressive muscle relaxation, which involves repeatedly tensing and relaxing large muscles of the body.
- Set small goals and break tasks into smaller, manageable chunks.
- Exercise and eat regular meals.
- Get proper sleep.
- Break the habit of relying on caffeine or energy drinks to get through the day.
- Visualize and practice feared situations.
- Focus on what you can control (your reactions, your actions) and let go of what you cannot (other people's opinions and expectations).
- Work through worst-case scenarios until they seem amusing or absurd.
- Lower unrealistic expectations.
- Schedule breaks and enjoyable activities.
- Accept yourself as you are; identify your unique strengths and build on them.
- Give up on the idea of perfection in yourself and in others.

From Dyl J: *Helping teens cope with stress. Lifespan.* Accessed November 2011 at www.lifespan.org/services/childhealth/parenting/teen-stress.html.

Adolescents are preoccupied with their bodies and body sensations. They are uncomfortable with their bodies because of the rapid changes they have experienced. They therefore respond to body sensations with increased intensity. An adolescent who is overly concerned may have problems with self-image. Somatization occurs when the adolescent has intense anxiety about his or her health. The nurse can provide information on healthy emotional functioning, including coping with stress and anxiety (Box 36-10).

By educating parents, teachers, and other community members on normal adolescent behavior, nurses support and encourage healthy, independent functioning. Parents and other adults often become frustrated, angry, and confused by the independent strivings of adolescents. **Encouraging independence and lessening power struggles can produce a positive change in adolescents' relationships with adults and in their feelings about themselves.** Listening to teens and providing them with space to think things through for themselves usually works best. Discussing the consequences of behaviors encourages adolescents to evaluate what they are doing, weigh the pros and cons of their choices, and ultimately make good decisions.

However, adults should still set limits. **Setting limits and providing structure can be done in a way that encourages the adolescent's independent functioning.** Many parents are conflicted about their children becoming adults. Together with the adolescent's own ambivalence and fears about independence, this can create havoc.

One of the best ways to educate parents on adolescent development is through a parents' group. The nurse can inform parents on normal adolescent functioning and provide them with much needed support from other parents in the same situation. Sharing mutual experiences and searching for solutions in a supportive environment can be extremely helpful to parents.

Parents have nurtured their children up to the stage of adolescence, and many believe that "showing them how" is their primary parental responsibility. It is difficult for them to suddenly switch from the how-to mode of instructing the child to the mode of guiding the teen toward adulthood.

Parents can learn the process of providing increased responsibilities based on a gradual progression of independent functioning. Despite parental fears of their teenagers getting into trouble, they can be educated to promote their child's self-reliance. The next two clinical examples show the need to educate parents and community members.

CLINICAL EXAMPLE

Mr. and Ms. B came to the attention of the psychiatric nurse as a result of their distressed calls to the community mental health center. Ms. B tearfully explained that they had lost all control of their 14-year-old daughter. She had become arrogant and hostile, locking herself in her bedroom after an argument they had about her going to the movies with a 14-year-old boy she had met at school. Further exploration revealed that Emily was an honor student at school and maintained a solid A average. She had many friends at school, was on the volleyball team, and babysat regularly on weekends for the neighbors' two children. She had always been pleasant, happy, and friendly.

A boy that the parents did not know called her at home. After many phone conversations, he asked Emily to join him on a weekend evening at the movies. Mr. and Ms. B felt that Emily was much too young to date and that she could get involved with drugs, sexual promiscuity, and other bad behaviors. They were sad and worried that they had lost their little girl who always did what she was told.

Emily was hurt and furious. She thought her parents were being totally unreasonable and that they did not trust her. It turns out that Ms. B had gotten into trouble sexually as a young girl. She did not want Emily to make the same mistake. Ms. B's parents had been very lenient, and she blamed their lack of guidelines for her error.

Ms. B became aware of her overreaction. After discussion with a psychiatric nurse, she was able to understand that dating was a normal part of adolescent development. A compromise was reached when she was able to recognize Emily's competent and responsible functioning. After Mr. and Ms. B met the boy, Emily was allowed to go to the movies with him and two other friends on a Saturday afternoon.

CLINICAL EXAMPLE

Lui Lee, an adolescent girl who was starting high school, had always functioned well. However, attending high school would be totally different than any experience she had had previously. She began school in September feeling quite anxious. She felt overwhelmed by the large building, increased academic responsibilities, and complex peer

relationships. By October, she had experienced numerous illnesses that prevented her from attending school. This came to the attention of the school guidance counselor, who had noticed her increased absences. The guidance counselor met with her and, when assessment revealed no medical problems, invited Lui Lee to come to her office whenever she felt sick at school, believing it would be helpful to Lui Lee to have a place of refuge.

When this strategy did not help, she suggested that Lui Lee receive instruction at home until she felt less anxious. This validated Lui Lee's fears that she could not handle high school and its increased pressures. Her solution of retreat was supported. Fortunately, her parents sought the help of a psychiatric nurse, who encouraged immediate return to school and involvement in a peer support group, along with individual sessions initially as needed. This enabled her to talk out her fears and receive support from her peers. This strengthened her confidence and fostered healthy functioning. She found she could handle high school after all. The nurse educated the guidance counselor on ways to be supportive while encouraging independent functioning.

Critical Reasoning What teaching methods or aids can be particularly effective when implementing a health education program for adolescents?

Family Therapy

The nurse needs to assess the level of family functioning and determine how to best interact with and help the family of the adolescent. Family therapy is particularly useful when disturbed family interaction is interfering with the adolescent's development. A series of family sessions may be enough, and the adolescent may benefit from individual or group approaches to support the effort to separate emotionally from the family.

Occasionally, after a few family sessions, it may become clear that the adolescent may not need the intervention directly. Engaging the parents may free the adolescent to progress developmentally. Whatever modality is selected in working with the adolescent, a family orientation and the adolescent's attempt to separate from the family and become an independent adult should be considered.

Group Therapy

Group therapy addresses adolescents' need for peer support. The conflict between dependence and independence with adults becomes somewhat diluted by the presence of other adolescents. Conflicts, especially about authority, can be dealt with by their peers rather than adults, making group therapy particularly helpful for adolescents. It also is valuable in teaching skills in relating and dealing with others. Group therapy helps meet the adolescent's need for a positive, meaningful peer group for identity formation.

Because of the age spread among adolescents, it is usually preferable to form at least two groups. One possibility is an early adolescence group consisting of 13- to 15-year-olds who are experiencing conflicts of separation from parents. An older adolescent group, ages 15 to 17 years, would probably focus on issues such as furthering the establishment of identity, dating, sex, handling money, responsibilities of driving, and college and vocational plans.

Group process with adolescents is often similar to that with adults. Specific aspects of working with groups are reviewed in Chapter 31.

Critical Reasoning When may a same-gender adolescent therapy group be most helpful? Compare this with the value of a mixed male and female group.

Individual Therapy

After the decision to engage in individual therapy is made, a pact or contract between the nurse and adolescent is established, and a therapeutic relationship is initiated (see Chapter 2).

Therapeutic Alliance. In a therapeutic alliance, the nurse aligns with the healthy, reality-oriented part of the adolescent. Movement is made toward an honest and critical understanding of the adolescent's thoughts and behaviors. The alliance is a central aspect of individual therapy. After it is established, a feeling of working together is apparent. Specific ways to establish and maintain this alliance include the following (Meeks, 1990):

- **Point out that behavior is motivated by thoughts and feelings.** Early in treatment, adolescents may express feelings of impatience, helplessness, and failure at having to seek treatment. Defenses are often seen in rebelliousness, passivity, shyness, negativism, and intellectualization. Adolescents generally have a tendency to act out and avoid examining their thoughts and feelings.
- **Limit acting out by pointing out how it interferes with the therapeutic process.** Reinforce that it must be controlled before the process can proceed. Maintain a neutral but interested attitude toward all behavior.
- **Point out the adolescent's tendencies to be judgmental and self-critical.** This is supportive and helps encourage the adolescent to reevaluate behaviors, attitudes, and feelings with greater tolerance.
- **Establish that the adolescent's behavior is the result of automatic thoughts and inner feelings that are interfering with his or her happiness**. This knowledge strengthens the motivation for therapy and maintains an alignment with the adolescent's wishes for autonomy.
- **Point out the adolescent's tendency to see things in extremes.** This can be expressed as the desire to be completely in control or fear of succumbing to feelings of total helplessness. Reveal areas of strength and competence that are often unrecognized. Avoiding exclusive focus on problems and weaknesses shows neutrality and is supportive. Giving the adolescent as much information as possible to make decisions helps the adolescent work toward self-direction.

- **Distinguish among thoughts, feelings, and actions, discouraging impulsiveness.** Encourage open expression of strong feeling but not strong action. For example, anger does not mean killing; sexual feeling does not mean intercourse. Adolescents sometimes confuse discussion with permission to experiment with action, especially with sexual issues.
- **Encourage emotional catharsis in sessions.** Express interest in and acceptance of feelings involving events outside the session. Point out the importance of feelings.
- **Be alert to the defenses of denial and reaction formation.** Maintain neutrality and encourage objectivity without directly attacking needed defenses.

The work of the nurse is to recognize the adolescent's anxiety and assist in finding coping strategies to deal with difficult thoughts and feelings. **Accepting any healthy and adaptive responses of the adolescent facilitates mastery and feelings of competency.** Adolescents often have wishes that they regard as crazy and frightening. Open discussion of fears helps adolescents realize that these feelings are uncomfortable but harmless thoughts.

Termination. Termination of therapy is an important part of the therapeutic process. Termination should be flexible and correctly timed. The decision should be made in line with adolescent norms, not adult ones. Adolescents frequently verbalize appropriate interest in termination. When this occurs, it is often helpful to open it to discussion without commitment to a set time. This implies that further work needs to be done in a definite time span, and it maintains a focus on the adolescent's responsibility to finish. Gradually supporting and approving of the adolescent's independence and mature functioning prepare for a positive termination.

Terminations may occur prematurely because an alliance has not been established or some external event has occurred. Occasionally, terminations are forced because of a nurse's or teen's change of location or other circumstance. The adolescent may express anger at the new therapist until the feelings about the lost therapist are accepted and resolved. In working out this attachment, a new therapeutic alliance can be established.

Pharmacotherapy

A particular challenge is to determine which of the changing and often tumultuous behaviors of adolescents are target symptoms for psychopharmacological interventions. The treatment strategy is more complex for adolescents because of the following:

- Need for comprehensive family involvement (often optional in adults)
- Developmental differences that affect assessment, treatment alliance, management, compliance, and pharmacokinetics
- Difficulty in diagnosing emerging first episodes versus adjustment disorders in this age group
- Lack of controlled clinical drug trials in adolescents

In terms of medication management, adolescents are neither children nor adults. They have a metabolism more like adults than like children. Dosing regimens for adolescents are usually closer to those of adults. Biologically, it cannot be assumed that the drug response will be within the generally expected range for adults.

The current state of the art in adolescent psychiatric practice is to carefully prescribe psychopharmacological agents when they are determined to be appropriate and necessary as part of a comprehensive treatment plan. The increased recognition of psychiatric disorders in adolescents and their resulting negative effects on social, psychological, and emotional development; the increasing efficacy and safety of these drugs in adults; and the increasing evidence of efficacy of these drugs in adolescents have contributed to this practice. Chapter 26 provides comprehensive information about psychopharmacology.

Some prescribing guidelines are available:

- The use of SSRIs usually is preferred over tricyclic antidepressants (TCAs) in the treatment of adolescents because of their lower side-effect profile and their relative safety in overdose. Evidence that indicates they are effective in the treatment of adolescent obsessive-compulsive disorder and some anxiety disorders, such as panic disorder, is increasing.
- The use of benzodiazepines for anxiety is not recommended in this age group because of the increase in drug experimentation by adolescents and the negative effects on learning and memory that these drugs may have.
- Lithium usually is well tolerated in this age-group and is effective in the treatment of mania, aggression, and conduct disorder. Other mood stabilizers such as Abilify and Seroquel have been used successfully.
- Antipsychotics are the standard treatment for psychotic symptoms in adolescents. Although few studies exist, it appears that children and adolescents respond to lower doses of antipsychotics than adults and are more likely to experience extrapyramidal side effects, particularly teenage males, when conventional rather than atypical drugs are used. Atypical antipsychotics usually are tried first because of their reduced side effects for teens with psychotic symptoms.
- Adolescents have a positive response to psychostimulants for attention deficit hyperactivity disorder (ADHD), similar to that seen in younger children.

Talking With Adolescents

The therapeutic alliance is based on open, supportive communication between the nurse and the adolescent.

Silence. Silence is often effective with adults but frightening to the adolescent, especially in the beginning stages of treatment or evaluation. This anxiety frequently reflects the adolescent's feelings of emptiness and lack of identity. Brief silences can be creative and productive when the adolescent is engaged in treatment. When the adolescent is able to tolerate

them without anxiety, it indicates growth in self-confidence and acceptance of inner feelings. More often, however, silence is used defensively by adolescents to avoid discovery of hostile feelings or fantasies.

Older adolescents may tolerate verbal discussion more readily than a younger teen. Younger adolescents usually respond best to an activity to help facilitate discussion and establish a relationship. For some adolescents, silence is a defense of inhibition and withdrawal because they have never learned to communicate in a positive way. In these cases, the therapist must be responsible for the dialogue.

Confidentiality. Confidentiality is a concern to many, but especially to the adolescent who is fearful of the nurse reporting to parents. **A blanket promise to tell nothing to the parents is not advised because the nurse may need to contact the parents if the adolescent reveals suicidal or homicidal behavior or the use of illegal drugs.**

It is best to tell the adolescent that the nurse will not give out any information without informing the adolescent in advance. It is also helpful to explain that feelings are confidential but that actions considered dangerous to the adolescent or others must be shared.

> **Critical Reasoning** You receive a call from the school guidance counselor of one of your adolescent patients asking what progress is being made in treatment. How do you respond?

Resistance. Adolescents often begin by testing nurses to see whether they will be authoritarian figures. The rebellious adolescent may deny the need for therapy or help. If the adolescent appears anxious, it is best to be supportive and sympathetic, expressing interest in getting to know the adolescent and then discussing a neutral area. An angrier, rebellious adolescent may require a direct approach, with the nurse saying openly that the adolescent is opposing the visit because of a false belief that no help is needed. This can lead to a further discussion of feelings about the visit (e.g., parental coercion to come to the session) or feelings about authority.

Some adolescents are baiting and testing to see whether the nurse is an anxious, defensive adult. If so, it is best to ignore their comments about not wanting treatment and move on. Some adolescents with an angry façade depend on their omnipotent control of the environment and are successful in manipulating their families. They are angry at attempts to disturb this power, and the anger is expressed in their lack of cooperation in the session.

Arguing. Adolescents often argue and, although they do not admit it, they learn from arguments. The adolescent may oppose the viewpoint of the nurse, but in the next session, he or she may adopt the nurse's opinion. It is best not to comment on this and accept it as a harmless defense.

Testing. Adolescents often need and want limits. They are confused and cannot set their own limits. They test nurses to see how firm and consistent they will be. Controls are effective if there is a basic positive relationship with the nurse. Limits should be set only when they are essential for current and future well-being. Adolescents will dare to be independent if it is conveyed that the nurse will serve as a control against carrying independence too far.

Embarrassment About Being in Therapy. Embarrassment may occur in any age group, but it is prominent in adolescents, especially during the early stages of treatment. It also can become an issue as therapy progresses because it often reveals the adolescent's embarrassment about a desire for dependency. Adolescents may become uncomfortable in the therapeutic relationship. This is usually dealt with by indicating that these feelings are normal. Behind the fear of accepting help is the wish for care, and this can be dealt with by pointing out the adolescent's strengths and areas of independence.

By expressing embarrassment about being in therapy, some adolescents are revealing a fear or social stigma that they have heard from their parents. The adolescent who has feelings of inferiority often focuses these on the therapeutic process, blaming therapy for discomfort. It is best to encourage and support the adolescent, gently refusing to accept blame for this discomfort.

> **Critical Reasoning** Do you think adolescents can benefit from treatment if their parents deny there is a problem, refuse to be involved, or are opposed to seeking help?

Parents of the Adolescent

If group or individual treatment is selected for the adolescent, the nurse must still consider the family. Parents cannot help with the adolescent's treatment if they do not understand and accept it. The nurse can work with the parents without revealing confidential material. It is helpful for parents to have treatment if the adolescent is asked to assume an inappropriate role at home because this interferes with the adolescent's adaptive responses. If the parents are resistant, the nurse usually must begin with the adolescent and wait until the parents are more receptive.

Telephone contact is a helpful way to ensure cooperation and support by having the parent call when necessary. Parents should tell the adolescent when they call. Parents should be told of normal adolescent behavior they can expect. The nurse should avoid advising the parents about specific actions and focus on attitudes and feelings, especially concerning discipline.

Parents can be helped with understanding the purpose of limit setting. Some parents exclude themselves entirely from their adolescent's life. They have brought the adolescent to treatment to ease their guilt by doing all that is possible. They may want the nurse to take over parenting functions. This should not be permitted, especially during crises. If the adolescent is suicidal or homicidal, the parents are informed and helped to take responsibility for action.

Adolescents often need help in dealing with their parents. Parents should be discussed in an open exploratory way, with

emphasis on them having their own feelings and reasons for their actions. Adolescents should be helped to see their parents realistically and to work on their own strengths and weaknesses. Adolescents may want to leave home because they hope they will feel more adult away from their parents. It is usually best to explore the wish to leave, emphasizing that it must be done in an adult way. If leaving is an impulsive thought with no feasible plan, it will result in failure, parental rescue, and continued dependency.

EVALUATING NURSING CARE

Problems presented by adolescents often activate the nurse's own unresolved conflicts. **Evaluating nursing care must begin with nurses monitoring their own responses, including countertransference reactions.** The nurse should watch for alignment with the parents against the adolescent or the adolescent against the parents.

Most adults are resistant to reexperiencing the feelings of adolescence and have repressed these experiences. As a result of anxiety, the nurse occasionally may have trouble listening or may encourage the adolescent (because of unrealized wishes) to do what the nurse never dared to do. The adolescent may be acting as the nurse did during adolescence. The nurse, in an effort to deny this, may see this adolescent behavior as a nonevent.

Identification of the nurse with the adolescent can contribute to delays in exploring areas important for psychological growth. The nurse may relate well to the adolescent but, because of unresolved, unrecognized conflicts or resentment toward the nurse's own parents, may be locked into adolescent rebellion. The nurse may overtly or covertly encourage adolescents to express rage toward their families. Both the adolescent and the nurse then avoid facing the reality of adult burdens.

Evaluation of psychiatric nursing care with adolescents also involves objective measurements of the adolescent's and the family's progress toward the goals of treatment. Specifically, the nurse may ask the following questions:

- Were the concerns of the adolescent and family addressed?
- Has the problematic behavior decreased and been replaced with more adaptive responses?
- Have the adolescent's relationships with others improved?
- Has school or work performance been enhanced?
- Are the adolescent and family satisfied with the treatment outcome?

By reviewing areas of growth and progress, the adolescent is able to integrate the learning that has been accomplished and gain from the experience a greater sense of self-efficacy and mastery.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Karen M. McHugh, BSN, RN, C

When I graduated with a bachelor's degree in nursing, I never imagined I would be interested in psychiatric nursing. After $1^1/_2$ years in medical-surgical nursing, I decided I wanted more interpersonal time with my patients rather than being so skill and task oriented. One of my first experiences as a psychiatric nurse was on a 32-bed adolescent unit in North Carolina. There I encountered a 14-year-old girl, S, who was admitted to our inpatient unit for depression. At that time, patients typically stayed for about 3 months, which is very different from the current length of stay for adolescents in the hospital, which is most often 5 days.

S had several problems, most occurring within the previous year. She had a history of running away, crying spells, skipping school, failing grades, and suicidal threats. She lived at home with her father and 9-year-old brother. Her mother was no longer involved in her life because she had left the family and given up custody of the children several years before.

S settled into the milieu but had a difficult time engaging with the staff. I began to spend time with her every day to establish a trusting relationship. The first few days, we sat in silence. Eventually, we were able to talk about her history of oppositional behavior and low self-esteem. S trusted me more and more over time. About 1 month after admission, she approached me and asked if we could talk again. S asked me if I could promise not to tell anyone (especially her father or doctors) if she confided in me about something. I knew then that something was troubling her, but I had to be honest with her. I told S that I couldn't make that promise because the treatment team works in the best interest of the patient, and I would have to share pertinent information with them. She decided not to confide in me then, but the next day she approached me again.

S began to tell me that the past few months her father had begun to drink and had hit her several times, leaving marks on her legs and arms. One day she had to stay home from school because her legs were swollen and painful from the bruises. She said that her father always apologized when he was sober and promised that he would never hit her again. I gathered a few more details and was honest with her and informed her that I would have to collaborate with the treatment team and possibly seek help from the Department of Social Services. After meeting with the treatment team the next day, I told S that we had to report her father to Social Services. She yelled and screamed, and she blamed me for telling everyone about her problems. Even though I had been honest with her, she could not understand that I was actually helping her.

At this point, I had to examine my feelings, and I even questioned my judgment. I went home from work that evening quite upset. I began to ask myself, "Did I do the right thing?

COMPETENT CARING—cont'd

A Clinical Exemplar of a Psychiatric Nurse

Karen M. McHugh, BSN, RN, C

Will S ever confide in me again or even talk with me?" Despite feeling a little guilty, I knew that I had made the right decision because protecting S and her future was of utmost importance. After a few days of cooling off, S approached me and was able to express her feelings of relief; she even apologized to me. We began to work on identifying and expressing her feelings of guilt, relief, sadness, and concern over the situation with her father. Social Services found no evidence of abuse to her 9-year-old brother, and he remained at home with the father.

At discharge, an aunt assumed foster care of S temporarily until her father could obtain the therapy he needed. S was referred to outpatient therapy. Several weeks after her discharge, I saw her at the mall and she thanked me for helping and listening to her even though she did not see it that way at first. She stated that she was happier now and was doing well in school and that she and her father were continuing therapy.

I had made the right decision. Being a young person's advocate and maintaining a patient's safety during an inpatient stay and after discharge are always a nurse's first priority. As I reflected on this experience, I learned not to take things in my personal life so much for granted, such as a loving and supportive family. I also realized that psychiatric nurses do provide excellence in nursing and that we truly can make a difference.

CHAPTER IN REVIEW

- Adolescence is a unique stage of development that occurs between ages 11 and 20 years, and it is accompanied by a shift in development and learning.
- Adolescence is understood from a biological perspective of changes in brain formation and hormonal alterations starting with puberty and affecting thoughts, feelings, and behaviors.
- Issues that are particularly problematic for adolescents include body image, identity, independence, social role, and sexual behavior.
- Approximately one in every four or five youth in the U.S. meets criteria for a mental disorder with severe impairment across their lifetime.
- Maladaptive responses impede growth and development and require nursing intervention. They are often related to inappropriate sexual activity, teen pregnancy, mood disorders, suicide, conduct/behavior disorders, bullying, violence, substance use, and weight and body image problems.
- Nursing interventions useful in working with adolescents include health education; family, group, and individual therapy; and medication management. Special attention should be given to talking with adolescents and working with their parents.
- Evaluation of nursing care requires special focus on countertransference issues and the need for objective measurements of the adolescent's and family's progress toward the treatment goals.

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CHAPTER

37

Geropsychiatric Nursing

Georgia L. Stevens

Youth is like a fresh flower in May. Age is like a rainbow that follows the storms of life. Each has its own beauty.

David Polis

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Examine the dimensions of mental illness in the elderly population and the role of the geropsychiatric nurse.
2. Compare the major biopsychosocial theories of aging.
3. Discuss the elements of a comprehensive geropsychiatric nursing assessment.
4. Formulate nursing diagnoses for geropsychiatric patients.
5. Analyze evidence-based nursing interventions for geropsychiatric patients.
6. Evaluate nursing care of geropsychiatric patients.

People age 85 years or older make up the fastest growing age group in the United States. By the year 2030, older adults will make up 20% of the population. By the year 2050, the oldest old (85 years or older) group will increase to between 24% and 30% of the total population. With projections of 10 to 14 million people requiring long-term care, this segment of the population will drive up the demand for services and programs that address chronic physical and mental illness and disability. **The demographics of aging and mental health make geropsychiatric nursing the specialty of the future.**

The future elderly population will be especially diverse. Socioeconomic factors that will affect the elderly's status are advances in health care and changes in the labor force, family structure, and caregiver characteristics. Many of the elderly will be better educated, healthier, and wealthier than those at the end of the twentieth century, resulting in a rethinking of our concepts of retirement, aging, and health care.

Minority groups are projected to have the highest growth rates as they become emerging majorities (Touhy and Jett, 2010). Historically, minority groups have had lower socioeconomic status and less access to health care. For many elderly people, disparity among health, income, and education levels will increase, presenting public health and policy challenges (Bell and McBride, 2011).

The elderly population has doubled approximately three times since 1900. Although this group has increased by more than 100% since 1960, the general population has increased by only 50%. This increase in the elderly-to-dependency ratio (the ratio of the elderly to the working-age population) will negatively impact the financial support of social programs such as Medicare, Social Security, and other federal and state health care and disability programs unless functional levels of the oldest old continue to improve or their labor force participation continues to increase.

MENTAL ILLNESS IN THE ELDERLY POPULATION

Mental illness is not an inevitable part of aging, although many older adults experience mental health and substance

use conditions, some with diminished functional capacity. As mortality rates for younger mentally ill patients decrease, many mentally ill individuals will live into old age. It is anticipated that aging baby boomers (those born between 1946 and 1964), who number 75 million in the United States, will be at greater risk for substance abuse, anxiety disorders, and depression than the current group of elders. These projections, coupled with a reduction in stigma, will increase the need and demand for specialty mental health services.

The current group of older adults with mental health problems has relied on their primary care providers for management of all their health needs. **The occurrence of mental illness is underestimated in nonpsychiatric settings because symptoms may be incorrectly attributed to physical disorders, normal aging, cognitive impairment, or the lack of age-appropriate diagnostic criteria.** Illnesses such as depression and anxiety are often misdiagnosed or undertreated (Aschbrenner et al, 2011). The comorbidity of somatic and psychiatric illnesses makes accurate diagnosis more difficult. Public resources for health care for older adults are increasingly jeopardized, with proposed Medicare and Medicaid reductions or reorganizations. The economic and personal costs of mental disorders of older adults are considerable.

On the positive side, there have been impressive changes in academic and research interests in aging and the elderly. New scientific findings about normal aging and the cause and treatment of mental disorders have been combined with concepts of health promotion and preventive medicine to address what *is possible* with aging. The importance of understanding potential in relation to aging is necessary to enable older people to access latent skills and talents in later life, strengthen positive lifestyle habits, and challenge current younger age groups to think differently about what is possible for them in their later years: aging well (Jeste and Depp, 2010).

Helping older adults maximize their potential can be a challenging and rewarding experience for the nurse. The opportunity to share the wisdom and resilience of an older adult can make this specialty area especially rewarding (Cangelosi, 2007; Reichstadt et al, 2010).

Although stereotypes and myths often depict elderly people as a homogeneous group, older adults have a wide range of biological, interpersonal, developmental, and situational experiences. The complexity and interaction of the needs and problems of old age are often understated and misunderstood. **Mental health in late life depends on a number of factors, including physiological and psychological status, personality, social support system, economic resources, and usual lifestyle.**

Role of the Geropsychiatric Nurse

Demographic shifts and the shortage of nurses have increased the demand for nurses who work with older adults with mental disorders (Institute of Medicine, 2008; Loge and Sorrell, 2010). Major initiatives by the Hartford Institute for Geriatric Nursing (HIGN), the American Academy of Nursing Geropsychiatric Nursing Collaborative (GPNC), and the American Association of Colleges of Nursing Geriatric Nursing Education Consortium (GNEC) program provide significant support and resources for manpower development and quality clinical outcomes by easy access to timely, significant, and evidence-based information (Box 37-1).

Geropsychiatric nursing practice offers flexibility in clinical practice settings. Mental health services are provided to this population in a variety of settings, including primary care, general and psychiatric hospitals, nursing homes, assisted living residential centers, outpatient mental health clinics, adult day-care programs, senior centers, and the person's own home.

The nurse who works with older adults with mental illness is challenged to integrate psychiatric nursing skills with knowledge of physiological disorders, the normal aging process, and sociocultural influences on elderly people and their families. Many nurses who work with these patients welcome the opportunity to integrate nurse practitioner and psychiatric nursing skills.

As a primary care provider, the geropsychiatric nurse should be proficient at **assessing patients' cognitive, affective, functional, physical, and behavioral status, as well as their family dynamics.** Geropsychiatric nursing is a collaborative partnership with the older adult, family or other caregivers, and the interdisciplinary team. Providing nursing care to these patients can be complex because they are often involved with a number of agencies requiring coordination of services.

Geropsychiatric nurses should be knowledgeable about somatic and interpersonal treatments, including **the safe use of psychotropic medication** with elderly people. They often work closely with physician and nurse prescribers to monitor complex medication regimens and help the patient or caregiver with medication management. They may lead a variety of groups, such as healthy aging, remotivation, bereavement, and socialization groups, whereas nurses with advanced degrees may also provide psychotherapy and prescribe medications.

As a **consultant,** the geropsychiatric nurse helps other providers address the behavioral, social, and cognitive aspects of the patient's care. For instance, a nurse may help nursing assistants understand how to respond to a person who wanders or one who is aggressive. Advanced practice geropsychiatric nurses may be employed by agencies to help the entire staff develop therapeutic evidence-based programs

BOX 37-1 GEROPSYCHIATRIC NURSING ONLINE RESOURCES*

American Academy of Nursing Geropsychiatric Nursing Collaborative (GPNC): http://www.aannet.org/i4a/pages/index.cfm?pageid=3833

American Association of Colleges of Nursing Geriatric Nursing Education Consortium (GNEC) program: http://www.aacn.nche.edu/webinars/handouts/10.4.11Handout.pdf

Hartford Institute for Geriatric Nursing (HIGN): http:/www.hartfordign.org

Portal of Geriatric Online Education (POGOE): http://www.pogoe.org

*All websites accessed November 2011.

for seniors with psychiatric or behavioral issues resulting in improved clinical outcomes.

The role of **patient advocate** is a critical one for the nurse caring for elders with mental illnesses, particularly those with concurrent physical illness. Because of stigma, cognitive changes, or symptoms of acute or chronic health problems, elders may not be able to effectively voice their wishes or concerns. Sensitivity is required when addressing the families of seriously mentally ill individuals because they might have been dealing with “caregiving challenges” for many years.

Reviewing legal options such as an advance directive or living will helps in the promotion of the elder’s wishes. When conflict exists regarding the elder’s care, particularly in long-term care settings, an ombudsman or guardian may be contacted to help resolve these issues. Information about ombudsman or other advocacy programs for the elderly may be obtained by contacting any local office on aging.

THEORIES OF AGING

Theories of aging provide a perspective on the possible causes and consequences of the aging process. Although the theories do not directly guide care, they address underlying values that influence how one understands, evaluates, and cares for geriatric patients. New evidence of the impact of healthy living on aging well is challenging the basis of some of these theories.

Biological Theories

Biological theories of aging address genetic, systemic, and cellular approaches:

Biological programming theory: The life span of a cell, its *biological clock*, is stored within the cell itself. The process of aging is genetically programmed in deoxyribonucleic acid (DNA).

> **Critical Reasoning** Give two examples that raise questions about the biological programming theory of aging. How do you feel about the idea of a biological clock determining life span?

Specific system theories: Neuroendocrine and immune systems become less effective in surveillance, self-regulation, and response, causing aging.

Cross-linkage theory: Collagen forms bonds between molecular structures, causing increasing rigidity over time.

Error theory: Errors manifested during protein synthesis create error cells that then multiply.

Free radical theory: Free radicals damage cell membranes, causing physical damage and decline.

Gene theories: Harmful genes activate in late life; cell divisions are finite; or failure to produce growth substances stops cell growth and division.

Stress adaptation theory: The positive and negative effects of stress on biopsychosocial development are emphasized. Stress may drain a person’s reserve capacity physiologically, socially, and economically, increasing vulnerability to illness or injury, accelerating the aging process.

Wear-and-tear theory: Cells wear out from internal and external causes. Structural and functional changes may be speeded by abuse and slowed by care. This theory is the basis of many myths and stereotypes (“What can you expect from someone his age?”).

> **Critical Reasoning** Discuss how the wear-and-tear theory of aging compares with the current emphasis on nutrition and physical fitness in U.S. culture.

Psychological Theories

Psychological theories of aging address the individual’s life span development:

Developmental theories: Developmental theories address the stages of psychological development as people age and the tasks such as adjusting to changes and losses, maintaining esteem, and preparing for death that must be accomplished.

Stability of personality: An individual’s personality is established by early adulthood and remains fairly stable but adaptable, rather than being a developmental progression over the life span. Radical changes in personality in old age may indicate brain disease.

> **Critical Reasoning** Do you think that personality traits can be altered in old age? If yes, how? If no, what does that mean for helping elders change maladaptive behaviors?

Sociocultural Theories

Sociocultural theories of aging address the interplay of the individual and the environment:

Activity theory: Activity produces the most positive psychological climate for older adults, and the aged should remain active as long as possible. Activity theory emphasizes the positive influence of activity on the older person’s personality, mental health, and life satisfaction.

> **Critical Reasoning** What type of program would you design for older adults who must stop working or participating in community activities?

Family theories: Family theories view the family as the basic unit of emotional development. Interrelated tasks, problems, and relationships are emphasized within the three-generational family. Physical, emotional, and social symptoms are believed to reflect problems in negotiating the transitions of the family life cycle.

Person-environment fit theory: The person-environment fit theory addresses the relationship of the personal competencies of older adults and their environments. If competencies change or decrease with age, an individual’s capacity to relate to the environment may be altered or diminished. Frail older adults are especially vulnerable to perceiving the environment as threatening.

ASSESSMENT

Nursing assessment of the geropsychiatric patient is complex. **The interplay of biological, psychological, and sociocultural factors related to aging may make it difficult to differentiate nursing problems.** It can be hard to sort out the behaviors related to the 4 *D*'s of geropsychiatric assessment: **depression, dementia, delirium,** and **delusions** (see Chapter 22). The co-existence of simple medical problems, such as a urinary tract infection or dehydration, can exacerbate behavioral symptoms.

For example, **delusions** can be part of psychotic **depression** in elders, and those with dementia may seem delusional because of the trouble they have in interpreting the environment. **Delirium is common with significant morbidity and mortality among older adults** (Botts, 2010). It has an acute onset and may occur as a reaction to physical illness, medications, or sensory deprivation. Behaviors associated with delirium may fluctuate and include marked psychomotor changes, changing level of consciousness, disorientation, and short attention span. Delirium may be mistaken for **dementia,** thereby depriving the patient of treatment to remedy the problem. Nurses are in an ideal position to lead efforts in delirium evaluation, prevention, and treatment.

Depressed elders may appear confused and cognitively impaired because of the lethargy and psychomotor retardation related to depression. Patients with dementia also may present with anxiety, agitation, and depression, especially if they are aware of their declining mental functioning. The onset of depression in later life is associated with greater chronicity, relapse, cognitive dysfunction, and an increased rate of dementia (Schultz, 2011).

Certain behaviors may help differentiate between depression and dementia. Depressed patients are oriented and maintain socially appropriate behaviors. They are unlikely to undress in public or be incontinent. Depressed patients may be annoyed and reject the questioner with silence or short, unresponsive answers. In contrast, patients with dementia may behave inappropriately and will try to answer questions but have trouble with logic and relevance. Irritability is characteristic of depression, whereas mood variability in patients with late-onset depression may be an early symptom of dementia (Verkaik et al, 2009).

Careful nursing assessment is essential in identifying the primary disorder. Nursing diagnoses are based on observation of patient behaviors and are related to current needs. A comprehensive nursing assessment sets the stage for the rest of the nursing process (Table 37-1).

The Interview

Establishing a supportive and trusting relationship is essential to fostering a positive interview with the geriatric patient. The elderly person may feel uneasy, vulnerable, and confused in a new place or with strangers. Patience and attentive listening promote a sense of security. Comfortable surroundings help the patient relax and focus on the conversation.

TABLE 37-1 **KEY COMPONENTS OF GEROPSYCHIATRIC NURSING ASSESSMENT**

COMPONENT	KEY ELEMENTS
Interviewing	Therapeutic communication skills Comfortable, quiet setting
Mental status	Mini-Mental State Examination Mental status examination Depression Anxiety Psychosis
Behavioral responses	Description of behavior and triggers Assessment of behavioral change Frequently observed challenging behaviors
Functional abilities	Mobility Activities of daily living Risk for falls
Physiological functioning	General health Nutrition Substance abuse
Social support	Social support systems past and current Family-patient interaction Caregiver concerns

Therapeutic Communication Skills. Addressing the patient by last name shows respect: "Good morning, Mr. Smith." Open the interview by introducing yourself and briefly orienting the patient to the purpose and length of the interview. Occasionally, reinforcing the amount of time left may help direct a wandering discussion and give the patient the security of knowing that the nurse is in control of the situation.

Older adults may respond to questions slowly because verbal response slows with age. It is important to give the person enough time to answer and not assume that a slow response is due to a lack of knowledge, comprehension, or memory.

Language is important because older people often are unfamiliar with slang, colloquialisms, jargon, abbreviations, or medical terminology. Choice of words should be based on knowledge of the person's sociocultural background and level of formal education.

Questions should be short and to the point, particularly if the patient has difficulty with abstract thinking and conceptualization. Techniques such as clarification, restating, and focusing, described in Chapter 2, are important in validating information. The nurse should rephrase a question if the patient does not answer appropriately or hesitates when answering.

Concentrated verbal interaction may be uncomfortable for the older person. Demonstrate interest and support by giving nonverbal cues and responses, such as direct eye contact, nodding, sitting close to the patient, and using touch appropriately. Touching the shoulder, arm, or hand of the patient in a firm, purposeful manner may convey support and interest. Avoid stroking or patting the patient. Cultural

background and altered tactile perception may result in misinterpretation.

The nurse's ability to collect useful data depends greatly on how comfortable the nurse feels during the interview. Negative feelings about older adults or ignorance about aging will surface in an interview. Older people are sensitive to others' disregard, lack of interest, and impatience.

Older adults have much to tell and active listening is validating. **Reminiscence and life review may be an excellent source of data about patients' current health problems and support resources, as well as their history.** Even though keeping the patient focused on the topic at hand may be difficult, these formats allow the nurse to assess subtle changes in long-term memory, decision-making ability, judgment, affect, and orientation to time, place, and person.

Although older adults may be aware of changes in their physical or psychological functioning, they may hesitate to have their fears confirmed. They may minimize or ignore symptoms, assuming that they are related to age and not to current medical or psychiatric problems. These beliefs may be reinforced by myths about aging and the false assumption of many health professionals that the problems of older people are irreversible or untreatable.

Contrary to popular myths, most older people do not dwell unrealistically on their health. However, some older people are preoccupied with the physical decline that occurs with age. The nurse should observe carefully for clues that help distinguish whether the patient's preoccupation reflects lifelong personality factors or current distress.

Older adults may not understand the purpose of the nurse's questions. Questions about habits, previous life experience, or social supports may not seem to be related to current concerns. Careful and repeated explanations strengthen the therapeutic alliance. The nurse should never assume that the patient understands the purpose for the assessment interview. It is better to overstate than to increase the patient's anxiety and stress by omitting information. **The nurse should take cues from the patient's responses by listening carefully and observing constantly.**

> **Critical Reasoning** What special challenges are you likely to face in obtaining informed consent for treatment from a geriatric patient? How can you deal with them?

The Interview Setting. The new and unfamiliar surroundings of the health care setting may distract the patient and increase fear of the unknown. **If possible, the nurse should assess the patient in a familiar environment to reduce the patient's anxiety.** The physical environment should promote comfort. Chairs should be comfortable. Because many older people are unable to sit for long periods because of arthritis or other joint disabilities, changing positions can be encouraged.

Most older people experience some form of sensory deficit, particularly diminished high-frequency hearing or changes in vision as a result of cataracts or glaucoma. The setting should be quiet and without distracting noises. The nurse should speak slowly and in a low-pitched voice. Because fatigue may contribute to diminished mental functioning and patients may tire as the day progresses, morning may be the best time for the interview.

The reliability of the data obtained from the assessment interview should be carefully evaluated. If there are questions about some of the patient's responses, the nurse should consult family members or other people who know the patient well. The nurse also should consider the impact of the patient's physical condition at the time of the interview and other factors, such as medications, nutrition, or anxiety level.

Mental Status Examination

A mental status examination should be part of the geropsychiatric assessment because of the following:

- Increased prevalence of dementia with age
- Reversibility of delirium if recognized and treated
- Close association of clinical symptoms of confusion and depression
- Frequency with which patients with physical health problems present with symptoms of confusion
- Need to identify specific areas of cognitive strength and limitation

An in-depth discussion of the assessment of mental status is presented in Chapter 6.

Depression. Affective status is an essential part of geropsychiatric assessment. The need to include a depression assessment is based on the following:

- Prevalence of depression and subsyndromal depression in the elderly
- Effectiveness of treatment for depression
- Potential negative outcomes of depression (e.g., suicide, neglect)
- Frequent misdiagnosis of depression as a physical problem
- Tendency to dismiss elders as complainers or demanding
- Necessity of accurately distinguishing between depressive and bipolar disorders
- Tendency for depression to recur with increasing age

Estimates of the prevalence of depression among the elderly in medical outpatient clinics are 7% to 36% (Brandon et al, 2011). The incidence of depression among people of all ages who have disabilities is higher. The number of physical disabilities tends to increase with age, which may account for some of the prevalence in the elderly. **Estimates of the prevalence for those in long-term care facilities range from 9% to 49%** (Adams-Fryatt, 2010). Depression is discussed in Chapter 18.

Depression in the elderly population is frequently unrecognized and untreated. This may be because its presentation differs from that in younger populations (e.g., physical complaints), it may be assumed to be part of the normal aging process, or the diagnosis may be complicated by comorbidity issues (Naegle, 2011). Depression may begin with decreased interest in usual activities and lack of energy. There may be an increased sense of helplessness and dependence on others. Conversation may focus almost entirely on the past.

There may be multiple somatic complaints with no diagnosable organic cause. The person may have pain, especially in the head, neck, back, or abdomen, with no history or evidence of a physical cause. Other symptoms in the elderly include sleep changes, weight loss, cognitive complaints, irritability/hostility, gastrointestinal distress, and refusal to eat or drink, with potentially life-threatening consequences.

Physical illness can cause secondary depression. Some illnesses that tend to be associated with depression include thyroid disorders, cancer (especially of the lung, pancreas, and brain), Parkinson disease, stroke, and dementia. Vascular depression has been identified from the association between depression and vascular lesions in the brain.

Many medications routinely prescribed for older people can also increase depression. Examples include antianxiety drugs and sedative-hypnotics, antipsychotics, cardiotonics (e.g., digoxin), and steroids. A medication history is an essential part of assessment, especially for the elderly, most of whom may take multiple medications.

Anxiety. **Anxiety disorders are common late life mental disorders.** Untreated or inappropriately treated anxiety among older people can contribute to sleep problems, cognitive impairments, and other significant medical problems (Lenze and Wetherell, 2011). **Co-morbid anxiety and depression are common in the elderly population and complicate diagnosis and treatment outcomes** (Flint, 2009).

A thorough assessment of anxiety levels, coping responses, and precipitating stressors helps the nurse plan individualized person-centered nursing care for the elderly. Anxiety disorders decrease function and quality of life for many elderly people and increase the burden on family, care providers, and health services.

Psychosis. Although the prevalence of schizophrenia is estimated to be only 0.6% among older adults, with about one fourth of those having late-onset (after age 40 years) disorders, the prevalence of psychotic symptoms increases with age. The nurse may find psychotic symptoms during the assessment of older adults related to delusional disorder, delirium, dementia, depression with psychosis, substance abuse, or very-late-onset psychosis after age 60 years. **Clinical risk factors for developing psychosis in later life include cognitive impairment, sensory impairments (vision and hearing), social isolation, female gender, confinement to bed with a conflicted caregiver relationship, somatic co-morbidity, multiple medications, or underlying medical disorders.**

Patients with a psychiatric diagnosis of psychosis may respond to supportive therapy and low doses of atypical antipsychotic drugs. **Therapeutic doses for older adults with schizophrenia are significantly lower than those for younger adults.**

Behavioral Responses

A thorough behavioral assessment is an essential part of planning nursing care for an elderly person. **Behavioral changes may be the first sign of many physical and mental disorders.** It is important to identify who is bothered by the behavior—the patient, the family, peers, or unrelated caregivers. Difficult behaviors are variously referred to as behavior problems, disruptive behaviors, disturbing behaviors, and **challenging behaviors.** The last is the better term to use because it reinforces the nurse's role in understanding what the behavior is communicating.

If possible, the initial assessment should be completed in a familiar environment to capitalize on environmental factors that reduce the elder's anxiety. It can also give the nurse a chance to observe possible triggers of disruptive behavior. Family members or other caregivers can be asked about their usual responses to the patient's behavior, especially what is helpful and unhelpful. This may provide further clues about the source of the behavior.

It is helpful to know why the behavior is bothersome. Elders and their families may be frightened by changes in behavior because they associate them with deterioration and the possible onset of dementia. Based on the assessment, the cause of the problem may be treated and the person returned to prior levels of function. For instance, a woman who is agitated because of an undiagnosed urinary tract infection returns to her usual calm self after the infection is treated.

In some cases, it may not be possible to remove the cause of the behavior, but nursing intervention can help the patient and family adapt to it. For example, a man is irritable because he is becoming forgetful. Early Alzheimer disease is diagnosed. The patient becomes less irritable after the nurse teaches him and his family ways to maximize his memory. Behavioral changes related to declining cognitive functioning are often difficult to manage and require creative treatment.

Behavioral assessment involves defining the behavior, its frequency, duration, and precipitating factors or triggers, including the environment. When a behavioral change occurs, it is important to analyze the underlying cause and meaning. For instance, the person may be experiencing a threat to self-esteem or a change in sensory input.

A complete physical examination is needed after any abrupt behavioral change to rule out delirium (Botts, 2010). Caregiver response to behavior also must be assessed because it may reinforce or increase challenging behaviors. Common challenging behaviors (behavioral excesses) in the elderly are listed in Box 37-2.

> **Critical Reasoning** Mr. Jones, an elderly patient, strikes out at the staff every morning when he is approached at bath time. Describe the steps you can take to assess this behavior. What questions can you ask his family? What advice can you give to the staff members who work with him?

Functional Abilities

Emotional health and overall functional ability are interrelated and cognitive impairment contributes to functional

BOX 37-2 CHALLENGING BEHAVIORS OBSERVED IN GEROPSYCHIATRIC PATIENTS

- Agitation
- Apathy
- Catastrophic reactions
- Confusion
- Delusions
- Disinhibition, including sexual
- Emotional lability
- Fatigue
- Forgetting
- Hallucinations
- Hand wringing
- Hitting
- Hoarding and hiding
- Incontinence
- Intrusiveness
- Isolating self
- Negativity
- Pacing
- Perseveration
- Refusal to eat/drink
- Repetitive movement
- Resistiveness
- Restlessness
- Suspiciousness
- Swearing/racial slurs
- Threats of harm
- Wandering

decline. This discussion emphasizes the aspects of the functional assessment that have the greatest impact on mental and emotional status.

Mobility. Mobility and independence are important to the elder's perception of personal health. Three aspects of mobility should be assessed:

1. **Moving within the environment**
2. **Participating in necessary activities**
3. **Maintaining contact with others**

In assessing ambulation, the nurse should address motor losses, adaptations made, use of assistive devices, balance, eyesight, and the amount and type of help needed. Factors that influence ambulation include restriction of joints caused by degenerative diseases, orthostatic hypotension, and the type and fit of footwear. Motor ability of the arms can be tested by observing the patient comb hair, shave, dress, and eat.

Many **medications** taken by older adults alter perception, making ambulation and mobility difficult and contributing to falls. These effects are particularly caused by sedative-hypnotic, antianxiety, cardiovascular, and hypertensive drugs. Patients should be cautioned about side effects of medications and should be encouraged to take time when ambulating and moving from one position to another.

The incidence of **falls** and negative outcomes increases with age; 30% of people older than 65 years fall every year, with women falling at twice the rate of men. Falls result in physical injuries, such as hip fractures, and in psychological effects, such as fearfulness (Van Leuven, 2010). **Risk factors for assessment are summarized in Table 37-2.**

TABLE 37-2 ASSESSMENT OF RISK FOR FALLS

RISK FACTORS	ASSESSMENT FACTORS
Environmental hazards	Excessive stimulation (noise) Poor lighting Slippery or wet surfaces Stairs (no handrails, steep, poorly lit) Loose objects on the floor Throw rugs Small pets underfoot
Patient variables	History of falls Diurnal alertness level Familiarity with surroundings Emotional state (e.g., agitated, angry) Willingness to request help Confusion Usual activity level Type of activity
Assistive devices	Presence and adequacy of the following: Eyeglasses Hearing aid Ambulation aids (cane, tripod, walker) Prostheses Environmental aids (grab bars, hand rails) Uncluttered surroundings
Medications	Taking medications (prescribed or over-the-counter) that cause the following: Drowsiness Confusion Orthostatic hypotension Incoordination Decreased sensation Polypharmacy
Physical or mental disorders	Cardiovascular Orthopedic Neuromuscular Perceptual Cognitive Affective Altered nutritional status Fatigue and weakness Unsteady gait/mobility problems

Activities of Daily Living. Assessment of self-care needs and activities of daily living (ADLs) is essential for determining the patient's potential for independence. Activity may be limited because of physical dysfunction or psychosocial impairment. Geriatric patients should be encouraged to be as independent as possible in self-care, although it is unrealistic to expect all patients to function independently, particularly in a hospital or long-term care setting. Conforming to the routines and procedures of the institutional environment fosters dependence in the patient. Because these behavioral deficits (excess disability) are associated with premature comorbidity and mortality, institutional environments present the nurse with opportunities for creative intervention and care planning.

ADLs (e.g., bathing, dressing, eating, grooming, toileting) are concrete and task oriented. They provide an opportunity for purposeful nurse-patient interaction. **Encouraging patients to be as independent as possible in performing their ADLs is important.** This helps elders meet their needs

for safety, security, personal space, self-esteem, autonomy, and personal identity.

Physiological Functioning

General Health. **Assessment of physical health is especially important with elderly patients because of the interaction of multiple chronic conditions, sensory deficits, polypharmacy, and the behavioral presentation of many physical health problems.** Chronic illnesses can reduce physiologic and functional capacity (Saxon et al, 2010). Despite chronic illnesses and some physical disability, most older adults in the community have a sense of aging well and self-mastery.

Diagnostic procedures that may be useful include blood and urine chemistry values; the electrocardiogram; and for some patients, the electroencephalogram, lumbar puncture, and brain imaging techniques, such as computed tomography (CT) and magnetic resonance imaging (MRI). In addition to these physiological factors, nutritional status and substance use should be assessed. **A complete medication profile that includes all prescription and over-the-counter drugs, drugs obtained from another person, and all herbal remedies (including teas) and dietary supplements is essential.**

There is a known relationship among stress, immune system functioning, and mood. Clinical observations have identified a **failure-to-thrive syndrome,** especially in the final phase of life. It includes weight loss, decreased appetite, poor nutrition, fatigue, weakness, and inactivity. It is often accompanied by dehydration, depressive symptoms, impaired immune functions, and a low serum cholesterol level. **Failure to thrive in the elderly occurs in acute and chronic forms, leading to impaired functional status, morbidity from infection, pressure wounds, and increased mortality rates.**

Nutrition. Many elderly patients do not require help to eat or plan a nutritious diet. However, some geropsychiatric patients do have psychosocial problems that create a need for help with eating and monitoring dietary intake (Amella et al, 2008). These problems include the following:

- Depression or loneliness, resulting in decreased appetite
- Changes in cognition, such as confusion, agnosia, or apraxia
- Suicidal tendencies
- Removal from familiar ethnic and cultural eating patterns
- Fear of institutional routines or procedures

The range of physical problems varies greatly. The following areas should be assessed:

- Mobility and strength to open cartons of milk, cut meat, and handle utensils
- Neurological or joint conditions that interfere with hand and arm coordination
- Vision problems
- Missing teeth and other losses of chewing ability
- Problems in swallowing or breathing
- Ulcerations on the tongue or elsewhere in the mouth
- Periodontal disease
- Dry mouth because of medications

The nurse should routinely evaluate the patient's dietary needs. Nutritional deficiencies are one of the most significant problems of the institutionalized elderly, and they can cause other problems, such as skin breakdown, inadequate absorption of medications, and impaired wound healing.

Nutritional assessment also should explore personal preferences, including prior routines (e.g., having the largest meal at lunchtime), time of day for meals, portion sizes, and food likes and dislikes. Serum cholesterol and albumin levels provide additional information about the person's nutritional status.

Substance Abuse. Substance abuse is one of the most underreported and undertreated problems in late adulthood (Saxon et al, 2010). **Alcohol is the most commonly abused substance by the elderly because it is readily available and not usually perceived as a drug.** Researchers are predicting a substantial increase (250%) in the need for substance abuse treatment for older adults by 2020, which is not limited to alcohol abuse (Arndt et al, 2011).

The abuse of prescription drugs, particularly sedative-hypnotic and antianxiety medications, is common but may not be seen as an addiction. Alcohol and substance abuse can lead to increased morbidity and mortality, and may compromise depression treatment (Satre et al, 2011). Abuse of alcohol or any substance may be a means of attaining distance from painful issues such as loss and loneliness.

Social Support

Positive support systems are essential for maintaining a sense of well-being throughout life, particularly for older adults (Reichstadt et al, 2010). With age, close family members and friends are lost. As a person's significant contacts decrease in number, it is important that the remaining support systems be consistent and meaningful. When assessing the older adult, the nurse should note previous success in dealing with life issues. The elder's adjustment to losses and changes associated with aging is affected by earlier life experiences, coping strategies, and **resilience.**

Caring relationships among elderly nursing home residents are a major way in which residents maintain their personal identity, sense of value, and continuation of personhood and should be fostered (Buckley and McCarthey, 2009).

Health behaviors, such as acceptance of outside interventions and self-efficacy, are guided by **cultural beliefs and life experiences**. For example, access to services is often limited for the poor, frail, and members of ethnic minority groups. These groups may depend more on informal caregivers, such as the extended and immediate family, and informal support networks (Touhy and Jett, 2010). Sensitivity to the individual's belief system aids assessment of the support systems available to the patient while at home, in the hospital, or in another health care setting. Family and friends can help reduce the shock and stress of hospitalization and offer reassurance and comfort to the distressed elder.

Family-Patient Interaction. Family demographics are changing. Increased life expectancy, declining birth rate, and higher life expectancy for women affect the availability of family members to participate in caregiving and support of the elder. Most elders have a minimum of weekly contact with their children.

> **Critical Reasoning** Discuss the ways in which changing demographics in U.S. society are affecting the social support systems of elderly people. What is the impact on their families?

Family members provide 85% of caregiving in the United States. Their expectations about caring for older members vary. The decision to care for an aging member at home or to include extended family members in the household may be precipitated by a crisis. Challenging behaviors in the elderly may result from the family's inability to deal with the losses and increasing dependence of an older member.

Significant issues that affect families in late adulthood are retirement, widowhood, grandparenthood, and illness. The cultural norms that previously placed elderly people in a position of respect as pivotal members of the community appear to have eroded in much of U.S. society. Social and organizational structures have not developed enough supports to replace those previously available through extended family networks and communities.

Nurses should become more comfortable and knowledgeable about dealing with issues of sexuality, marital discord, cohabitation, spousal abuse, and **elder abuse.** The nurse should be aware of changing trends and be alert for the possibility of elder abuse, which is addressed in detail in Chapter 38.

DIAGNOSIS

Valid and reliable assessment tools, along with a careful diagnosis, help strengthen the nursing process, moving it from intuitive to evidence-based assessment and diagnosis. Although older adults may experience a wide range of psychiatric problems, the nursing diagnosis of greatest significance to the nurse and patient in promoting a therapeutic outcome is disturbed thought processes.

Cognitive Responses

Impaired Memory. **Memory loss is one of the most distressing and frustrating aspects of aging.** Although memory loss may be caused by organic brain disease or depression, it is not necessarily related to a disease process. **With age, loss of short-term memory (recall of recent events) is more likely to occur than loss of long-term memory (recall of events that occurred in the distant past).** Speed of access to memories also appears to slow with increasing age.

Many factors contribute to altered memory in older adults. Stress or crisis, depression, a sense of worthlessness, loss of interest in current events, cerebrovascular changes that affect cerebral function, loss of neural cells because of disease or trauma, and sensory deprivation or social isolation may occur with advancing age. Impaired memory for recent events may be a result of decreased vision or hearing. This may lead the older person to seek comfort in old memories and experiences, which may replace the need to remain in touch with the present.

Institutionalized elderly people appear to have more difficulty with memory than those who live at home or in other community settings. Psychosocial, functional, and environmental approaches to nursing intervention can counteract and often reverse decline and withdrawal in the elderly psychiatric patient. As the person becomes more comfortably involved in relationships and activities, memory and function may improve.

Confusion. Confusion implies a constellation of behaviors. These include inattention and memory deficits; **challenging behaviors** such as aggressiveness, combativeness, and delusions (called *behavioral excesses*); and inability or failure to perform ADLs (called *behavioral deficits*). Often, confusion is a nonspecific term used by staff to label apathetic, withdrawn, or uncooperative patients.

Institutionalized elders are at particular risk of confusion. From 40% to 80% experience some degree of organic brain disease, with disorientation to time, place, and person; remote and recent memory loss; and inability to do simple calculations. In many long-term care facilities, more than 30% of the patients have severe confusion (Touhy and Jett, 2010). The precipitating factors depend on both the physiological and psychological condition of the patient.

Early morning confusion, sometimes called **sunrise syndrome,** may result from the hangover effects of sedative-hypnotics or other nighttime medications that interact with drugs for sleep. Sleep problems and insomnia are common in the elderly population. Adverse reactions to drugs prescribed for sleep often occur.

Increasing disorientation or confusion at night, resulting from loss of visual accommodation and other factors, is known as **sundowning syndrome**. The nurse should take special precautions to prevent falls at these times. The most logical cause of sundowning is the deterioration of the suprachiasmatic nucleus in the hypothalamus. This major pacemaker of circadian rhythms regulates the sleep-wake cycle (see Chapter 5), and it is deteriorated in demented people.

The nurse can assess and minimize or eliminate many environmental and underlying physiological causes of afternoon or evening confusion or irritability by the following:

- Elimination of psychosocial, toxic, infectious, metabolic, or pharmacological causes of delirium
- Elimination of underlying physiological causes of agitation and confusion, such as pain, febrile illnesses, and incontinence
- Minimization or elimination of daytime sleep
- At least minimal exposure to direct sunlight each day, particularly in the morning, to reset the circadian pacemaker
- Increase in mild activity, such as walking

- Increase in conversations and other social interactions with staff and others
- Evaluation of the need for short-term use of low-dose antipsychotic drugs

Critical Reasoning A nurse's aide tells you that a patient is "wandering down the hall, staggering, pajama top unbuttoned." It is early morning, and the other patients are asleep. What would you do in this situation?

Never assume that confusion and disorientation are natural results of changes in cognitive or physiological status. **Confusion is reversible in more than one half of the patients who experience it**. It is usually transient or short term. The nurse has primary responsibility for intervening in this problem. Well-planned nursing care can be a significant factor in preventing and intervening in this distressing condition.

Although the term **disorientation** is often used interchangeably with **confusion,** they are different. A disoriented patient is not necessarily confused, and a confused patient does not necessarily experience complete disorientation. Mental status tests differentiate disorientation to place, person, and time from components of confusion, such as alterations in memory, judgment, decision making, and problem solving. Cognitive responses are discussed in detail in Chapter 22.

Paranoia. Some older people react to loss, isolation, and loneliness with paranoia and fear. **Classic paranoia, involving a well-organized and elaborate delusional system, is rare in older people.** Paranoid delusions and disturbances in mood, behavior, and thinking may be caused by anxiety, confusion, sensory deprivation, sensory loss, social isolation, medications, deliriums, and dementias.

Paranoid symptoms may be general or specific. The geriatric patient may feel threatened by certain people (e.g., unfamiliar staff; family, friends, or neighbors) or at certain times (e.g., night). Relocation to a new home, new room, or strange environment may cause fear, anxiety, and for some, paranoid ideation. Validating a person's paranoid ideation is not appropriate. The provision of a sense of safety and security is comforting and helpful.

Aging paranoid patients present with withdrawal, aloofness, fearfulness, oversensitivity, and often secretiveness. As long as patients do not call attention to themselves or threaten themselves or others, their paranoia may remain hidden. After they become a potential threat to themselves or others, institutionalization may be needed. Older people who have transient or chronic paranoia are at high risk for victimization by others as well as self-neglect and self-abuse (e.g., refusal to eat, take prescribed medications, or attend to hygiene needs).

Affective Responses

Disturbances in mood, mood swings, or oversensitive emotional reactions are common to people of all ages. An older person's reaction to physical limitations or disabilities, psychological loss (particularly of a spouse or other close person), or the possibility of institutionalization depends on past coping styles, support systems (especially family), and current psychological and physiological strength.

Extreme or sudden mood changes occur in response to stress or as inadequate coping mechanisms in people facing progressive loss or dependency. When this behavior is seen in elderly people who have been content and happy, physiological factors, including side effects of medications, should be considered. Reassurance and support are given to reduce the patient's anxiety and diminish the perceived threat.

Dysfunctional Grieving and Hopelessness. Depression and sadness are sometimes viewed as a natural part of aging. Grief and loss are common in later life. **Prolonged grief and mourning over a real or imagined loss should be recognized and treated as depression**. Common symptoms include weight loss; appetite loss; fatigue; apathy; loss of interest in friends, family, and usual activities; and psychomotor retardation. None of the symptoms is caused by increasing age; all are problems that can be effectively treated (see Chapter 18).

Death of a life partner can add to the many losses of aging. Key points for the nurse to remember when caring for a grieving elder are as follows:

- Elderly widows or widowers are likely to have experienced many losses with aging, which complicates the grieving process.
- Coping strategies of elderly widows or widowers include faith, flexibility, participation in activities, and support of family or friends.
- Symptoms of grief, such as disruptions in sleeping and eating patterns, can lead to false labels of dementia.
- Peaks and valleys of grief are less intense in the eldest widow(er)s because they are more at peace with their own mortality.

The loss of hope expressed by some older people, particularly those with increasing disabilities, may cause or result from a depressive reaction. Undiagnosed depression may have serious effects on the elderly because depression always involves physical symptoms.

The person's attitude toward aging, dying, and death influences whether the depression can be treated successfully. The old differ from the young in their attitudes toward death in several ways. Elderly people tend to:

(1) Integrate attitudes about death with their religious beliefs
(2) Have experienced the death of significant others
(3) Be more accepting of death
(4) Approach problems primarily from an internal focus

The state of the elderly person's health, in addition to what the person has learned from seeing other people die, may signal that life is ending. Awareness of the older person's "sense of dying" is important to understanding the person's needs and concerns.

Risk for Self-Directed Violence. Intentional deaths among the elderly are common. **Elderly people in the United States have the highest suicide rate of any age group.** The suicide

BOX 37-3 RISK FACTORS FOR SUICIDE IN THE ELDERLY

- Depression, which is often undiagnosed and untreated
- Recent death of a loved one
- Physical illness, uncontrollable pain, or fear of a prolonged illness
- Substance abuse
- Perceived poor health
- Social isolation and loneliness
- Major changes in social roles (retirement)

rate of white males older than 75 years is especially high (Centers for Disease Control and Prevention, 2010). **The risk factors for suicide in the elderly are presented in Box 37-3.**

Although the elderly who plan suicide talk about it less, they use more violent and lethal means to take their lives, resulting in a higher ratio of completed-to-attempted suicides. **Effective treatment must include prevention.** Sadly, most elderly suicide victims have seen their primary care provider in the month before their deaths, but their suicidal intentions were not detected, and they were not treated for their depression.

Other examples of intentional deaths include excessive risk taking; lack of caution in the management of ordinary affairs; refusal to eat; overuse or misuse of alcohol or drugs; and noncompliance with life-sustaining medical regimens, such as refusal to take insulin or digoxin. Intervening in suicidal behavior is discussed in detail in Chapter 19.

> **Critical Reasoning** Were you surprised to learn that the elderly have the highest suicide rate? How would you increase public awareness of this important public health problem?

Situational Low Self-Esteem. Low self-esteem in the elderly is often expressed through preoccupation with physical and emotional health and expression of concern through body complaints. This may be labeled *hypochondriasis,* but it really represents the person's insecurity.

One of the problems encountered by elders with a history of somatization is health professionals' tendency to dismiss their complaints, assuming there is no real illness. All symptoms should be taken seriously and investigated thoroughly. Somatization is discussed in Chapter 16.

As a sign of the geriatric patient's sense of deterioration, somatization communicates the distress that accompanies decreased self-worth. The sick role is a legitimate and socially acceptable way to deal with stress and anxiety. The patient receives support, concern, and interest and experiences a sense of control. Unfortunately, caregivers may reinforce the elder's dependency by providing care that discourages the patient from doing for himself. This vicious cycle sets the stage for behavioral deficits, excess disability, and decreased self-worth (Lubkin and Larsen, 2006). Ways in which to promote self-esteem are discussed in Chapter 17.

Somatic Responses

Disturbed Sleep Pattern. Insomnia may be a symptom or a problem in itself for the geropsychiatric patient. **Many older adults experience chronic or intermittent sleep problems.** Persistent insomnia, a risk factor for major depression, occurs among 5% to 10% of elders. Complaints of interrupted sleep; loss of sleep; or poor sleep, with frequent awakenings and morning exhaustion, are common. Daytime napping and drowsiness add to the problem. Nonetheless, sleep disorders in the elderly can be systematically diagnosed and treated (Saxon et al, 2010).

Opinions vary regarding normal sleep patterns in older adults. Some researchers suggest that people need less sleep as they age. However, chronic fatigue, physical illness, pain, and decreased mobility may cause a need for more sleep. Geriatric patients often express distress over their inability to sleep well. Perceived lack of sleep becomes a cyclical reaction. Worry about lack of sleep prevents falling asleep. Fatigue is the most common physical complaint of adults older than 75 years. Lack of exercise, limited mobility, and side effects of drugs also may contribute to insomnia. Sleep hygiene measures are described in Chapter 16.

Imbalanced Nutrition: Less than Body Requirements. Appetite loss is common in patients with depression. Inadequate dietary intake also occurs in confused or disoriented patients. Forgetting to eat or being unable to prepare meals may add to the problem of appetite loss.

Side effects of some drugs (e.g., dry mouth, change in taste) contribute to lack of interest in food. The toothless patient or someone with ill-fitting dentures or gum disease avoids chewing when possible. The interaction of appetite loss and emotional dysfunction should always be considered in the nutritional evaluation. **Poor nutrition contributes to fatigue, listlessness, and immobility.**

Stress Responses

Progressively Lowered Stress Threshold. Nurses should know the competencies and capacities for environmental mastery of cognitively impaired patients. For instance, as cognitive responses slow, the stress threshold decreases and capacities deteriorate. This is known as **progressively lowered stress threshold (PLST).** Staff members often overwhelm sensory processing and coping abilities of elderly patients, leading to **catastrophic reactions** and other challenging behaviors. Finding a better fit between the patient's stress threshold and the demands of the environment can strengthen patient competencies and reduce behavioral excesses.

Relocation Stress Syndrome. **Relocation stress syndrome** involves physical or psychosocial disturbances related to moving from one environment to another. The care of many of the elderly has shifted to assisted living or long-term care facilities. This shift drew attention to the process and consequences of relocation. Behaviors associated with relocation stress syndrome are listed in Box 37-4.

BOX 37-4 BEHAVIORS ASSOCIATED WITH RELOCATION STRESS SYNDROME

- Anxiety, apprehension, restlessness, and verbalization of being concerned/upset about transfer
- Vigilance; dependency; increased verbalization of needs, insecurity, and lack of trust
- Increased confusion
- Depression, sad affect, withdrawal, and loneliness
- Sleep disturbance
- Change in eating habits, gastrointestinal disturbances, and weight changes
- Unfavorable comparison of posttransfer and pretransfer staff

Risk factors related to relocation stress syndrome include the following:

- Impaired psychosocial or physical health status
- Other recent losses
- Losses associated with the move
- Inadequate preparation for the move
- Feelings of powerlessness
- Moderate to great difference between the old and new environments
- Prior relocation experiences
- Inadequate support system

The stress of relocation should be anticipated for all geriatric patients. Interventions should be planned to reduce the impact. It may be helpful to arrange for the patient to visit the new location before the actual move. This allows the patient to meet other residents and staff, see the physical surroundings, and ask questions. Allowing the patient to have personal belongings and careful explanations of the programs, schedules and routines of the new location are some ways in which the stress of change can be minimized.

It has been suggested that relocation stress may be related more to residents' perceptions of their new environment than the actual move. Nurses should also consider that what appears to be relocation stress syndrome may be undiagnosed and untreated depression.

Risk for Caregiver Role Strain. Disabled elderly people who live in the community rely on support and care from family members. As the percentage of elderly people in the population grows, family resources will be increasingly important to keep elders in the community and provide care that is less expensive than professional care.

This role carries rewards and burdens and can be stressful for people who care for frail elders. **Providing elder care can result in emotional, physical, interpersonal, and occupational problems for the caregiver.** Stress to the caregiver increases over time. A caregiver under stress is at risk for problems in performing the caregiver role. Risk factors for caregiver role strain are listed in Table 37-3.

TABLE 37-3 RISK FACTORS FOR CAREGIVER ROLE STRAIN

CATEGORY	RISK FACTORS
Pathophysiological	Severe illness of elder Unpredictable illness course Addiction or co-dependency Elder discharged with serious home-care needs Caregiver health impairment
Psychosocial	Female caregiver Psychosocial/cognitive problems in care receiver Family problems before caregiving Marginal caregiver coping patterns Poor relationship between caregiver and receiver Spouse caregiver Deviant or bizarre behavior of care receiver
Situational	Abuse or violence Other sources of stress on family Need for long-term caregiving Inadequate physical environment Family/caregiver isolation Lack of caregiver respite or recreation Inexperience Competing role commitments Complex/demanding caregiving tasks

Other factors affecting the caregiver that can predict institutionalization of the elderly, include the following:

- Safety concerns
- Incontinence
- Erratic sleep patterns of care recipient
- Critical health events (e.g., falls, wandering, hospitalization)

Nurses are in a unique position to identify and address the caregiver's needs for education, intervention, and support services. This includes developing outreach programs and coordinating information to encourage caregivers to address their own symptoms, identify services available in the community, and learn how to access them. Such support can decrease caregiver role strain and premature institutionalization of the elder (Cangelosi, 2009; Sörensen and Conwell, 2011).

Behavioral Responses

Social Isolation. **Multiple social losses or fear of loss may lead to social isolation.** Prolonged grief after the loss of a spouse, sibling, child, or close friend may make the elder hesitant to become involved in other close relationships. The person who has been close to only a few family members or friends will have even more difficulty with loss.

Elderly patients experiencing organic cognitive impairment (e.g., Alzheimer disease, related disorders) often withdraw from social contacts, daily routines, and ADLs. They may deny having a problem or fear the consequences of memory

changes. Social isolation can become a defense mechanism, reinforcing denial of perceived disability but worsening the cognitive deficits. Sensory deficits such as hearing or vision impairment also can contribute to isolation for the elderly.

Self-Care Deficit/Behavioral Deficit. **Chronic illness is one aspect of aging that may result in the inability to care for oneself.** With increasing age comes a greater chance of multiple long-term health problems. Affective illnesses such as major depression or bipolar disorder may cause psychomotor retardation, preventing elders from meeting their basic needs. Medications may cause forgetfulness, lethargy, and physical impairment.

Because of increasing frailty or cognitive impairment, many elders are unable to converse or complete basic self-care activities such as bathing, toileting, grooming, and feeding. The underlying cause of the deficit must be determined and appropriate nursing interventions planned.

Aphasia, agnosia, and apraxia contribute to self-care deficits. Admission to a nursing home often results in dependency in ADLs among those who previously were independent in such basic activities. Nurses are in a unique position to reduce the incidence of behavioral deficits and excess disability by enhancing self-efficacy and environmental competence.

Challenging Behaviors and Behavioral Excess. **The high incidence of challenging behaviors is very troubling to caregivers.** Even one resident displaying such behaviors can disrupt an inpatient unit or nursing home floor, setting off a chain reaction in other residents and contributing significantly to caregiver stress. Nurses can assist staff members to assess and intervene effectively using a variety of behavioral and environmental strategies, reducing use of physical and chemical restraints. Enhancing the self-efficacy of staff members in perceiving and coping with challenging behaviors decreases negative feelings of stress and vulnerability to burnout.

PLANNING AND IMPLEMENTATION

Expected outcomes related to the nursing care of the geropsychiatric patient should be realistically based on the person's potential to change. If the person's challenging behaviors result from a treatable disorder, expected outcomes and short-term goals may reflect a return to prior functioning. For example, a goal for a patient with depression who is neglectful of personal hygiene may be as follows: The patient will bathe, dress, and brush teeth independently.

If the condition is chronic and either no change or progressive deterioration is expected and current treatments do not effect change in target behaviors, the outcomes of care focus on adaptation to the situation. For example, a goal for a person with Alzheimer disease who neglects personal hygiene may be as follows: The patient will help with bathing, dressing, and brushing teeth.

If the patient's condition is not expected to improve, the expected outcomes and goals may focus on the caregiver as well as the patient. For example, a goal for a caregiver of a person with Alzheimer disease may be as follows: At least once each week, the caregiver will participate in a recreational activity outside the home while the home health aide is with the patient.

The plan of care must be developed with the active participation of the patient and the caregiver. It must be reviewed often to ensure that it is relevant to the patient's current needs and goals. Caregiver education is an important part of the plan.

Older adults respond well to both individual and group interventions. They need the opportunity to talk, be supported in their efforts to deal with day-to-day life and challenges, and plan for a meaningful future. The type of nursing intervention selected depends on the nursing care problems identified, the interests and preferences of the elder, and the setting in which the care is to be provided. Nursing care for cognitively impaired patients is addressed in Chapter 22. **Evidence-based treatments for depression in the aged are summarized in Table 37-4.**

Therapeutic Milieu

Whether in a hospital, nursing home, community program, or at home, the care environment should support effective interventions. There are several basic characteristics of a therapeutic milieu for the elderly.

Cognitive Stimulation. Activities should be planned to maintain or improve the patients' cognitive functioning. Discussion groups help patients focus on topics of interest to them while they socialize. Projects can reinforce skills and offer an opportunity for success. Patients with dementia can

TABLE 37-4 SUMMARIZING EVIDENCE-BASED TREATMENT FOR

Practice on Depression in the Aged

TREATMENT	APPLICATIONS
Pharmacological therapy	Antidepressant medications (selective serotonin reuptake inhibitors [SSRIs], serotonin-norepinephrine reuptake inhibitors [SNRIs], and tricyclic antidepressants [TCAs]) were effective in the acute and maintenance phases of late-life depression, although the latter has a heightened risk of adverse side effects.
Electroconvulsive therapy (ECT)	ECT has shown its effectiveness and safety in the short-term management of late-life severe depression, psychotic depression, and suicidal state.
Psychological therapy	Cognitive behavioral therapy, reminiscence therapy, brief psychodynamic therapy, and a combination of interpersonal therapy and medication have the most evidentiary support for the treatment of mild to moderate major depression.

participate in a wide variety of activities. The nurse can collaborate with the rehabilitation therapist in planning interesting and appropriate activities.

Promotion of a Sense of Calm and Quiet. Elders often do best in a setting that is designated for their care. In particular, inpatient units that admit all age groups may be too stimulating for confused elder patients. In general, the geropsychiatric setting should be decorated in soft colors. If music is played, it should be soothing and preferably familiar to the elderly. Bright lights that create glare should be avoided.

Although the environmental background should be subdued, planned periods of increased activity help maintain interest and alertness. For elders who are not in their own home, personal articles such as family pictures, religious objects, favorite books, afghans, or decorative objects are reassuring and offer a sense of security.

Consistent Physical Layout. In residential or inpatient settings, room changes should be avoided as much as possible. Furniture arrangements should be stable, which helps disoriented people orient themselves and adds to their security. Environmental barriers should be removed for wandering patients.

Structured Routine. The daily schedule should be as predictable as possible. Bedtime, waking time, nap times, and mealtimes should not vary. For elders who have recently moved to a new setting, it is helpful to give them and their families copies of the weekly schedule. Time should be allowed for reviewing the schedule together. Periodic reinforcement of the routines may be needed until patients adjust to the environment. A predictable routine can enhance an elder's capacity to function at maximum level.

Focus on Strengths and Abilities. Elders have a lifetime of experience and wisdom and strengths related to their past accomplishments. If the person is unable to communicate, family members can give information about the patient's life and suggest activities that are likely to be successful. Nursing creativity can be used to find ways to capitalize on elders' strengths by planning opportunities for them to help staff members and other patients participate in activities based on their abilities. Successful experiences can enhance perceptions of self-efficacy, resilience, and control while decreasing premature dependency.

Minimization of Challenging Behavior. Understanding the patient's behavioral patterns can help reduce agitation and behavioral crises. Observation reveals situations and early warning signs of escalation that lead to challenging behaviors. Adhering to the person's usual lifestyle as closely as possible reduces conflicts. For instance, a person who has always taken a bath in the evening before bed should not be forced to shower before breakfast.

Patients who agitate each other should be kept apart as much as possible. Distraction often can interrupt a conflict before it gets out of control. Understanding challenging behaviors or behavioral excesses from the elder's perspective can strengthen the nurse's ability to design interventions that affect underlying causes.

Minimal Demands for Compliant Behavior. Older adults have the right to make choices and have control. Some older adults resent being under the control of others and feel the need to assert themselves. If the patient needs to be in control, it is helpful to negotiate a time of voluntary compliance. Providing areas of choice and control can reduce resistive behavior. Elders who are cognitively impaired often resist demands from others. They may not understand what is being asked of them, or they may be frightened of an unexpected change in activity. It is best to avoid pressuring the patient to comply. Approaching the person at another time is often successful.

> **Critical Reasoning** How would the therapeutic milieu differ if most patients were elderly and (1) depressed, (2) demented, (3) delusional, or (4) cognitively intact?

Provision of Safety. **Safety is fundamental to a therapeutic milieu.** The nurse should be alert for safety hazards and remove them. Because falls are a concern, floors should be free from slippery spots, obstacles, uneven surfaces, and loose rugs. Thresholds should be flush with the surrounding floor. Hand rails and grab bars are helpful for frail elders. Fire is also a concern. Open flames should be avoided.

In a few facilities, **restraints** are still used in the mistaken notion that they enhance the patient's safety or control challenging behavior. Physical restraints include a variety of devices, such as mitts, Posey vests, and Geri-chairs, applied with a physician's order, although nurses are the professionals most intimately involved in decisions to restrain patients. Although these devices may help staff, they limit patient freedom of choice and movement, can cause serious injury, and can threaten dignity.

Reducing the use of physical restraints is a national goal, which is being promoted by all members of the health care team. Six myths related to physical restraint of elderly patients are summarized in Table 37-5.

To limit the use of restraints and to incorporate more appropriate methods to address safety concerning the elderly, nurses, in collaboration with other health care professionals, should develop a hospital or facility policy and protocol related to the use of restraints. National nursing efforts to expose these myths and realities led to federal regulations to implement less-restrictive alternatives, resulting in a significant reduction in use of restraints.

Somatic Therapies

Electroconvulsive Therapy. Electroconvulsive therapy (ECT) has been an effective treatment for depression in the older adult. It is used particularly for patients with severe major depressive disorder, nonresponders, or those who

TABLE 37-5 MYTHS AND REALITIES ABOUT PHYSICAL RESTRAINT

MYTH	REALITY
Restraints reduce the risk of injury related to falls.	Restraints do not reduce the risk of injury from falls and may increase it. Falls do increase the likelihood of future restraint.
Restraining meets the nurse's moral duty to protect the patient from harm.	Restraints may increase the risk of injury and lead to problems related to immobility, confusion, aggression, depression, and incontinence.
Failure to restrain results in legal liability.	Federal and state laws and regulations prohibit the unnecessary use of restraint.
Older people do not mind being restrained.	Older people do not wish to be restrained. They feel angry, hurt, and embarrassed by the experience.
Inadequate staffing justifies restraining patients.	Federal and state laws and regulations forbid restraining patients for staff convenience. Providing adequate nursing care to a restrained patient takes at least as much time as caring for an unrestrained one.
There are no adequate alternatives to physical restraint.	Nursing care alternatives have been identified in several categories: Physical care: comfort, relief of pain, positioning Psychosocial care: remotivation, communication, attention Activities Environmental manipulation: improved lighting, removal of restraint devices, redesigned furniture Administrative support and staff training

cannot tolerate antidepressant side effects (McClintock et al, 2011). ECT is discussed further in Chapter 27.

Psychotropic Medications. The addition of psychotropic medications to the care regimen of elders must be approached carefully and competently (Schatzberg et al, 2010). **Basic guidelines for medication administration for elders include the slow initiation of medications, preferably one at a time, using lower dosages: "start low and go slow," although treatment must be maintained at a therapeutic level for an appropriate duration to be effective.**

Special consideration must be given to psychotropic medications and elders, because drugs that affect behavior also affect the central nervous system. Elderly patients are especially vulnerable to developing side effects, with sedation, orthostatic hypotension, agitation, extrapyramidal symptoms, and anticholinergic effects being particularly troublesome. The side-effect profiles of newer medications that more specifically impact target neurotransmitters are more favorable for older adults, although careful assessment of risks and benefits is essential.

The nurse should remember that age-related pharmacokinetic and pharmacodynamic changes affect drug response and increase the risk for side effects in the elderly. Table 37-6 describes recommended starting and daily dosages of psychotropic medications for the elderly. **Antipsychotic medications taken by patients with dementia are associated with higher mortality rates and the worsening of cognitive functioning** (Vigen et al, 2011). Other medications, such as benzodiazepines, also have adverse cognitive effects. Despite these effects, antipsychotic use is frequent, with a report that 29% of nursing home patients receive at least one antipsychotic medication (Chen et al, 2010). Chapter 26 has a thorough discussion of psychopharmacology.

Special attention must be given to the older adult when assessing medication use. **Four factors place the elder at risk for drug toxicity and should be included in any assessment: advanced age, polypharmacy, decreased medication adherence, and co-morbidity.** Misuse of drugs by the elderly is also a factor in the rising cost of health care for this population.

Age. As a person ages, physiological responses to medications change. **For those older than 65 years, drug dosages must be monitored carefully for continuing effectiveness.** A medication dosage that is safe and effective at age 65 years may be toxic at age 75 years. Gastrointestinal absorption, hepatic blood flow and metabolism, and renal clearance may all decline.

The ratio of fat to lean muscle mass increases with age. Many psychoactive medications are **lipophilic** (attach to fat), which increases the risk of drugs building up in fatty tissue and causing toxicity. Experimental drugs are often tested on nonelderly adult populations. This does not allow evaluation of the differing effects of newly approved drugs on older people before they are made available in the marketplace.

Polypharmacy. **It has been estimated that older adults take an average of 8 to 10 medications daily**. It is also suggested that the use of over-the-counter medicines is underreported because they are not thought to be significant. Drugs such as alcohol and acetaminophen (Tylenol) are not always reported but can be toxic in combination with other drugs. The risk for drug-drug interactions is significantly increased.

Adherence. Many drugs may take up to 6 weeks to effect a change in affective disorders. In the interim, elders may see no benefit to continued adherence and may abandon their medication regimen. Education regarding the time to effectiveness, the purpose, therapeutic value, and side effects (and their treatments) of medications should be provided to elders to enhance medication adherence and awareness.

Co-morbidity. Acute and chronic illnesses and their treatments can alter the body's response to psychotropic medications, including chronic renal or liver failure, congestive heart failure, and structural and functional changes in the central

TABLE 37-6 **PSYCHOTROPIC MEDICATIONS**

CATEGORY	RECOMMENDED STARTING/DAILY DOSAGE RANGE FOR OLDER ADULTS
Selective Serotonin Reuptake Inhibitors and Other Antidepressants	
Bupropion (Wellbutrin SR) (NDRI)	100/100-300 mg/day
Bupropion (Wellbutrin) (NDRI)	37.5-75/75-225 mg/day
Citalopram (Celexa) (SSRI)	10-20/10-40 mg/day
Duloxetine (Cymbalta) (SNRI)	20/20-60 mg/day (40-60 mg divided bid)
Escitalopram (Lexapro) (SSRI)	10/10-20 mg/day
Fluoxetine (Prozac) (SSRI)	5-10/5-40 mg/day
Fluvoxamine (Luvox) (SSRI)	50/50-150 mg/day
Milnacipran (Savella)	12-50 mg
Mirtazapine (Remeron) (NaSSA)	7.5/7.5-45 mg/day
Nefazodone (Serzone) (SARI)	25-50/50-200 mg/day
Paroxetine (Paxil) (SSRI)	10-40 mg/day
Sertraline (Zoloft) (SSRI)	12.5-25/12.5-200 mg/day
Trazodone (Desyrel) (SARI)	25/25-100 mg/day (insomnia) 25/75-150 mg/day (antidepressant)
Venlafaxine (Effexor) (SNRI)	25/150-225 mg/day IR (divided bid to tid)
Venlafaxine (Effexor XR) (SNRI)	37.5/150-225 mg/day
Vilazodone (Viibyrd)	10-40mg/day
Tricyclic Antidepressants (TCAs)	
Desipramine (Norpramin)	25/25-150 mg/day
Nortriptyline (Aventyl, Pamelor)	10-25/10-100 mg/day
Monoamine Oxidase Inhibitors (MAOIs)	
Phenelzine (Nardil)	7.5/7.5-45 mg/day
Tranylcypromine (Parnate)	5/5-30 mg/day
Mood Stabilizers	
Carbamazepine (Tegretol)	200/200-800 mg/day (divided bid)
Lamotrigine (Lamictal)	12.5/100-300 mg/day
Lithium	75-150/150-1200 mg/day
Valproate (Depakote)	125-250/250-1500 mg/day (divided bid)
Anxiolytic and Sedative-Hypnotic Agents	
Buspirone (BuSpar)	10/10-60 mg/day, divided doses
Clonazepam (Klonopin)	0.25-0.5/0.25-2 mg/day
Estazolam (ProSom)	0.5/0.5-2 mg qhs
Eszopiclone (Lunesta)	1-2/1-2 mg hs
Gabapentin (Neurontin)	100/100-1800 mg/day
Lorazepam (Ativan)	0.5-1/0.5-1 mg bid to tid (anxiety) 0.5-1/0.5-1 mg hs (insomnia)
Oxazepam (Serax)	10 bid to tid/10-15 mg/day tid (anxiety) 10-15/10-30 mg hs (insomnia)
Ramelteon (Rozerem)	8/8 mg hs
Temazepam (Restoril)	7.5/7.5-15 mg qhs
Zaleplon (Sonata)	5/5-10 mg hs
Zolpidem (Ambien)	5/5-10 mg qhs
Antipsychotics, Atypical	
Aripiprazole (Abilify)	5-15 mg/day
Asenapine (Saphris)	10 OCT
Clozapine (Clozaril)	6.25-12.5/6.25-400 mg/day (divided doses)
Olanzapine (Zyprexa)	2.5/2.5-10 mg/day
Quetiapine (Seroquel)	25/25-400 mg/day (divided bid to tid)
Risperidone (Risperdal Consta)	25/25-50 mg IM every 2 weeks (continue oral antipsychotic for 3 weeks after first injection)
Risperidone (Risperdal)	0.25-0.5/0.25-3 mg/day

Continued

TABLE 37-6 PSYCHOTROPIC MEDICATIONS—cont'd

CATEGORY	RECOMMENDED STARTING/DAILY DOSAGE RANGE FOR OLDER ADULTS
Antipsychotics, Typical	
Perphenazine (Trilafon)	2-8/2-32 mg/day
Fluphenazine (Prolixin Decanoate)	10/5-100 mg/mo
Thioridazine (Mellaril)	10/10-200 mg/day
Chlorpromazine (Thorazine)	10/10-200 mg/day
Haloperidol (Haldol)	0.25-0.5/0.25-4 mg/day
Fluphenazine (Prolixin)	0.25-0.5/0.25-4 mg/day (oral; divided)

bid, Twice daily; *hs*, at bedtime (hour of sleep); *IM*, injection; *IR*, immediate release; OCT orally disintegrating tablet; *NaSSA*, noradrenergic and specific serotonergic antidepressant; *NDRI*, norepinephrine and dopamine reuptake inhibitor; *qhs*, every night at bedtime; *PO*, orally; *SARI*, serotonergic 2 antagonist reuptake inhibitor; *SNRI*, serotonin-norepinephrine reuptake inhibitor; *SR*, sustained release; *SSRI*, selective serotonin reuptake inhibitor; *tid*, three times daily; *XR*, extended release.

nervous system. These conditions may result in heightened sensitivity to psychotropic drugs.

Interpersonal Interventions

Psychotherapy. Elderly patients can benefit from both individual and group psychotherapy. It is unfortunate that the use of psychotherapy remains uncommon among elder adults despite its widely acknowledged efficacy. Nurses who have advanced degrees in psychiatric nursing are qualified to provide these services. The following evidence-based therapeutic approaches are used in treating a variety of psychiatric problems:

- **Interpersonal psychotherapy** (IPT) has been demonstrated to be effective in treating depression and anxiety in older adults, although most studies have evaluated IPT in combination with psychopharmacology. The foci of treatment include grief, role changes, caregiving burden or stress, multiple losses, bereavement, social isolation, and helplessness (Hinrichsen, 2009).
- **Cognitive behavioral therapy (CBT) is the most researched psychotherapy with older adults with proven efficacy.** It has several goals that include changing thoughts and behaviors, improving skills, and modifying emotional states. CBT is an evidence-based treatment for many psychiatric disorders (Bienenfeld, 2009). It is described in Chapter 27.
- **Problem-solving therapy** is also an evidence-based treatment for elders with mild depression (Arean, 2009). Problem-solving therapy is person-centered, helping patients in identifying issues that are critical in their lives. These issues should be described in a measurable and observable format, appropriate solutions to these issues should be devised, and possible consequences should be predicted.

Life Review Therapy. **Life review and reminiscence therapies are effective nursing interventions**. They provide an opportunity for the person to reflect on life and resolve, reorganize, and reintegrate troubling or disturbing areas.

Life review works well with groups or individuals. In a group, members may positively reinforce each other and stimulate mutual learning. Developing individual autobiographies to share with the group is one way to introduce common experiences and interests among the members and put them at ease. In addition to the positive effect of the review itself, group cohesion and sharing can build self-esteem and a feeling of belonging.

Life review therapy differs from **reminiscence.** Both are planned interventions that are led by a mental health professional.

- **Reminiscence is usually a pleasant unstructured experience in which the patient reviews life events and talks about meanings and feelings.** The nurse listens and responds but does not try to interpret or probe for deeper meanings.
- **The life review is structured, with the emphasis on analyzing life events.** The nurse helps the patient look for the meaning of experiences and resolve conflicts and lingering feelings. Life review may help the elder achieve the ego integrity and wisdom identified by Erikson (1963) as the goal of the last stage of life.

Cognitive Approaches. Cognitive interventions are critical for healthy as well as ill older adults (Williams and Kemper, 2010). For those with cognitive impairment, reality orientation, along with a discussion of current events, stimulates patients to maintain contact with the world and their place in it. Current events discussions, used alone, may be structured in various ways, such as sharing of newspaper articles or group viewing of television news programs. The scope of the group depends on the patients' abilities and the other therapeutic modalities at hand. Reality orientation discussion is not meant to be a "do you know" test but rather an orienting conversational aid, avoiding potential adverse emotional responses.

The environment, when it is kept simple and focused, reinforces contact with reality, the here and now. Helpful physical props include pictures, photos, clocks, directional signs, calendars, and orientation boards (e.g., season of the year, weather).

Validation Therapy. Some elders may become more anxious or agitated if constantly reminded of environmental realities. An alternate approach to confused and disoriented

older adults was developed by Feil (1984) working with those who did not respond to reality orientation. **Validation therapy involves searching for the emotion and meaning in the patient's disoriented or confused words and behavior (e.g., wandering) and validating them verbally with the patient.**

A series of verbal cues allow the patient to focus on key words or phrases in the confused interaction, and the nurse validates by asking for description, more detail, or clarification. What is sometimes identified as meaningless or incoherent conversation may have significant meaning for the patient related to current or past events. Validation is being used successfully with both mild and moderately impaired elders.

Stimulation Approaches. Intelligence does not decline with age, but it may be dulled by depression, drugs, or lack of use. Stimulating activities or recreational therapies can keep older adults active mentally, which enhances emotional well-being and positive engagement while decreasing passive behaviors. **The "use it or lose it" adage is true for the maintenance of mental, emotional, and physical functioning.**

The nurse must be familiar with the patient's past occupation, hobbies, and leisure activities to be able to capitalize on the patient's interests and skills in developing stimulating activities. The nurse should gather as much of that information as possible in the nursing interview on admission and add it to the database to strengthen the therapeutic alliance.

Relaxation Therapy. Besides promoting a sense of physical well-being, relaxation can release tension and reduce stress, reducing barriers to communication. Information about relaxation training is presented in Chapter 15. Relaxation, combined with mild isometric exercises, increases cardiovascular output, energy, and mobility and reduces stress. Relaxation and exercise strategies, used individually or in groups, do not require advanced skills of the nurse or the patient.

The patient should begin with simple tension-releasing muscle exercises, coupled with the nurse's verbal instructions about breathing and concentration. Other sensory stimulation strategies include music, aromatherapy, and therapeutic touch. Meaningful activity programs are increasingly being used to meet patients' physical activity and social needs while reducing the incidence of behavioral challenges such as wandering (Tampi et al, 2011).

Supportive and Counseling Groups. Geropsychiatric patients respond well to both supportive and counseling groups. These interventions may use either a nondirective or unstructured format or a more structured, didactic approach. Group members can ventilate feelings, try out problem-solving approaches, and resolve conflict in a thoughtful, systematic way. The groups may incorporate some aspects of cognitive training or reminiscence. Older adults respond well to a supportive group structure that increases self-esteem, self-confidence, risk taking, and empathy.

Humor may be an effective way to reach the nonverbal or withdrawn elder. The ability to laugh at oneself and see the irony in everyday events provides an effective outlet for frustration, anger, stress, and anxiety. Promoting humor by telling jokes and stories and watching cartoons or situation comedies can be therapeutic in a group or with individual patients and caregivers. Expressions of humor and active laughter allow older adults to step out of their situations, releasing some of the tension related to coping with changes accompanying aging.

Patient Education. Older adults often question the physiological and cognitive changes that occur naturally in aging. Slowed response time, benign memory loss, altered gait, and interrupted sleep patterns are a few of the normal changes of aging that elders may interpret as pathological. The nurse can teach patients about their own developmental changes during the assessment.

Dispelling myths and stereotypes related to aging is a primary goal for patient education. Exercises for promoting positive thoughts and images, visualization, and repetitive cognitive games can be used as a basis for teaching new patterns of behavior. Cognitive training, relaxation, and life review approaches are well suited to patient education formats. Given the significant adherence issues among older adults, user-friendly education about medications and drug regimens must be reinforced regularly.

Critical Reasoning Your friend's grandfather is 85 years old and constantly complains of feeling tired and forgetful. He has been to many physicians and still feels no better. Your friend asks what she should do next. How do you respond?

Family Education and Support. Because 80% to 85% of the elders living at home are cared for by a spouse, sibling, their adult child, or that child's spouse, education and support groups for family caregivers are essential. Many community agencies, clinics, and senior citizen centers are responding to the needs of family caregivers with special activities, classes, and support groups. Family members often view nurses as the most approachable health care professionals in understanding family relationships, conflicts, needs, and resources.

Family education about aging processes, family dynamics, problem solving, behavioral management, the caregiving trajectory, and stresses inherent in the caregiver role need to be integrated into counseling sessions with family members regardless of the setting. Families genuinely want to provide good caregiving for as long as possible. Nurses can support family caregivers of geropsychiatric patients to help them be successful and feel less burdened.

EVALUATION

Evaluation of patient care should be based on a model that explains the progression of behavior from adaptive to maladaptive. The type of care and the evaluation of outcome are directly related to the level of behavior targeted for intervention. The goal of nursing intervention is to promote

maximum independence of the older adult based on capacity and functional abilities.

Evaluation of outcomes of nursing care should not be based on reversal of behaviors or elimination of patient needs but on the change the patient demonstrates based in individual abilities. This approach reinforces the emphasis on the patient as an individual and allows for patient differences and for the process of change over time.

The effectiveness of family caregiver interventions also must be evaluated. Important dimensions include the caregiver's health and stress level, family coping strategies, caregiver knowledge and competence, status of the elder, and freedom from abuse.

Community geropsychiatric programs will become increasingly important in addressing the impending demographic shift. Important evaluative criteria will include accessibility and coordination of services; patient, family, and systems outcomes and satisfaction; staff training; compliance with patient-centered regulatory systems; program goals; and cost-effectiveness.

In the final analysis, the most important evaluation criterion is the feedback from the patient, family, and caregivers that nursing care was helpful and growth producing. The challenge to the nurse is to be creative in producing a positive experience for each elderly patient.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Sharon Corwell, RN, NHA

I have been working in the same nursing home for 40 years, first as a nursing assistant, then as a nurse, then as the Director of Nursing, and now as the Administrator. In a facility such as this (22 beds in a converted home), things are much more informal than at other care settings, and we feel more like a family. In assessing our ability to provide care, I look at the total person and consider all of the person's needs; it does not matter whether these are psychiatric or somatic. I think about whether we can give adequate care to the resident and help make a good life for the person. By that I mean preventing decompensation as long as possible while we treat people as individuals, meeting them where they are, and not trying to change them.

J came to us when she was 63 years old. She had been in an acute psychiatric unit because of verbal and physical threats and inappropriate behavior secondary to her early-onset dementia. She also had chronic obstructive pulmonary disease (COPD), depression, hypertension, and Parkinson disease. Her daughter lived $2\frac{1}{2}$ hours away, but J had been turned down by three other facilities closer to where her daughter lived when she was placed in our care. Caring for J also meant caring for her daughter. We did this by giving her emotional support and reassurance, by focusing on the positive, and sometimes by just listening. J's daughter was an only child who was devoted to her mom. She made a visit every month for the $2\frac{1}{2}$ years J was with us.

When J first came to stay with us, she could barely feed herself and needed help to stand up. However, she would say things such as "I'm going to kill you" or "I'm going to cut you up." You could say her behavior was inappropriate, but you had to look at J the person. Because she couldn't understand what we were saying, her actions were based on fear. Her striking out was a protective instinctual reaction, the same as anyone's normal reaction. As J continued to deteriorate, she was no longer able to express what she was feeling inside, but you could tell from her eyes that she was still there.

J required a lot of physical care as she deteriorated. She would tense up during care and pull back. Nonetheless we had her up every day. We would clean her, keep her comfortable, and feed her. It often took $1\frac{1}{2}$ hours to feed her a single meal. She was evaluated for surgical insertion of a feeding tube and was cleared to have the procedure, but she soon developed shortness of breath and was hospitalized with a viral infection. She died 2 weeks later. During those last weeks, when I looked into her eyes, it was as though they were saying "enough is enough."

We received the nicest note from her daughter that reflected what we try to do in our facility:

"Watching a loved one deteriorate is one of the hardest things a family can go through. There are so many worries and heartbreaks along the way. The genuine caring and individual attention you gave to my mother went beyond a job. It speaks of your true love, caring, and dedication for the people you protect and nurture. You remembered there was someone beneath her shell who had lived and loved and was still loved deeply by everyone who knew her. You treated her with dignity and care. There will never be enough words to express my feelings of gratitude for the care you gave to my mother and the peace of mind you gave my family and me."

CHAPTER IN REVIEW

- The demographics of aging continue to expand. The twenty-first century will see increasing longevity, geropsychiatric disability, and the need for evidence-based, accessible, cost-effective programs and geropsychiatric nurses.
- The role of the geropsychiatric nurse includes providing primary mental health nursing care, including intervening with caregivers, providing case management, and consulting with other care providers. Advanced practice nurses provide individual and group psychotherapy, take leadership in program development, and prescribe medications in most states.
- Biological, psychological, and sociocultural theories of aging guide the development of evidence-based nursing practice.
- A comprehensive geropsychiatric nursing assessment requires strong interviewing skills. The areas to be assessed include mental status, behavioral responses, functional abilities, physiological functioning, and social support.
- NANDA nursing diagnoses for geropsychiatric patients are related to disturbed cognitive, affective, somatic, stress, and behavioral responses.
- Nursing interventions with geropsychiatric patients include creation of a therapeutic milieu, involvement in somatic therapies, and interpersonal interventions. Caregivers should be involved in planning, implementing, and evaluating nursing interventions.
- Evaluation of geropsychiatric nursing care focuses on the patient's ability to reach and maintain maximum function and well-being.

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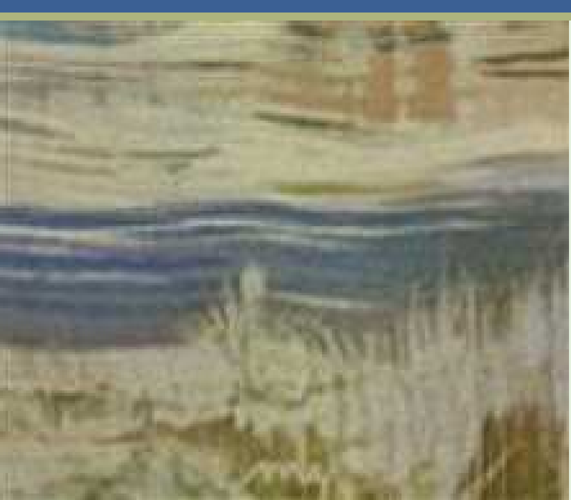

CHAPTER

38

Care of Survivors of Abuse and Violence

Nancy Fishwick, Barbara Parker, and Jacquelyn C. Campbell

When I was a laddie I lived with my granny
And many a hiding my granny di'ed me.
Now I am a man and I live with my granny
And do to my granny what she did to me.

Traditional Rhyme, Anonymous

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Define family violence, its possible causes, and characteristics of violent families.
2. Describe behaviors and values of nurses related to survivors of family violence.
3. Examine short-term and long-term effects of family violence on the physical and mental health of affected individuals.
4. Discuss primary, secondary, and tertiary prevention nursing actions related to family violence.
5. Analyze nursing assessment and intervention in abuse and violence among specific populations.
6. Evaluate issues and nursing care related to survivors of sexual assault.

Nurses encounter survivors of abuse and violence in all settings. The violence sometimes is openly discussed and recognized as a reason for the current health care visit, such as when a survivor of sexual assault is treated in an emergency room. Often, however, violence is disclosed only after a trusting nurse-patient relationship is formed.

Although there are various forms of violence, such as gang behavior and drug-related violence, the types most often described by patients are family violence and nonfamily rape and sexual assault. Because the dynamics of these two forms of violence are different, they are covered in separate sections of this chapter. Rape and sexual assault also can be forms of family violence. Attention is given to populations that are particularly at risk for abuse: children, intimate partners, and the elderly.

The words used to describe people who have experienced violence are important. Traditionally, the word *victim* has been used. **In this chapter, the word *survivor* is used to emphasize that the person who has experienced abuse has many strengths and coping strategies that can be incorporated into the plan of care.**

> **Critical Reasoning** Do you agree with the use of the word *survivor* instead of *victim* in this chapter? What do you think of when you hear the words *victim* and *survivor*?

DIMENSIONS OF FAMILY VIOLENCE

Family violence is a range of harmful behaviors that occur among family and other household members. **It includes physical and emotional abuse of children, child neglect, abuse between adult intimate partners, marital rape, and elder abuse.** Regardless of the type of abuse occurring within

a family, all members, including the extended family, are affected. Family violence, although often unnoted, is at the core of many family disturbances.

Violence may be a family secret and often continues through generations. Some believe that the family is the training ground for violence and ask why the social group that is supposed to provide love and support is also the most violent group to which most people belong. Behaviors that would be unacceptable among strangers, co-workers, or friends are often tolerated within families.

Violence and abuse are caused by an interaction of personality, demographic, biological, situational, and sociocultural factors. Many of the unique characteristics of the family as a social group—time spent together, emotional involvement, privacy, and in-depth knowledge of each other—can lead to intimacy and violence. A family may be loving and supportive as well as abusive.

The United States has a high level of violence overall compared with other Western nations. Social norms are sometimes used to justify violence to maintain the family system. For example, a husband's use of violence may be considered legitimate if the wife is having an extramarital affair. Many men believe they have a patriarchal right to expect and enforce obedience from all family members, and they view their abusive behaviors as normal or justified.

Historical attitudes toward women, children, and the elderly; economic discrimination; the unreliable response of the criminal justice system; and the belief that women and children are property are social factors that promote violence. Changing norms about family privacy and the role of governmental intervention in family matters have also influenced the definition and recognition of family violence.

Critical Reasoning Why do you think more violence occurs in U.S. society than in other Western nations? What societal factors influence the use of violence?

Characteristics of Violent Families

Factors common to violent families include multigenerational transmission, social isolation, the use and abuse of power, and the effect of alcohol and drug abuse.

Multigenerational Transmission. **Multigenerational transmission** means that family violence is often perpetuated through generations by a cycle of violence. Figure 38-1 shows the multigenerational transmission of family violence. Social learning theory related to violence suggests that a child learns this behavior pattern in a family setting by having an abusive parent as a role model.

Violence and victimization are behaviors learned through childhood experience. The child learns both the means and the approval of violence. Children who witness violence between adults in the household or who experience abuse from a parental figure learn specific aggressive behaviors and come to believe that violence is a legitimate way to solve problems. When frustrated or angry as an adult, the person relies on this learned behavior and responds with violence.

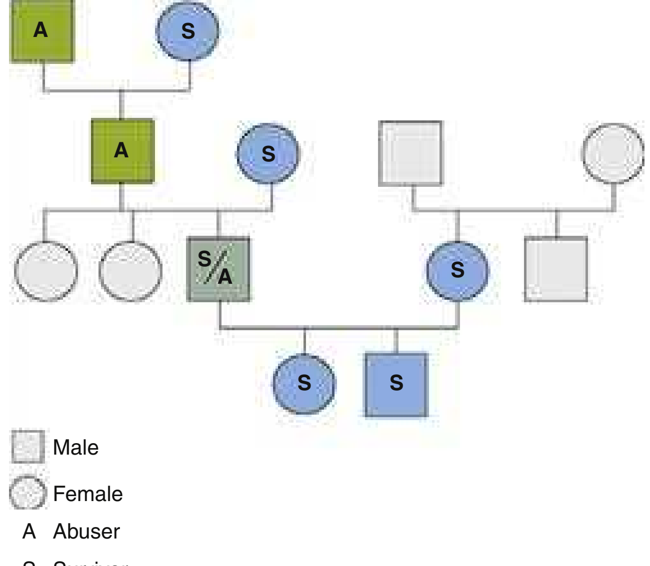

FIG 38-1 Genogram demonstrates the multigenerational transmission of family violence.

Experiencing abuse as a child does not necessarily determine an adult's later behaviors. Many people who were abused as children are able to avoid violence within their intimate relationships and with their own children. The younger the child at the onset of abuse, the longer the duration and the more severe the nature of the abuse; multiple life adversities may set the stage for being abusive as a parent. A study with adult survivors of childhood sexual abuse found that many survivors felt they "passed on the family legacy" to their children, whereas other survivors made conscientious attempts to reject their family legacy and to create a new legacy for the well-being of their children (Martsolf and Draucker, 2008).

Social Isolation. **Social isolation is a factor in child abuse, intimate partner violence, and elder abuse.** The social isolation may be related to rural location, but even in suburban and urban areas, violent families often have restricted interactions outside the home. Social engagement carries a risk of discovery of the abusive behaviors that are occurring in the household. Exposure of family violence can result in formal and informal sanctions from other family members, neighbors, the police, or the judicial system; the abuser therefore may purposely keep the family isolated.

Use and Abuse of Power. Another common factor within the various forms of family violence is the use and abuse of power. **In almost all forms of family violence, the abuser has some form of power or control over those whom they abuse.** For example, with the sexual abuse of children, the abuser is usually older than the victim and is in an authority position over the child.

BOX 38-1 FORMS OF ABUSE IN INTIMATE PARTNER RELATIONSHIPS

Definition
Domestic violence is a pattern of abusive behavior in any relationship used by one partner to gain or maintain power and control over another. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound.

Physical Abuse
Any form of direct or indirect physical injury or illness. Includes hitting, slapping, shoving, grabbing, pinching, biting, hair-pulling, etc. Physical abuse also includes denying a partner medical care or resources needed to preserve health (e.g., medications, wheelchair) and forcing alcohol or drug use.

Sexual Abuse
Coercing or attempting to coerce any sexual contact or behavior without consent. This includes marital rape, attacks on sexual parts of the body, forcing sex after physical violence, or treating one in a sexually demeaning manner. Examples are talking about the person in a sexually demeaning manner and accusing the person of infidelity or promiscuity.

Emotional Abuse
Undermining an individual's sense of self-worth or self-esteem. This may include constant criticism, diminishing of abilities, or damaging relationships with children, family, or significant others.

Economic Abuse
Making or attempting to make an individual financially dependent by maintaining total control over financial resources. This includes withholding access to money or forbidding attendance at school or employment. Harassment while on the job, withholding information about family finances, and spending and hiding the bills from another family member are also forms of abuse.

Psychological Abuse
Causing fear by intimidation and forcing isolation from family, friends, school, or work. This includes threatening physical harm to self, a partner, children, or a partner's family or friends; destruction of pets and property; mind games; blackmail; and constant unfounded accusations as a means of control.

From U.S. Department of Justice: Domestic violence, updated May 2011. Accessed November 2011 at www.ovw.usdoj.gov/domviolence.htm.

Power issues appear to be a central factor in intimate partner abuse and violence. In marriage, abusers may justify the use of violence for trivial events, such as not having a meal ready or not keeping the children quiet. However, the controlling behaviors and violence often are related to one spouse's need for total domination of the other spouse. For example, wife abuse often begins or escalates when the woman behaves more independently by working or attending school. Box 38-1 describes five forms of abuse within intimate relationships that reflect domestic struggles for power and control.

Alcohol and Drug Abuse. Survivors of violence often report substance abuse by the abuser. However, people who abuse alcohol or drugs are not consistently violent, and people who are violent are not always intoxicated. Instead, **the person may use alcohol or drug intoxication as a socially acceptable explanation for the violent behavior.** Family and friends may attribute the conduct to the effects of alcohol or drugs, which to some extent may decrease the degree of blame. The use of alcohol or drugs also may increase violent behavior by reducing fear or inhibitions and decreasing sensitivity to the impact of the behavior.

Research on aggressiveness and illicit drugs indicates that marijuana and heroin use are not correlated with violence. In contrast, crack cocaine, amphetamines, mescaline, angel dust (phencyclidine, or PCP), and steroids have been associated with increased violence in general. The current use of date-rape drugs, such as flunitrazepam (Rohypnol) and ecstasy (3,4-methylenedioxymethamphetamine), clearly places people, primarily young women, in danger of sexual exploitation and physical harm.

Nursing Attitudes Toward Survivors of Violence

Nursing care of survivors of violence can be challenging. The attitudes nurses bring to these situations shape their responses. Studies of health care professionals' attitudes indicate that myths about family violence are accepted even though there is sympathy toward the survivor. Table 38-1 describes common myths and facts about survivors of abuse.

Although most nurses do not blame survivors for what has happened to them, they can be less tolerant of certain behaviors. For example, nurses are more likely to blame a rape survivor if the woman had gone out late at night, had not locked her car doors, or did not resist the assault "enough." They have difficulty understanding abused children who want to return to abusive parents and battered women who do not leave their abusers.

Survivors often find the health care system to be unhelpful and even traumatizing when they go for help. Health care providers who use a **paternalistic helping model** rather than a **model of empowerment** will be frustrated by survivors who do follow the prescribed advice. Table 38-2 compares the characteristics of the paternalistic and the empowerment models. **The empowerment model is more helpful to the survivor and is more professionally satisfying for the nurse.**

Creating Positive Attitudes. The first step in providing effective nursing care is exploring your own attitudes toward survivors of abuse and violence. **Self-directed learning and formal continuing education on family violence should focus on recognizing and changing beliefs and feelings, as well as learning facts about violence.** Professional education materials from agencies such as Futures Without

TABLE 38-1 BEYOND THE MYTHS: RECOGNIZING ABUSE SURVIVORS

MYTH	FACT
Family violence is most common among families living in poverty.	Family violence occurs at all levels of society without regard to age, race, culture, status, education, or religion. It may be less evident among the affluent because they can afford private physicians, attorneys, counselors, and shelters. People with less money must turn to public agencies for help.
Violence rarely occurs between dating partners.	Estimates vary, but violence does occur in a large percentage of dating relationships.
Abused spouses can end the violence by divorcing their abuser.	About 75% of all spousal attacks occur between people who are separated or divorced. In many cases, the separation process brings on an increased level of harassment and violence.
The abused partner can learn to stop doing things that provoke the violence.	In a battering relationship, the abuser needs no provocation to become violent. Violence is the abuser's pattern of behavior, and the abused partner cannot learn how to control it. Even so, many abused partners blame themselves for the abuse, feeling guilty—even responsible—for doing or saying something that seems to trigger the abuser's behavior.
Alcohol, stress, and mental illness are major causes of physical and verbal abuse.	Abusive people and even those who are abused often use those conditions to excuse or minimize the abuse; but abuse is a learned behavior, not an uncontrollable reaction. People are abusive because they have acquired the belief that violence and aggression are acceptable and effective responses to real or imagined threats. Fortunately, because violence is a learned behavior, abusers can benefit from counseling and professional help to alter their behavior; but dealing only with the perceived problem (e.g., alcohol, stress, mental illness) will not change the abusive tendencies.
Violence occurs only between heterosexual partners.	Gay and lesbian partners experience violence for varied reasons, similar to heterosexual partners.
Being pregnant protects a woman from battering.	Battering often begins or escalates during pregnancy. According to one theory, the abuser who already has low self-esteem views his wife as his property. He resents the intrusion of the fetus and the extra attention his wife gets from friends, family, and health care providers.
Abused women accept the abuse by concealing it, not reporting it, or failing to seek help.	Many women, when they do try to disclose their situation, are met with denial or disbelief. This only discourages them from persevering.

TABLE 38-2 COMPARISON OF THE PATERNALISTIC AND EMPOWERMENT MODELS OF INTERVENTION WITH BATTERED WOMEN

PATERNALISTIC MODEL	EMPOWERMENT MODEL
Nurse is perceived to be more knowledgeable than the survivor.	Knowledge and information are shared mutually.
Responsibility for ending the violence is placed on the survivor.	The nurse strategizes with the survivor. Survivors are helped to recognize societal influences.
Advice and sympathy are given rather than respect.	The survivor's competence and experience are respected.

Violence (formerly the Family Violence Prevention Fund: http://www.futureswithoutviolence.org/section/our_work/health [accessed November 2011]) and the Centers for Disease Control and Prevention (http://www.cdc.gov/ViolencePrevention [accessed November 2011]); volunteer experiences with community-based rape crisis centers, domestic violence programs, or child protection programs; and attention to public education campaigns are constructive ways to increase understanding of and degree of comfort in addressing the experiences and responses of survivors.

Critical Reasoning Many television shows and movies explore the issues of family abuse and violence. Do you think they have helped change attitudes or reinforced fears and stereotypes?

Health Effects of Family Abuse and Violence

A growing body of knowledge provides nurses with an understanding of the short- and long-term effects of family abuse and violence on the physical, behavioral, and mental health of individuals (Sato-DiLorenzo and Sharps, 2007; Straus et al, 2009; McGuinness, 2010; Okuda et al, 2011). For example, a study of the cumulative effects of adverse childhood experiences (ACEs) indicates a link between childhood adversity and the development of risky behaviors and chronic health problems in adulthood.

The ACE study correlated adults' childhood experiences of abuse, neglect, and various household problems such as

witnessing domestic violence, having a family member with mental illness or substance abuse, or having a family member incarcerated, with later health behaviors such as early initiation of cigarette smoking, early initiation of sexual activity, or illicit drug use. It found that a significant number of adults with one or more adverse childhood events went on to develop alcoholism, depression, suicidality, unplanned pregnancies, sexually transmitted infections, liver disease, chronic obstructive pulmonary disease, and heart disease. The greater the number of types of adverse experiences in childhood, the higher the risk for adult health problems (Waite et al, 2010; Centers for Disease Control and Prevention, 2011). This work highlights the need for nurses to include assessment of adverse childhood experiences during intake of children, adolescents, and adults in mental health and substance abuse care settings.

Physical Health Effects. A characteristic pattern of injuries, especially to the head, neck, face, throat, trunk, and sexual organs, may be seen when physical assault, forced restraint, or sexual abuse has been perpetrated. **Physical injuries can be present at multiple sites and in various stages of healing.** Although rarely mentioned by the abused individual, sexual assault often accompanies physical abuse.

Survivors of family violence often experience a range of physical symptoms not obviously related to their injuries, such as headaches, menstrual problems, chronic pain, and digestive and sleeping disturbances. Symptoms such as headaches and other forms of chronic pain may be the result of repeated blows to the head or other parts of the body. The stress experienced from past or ongoing family violence may negatively affect the immune system, putting the individual at risk for a variety of health problems. Maternal exposure to domestic violence is associated with significantly increased risk for low birth weight and preterm birth (Shah and Shah, 2010).

Psychological Effects. An emotionally abusive family environment, the experience of physical and sexual abuse, and witnessing maternal battering can have a negative impact on a person's mental health immediately or as delayed reactions (Warshaw et al, 2009; Yanos et al, 2010). Nurses often are involved in the recovery process of adults who, years after the traumatic events, are dealing with the effects of childhood sexual abuse.

Common psychological responses include the cognitive responses of self-blame and poor problem solving and the emotional responses of depression, anxiety, and lowered self-esteem (Al-Modallal et al, 2008). In children, trauma as a result of maltreatment can even result in psychotic symptoms (Arseneault at el, 2011).

Many adults who witnessed family violence in their childhood, who personally experienced childhood abuse, or who survived abuse in adult intimate relationships can display remarkable adaptability in the wake of such trauma. **Resilience, a pattern of successful coping despite challenging or threatening circumstances, can buffer a person from serious psychological effects.** Access to social support and having a sense of control over the recovery process also contribute to favorable outcomes after abuse or assault (Paranjape and Kaslow, 2010).

Depression and low self-esteem are common among women in abusive relationships, adult survivors of childhood sexual abuse, abused children, and survivors of other forms of violence. Problems with self-concept are described in Chapter 17, depression is discussed in Chapter 18, and resilience is explained in Chapter 12.

Behavioral Health Effects. Many attempts have been made to understand the behavior of survivors of family violence, especially their continued involvement with an abuser. This has been especially damaging in addressing the question of why a battered woman remains in the relationship. It is assumed that she should leave rather than stay, but **a woman is in the most danger of being stalked and killed by her partner when she leaves the abuser.** Constraints that make it difficult to leave include concern for her children, cultural sanctions, perceived stigma, strong emotional attachment to her partner, and lack of money, social support, and other resources.

Although most women eventually leave a relationship that is continuously violent, there is often a pattern of leaving and returning many times before making a final break. Rather than being a sign of weakness, this can be seen as a normal process that is influenced by the quality of social support and assistance to the woman and the abuser's behavior. Leaving and returning are purposeful and meant to pressure the abuser into meaningful change, test external and internal resources, or evaluate how the children react without their father.

Critical Reasoning Discuss the issue of women remaining in abusive relationships. What factors keep them in these relationships? How do health professionals usually respond to a woman who has remained in an abusive relationship? What approach would help her?

Preventive Nursing Interventions

All nurses have important roles to play in the prevention of family violence. They do this through educating the public, identifying risk factors, and detecting the actual occurrence of family violence to assure timely intervention and prevent future recurrence (Humphreys and Campbell, 2011).

Primary Prevention. **Changing society's acceptance of violence and abuse is an important first step in prevention.** Effective primary prevention includes eliminating cultural norms and values that accept and glamorize violence. This can begin by limiting the amount of violence permitted on television and in other media. The prevalence of violence on television, in movies, and in advertising plays a role in creating a social climate that says violence is exciting and appropriate. The average child watches television 20 hours per week. It has been estimated that U.S. children observe 18,000 killings before they graduate from high school. Violent content in children's video and computer games and on the Internet also is of great concern.

A related area of primary prevention is the elimination of pornography, especially violent pornography, which has been associated with sexual violence. Concerned parents and law enforcement also are challenged by the ease of sexual predators' access to vulnerable children and adolescents through the Internet and continued exploitation of children through child pornography websites.

Primary prevention of abuse includes strengthening individuals, families, and communities so they can cope more effectively with stress and resolve conflict nonviolently. By working collaboratively with school nurses, community health nurses, social services, law enforcement, and other community stakeholders, nurses can help develop and implement educational programs in a variety of arenas, such as schools, workplaces, and senior citizen centers. Programs can focus on healthy growth and development across the life span, healthy intimate relationships, preparation for parenting, ways to discipline children nonviolently, safe storage of firearms in the home, and raising awareness of the ways in which people can become controlled, manipulated, and potentially exploited by others.

Nurses can be involved in teaching family life and sex education courses in elementary and middle schools. Child sexual abuse can be prevented or detected when children are taught about inappropriate sexual contact and what they should do if it occurs. Middle school students need information about how to develop mutually respectful relationships in which jealousy is not viewed as a sign of love and domination of one partner over the other is not tolerated.

Family violence prevention also includes anticipatory guidance while working with families. For example, respite care is needed for families with chronically ill or incapacitated members, including the elderly and children. Planning in advance for relief from responsibility will prevent strained relationships and potential violence or abuse.

Families need to anticipate the difficult developmental stages of children. Parents need to know that infants are not intentionally frustrating to parents, that toddlers' obstinacy is necessary for independence in later childhood, and that bed wetting signals the need for increased positive attention, not punishment.

A society must develop programs and policies that support families and reduce stresses and inequities. This includes adequate and appropriate day care for children and incapacitated elders, equity in salary and wages to make women less financially dependent, public education that ensures an adequate foundation for full employment of all, and sufficient financing of prevention and treatment programs.

> **Critical Reasoning** Go to a store, and search for the most popular video and computer games. Evaluate them for level of violence, sexual roles, and issues related to power and control.

Secondary Prevention. Secondary prevention efforts involve identification of families at risk for abuse, neglect, or exploitation, as well as early detection of those who are being abused or who are beginning to become violent. Systematic assessment for abuse through specific questions in the health history and through careful observations of physical health and behavior are recommended in all health care settings (Svavarsdottir and Orlygsdottir, 2008; O'Campo et al, 2011).

Studies conducted in emergency departments, prenatal care settings, primary care settings, and in mental health care and substance abuse settings indicate that individuals are likely to disclose abuse when a concerned health care professional asks questions that invite disclosure. Several protocols are available for routine assessment for potential child abuse, abuse of intimate partners, and for abuse of elder adults. These resources are available for free download on the Futures without Violence website (http://www.futureswithoutviolence.org [accessed November 2011]).

Box 38-2 lists indicators of actual or potential abuse that should be included in a nursing assessment. Availability and storage of firearms or other deadly weapons in the home need to be addressed because easy access has played a role in intentional injuries to family members and in communities and schools. **Early indicators of families at risk include violence in the family of origin of either partner, communication problems, and excessive family stress, such as an unplanned pregnancy, unemployment, or inadequate family resources.**

When the nurse becomes aware of risk factors, immediate nursing intervention is required. Taking the time to explore the risk factors, discuss perceptions and attitudes, and create a safety planning checklist with the patient is time well spent (Box 38-3). Providing links with community agencies that address the needs of persons affected by abuse and violence is an important intervention.

Tertiary Prevention. Tertiary prevention consists of nursing activities that address the immediate and long-term needs of survivors as they recover from their experiences. It also focuses on stopping the current abuse and preventing the recurrence of abuse. For example, if the survivor is a child or dependent elder adult, the individual may need to be removed from the home for safety. In some cases, such as abuse of an elder adult by a personal care attendant in the home, it may be possible to remove the perpetrator from the home rather than disrupt the security of the elder adult. Legal recourse against the perpetrator may be mandated in the case of abuse of a child or elder adult and may be voluntarily pursued by an adult survivor of intimate partner violence.

Nurses must know the mandatory reporting laws in their state. **All 50 states mandate reporting of child abuse and neglect, and most states have some form of mandatory reporting of abuse, neglect, or exploitation of the elderly.** At this time, however, reporting of domestic violence is mandated only in California, Connecticut, Colorado, Kentucky, and Tennessee. Many nursing, medical, and domestic violence organizations are opposed to mandatory reporting of domestic violence because it violates the autonomy and confidentiality of a competent adult.

BOX 38-2 INDICATORS OF ACTUAL OR POTENTIAL ABUSE

Nursing History

Primary Reason for Contact

Vague information about cause of problem
Discrepancy between physical findings and description of cause
Minimizing injuries
Inappropriate delay between time of injury and treatment
Inappropriate family reactions (e.g., lack of concern, overconcern, threatening demeanor)

Information from Family Genogram

Family violence in history (child, spouse, elder)
History of violence outside of home
Incarcerations
Violent deaths in extended family
Alcoholism/drug abuse in family history

Health History

History of traumatic injuries
Spontaneous abortions
Psychiatric hospitalizations
History of depression
Substance abuse

Sexual History

Prior sexual abuse
Use of force in sexual activities
Venereal disease
Child with sexual knowledge beyond that appropriate for age
Promiscuity

Personal/Social History

Access to firearms or other weapons
Unwanted or unplanned pregnancy
Adolescent pregnancy
Social isolation (difficulty naming people available for help in a crisis)
Lack of contact with extended family
Extreme jealousy by spouse
Rigid, traditional gender-role beliefs
Verbal aggression
Belief in use of physical punishment
Difficulties in school
Truancy, running away

Psychological History

Feelings of helplessness/hopelessness
Difficulty making plans for future
Tearfulness
Chronic fatigue, apathy
Suicide attempts

Financial History

Poverty
Finances rigidly controlled by one family member
Unwillingness to spend money on health care or adequate nutrition
Complaints about spending money on family members
Unemployment
Use of elders' finances for other family members

Family Beliefs/Values

Belief in importance of physical discipline
Autocratic decision making
Intolerance of differing views among members
Mistrust of outsiders

Family Relations

Lack of visible affection or nurturing among family members
Extreme dependency among family members
Autonomy discouraged
Numerous arguments
Temporary separations
Dissatisfaction with family members
Lack of enjoyable family activities
Extramarital affairs
Role rigidity (inability of members to assume nontraditional roles)

Physical Examination

General Appearance

Fearful, anxious, hyperactive, or hypoactive
Poor hygiene, careless grooming
Inappropriate dress
Increased anxiety in presence of abuser
Looking to abuser for answers to questions
Inappropriate or anxious nonverbal behavior (e.g., giggling at serious questions or questions related to abuse)
Flinching when touched

Vital Statistics

Overweight or underweight
Hypertension

Skin

Bruises, welts, edema
Presence of scars and indications of injuries in various stages of healing
Cigarette burns

Head

Bald patches on scalp from pulling hair
Subdural hematoma

Eyes

Subconjunctival hemorrhage
Swelling
Black eyes

Ears

Hearing loss from prior injury or untreated infections

Mouth

Bruising
Lacerations
Untreated dental caries
Venereal infection

Abdomen

Intraabdominal injuries
Abdominal injuries during pregnancy

Continued

BOX 38-2 INDICATORS OF ACTUAL OR POTENTIAL ABUSE—cont'd

Extremities

Bruising to forearms from attempts to protect self from blows
Broken arms
Radiological indications of previous fractures

Neurological System

Developmental delays
Difficulty with speech or swallowing
Hyperactive reflex response

Genital/Urinary System

Genital lacerations or bruising
Urinary tract infections
Sexually transmitted disease

Rectum

Rectal bruising
Bleeding
Edema
Tenderness
Poor sphincter tone

Nursing Observations

General Observations

Observations that differ significantly from history
Family members inadequately clothed or groomed

Home Environment

Inadequate heating
Inappropriate sleeping arrangements
Household disorganization
Inadequate food
Spoiled food not discarded

Family Communication Pattern

One parent answering all questions
Looking for approval of other family members before answering questions
Members continually interrupting each other
Negative nonverbal behavior in other members when one member speaking
Taboo topics (family secrets)

Emotional Climate

Tense, secretive atmosphere
Sadness
Lack of affection
Apparent fear of other family members
Verbal arguing

BOX 38-3 SAFETY PLAN TIPS

- During an argument or if you feel tension building, avoid areas in your home where weapons might be available—the kitchen, bathroom, or workshops.
- If there are weapons in your household such as firearms, lock them up!
- Know where there is a safe exit from your home—a window, elevator, or stairwell.
- Discuss the situation with a trusted neighbor if you can. Ask the neighbor to call 911 if he or she hears a disturbance. Agree with the neighbor on a code word to use if you need the police.
- Always keep a packed bag ready.
- Know where you would go to be safe if you have to leave, even if you do not think you need to.

Steps to Take If You Are Planning to Leave Your Situation

- Open a bank account in your own name.
- Give an extra set of keys, copies of important documents, extra clothes, and some money with a trusted friend or neighbor in case you have to leave quickly.
- Think about whom your best resources are if you need to find shelter or money.
- Have change on hand to make emergency calls.
- Remember that your safety and that of your children should always come first!

Things To Take With You

- *Identification:* Birth certificate(s), driver's license/military ID, Social Security card(s), passport(s), insurance documents
- *Financial items:* Money/credit cards, checkbook, bankbooks, savings bonds, food stamps
- *Legal papers:* Copy of your order of protection, marriage certificate, divorce papers, health insurance and medical cards, car registration, title, insurance, copy of lease/deed to home, medical and school records, separation/custody papers, power of attorney/will
- *Other items:* Medications, prescriptions, keys to home and vehicles, address book/telephone cards/cell phone, clothes, things to help to cope (e.g., pictures, keepsakes), children's favorite toys and books

More Safety Steps After You Have Left

- Keep your order of protection with you at all times.
- Give photocopies of your order of protection to your children's school, your employer, your neighbors, and your local police department.
- Change the locks on your doors.
- Discuss safety plans with your children.
- Inform children's school about who has permission to pick up your children.
- Ask neighbors to call the police if they see your abuser nearby. Show your neighbors a photo of the abuser and tell them about your order of protection.
- Ask someone to screen your telephone calls at home and at work.
- Have someone escort you to your car or walk with other people if possible.
- If communication is necessary between you and your partner, meet in public places or have a third party make contact and relay messages.
- Talk with people who can provide you with support on domestic violence issues.

ALWAYS CALL THE POLICE IF YOU ARE CONCERNED FOR YOUR SAFETY!

Modified from the National Domestic Violence Hotline: Safety planning. Accessed November 2011 at http://www.thehotline.org/get-help/safety-planning/.

Critical Reasoning Do you think it should be mandatory to report cases of domestic violence? Why or why not?

SPECIAL POPULATIONS

Child Abuse

The many forms of **child abuse** include physical abuse, emotional abuse, sexual abuse, neglect and abduction. Most maltreated children have been exposed to multiple types of abuse. Children who witness family violence and abuse are themselves victimized. Although they are often overlooked, they can be affected in many ways as a result of this abuse (Box 38-4).

BOX 38-4 EFFECTS OF WITNESSING VIOLENCE IN CHILDHOOD

Infant
- Disrupted attachment
- Disrupted routines (sleeping, eating)
- Risk of physical injury
- Eating and sleeping problems in 50%
- Decreased responsiveness to adults, increased crying

Preschool
- Feeling that the world is not safe or stable
- Yelling, irritability, hiding, stuttering; signs of terror
- Many somatic complaints and regressive behaviors
- Anxious attachment behaviors: whining, crying, clinging
- Increased separation and stranger anxiety
- Insomnia, sleepwalking, nightmares, bed wetting

School Age
- Greater willingness to use violence
- Holding self responsible for violence at home
- Shame and embarrassment about the family secret
- Distracted and inattentive, labile, and hypervigilant
- Limited range of emotional responses
- Psychosomatic complaints
- Uncooperative, suspicious, guarded behavior

Adolescent
- Feelings of rage, shame, betrayal
- School truancy, early sexual activity, substance abuse, delinquency
- Unresponsiveness
- Little memory of childhood
- Defensiveness
- Short attention span

Sexual Abuse of Children and Adolescents. **Sexual abuse** is the involvement of children and adolescents in sexual activities they do not fully comprehend and to which they do not or cannot freely consent. When this occurs within families, the perpetrator is a relative or surrogate relative who exploits the child for the perpetrator's sexual gratification. Sexual assault of children and adolescents by nonfamily members is discussed later in this chapter.

Sexual abuse within families violates children's trust in an adult who is supposed to love and protect them. Threats of harm to the child or to other family members, pets, or cherished possessions and threats of humiliation keep the child from disclosing the abuse to others. Subsequent feelings of confusion, helplessness, and shame can profoundly affect a child's mental health at the time of abuse and for the rest of their life. As an adult, sexual problems, difficulty trusting others, and the development of depression and anxiety disorders may be rooted in the earlier trauma of sexual abuse.

Although sexual abuse within families is usually a well-guarded secret, nurses may observe behavioral signals from the child that may indicate past or current sexual abuse from a family member. **Observable signs of sexual abuse include sexual acting out, physical aggression, excessive masturbation, social withdrawal, expressions of low self-esteem, impaired school performance, and disturbed sleep.** Children also may develop a variety of physical problems related to sexual abuse, including sexually transmitted infections; bleeding, soreness, or itching in or around the genitalia, perineum, or rectal area; recurrent urinary tract infections; chronic pain syndromes; or unintended pregnancy.

Critical Reasoning Identify two ways in which school nurses can intervene to help prevent child abuse.

Abduction of Children. Most cases of child abduction involve a family member, usually a parent, taking or keeping the child in violation of a custody order or other legitimate custodial right. Cases in which a child or adolescent is kidnapped by a stranger or slight acquaintance are less common but typically receive media attention.

Children younger than 6 years were particularly vulnerable to abduction. Researchers have developed profiles of parents at risk for abducting their children. Key characteristics of such parents include making a prior threat of or completing an abduction; suspecting that the other parent is abusing, molesting, or neglecting the child and feeling that authorities have not investigated adequately; being paranoid and markedly irrational, believing that they have been betrayed by their former partner and they therefore must protect themselves and the child; being sociopathic and using the child as an instrument of revenge or punishment or as a trophy in their fight with the former partner; or being from another country and wanting the child to be raised in the home country of origin.

Nursing Assessment. Nursing assessment of actual or potential child abuse begins with a thorough history and physical examination. Gathering a history of child abuse can be a stressful experience for the nurse and the family. It is essential for the nurse to examine personal values and past experiences to maintain a therapeutic and nonjudgmental clinical approach that does not shame the child or the parent. Many abusive parents are genuinely embarrassed about their behavior and would like help in developing alternative approaches to discipline. The setting for the interview must be private and uninterrupted. In general, the child and the adults should be

separated for the initial interview. However, deciding whether to do this depends on the child's age and other factors.

The interview with the parent can begin with a discussion of the problem that first brought the child to a health care facility. During this discussion, the nurse should pay particular attention to the parent's understanding of the problem, discrepancies in the stories, and the parent's emotional responses during the interview. The interview can then be expanded to discussions of how the parent disciplines or spanks the child. Nurses should be alert to risk factors for child abduction, such as ongoing divisive custody disputes between the child's parents. The initial interview is not the time to confront a suspected abuser directly, because measures must be taken to document and report the abuse in a way that will ensure the child's safety.

Nursing Interventions. **When child abuse is suspected, the nurse must report his or her observations to protective services.** An investigation by the state protective service agency is legally mandated and reinforces to the family the seriousness of the problem. When protective services are involved, the nurse should explain to the family what will happen in an investigation and the amount of time involved. The nurse should maintain frequent contact with the assigned case worker to ensure a comprehensive, consistent approach. Forensic specialists, including advanced practice nurses, may need to conduct additional interviews and perform a detailed physical examination for evidence collection.

Nurses who work with violent families need to know how protective services in their community operate. In cases of separated or divorced parents, all staff members involved in the care of the child must be clear about custody and visitation arrangements for that child and about any restrictions placed on one or both parents' access to their child.

Intimate Partner Violence

Intimate partner violence refers to a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological abuse and violence that adults or adolescents use against their intimate partners. Intimate partnerships include current or former dating, married, or co-habiting relationships of heterosexuals, lesbian women, or gay men. It is purposeful behavior directed at achieving compliance from or control over the targeted person. The violence is part of a system of coercive control that also may include financial coercion, threats against children and other family members, and destruction of property.

Abuse of adolescent and adult females by their male intimate partners is the most widespread form of family violence (Box 38-5). One in three adult women experiences at least one physical assault by a partner during adulthood (Thomas et al, 2010). Sexual abuse, or marital rape, is part of the violence against female partners in almost one half of the cases. Although women do hit men, female violence is more likely to be in self-defense. It seldom takes the intentional repeated, serious, and controlling form characteristic of abuse against female partners.

BOX 38-5 FACT SHEET ON DOMESTIC VIOLENCE

- Thirty-one percent of U.S. women report being physically or sexually abused by a husband, former spouse, or boyfriend at some point in their lives.
- Domestic violence leads to long-term health problems, including chronic neck or back pain; migraine and other frequent headaches; visual and hearing loss; sexually transmitted diseases; chronic pelvic pain; and chronic gastrointestinal disorders.
- Emotional health effects include the following: 56% of women in violent relationships are diagnosed with a psychiatric disorder; 29% of all women who attempt suicide are battered; 37% of battered women are depressed; 46% have anxiety disorders; and 45% experience posttraumatic stress disorder.
- Ninety-two percent of women who were battered did not discuss these incidents with their physicians; 57% did not discuss these incidents with anyone.
- Eighty percent of patients report that they would like their health care providers to ask them privately about intimate partner violence.

One of the most frightening realities of intimate partner violence is the potential for homicide of the abused partner or the abuser or for homicide-suicide in which the abuser kills his partner and sometimes kills their children and then commits suicide. **Most female homicide victims in the United States are killed by a husband, lover, ex-husband, or ex-lover.** Most of these murders are preceded by extensive abuse.

A woman is in most danger of homicide when she leaves her abusive partner or makes it clear to him that she is ending the relationship. Risk factors for this degree of danger include having a handgun in the house, a history of suicide threats or attempts in either partner, battering during pregnancy, sexual abuse, substance abuse, and extreme jealousy and controlling behavior. A statement often made by potentially lethal abusers is, "If I can't have you, no one can."

Some women kill their abusive partners, usually after repeated and extensive abuse and after repeated inadequate responses from police and other helpers. The number of women who kill their abusers has decreased as the availability of community-based domestic violence programs and effective law enforcement responses have increased.

Critical Reasoning Do you support the "battered woman" legal defense?

Nursing Assessment. The most prevalent cause of trauma in women treated in emergency rooms is abuse by an intimate partner. It also is a common experience of women who seek mental health or substance abuse services, although it may not be readily disclosed. A systematic nursing assessment for all forms of violence is critical. **Assessment for intimate partner violence is recommended in all health care settings, particularly emergency rooms, prenatal settings, primary care facilities, and mental health settings.**

When no injuries are obvious, assessment for abuse is best included with the history about the patient's primary intimate attachment relationship. Answers to general questions on the quality of that relationship should be assessed for feelings of being controlled or needing to control. A relationship characterized by excessive jealousy (of possessions, children, jobs, friends, other family members, and potential sexual partners) is more likely to be violent.

The patient can be asked about how the couple solves conflicts; one partner needing to have the final say and frequent, forceful verbal aggression also can be considered risk factors. The patient should be asked whether arguments ever involve "pushing or shoving." Questions about minor violence within a relationship help to normalize the woman's experience and lessen the stigma of disclosure. The patient who hesitates, looks away, displays other uncomfortable nonverbal behavior, or reveals risk factors for abuse can be asked again later in the interview about physical violence.

If abuse is revealed, the nurse's first response is very important. To reduce the individual's sense of isolation and self-blame, a normalizing, affirming statement about the frequency of abuse in U.S. society can be given. The extent and types of the abuse must be identified and described in the record. Careful documentation using a body map to locate bruises, contusions, or cuts is necessary for potential legal actions, which are often child custody suits or criminal actions related to the violence.

The individual's responses to the violence are a critical area for mental health assessment. It is important to interpret these responses as normal within the difficult circumstances. **An affirming nursing response is sharing the observation that the person's very survival suggests strength in the face of adversity**.

Signs of depression, anxiety, low self-esteem, or substance abuse must be evaluated. Attribution regarding the abuse is also important. For example, the nurse must carefully assess a woman's beliefs regarding the abuse and responsibility for the abuse. Because many abusive male partners find an excuse for the violence, the woman may be unnecessarily accepting the blame for the abuser's actions.

If the patient is an abuser, mental state is also important, and the potential for further violence must be assessed carefully. The safety of the abuser's targets is a concern, as is treatment for the abuser. Consultation with legal advisors about the nurse's duty to warn may be needed (see Chapter 9).

Nursing Interventions. Many communities have treatment programs for abusive men. They have been found to be most effective when the court has ordered treatment, with punishment for nonattendance. Severely abusive men seldom admit they have a problem and often need to be mandated to enter and remain in treatment. **The nurse needs to confront the violence and clarify that the responsibility lies with the abuser.**

The type of referral chosen is extremely important. Long-lasting change is more likely if the treatment combines behavioral therapy centered on anger control with a program designed to change attitudes toward women. Traditional marriage therapy or couple counseling as the only treatment is potentially dangerous to the woman because of the unequal power in the relationship and the possibility of retaliatory violence.

BOX 38-6 INTERVENTIONS FOR SURVIVORS OF INTIMATE PARTNER VIOLENCE

- **Alone:** Tell survivors they are not alone. Intimate partner violence happens to many others, and help is available.
- **Believe** in the survivors; they are not to blame for what happened to them. Believing in them helps empower them to take the first step toward caring for themselves.
- **Confidentiality** counts. Limit access to the patient's personally identifiable information to a need-to-know basis.
- **Document** the situation thoroughly.
- **Educate** the survivor. Teach about the legal aspects and available community resources.
- **Safety** is the highest priority, especially if the survivor is planning to leave the relationship. Ensure that the survivor has a safety plan.

Interventions for survivors of intimate partner violence are presented in Box 38-6. **To empower an abused woman, the nurse must first make sure she has accurate information on which to base difficult decisions.** This includes knowledge of the related state and local laws and ordinances. She also needs to be aware of community resources, such as domestic violence programs that provide information, support, legal advocacy, and if needed immediately or in the future, safe shelter for herself and her children.

Mutual goal setting is particularly important when working with abused women. Nurses can be frustrated if they impose their goals on a woman who may not be ready for drastic action. Ideally, they will have an established relationship during which the nurse and survivor can work through the normal denial and minimization that take place when the primary attachment relationship is threatened.

The nurse and patient can then consider all the options the woman has thought about and explore other possibilities. Dealing with an abusive situation is a recovery process that takes time and ongoing support. The nurse can help the patient mobilize natural, social, and professional support so that her economic, emotional, and physical needs are addressed (Johnson and Zlotnick, 2007).

Because becoming free of abuse evolves over time, often in gradual steps, evaluation of nursing interventions must be based on achievement of immediate goals. For example, disclosure of abuse to a concerned listener is itself a powerful therapeutic intervention. The nurse who eases disclosure of abuse has already provided a crucial intervention. **Effective nursing interventions are those that reduce isolation, empower through accurate knowledge about abuse and about community resources, and attend to safety needs.**

Elder Abuse

Estimates of the numbers of elder people in the United States who are abused, neglected, or exploited vary widely

because the problem is underreported. There may be as many as 5 million survivors each year. Elder adults are primarily abused, neglected, or exploited by their caregivers, most of whom are spouses, adult children, or other family members. Personal care attendants, paid or volunteer, in the home or in long-term care facilities also are perpetrators of elder abuse, neglect, and exploitation.

Because much of the abuse is by spouses, spousal abuse and elder abuse are often overlapping categories. **Elder persons who are socially isolated, cognitively impaired, or dependent on others for daily personal care are most vulnerable to abuse and neglect.** Social isolation also puts an elder person at risk for financial exploitation by a family member or by scams perpetrated by nonfamily members. Characteristics of the abuser, such as having mental and emotional problems including substance abuse, create a family situation at risk for elder abuse.

Nursing Assessment. **It is difficult for abused elders to admit being physically hurt by an adult child, spouse, or caregiver.** Gentle inquiry about the family's usual approach to resolving interpersonal difficulties is useful. At least part of this assessment must take place with the elder alone. An elder may be reluctant to disclose abuse because of fear of being abandoned by their caregivers or relocated to a nursing home. Only by establishing a trusting relationship over time or using an already established relationship can the nurse completely explore the abusive situation. The Hartford Institute for Geriatric Nursing "Try This" series includes an evidence-based assessment tool for elder mistreatment (http://consultgerirn.org/resources [accessed November 2011]).

Assessment is even more difficult when the elder is cognitively impaired. In those cases, physical assessment and careful attention to nonverbal behavior are critical. Bruises to the upper arms from shaking are especially common in elder abuse. Although bruises from abuse are difficult to differentiate from those normally seen in aging, bilateral upper outer arm bruises are definitive. Bruises from being tied into a chair or bed may be found on the wrists or ankles. Abrasions and lacerations, especially to the face or torso, are not usually caused by falls and should be regarded with suspicion. Vaginal lacerations or bruises and twisting bone fractures are particularly indicative of abuse.

Signs of neglect among the elderly are more common than those of physical abuse. Neglect may be manifested by poor hygiene, breakdown of the skin, malnutrition, dehydration, or underdosing or overdosing of prescriptive medications. Determining whether the neglect is intentional is the key to planning a nursing course of action.

Whenever a dependent elderly person is being cared for by another, their interaction can give important clues about the relationship. Flinching or shrinking away by the elder and rough physical treatment accompanied by verbal denigration by the caretaker are possible indicators of abuse. As with all types of family violence, the nurse needs to analyze the data from the history, physical examination, and direct observations to make an assessment of abuse.

The decision to report is difficult, especially if it appears likely that the outcome will be a nursing home placement unwanted by the elder. However, most states have laws that require nurses to report suspected elder abuse.

> **Critical Reasoning** You are providing home care services to an elderly person who shows evidence of physical abuse. The patient's caregiver handles her roughly and is impatient with her. The patient denies that she is unhappy or abused. Describe your response to this situation. What is your obligation to report your suspicions?

Nursing Interventions. When the nurse must report elder abuse, it is usually less damaging to the therapeutic relationship to inform the family first. **Deciding whether to discuss reporting beforehand is influenced by the likelihood that the abusing family member might disappear and the severity of the abuse.**

If the abuse is less severe or mainly a neglectful or caretaker stress situation, discussing the intent to report first makes the action seem less a condemnation, allows protective services to be perceived as a helping agency rather than a punitive one, and increases the chances that the nurse will be seen as a continuing source of help. Respite care or other stress relievers may be the key interventions for an overburdened caretaker. In other cases, the primary intervention may be therapeutic assistance for the abusers. This may include counseling, therapy for mental disorders, or substance abuse treatment.

An interdisciplinary approach is needed to address the complex components of elder abuse, neglect, and exploitation. Nurses in long-term care facilities and home health agencies may need to coordinate the services of health care professionals, state agencies, and community programs in cases of elder abuse.

RAPE AND SEXUAL ASSAULT

Rape and sexual assault are concerns for individuals, families, and the community. Sexual assaults against women and children (the most common targets) result in physical trauma, psychic and spiritual disruptions, and deterioration of social relationships. Fear of rape and sexual assault shapes women's daily conduct as they restrict their activities in attempts to ensure personal safety.

Survivors of sexual assaults include women and men of all ages, social classes, races, and occupations. Sexual assault can disrupt every aspect of the survivor's life, including social activities, interpersonal relationships, employment, and career.

> **Critical Reasoning** How would you respond to a roommate who returned from a date tearful and saying that her boyfriend forced her to have sex even though she refused? Would it make any difference if she had been sexually active with him in the past? Why or why not?

Definition of Sexual Assault

Sexual assault is the forced perpetration of an act of sexual contact with another person without consent. Sexual consent can be thought of as a continuum (Box 38-7), which demonstrates degrees of coercion, including bribery, taking advantage of one's position of power or trust in a relationship, or the survivor's inability to consent freely.

Sexual assault is not a sexual act but is motivated by a desire to humiliate, defile, and dominate the survivor. It has occurred for centuries around the world, but it is now recognized as a social and public health problem and as a weapon of war (Carretta, 2008). A sexual assault occurs once every 6.4 minutes in the United States. One in every six women will be raped in her lifetime. Although a woman is four times more likely to be assaulted by someone she knows than by someone she does not know, most of these crimes go unreported even though rape is a felony (Amstader et al, 2008).

Marital Rape

Marital rape is legally recognized in most states and is often reported along with physical abuse. Many husbands of abused women believe it is their right to have sex whenever they want. Marital rape is especially devastating for the survivor, who often must continue to interact with the rapist because of her dependence on him. Many survivors do not seek health care or the support of family members or friends because of embarrassment or humiliation.

BOX 38-7 SEXUAL BEHAVIOR: THE FORCE CONTINUUM

1. **Freely consenting:** Partners with equal power mutually choosing sexual activity. Equal power means each partner has equal status, knowledge, and ability to consent. This includes one partner agreeing to engage in sexual activity, even if not aroused, as an expression of love and caring for the other person.
2. **Economic partnership:** One person agrees to sexual activity as part of an economic agreement. The types of sexual behavior permitted are mutually determined as part of the economic agreement.
3. **Seduction:** One party attempts to persuade the other to engage in sexual activities.
4. **Psychic rape:** Assault to another person's dignity and self-respect, such as verbal abuse, street harassment, or the portrayal of violence or pornography in the media, occurs.
5. **Bribery or coercion:** Emotional or psychological force is used to persuade the other to take part in sexual activities. This includes situations of unequal power, especially when one person is in a position of authority.
6. **Acquaintance rape:** Sexual assault occurs when one party abuses the trust of a relationship and forces the other into sexual activities.
7. **Fear rape:** One party engages in sexual activities out of fear of potential violence if resisting.
8. **Violent rape:** Violence is threatened or occurs. This includes forced sexual activity between spouses, acquaintances, or strangers.

Nursing Care of the Sexual Assault Survivor

Nursing Assessment. The initial assessment is an important phase of the treatment of rape and sexual assault survivors. Although most nurses can quickly recognize the woman brought to the emergency department by the police after an attack by a stranger, many survivors of sexual assault are not so easily identified. **All nursing assessments must include questions to determine current or past sexual abuse.**

Because people have different definitions of rape, the assessment question must be broadly stated, such as "Has anyone ever forced you into sex that you did not wish to participate in?" This question may uncover other types of sexual trauma, such as incest, date rape, or childhood sexual abuse. If the answer is yes, it can be gently followed with broad questions, such as "Can you tell me more about it?" or "How often has it happened?"

The response often may be hesitation, questioning, or an embarrassed laugh. When this occurs, the nurse can increase the patient's comfort by explaining that the question is routine because sexual assault is common and that it affects health in many ways.

Nursing Interventions. Disclosure of sexual abuse indicates trust in the nurse (Courey et al, 2008). Rather than immediately referring the patient elsewhere, **the nurse's initial response of nonjudgmental listening and psychological support is essential.** If recent assault is disclosed, **physical evidence** will be needed if the survivor chooses to take legal action against the perpetrator. Forensic evidence collection is an appropriate nursing responsibility that requires training as a sexual assault nurse examiner (SANE). Later interventions may include referrals to survivors' groups, shelters for battered women, or legal services.

People respond to sexual assault according to their past experiences, personal characteristics, and the amount and type of support received from significant others, health care providers, and the criminal justice system. **The acute stage, immediately after the attack, is characterized by extreme confusion, fear, disorganization, and restlessness.** Although many may be visibly upset, some survivors may mask these feelings and appear to be outwardly calm or subdued.

The second phase involves the long-term process of reorganization. It usually begins several weeks after the attack. This phase may include intrusive memories of the traumatic event during the day and while asleep; fears; or phobias, such as extreme fears of being alone, being in a crowd, or traveling. Survivors often have a sense of living in a dangerous, unpredictable world and may become preoccupied with feelings of victimization and vulnerability. They may encounter difficulties in sexual relationships or in their ability to relate comfortably to persons of the same gender as the perpetrator. Some survivors develop secondary phobic reactions to people, places, or situations that remind them of the attack.

Critical Reasoning How do you think the woman's movement and feminist thinking have influenced society's views on family violence? On rape and sexual assault? On pornography?

Coping strategies may include changing one's telephone number or residence, talking with friends or family, or taking classes in self-defense. Nursing actions to help the survivor of sexual assault include active listening, empathic responses, active concern and caring, assistance in problem solving, and referral to sexual assault crisis centers.

Table 38-3 presents a sample Nursing Treatment Plan Summary for survivors of sexual assault. Organizations listed in Box 38-8 may be useful when helping survivors of abuse and violence identify sources of assistance for immediate and future needs.

TABLE 38-3 NURSING TREATMENT PLAN SUMMARY

Survivors of Abuse and Violence

Nursing Diagnosis: Rape-trauma syndrome

Expected Outcome: The patient will resume the usual lifestyle and social relationships.

SHORT-TERM GOAL	INTERVENTION	RATIONALE
The patient will express feelings related to the assault, including guilt, fear, and vulnerability.	Allow patient to discuss feelings regarding assault. Communicate knowledge and understanding of emotional responses to sexual assault to help in identification of feelings. Provide anticipatory guidance regarding common physical, psychological, and social responses.	Women often experience various feelings, including guilt, shame, anger, and embarrassment. It is necessary to identify and express these feelings to develop coping skills. Knowing what to expect reassures the patient that reactions are normal and can be managed.
The patient will identify supportive people to help in dealing with this crisis.	Explore relationships with significant others. Encourage the patient to discuss the situation with trusted and supportive people.	According to the principles of crisis intervention, it is important for the person in crisis to identify and use a social support system.
The patient will seek medical care for physical problems related to the assault.	Advise patient of the potential for sexually transmitted diseases or pregnancy. Help in identifying a medical care provider. Offer to accompany to the medical examination.	Early identification of physical problems provides the patient with the maximum number of treatment choices. Many women relive the assault during a gynecological examination. Support from a trusted person can be helpful.
The patient will be actively involved in mobilizing systems.	Support decision making and active problem solving. Provide written information about community services, and encourage use of them. Plan for a follow-up phone contact within a few days.	Active involvement in seeking resources gives the patient a sense of control over life, counteracting the helplessness related to the assault.

BOX 38-8 INFORMATION SOURCES FOR SURVIVORS OF ABUSE AND VIOLENCE*

National Sexual Violence Resource Center
1-877-739-3895 (http://www.nsvrc.org)
Serves as the nation's information and resource center on all aspects of sexual violence

National Domestic Violence Hotline
1-800-799-7233 (TDD: 1-800-787-3224)
Provides crisis intervention, information, and referrals

U.S. Administration for Children and Families
http://www.childwelfare.gov
The Child Welfare Information Gateway provides comprehensive information and resources to help protect children and strengthen families. Links to the reporting of child abuse.

National Center on Elder Abuse
http://www.ncea.aoa.gov
U.S. Administration on Aging resource on elder abuse, neglect, and exploitation.

Futures Without Violence (formerly the Family Violence Prevention Fund)
http://www.futureswithoutviolence.org
Public service programs and family violence resources for health care professionals

National Center for Victims of Crime
1-800-FYI CALL (394-2255)
Provides immediate referrals to the closest, most appropriate services in the survivor's community (includes sexual assault)

National Organization for Victim Assistance (NOVA)
1-800-TRY-NOVA (879-6682)
Provides advocacy, information, and referrals for crime survivors (including sexual assault)

*All websites accessed November 2011.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Pat Engdahl, RN, C

When thinking about how I may have made a difference in a patient's life, I remembered an experience I had with a 30-year-old woman who was admitted to the unit in a state of extreme panic, hardly able to process a simple request such as "I need you to please move away from the door." She told me this later, saying her first memories of being on our floor included a voice saying these words "in the kindest, firmest, most caring tones" she had ever heard—and she felt safe. She said she did not want to move away from the locked door, but she did it anyway, and she said, "I think it was your voice."

We worked very hard together. She was a survivor of childhood sexual and physical abuse and, as often happens, married a man who also abused her. She talked; I listened. She said she had shed enough tears and was not going to cry anymore. I replied that she needed to "cry a river" for the therapeutic process to begin. We role played. We practiced handling verbal abuse and daring to express anger—the latter frightened her more than the former. However, she was not able to deal with issues related to her abusive husband and her angry feelings of being victimized in the marriage.

The night before her discharge, she began to discuss these feelings, because they had suddenly risen to the surface during a group meeting. In this meeting a male patient had boasted that he never struck his wife except when he was drunk, and then he "only slapped her around a few times, not enough to send her to the hospital or such—nothing like that." When my patient heard this, she got up in a rage and ran out of the group. Several hours later, during our one-on-one session, she was able to discuss the episode. She berated herself for being "gutless" and not being able to say something right then. She paced and questioned whether she really was ready to go home and said that maybe she was not as strong as she thought.

We continued exploring her feelings of childhood helplessness. She talked until her rage was spent, but she did not seem to reach closure in her thoughts or feelings. She was discharged the next morning before I came to work for my evening shift. However, in my mailbox, I found a powerful note in which, among other things, she wrote, "I was able to confront that male patient in group today. … I guess I was ready for discharge after all. Thanks." It was my turn to become a little emotional as my eyes filled with tears and I whispered, "You're welcome; you'll never know how welcome."

CHAPTER IN REVIEW

- Family violence refers to a range of behaviors occurring among family members and includes physical, emotional, and sexual abuse of children, child neglect, intimate partner violence, and elder abuse. It may be a family secret and often continues through generations.
- Characteristics of violent families include multigenerational transmission, social isolation, use and abuse of power, and alcohol and drug abuse.
- Physical health effects of family violence include a characteristic pattern of injuries and the occurrence of a variety of stress-related symptoms. Physical injuries can be present at multiple sites and in various stages of healing.
- Psychological health effects of family violence include self-blame, poor problem-solving, anxiety, depression and lowered self-esteem.
- Behavioral health effects of family violence include reluctance to leave the abusive situation due to concern for one's children, cultural sanctions, perceived stigma, emotional attachment to the partner, and lack of money, social support and other resources.
- Nursing actions related to the prevention of family violence include strategies to change social norms and values, preventive education, identification of families and individuals at high risk for abuse and violence, and early detection of family violence for timely and appropriate interventions.
- Nurses must know the mandatory reporting laws in their state. All 50 states mandate reporting of child abuse and neglect, and most states have some form of mandatory reporting of abuse, neglect, or exploitation of the elderly.
- The many forms of child abuse include physical abuse, emotional abuse, sexual abuse, neglect and abduction. Most maltreated children have been exposed to multiple types of abuse. When child abuse is suspected the nurse must report it to protective services. Children who witness family violence and abuse are themselves victimized.
- Intimate partner violence refers to a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological abuse and violence that adults or adolescents use against their intimate partners. It is purposeful behavior directed at achieving compliance from or control over the targeted person and is part of a system of coercive control that also may include financial coercion, threats against children and other family members, and destruction of property.
- Assessment for intimate partner violence is recommended in all health care settings, particularly emergency rooms, prenatal settings, primary care facilities, and mental health settings.
- Effective nursing interventions are those that reduce isolation, empower through accurate knowledge about abuse and about community resources, and attend to safety needs.
- Elder adults are primarily abused, neglected, or exploited by their caregivers, most of whom are spouses, adult children, or other family members. Elder persons who are socially isolated, cognitively impaired, or dependent on others for daily personal care are most vulnerable to abuse and neglect.
- Nursing care of survivors of sexual assault includes nonjudgmental listening, psychological support, forensic evidence collection, and mobilization of community support, such as rape response programs, domestic violence programs, and legal services.

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CHAPTER

39

The Military and Their Families

Stephen T. Lesieur, James L. Harris, and Mary Fraggos

In war, there are no unwounded soldiers.

José Narosky

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe the medical problems experienced by veterans.
2. Analyze the psychiatric disorders of veterans including posttraumatic stress, suicide, substance abuse, and sexual trauma.
3. Discuss the unique needs of women veterans.
4. Evaluate challenges in caring for veterans and their families and related nursing implications.

Military troop deployment for the United States has historically extended to 130 countries. For the past 50 years, deployments in Japan, Germany, South Korea, and, more recently, Iraq and Afghanistan have included troops from the Army, Air Force, Navy, Marine Corps, Coast Guard, National Guard, and Reserves (*Deployments and conflicts,* 2011; Military Hub, 2011). The Department of Defense (DOD) estimates of military troop deployment in past wars and current deployments are presented in Table 39-1 (Sayer et al, 2010; Deployments and Conflicts, 2011).

Multiple illnesses, health risks, and concerns have been identified in military service personnel during past and current wars. **For veterans of wars in Iraq and Afghanistan, the incidence of mental health issues has become one of the leading health problems, second only to orthopedic issues** (Rosenberg, 2008; Walker, 2010). Veterans and their families are confronted with many mental health issues that range from coping with initial and multiple deployments to depression, substance abuse, anxiety, family dissolution, homelessness, violence, and incarceration (Seal et al, 2007; Snell and Tusaie, 2008; Vietnam Veterans of America 2008).

Military culture is complex and separate from civilian life. **Deployment can adversely affect one's health and psychological well-being.** The toll of combat experiences can be substantial and not readily evident to health care providers and the public (Capps, 2010). **The most pervasive and disabling experiences to military troops, families, and survivors are threats to psychological health and well-being.** Examples of health risks and illnesses dating from the Vietnam War to the present global war on terror are identified in Table 39-2 (Vietnam Veterans of America 2008; U.S. Department of Veterans Affairs [VA] Office of Academic Affiliations, 2009).

Critical Reasoning Talk to someone who served in Vietnam and then a veteran from the wars in Iraq and Afghanistan. Compare and contrast their experiences and health care needs.

MEDICAL DISORDERS OF VETERANS

Military personnel are exposed to conditions that make them vulnerable to developing a variety of medical problems. Soldiers may be exposed to illnesses such as malaria,

TABLE 39-1 U.S. MILITARY TROOP DEPLOYMENT

WAR	DEPLOYMENT ESTIMATES
Korean War (1950-1953)	1,790,000 (31% of active duty forces)
Vietnam War (1955-1975)	3,400,000 (39% of active duty forces)
Desert Shield and Desert Storm	584,342 (26% of active duty forces) plus 110,208 National Guard and reserve forces
Iraq and Afghanistan	>2,000,000 active duty/ National Guard/reserve forces (27% deployed more than once)

TABLE 39-2 HEALTH RISKS AND ILLNESSES FROM THE VIETNAM WAR TO THE PRESENT WAR ON TERROR

WAR	HEALTH RISKS AND ILLNESSES
Vietnam War February 28, 1961-May 7, 1975	Posttraumatic stress disorder (PTSD) Exposure to Agent Orange (dioxin) and other toxic chemical herbicides Birth defects Birth deficits in children born to female Vietnam War veterans Hepatitis B, C Human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS) Substance abuse Military sexual trauma
Persian Gulf War August 2, 1990-date undetermined, includes Operations Desert Shield and Desert Storm	PTSD Gulf War illnesses Leishmaniasis Amyotrophic lateral sclerosis (ALS) Exposure to chemical smoke, chemical and biological agents, and depleted uranium Immunizations Substance abuse Military sexual trauma
Global War on Terror September 11, 2001-date undetermined, includes Operations Iraqi Freedom and Enduring Freedom	PTSD Traumatic brain injury (TBI) Multidrug resistant *Acinetobacter* Leishmaniasis Vision loss Hearing loss, tinnitus Traumatic amputation Exposure to depleted uranium Substance abuse Military sexual trauma

tuberculosis, and hepatitis A, B, and C. Another exposure-linked illness, leishmaniasis, has been found in 88 countries of the Middle East, Central and South America, Africa, Asia, and southern Europe. This condition is transmitted by the sand fly and can cause skin lesions or even damage to bone marrow, liver, and spleen.

Exposure to various adverse conditions also contributes to the development of a variety of neurological problems. Many military personnel who returned from the Persian Gulf War developed conditions such as chronic fatigue, idiopathic migraines, fibromyalgia, and irritable bowel syndrome. These illnesses were originally referred to as Gulf War Syndrome but are now more commonly referred to as Medically Unexplained Symptoms (MUS).

Hearing problems are a common condition afflicting military personnel, accounting for 10% of all service-connected disabilities. Hearing problems may develop as the result of traumatic injury or repeated exposure to noise hazards including gunfire, explosions, and loud equipment. Examples of hearing problems include partial or total hearing loss and tinnitus (ringing in the ears). Each of these may be temporary or permanent.

Returning veterans may experience cognitive difficulties such as concentration problems and memory loss. Other complications can include physical illness, traumatic injury, sleep deprivation, stress, migraine headaches, and psychiatric conditions. Veterans commonly experience sleep disorders including insomnia, sleep apnea, restless legs syndrome, and narcolepsy. These conditions, if left untreated, can contribute to other medical problems such as obesity and heart disease, as well as lethargy, fatigue, increased trauma from accidents, and decreased quality of life.

Traumatic Brain Injury

There has been a significant increase in the number of veterans with traumatic brain injury (TBI) during recent military conflicts. The increase in number of identified cases may be related to more sophisticated diagnostic capabilities. **TBI is a complex injury with a broad spectrum of symptoms and disabilities that can be disabling and can adversely impact quality of life** (Snell and Halter 2010). It is discussed in Chapter 22.

Advances in technology have led to improvements in protective gear, which have increased survival rates from traumatic injury. The style of current warfare contributes to the increase in the number of TBI cases. Improvised explosive devices (IEDs) are the typical weapons of choice used by the opposing forces in Iraq and Afghanistan, and multiple blast injuries including TBIs have occurred as the result of these explosive devices. In spite of advances in protective equipment, the head, face, eyes, ears, and brain often remain vulnerable to blast injuries.

Many cases of TBI are overlooked because the symptoms are diffuse and may not initially suggest any specific brain injury as the primary cause. Often symptoms do not surface until well after the initial injury, which can further complicate accurate diagnosis of TBI. Also, mild TBI may not be the primary or most urgent injury that occurs in the field, and it may be missed during triage.

TBI can be classified based on intensity (i.e., mild, moderate, or severe) or on the actual type of blast injury:

- Primary blast injuries occur as a direct injury from changes in atmospheric pressure.
- Secondary injuries are caused by shrapnel or missiles that are propelled by the blast.
- Tertiary injuries are caused when the individual is propelled by the blast and strikes the ground or other object.
- Quaternary injuries result from the sequelae of the blast, such as burns, inhalation injuries, or even posttraumatic stress disorder (PTSD).

Cognitive symptoms associated with TBI include problems with memory, concentration, language, and executive function. Emotional and behavioral problems may include depression, anxiety, increased mood lability, apathy, anger, irritability, impulsivity, and personality changes. Physiological problems related to TBI can include headache, pain, vision and hearing problems, dizziness, seizures, insomnia, appetite and weight changes, fatigue, and sexual dysfunction (Zeitzer and Brooks, 2008).

Effectiveness of treatment is dependent on early and accurate diagnosis of symptoms. A useful three-question TBI self-report instrument for detecting TBI in troops returning from deployment in Iraq and Afghanistan is presented in Figure 39-1.

Critical Reasoning How would you respond if the spouse of your patient, who is a veteran, asks you whether his TBI will have permanent effects?

PSYCHIATRIC DISORDERS OF VETERANS

Veterans may develop a variety of mental health disorders, including mood disorders, anxiety disorders, thought disorders, and substance abuse disorders. Exposure to certain conditions can exacerbate symptoms of a personality disorder that may have been previously undiagnosed or in remission.

There are often significant physical and mental health comorbidities in veterans. Symptoms may include pain, somatic problems, neurological problems, memory/cognitive problems, sleep disturbance, anxiety, and mood and behavioral changes. Psychiatric symptoms can have an acute or insidious onset. They often evolve diffusely and with unclear etiology, which can complicate the diagnostic and treatment profile.

Presentation of multiple complex symptoms often requires the use of polypharmacy, which becomes the rule rather than the exception. This in turn can contribute to treatment adherence issues and increase the potential for adverse medication reactions.

Posttraumatic Stress Disorder

PTSD is defined as an anxiety disorder that arises when a person has been exposed to a life-threatening traumatic event that provokes terror, horror, and helplessness, such as combat experiences (American Psychiatric Association, 2000). PTSD involves a range of physical, cognitive, emotional, and behavioral symptoms resulting from psychological trauma (see Chapter 15). The cause of PTSD is complex and involves many factors. There is evidence that the potential to develop PTSD may be influenced by genetics, early life experience, and health disparities as well as the exposure to a traumatic experience.

Like other anxiety disorders, PTSD symptoms result from excessive activity of the sympathetic nervous system. The exaggerated effect of the fight-or-flight response is responsible for physiological symptoms associated with hyperarousal and re-experiencing phenomena. This response also stimulates the limbic system and fear circuitry of the brain, which in turn triggers abnormal emotional and behavioral responses.

PTSD consists primarily of three groups of symptoms:

1. Re-experiencing symptoms (one or more)
    - Recurrent intrusive thoughts
    - Disturbing dreams
    - Flashbacks
    - Emotional distress from reminders
    - Physical reaction from reminders
2. Avoidance symptoms (three or more)
    - Avoids thoughts or feelings reminding them of trauma
    - Avoids people, places, or things reminding them of trauma
    - Traumatic events blocked from memory
    - Decreased interest in activities
    - Feeling detached/aloof
    - Blunted affect
    - Sense of foreshortened future
3. Hyperarousal symptoms (two or more):
    - Sleep disturbance
    - Increased anger/irritability
    - Decreased concentration
    - Hypervigilance
    - Hyperactive startle

A diagnosis of **acute stress disorder** is made when criteria for PTSD have been met but symptoms have persisted for less than 30 days since the initial trauma. **Early diagnosis and treatment of symptoms have been found to provide better outcomes for individuals with PTSD.** A useful tool for diagnosis and screening for PTSD is the PTSD Checklist—Military Version (PCL-M), presented in Figure 39-2.

Persons diagnosed with PTSD have a greater incidence of behavioral health problems and social dysfunction (Nayback, 2008; Jankowski, 2011). **Approximately 18% to 20% of returning veterans who were deployed multiple times suffer from PTSD.** The number of veterans seeking treatment for PTSD increased an estimated 70% from 2006 to 2007, and mental health treatment is the second largest treatment provided for returnees from Iraq and Afghanistan (National Security Archive, 2006).

Careful attention is needed to distinguish between trauma exposure and PTSD. A measure of trauma exposure examines whether a person has gone through a traumatic event such as combat, an accident, or sexual abuse, identifying when the event occurred and how the experience affected the person. In contrast, a measure of PTSD identifies how a person felt or acted

1. Did you have any injury(ies) during your deployment from any of the following? (Check all that apply.)
   A. ____Fragment
   B. ____Bullet
   C. ____Vehicular (i.e., any type of vehicle, including airplane)
   D. ____Fall
   E. ____Blast (e.g., improvised explosive device, rocket-propelled grenade, land mine, grenade)
   F. ____Other (specify): ______________________________
2. Did any injury received while you were deployed result in any of the following? (Check all that apply.)
   A. ____Being dazed, confused, or "seeing stars"
   B. ____Not remembering the injury
   C. ____Losing consciousness (i.e., knocked out) for less than a minute
   D. ____Losing consciousness for 1 to 20 minutes
   E. ____Losing consciousness for longer than 20 minutes
   F. ____Having symptoms of concussion afterward (e.g., headache, dizziness, irritability)
   G. ____Head injury
   H. ____None of the above

Note: Endorsement of Question 2 (A through E) meets criteria for positive TBI screen. Endorsement of Question 2 (F through G) should be confirmed by clinical interviewer.

3. Are you currently experiencing any of the following problems that you think might be related to a possible injury or concussion? (Check all that apply.)
   A. ____Headaches
   B. ____Dizziness
   C. ____Memory problems
   D. ____Balance problems
   E. ____Ringing in the ears
   F. ____Irritability
   G. ____Sleep problems
   H. ____Other (specify): ______________________________

Screening Instructions

Question 1: A checked response to any items A through F verifies injury.

Question 2: A checked response to items A through E meets criteria for a positive screen, and a further interview is indicated. A positive response to item F through G does not indicate a positive screen but should be further evaluated in a clinical interview.

Question 3: Endorsement of any item verifies current symptoms that may be related to mild TBI (m-TBI) if the screening and interview process determines an m-TBI occurred.

FIG 39-1 Defense and Veterans Brain Center Traumatic Brain Injury (TBI) screening tool. (From Schwab KA et al: The Brief Traumatic Brain Injury screen (BTBIS): investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq, *Neurology* 66[suppl 2]:A235, 2006. Accessed November 2011 at http://www.dvbic.org/images/pdfs/3-Question-Screening-Tool.aspx.)

after going through a traumatic event. Some evaluations inquire about other issues, such as depression or relationship problems, but these are not used in making a diagnosis of PTSD.

Critical Reasoning PTSD can develop after a traumatic event. Do you think responses differ based on whether the event includes physical or psychological trauma?

Pharmacological Treatment of PTSD. Pharmacological interventions have been found to be useful in the treatment of the positive symptoms of PTSD including hyperarousal and re-experiencing phenomena, and to a lesser extent the negative symptoms of PTSD, including avoidance symptoms. **Selective serotonin reuptake inhibitors (SSRIs) are considered the first line of pharmacological treatment for individuals diagnosed with PTSD.** These medications help

Patient's name: ___

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in the last month.

No.	Response:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing memories, thoughts, or images of a stressful military experience?					
2.	Repeated, disturbing dreams of a stressful military experience?					
3.	Suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?					
4.	Feeling very upset when something reminded you of a stressful military experience?					
5.	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful military experience?					
6.	Avoid thinking about or talking about a stressful military experience or avoid having feelings related to it?					
7.	Avoid activities or situations because they remind you of a stressful military experience?					
8.	Trouble remembering important parts of a stressful military experience?					
9.	Loss of interest in things that you used to enjoy?					
10.	Feeling distant or cut off from other people?					
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12.	Feeling as if your future will somehow be cut short?					
13.	Trouble falling or staying asleep?					
14.	Feeling irritable or having angry outbursts?					
15.	Having difficulty concentrating?					
16.	Being "super alert" or watchful on guard?					
17.	Feeling jumpy or easily startled?					

Total score: ___

*A score ≥50 suggests the possibility of PTSD. The diagnosis of PTSD requires further confirmation by clinician interview.

FIG 39-2 PTSD Checklist: Military Version (PCL-M). (From Weathers FW, Huska JA, Keane TM: *PLC-M for DSM-IV*, Boston, 1991, National Center for PTSD, Behavioral Science Division.)

with symptoms including depression, irritability, anxiety, and intrusive thoughts. The serotonin-norepinephrine reuptake inhibitor (SNRI), venlafaxine, also has been found to be helpful in the management of this disorder.

Atypical antipsychotics have been used alone or in combination with antidepressants in individuals who have demonstrated a suboptimal response to antidepressants alone. Benzodiazepines may be helpful in managing anxiety, insomnia, and hyperarousal, but they should be used cautiously because of the high degree of co-morbid substance abuse in veterans. Mood stabilizers have not been demonstrated to be effective in the management of PTSD symptoms. The alpha-blocker prazosin (Minipress) has been shown to be effective in managing hyperarousal and re-experiencing symptoms by decreasing nightmares and normalizing sleep.

Nonpharmacological Treatment of PTSD. **Psychotherapeutic approaches including cognitive behavioral therapy (CBT) and prolonged exposure (PE) therapy have been found to be useful treatments for PTSD symptoms** (see

Chapter 27). Cognitive therapies focus on the development of an awareness of faulty patterns of learning or cognition. After these patterns of problematic thinking are identified, the individual is guided to replace maladaptive thoughts with healthier, positive ways of thinking.

In PE therapy, the individual with PTSD is helped to re-experience painful memories in a therapeutic and controlled environment. Through repeatedly reliving these traumatic memories in a safe environment over time, patients are able to relive these experiences in a less painful and threatening manner. In this way, they learn healthier ways of dealing with their experiences and will be less likely to experience avoidant symptoms.

Suicide

Suicide risk in veterans, increased rates of suicide morbidity and mortality in veteran and military personnel, and the need for specific interventions are identified in many policy reports, with alarmingly high rates for veterans of the Iraq and Afghanistan conflicts (Karch et al, 2008; Sundararaman et al, 2008; VA Employee Education System, 2011; VA Mental Health, 2011). **It has been estimated that as many as 20% of all suicides in this country are documented among veterans. In the first half of 2009, more American soldiers committed suicide than died in combat.** Knowing the warning signs for suicide and appropriate interventions is essential for the psychiatric nurse (see Chapter 19).

Substance Use Disorders

In veterans, substance abuse and addiction pose significant health problems with widespread social, economic, and physical consequences. **It is estimated that one in four deaths among veterans is attributable to use of alcohol, tobacco, or hallucinogens and that more than 7% of veterans meet criteria for a substance abuse problem.** These rates continue to rise (National Institutes of Health, 2009). Substance abuse may be the most significant factor that causes homelessness, affecting treatment outcomes and costs among veterans (Buchholz et al, 2010).

The role of the psychiatric/mental health nurse is to offer emotional support and to possess the skills needed to provide care to those attempting to resolve substance abuse dependencies (see Chapter 23). From the initial assessment through rehabilitation, the nurse must be mindful that substance abuse is a disease and that individuals may revert to previous behaviors when coping with stressful and unplanned events.

Military Sexual Trauma

Nurses encounter survivors of abuse and neglect in many settings (see Chapter 38). In civilian and military settings, service members may experience unwanted sexual behaviors that can have detrimental effects. The VA refers to experiences of sexual assault or repeated, threatening acts of sexual assault as **military sexual trauma (MST)** (VA National Center for PTSD, 2011). Both women and men can become victims of MST. **Approximately 1 in 5 women and 1 in 100 men seeking treatment from the VA respond "yes" when screened for MST.**

Given the high ratio of men to women in the military, there may be almost as many male victims as female victims of MST. However, males and females may experience MST in different ways. Males typically do not view themselves as being potential victims of sexual abuse and may therefore experience it as a narcissistic insult, causing confusion and even questioning of their masculinity or sexual preference. Females may feel helpless and vulnerable, particularly if they serve in areas that are dominated by men. They may feel the need to become excessively cold or aggressive out of fear for personal safety.

Male and female survivors of MST share a similar experience of interpersonal trauma as the abuse is transferred from one person to another, often by someone who was formerly trusted or in a position of superiority. This situation can result in an emotional invalidation of the traumatic experience when the individual reports the incident to superiors, only to be discouraged from following up on the claim or told that the abuse never happened.

Survivors of MST may be prone to develop psychological problems including depression, difficulty with interpersonal relationships, intense emotions or emotional numbness, avoidance/withdrawal, difficulty sleeping, attention and memory deficits, and substance abuse. Physical problems can mimic those of PTSD, including chronic fatigue, gastrointestinal problems, headaches, pain, and other neurological problems.

MST survivors may develop significant trust issues and may experience emotional dysregulation, which can interfere with personal and professional relationships. These effects may be intensified in relationships where one individual has power over another. They may experience self-blame and doubt and may even have feelings of guilt that they somehow brought on the assault. These individuals may experience difficulty with sexuality and with recognizing and establishing appropriate interpersonal boundaries.

Survivors of MST may be reluctant to report abuse. They may experience feelings of guilt, shame, or even fear of retaliation by their perpetrators. The psychiatric nurse must be astute to signs of MST. Providers should be vigilant in screening any potential victim of MST. This is particularly true of those working in mental health settings where individuals may feel more comfortable reporting abuse.

Nurses and other health professionals should provide education, support, empathy, and normalization of symptoms (Williams and Bernstein, 2011). Survivors of MST should be referred for additional services including supportive psychotherapy, CBT, dialectical behavioral therapy, and PE therapy.

> **Critical Reasoning** What steps can the military take to ensure that episodes of reported sexual trauma are given full review and action?

WOMEN VETERANS

Women soldiers are currently being deployed in unprecedented numbers. Although female soldiers are officially barred from ground combat, their role has expanded into the

realm of hostile environments. In the current military arena, there are few safe grounds, and almost everyone is vulnerable to attack at any given time. In fact, female soldiers may be singled out and targeted by enemy combatants. Women may have different vulnerabilities to developing mental health problems compared with their male counterparts. Given the new and expanded roles of female soldiers serving in often hostile environments, both immediate and long-term mental health risks are not yet clearly understood.

Women are more likely to suffer childhood abuse or other types of trauma compared with men. Survivors of multiple traumas may experience cumulative effects from revictimization. These individuals may be less resilient and more vulnerable to development of psychiatric disorders including depression, PTSD, and other anxiety disorders. **Women are more likely to be victims of physical and domestic abuse and 10 times more likely than their male counterparts of being victims of MST.**

Women traditionally serve in the role of family matriarch. Culturally, this may make them less likely to seek help, because they view themselves as the primary providers rather than the recipients of care for their family. On deployment, they may have a particularly difficult time adjusting to a new role that includes being separated from home, family, and children. This may cause feelings of guilt and inadequacy that can lead to depression and anxiety. Female soldiers are outnumbered and often outranked by men in the military. This may cause them to feel that they need to work harder than their male counterparts to maintain a tough facade, and therefore they may be less likely to ask for emotional help.

> **Critical Reasoning** Do you think women serving in the military are at greater risk than men? If so, in what way?

CHALLENGES TO CARE

Although there is no consensus among mental health staff on the top issues and challenges to military troops and families during the current global war on terror, five have been identified during briefings and dialogue among military leaders (Booth et al, 2010). **The five challenges to care are psychological health, access to services and support, communication challenges, deployment, and frequent relocation.**

Active duty military personnel receive an initial physical examination to establish fitness for duty and baseline health records. The use of a predeployment mental health screening can reduce mental health problems, medical evacuations from war zones for mental health problems, and suicidal ideation (Warner et al, 2011). On termination from active service, a follow-up physical examination is conducted to determine any physical or mental health problems that may have developed during the period of service. The veteran must apply for a service connection for any medical conditions that they suffered during active duty, with the assistance of designated VA personnel.

Today's veterans are younger, are less resilient, and have fewer emotional resources compared with those from the previous generation who served during a primarily noncombat era. Deployed soldiers survive the everyday stress of combat out of a sense of duty and camaraderie. On returning home from active duty, they find that they may no longer have the psychological and emotional support of their comrades in arms. They find little solace from their family and friends who cannot share their experiences, and often they have difficulty reassimilating into their previous lives. **Education, debriefing, and supportive therapy are essential to ensure smooth reintegration for these veterans** (Benetato, 2011)**.**

An estimated 1 to 2 million veterans have been deployed to Iraq and Afghanistan, and many of them have been redeployed on multiple occasions. **Although the rates of those suffering physical and psychological injuries may be fairly high, the percentage who actually seek treatment is disproportionately low,** for a variety of reasons. The vast majority of these individuals are young and comparatively healthy overall. They may not be aware of the complex and ambiguous clues that suggest the onset of various invisible conditions such as PTSD and TBI.

Veterans also may delay seeking treatment for cultural reasons. Military training has traditionally developed the sense of a "warrior mentality," and asking for help is viewed as a sign of weakness. This type of conditioning may have an adaptive benefit in the field of war, where soldiers may be expected to go on fighting despite injury to ensure the survival of the individual as well as the unit. However, this conditioning can be maladaptive for the postdeployment veteran who may be in desperate need of care.

The military has gone to great lengths to identify individuals as well as groups of individuals who may be vulnerable to developing these invisible injuries. There are many VA resources focused on education and debriefing to help facilitate successful reintegration. The Department of Veterans Affairs has designated staff to assist veterans to determine eligibility for service-connected injuries that they may have incurred. In spite of these efforts, many veterans of recent conflicts fail to seek the services for which they are entitled. These individuals often present for treatment only after struggling and exhausting all other resources.

Veterans appear to seek mental health treatment primarily for two reasons: (1) when they are threatened with the loss of a relationship of a significant other, and (2) when they have problems with significant anger and irritability (Snell and Tusaie, 2008). Too often, veterans stigmatize mental health services and view attending mental health appointments as an "interruption in their progress" and a barrier preventing them from progressing forward with their lives. Soldiers who perceive stigmatizing behaviors from society will have lower self-esteem, which may reduce the likelihood of their seeking support and treatment for mental illness (Green-Shortridge et al, 2007; Kim et al, 2010).

In addition to the stigma of seeking services, other barriers include geographical dispersion resulting in limited access to care in rural areas and the inconsistency of programs and

services available to military families when relocating and or during redeployments (Booth et al, 2010). Messages must be tailored to reach diverse families in various locations and to reduce the stigma associated with seeking needed assistance.

Many of those who actually seek mental health services are resistant to pharmacological interventions. They may see psychiatric medications as a stigma and a means of "mind control" or "turning them into a zombie." Young and otherwise healthy veterans who may not have been accustomed to taking medications on a regular basis may be less inclined to take medications that treat invisible injuries. They may become impatient and prematurely discontinue antidepressant medications, which are typically titrated over the course of several weeks. Others may be unwilling to tolerate common side effects including sexual dysfunction and other problems.

If veterans are not seeking help for PTSD and other psychiatric disorders through traditional sources, how are they coping with the potentially devastating impact of these illnesses? Some manage their symptoms through avoidance strategies, such as staying busy to escape their problems. Others use social isolation and exercise as coping strategies. Many self-medicate with alcohol, which is legal, easily obtained, and perhaps, in their view, less culturally stigmatizing than going to the mental health clinic for care. However self-medicating with alcohol or other drugs is a temporary and ultimately ineffective way to manage the symptoms of psychiatric illness and may ultimately serve to complicate their condition.

Although there appears to be progress, there need to be adequate resources to screen and predict veterans who have experienced or may be vulnerable to developing mental health problems. **Efforts must be increased to change the culture and educate veterans about the potential benefits of services including mental health services to make it more likely that these services will be utilized.** Nurses are ideally suited to eliminate barriers and minimize disparities through their expertise in assessment, patient education, and providing empathy.

Impact on Families

Deployment for military families can produce many issues and hardships. Disruption in daily life events such as changes in schools for children, care of family members requiring special needs, negative employment consequences for spouses, and real or perceived lower quality of life are but a few of the issues. Psychiatric nurses need to be aware of these issues during assessments and to develop their interventions accordingly. Whenever possible, linking families to other community partnerships can reduce stressors and assist in meeting identified needs. Being involved in community options that support military families can be rewarding personally and professionally.

The challenges of frequent relocation have no parallel in the history of today's volunteer military force and high use of reservists, as seen in the military operations in Iraq and Afghanistan. Families are challenged on many fronts. They must deal with service members who return with mental health problems such as PTSD and TBI (Hayes et al, 2010); assume caregiver roles for injured soldiers; deal with financial stressors related to loss of income when one spouse is deployed; cope with potential behavioral problems by children of soldiers when one or both parents are deployed; and learn to readjust after a service member returns from active duty.

The psychiatric nurse must be aware of these stressors and during initial assessments must allow families to be heard and to communicate their needs. **Creating avenues and opportunities for family members to cope with deployment and healthy reintegration in routines prior to deployment is a key supportive intervention for the psychiatric nurse.**

Impact on Clinicians

Mental health providers and other individuals working with survivors of PTSD may become vulnerable to the effects of trauma by proxy, sometimes called *vicarious traumatization*. This occurs when clinicians experience secondary traumatic stress reactions brought on by helping or wanting to help a traumatized person. Vicarious traumatization refers to negative perceptions and reactions that develop as the result of caring for these individuals. However, the experience of working with this population can cause clinicians to change their beliefs in both positive and negative ways.

A similar phenomenon called *secondary traumatic stress*, also known as **compassion fatigue,** involves the development of PTSD symptoms in clinicians who are trying to empathize or relate to the traumatizing experience of the PTSD victim. This is a natural consequence of the dynamic of caring between two people that occurs when the second person becomes affected by the traumatic experience of the first person. It can result in **burnout,** which is physical, emotional, and mental exhaustion as a consequence of working in emotionally demanding situations. Burnout can negatively impact morale, job satisfaction, attendance, and turnover rate.

Previous life experiences of clinicians can determine how they are affected by working with survivors of trauma. For example, individuals who have negative perceptions of traumatic events from the past may be more vulnerable to the negative emotional aspects in working with trauma victims. There also is **compassion satisfaction,** which may have protective value, preventing burnout or other negative outcomes in working with this population. **It is critical that providers working with survivors of trauma be aware of their personal feelings and vulnerabilities to provide quality clinical care.**

NURSING IMPLICATIONS

Nurses care for veterans and their families in VA hospitals, general hospitals, and community-based clinics. Veterans are among the parents of children seen by nurses, the young adults seen in primary care, the older adults who need chronic care management, and the elderly being cared for in nursing homes (Lemke and Schaefer, 2010; Sorrell and Durham, 2011).

Changes in the provision of health care have affected everyone, perhaps no group more than the veteran population. Suicide among veterans is a compelling issue for all health care providers. Given the increase in recent violent

conflicts abroad, there has been a dramatic shift in the need to increase services for trauma victims as well as those needing mental health care. Veterans have considerable medical and mental health co-morbidities. Just as physiological illness can give rise to mental health problems, it is now understood that mental illness can give rise to physiological problems such as fibromyalgia, migraines, chronic fatigue, and irritable bowel syndrome.

Veterans who have served this country have survived an experience that most nurses will never know. As a result of their commitment and sacrifices, many veterans have sustained visible and invisible injuries. Nurses are uniquely prepared to address their complex health problems (Wynn and Sherrod, 2010; Hagerty et al, 2011). The needs of returning veterans are physical, psychological, social, cultural, and spiritual. Nurses are an invaluable resource in the care of this population.

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Eugenia Reeves, MSN, PMHCNS-BC

I think that everything happens for a reason. I also think that the fact that I am working with veterans is what I am supposed to be doing right now. I have been a nurse for 37 years, and every time I think I have heard or seen it all, something happens to change that belief. Especially while working at the VA during the past 6 years of my career, I have learned to leave my judgment at the door.

As a case manager with substance abuse clients, part of my role is to work with veterans as they enter their first group in an intensive substance abuse treatment program. These clients come with many stories. Some have been "clean" and have been using their community resources. Others are not. They are not real sure that this is for them or even if they want to do this. In other words, they are in a pre-contemplative state as far as their sobriety and recovery are concerned. For them my role is to engage and attempt to motivate them to begin to own and identify their issues with substance use and the thinking that accompanies this condition.

Let me share one example. There was a veteran who came to the group just like he had on any other day. He shared his story about the personal consequences of his addiction—how he had lost two wives; many relationships, especially with his four children; many jobs; and several thousands of dollars. It seemed like I had heard this all before. He also stated that he was living under one of the local bridges in the area by choice, sleeping on a pasteboard box that he had cut and flattened to make what he called his bed. When asked about moving to the local shelter to keep warm and dry, he clearly stated that he wanted to do this "his way." He shared that he feared the local shelter would trigger his substance use.

As much as I was concerned about his safety, I began to respect his plan. He came in day after day, focused on his own agenda. He continued in our program, was assigned a case manager, and worked through the four tracks of intensive treatment. He progressed through his recovery, working actively, obtaining a sponsor, attending AA and NA meetings daily, and gaining valuable "clean" time.

He soon applied for VA supported housing and moved from his home under the bridge. To assist with the housing of our homeless veterans, former officers' quarters on the local naval base are used. He continued to take advantage of everything that the Ralph H. Johnson Medical Center offered. This included a compensated work therapy program. A veteran is eligible for this program if he or she has a poor work history, usually related to their substance abuse. He applied for this and worked the required 6 months. I am pleased to say that he is currently working in a full-time permanent position.

So what I have learned after 37 years is that when you think that you know what the outcome is going to be, you sometimes get a real life lesson … a really nice life lesson!

CHAPTER IN REVIEW

- Approximately 1 in 5 women and 1 in 100 men seeking treatment at the VA respond "yes" when screened for military sexual trauma (MST). Women are more likely to be victims of physical and domestic abuse, and 10 times more likely than their male counterparts of being victims of MST.
- Five challenges to care are psychological health, access to services and support, communication challenges, deployment, and frequent relocation.
- Creating avenues and opportunities for family members to cope with deployment and healthy reintegration in routines prior to deployment is a key supportive intervention for the psychiatric nurse.
- For veterans of wars in Iraq and Afghanistan, the incidence of mental health issues has become one of the leading health problems, second only to orthopedic issues.
- Military personnel are vulnerable to developing a variety of medical problems, such as malaria; tuberculosis; hepatitis A, B, and C; leishmaniasis; and hearing loss.
- There has been a significant increase in the number of veterans with TBI, which has many symptoms and can be disabling and adversely affect quality of life.
- Approximately 18% to 20% of returning veterans who were deployed multiple times suffer from PTSD.
- Selective serotonin reuptake inhibitors (SSRIs) are the first line of pharmacological treatment for individuals diagnosed with PTSD.

CHAPTER IN REVIEW—cont'd

- Psychotherapeutic approaches for PTSD include cognitive behavioral therapy, prolonged exposure therapy, and eye movement desensitization and reprocessing therapy.
- As many as 20% of all suicides in this country are documented among veterans. In the first half of 2009, more American soldiers committed suicide than died in combat.
- It is estimated that one in four deaths among veterans is attributable to use of alcohol, tobacco, or hallucinogens and that more than 7% of veterans meet criteria for a substance abuse problem.
- It is critical that nurses working with survivors of trauma be aware of their personal feelings and vulnerabilities to provide quality clinical care.

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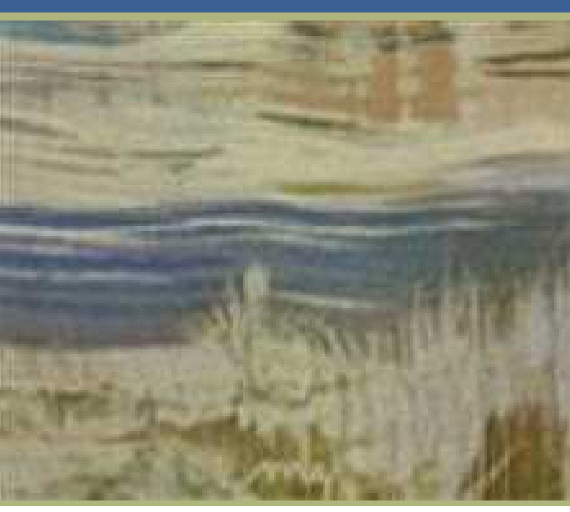
CHAPTER

40



Psychological Care of Patients With a Life-Threatening Illness

Gail W. Stuart and Penelope Chase

Watering the seeds of happiness is a very important practice for the sick or dying. All of us have seeds of happiness inside us, and in difficult moments when we are sick or when we are dying there should be a friend sitting with us to help touch the seeds of happiness within. Otherwise the seeds of fear, of regret or of despair can easily overwhelm us.

Thich Nhat Hanh

http://evolve.elsevier.com/Stuart

LEARNING OBJECTIVES

1. Describe effective and compassionate psychosocial and mental health care for patients with a life-threatening illness, their caregivers, and families.
2. Discuss palliative care approaches for managing distressing symptoms to promote a comfortable and humane death.
3. Analyze issues related to transitioning patients and families to end-of-life care and preparing for death.
4. Evaluate personal and professional responses to caring for persons who may not survive their illness.

The Latin origin of the word *compassion* means "to suffer with." Because nurses work in diverse settings, they are likely to find themselves caring for a person with a life-threatening illness. Doing so with compassion as well as skill is an essential aspect of the art of nursing.

WORKING WITH PATIENTS AND FAMILIES WITH LIFE-THREATENING DIAGNOSES

Many illnesses or chronic diseases can threaten life. Box 40-1 lists some of the most common life-threatening illnesses. These illnesses affect all patient populations, including neonatal, pediatric, young adult, adult, and elderly patients. **Intensive proactive communication with patients, families, and caregivers empowers care planning, informs decision making, reduces family burden, and is vital to patient and family satisfaction with care.**

One of the most skillful and valued interventions a nurse can make while caring for these patients and families is the use of presence. **Therapeutic presence** is a term used to describe the healing, respectful, watchful, and compassionate experience of being present in relationship with another human being in a state of respect, empathy, and positive regard (Finfgeld-Connett, 2006). Presence is an essential part of the therapeutic relationship (see Chapter 2). Presence is also described as "being with" rather than "doing to" (Dettmore and Gabriels, 2011). **Using therapeutic presence involves focus, intuition, openness, active listening, and being at ease with silence.**

Time of Uncertainty

Between the development of symptoms and a life-threatening diagnosis, patients and their families or loved ones have to endure a time of uncertainty. Uncertainty is anxiety producing.

BOX 40-1 COMMON LIFE-THREATENING ILLNESSES AND CONDITIONS

- Acquired immunodeficiency syndrome (AIDS)
- Amyotrophic lateral sclerosis (ALS, Lou Gehrig disease)
- Alzheimer disease
- Cancer
- Cerebrovascular accident (CVA)
- Certain congenital anomalies in newborns or infants
- Chronic obstructive pulmonary disease (COPD)
- Complications of diabetes mellitus
- Congestive heart failure (CHF)
- End-stage cardiomyopathy
- End-stage liver disease
- End-stage renal disease
- Hepatitis C
- Multiple sclerosis
- Parkinson disease
- Persistent vegetative state
- Scleroderma
- Severe asthma
- Severe burns or trauma

The nurse should assess for hopes, worries, fears, or anxieties a patient or family member may be experiencing. The best way to begin the intervention may be to gently tell the person what behavior or emotion you are observing and give it a name (e.g., shock, disbelief, fear, sadness). It is important to validate and seek the person's agreement with or refinement of this perception.

Nursing interventions should help patients separate issues and decisions over which they have control from those they cannot change or control. **This is an appropriate time to begin advance care planning.** Ask whether the patient has an advance directive such as a living will and a health care power of attorney and the patient's preferences about attempting cardiopulmonary resuscitation (CPR), intubation for feeding, or ventilatory support; limiting renal dialysis; or organ donation.

The competent nurse encourages patients to discuss their wishes about life-sustaining treatment with a surrogate decision maker. This is very important in the event that patients become unable to speak for themselves in the future. The health care surrogate may be called on to make a treatment decision if the patient becomes demented, experiences delirium, is in a coma, is intubated on a ventilator, or is sedated.

Concentrating is often difficult while waiting for a diagnosis. Providing distraction helps alleviate anxiety. Some patients find that a simple task such as checking e-mails or working with a puzzle book helps distract them from distressing and intrusive thoughts. Most children's services have specialists, age-appropriate activities, and unique settings for seriously ill pediatric patients and their families where play therapy or counseling is provided.

Critical Reasoning Have you or one of your family members or friends experienced the "time of uncertainty" waiting for diagnostic test results? If so, what was helpful during this time?

Concerns of Patients and Family Members

If a diagnostic test or tumor biopsy is reported as normal or benign, patients and their family members usually experience relief. At this point, families may be open to education regarding healthy behaviors. They may be motivated to change unhealthy habits by losing weight, quitting smoking, exercising, complying with medication regimens, or choosing more healthy foods.

However, if the diagnosis shows pathology or malignancy, patients and families will have concerns, which they may or may not express. Many patients are afraid that verbalization of these fears may upset family members and therefore avoid voicing them. Nurses should ask questions about hopes and fears. Acknowledging these concerns with patients and families helps normalize them, and then they can be discussed with the health care team.

Concerns that patients frequently have include the following:

- How long do people with this illness usually live?
- Will I be able to pay for treatment and other financial obligations?
- How will my family and friends be affected?
- Will I be a burden or become dependent on others?
- Will surgery leave me disfigured?
- Will I suffer much pain?
- Will I die all alone?
- Am I being punished with this illness?
- Why can't I be in control of what is happening to me?
- How can I die when I have so much left to do in my life?
- Will I be abandoned if I choose to stop treatment?

Patients and family members may project their anger and helplessness onto nurses or the medical team, complaining about things such as poor care, lack of communication, delay in call lights being answered, and the poor quality of the food that is served. Many patient and family complaints are valid. However, some complaints are maladaptive responses to loss of control and stress.

It is important for nurses to acknowledge complaints and respond to them with patience and without defensiveness. Family members tend to feel calmer, more satisfied, and more in control when problems they identify are attended to promptly and respectfully. Ways in which the nurse can respond to patient or family concerns include the following:

- **Listen without interrupting or defending.** This allows the person to ventilate and feel respected and more in control. See if there is anything you can do to resolve the situation. Be creative. Use your available resources.
- **Provide what is asked for, if possible,** such as asking a dietitian to see the patient about food preferences.
- **Explain the process of how you dispense medications,** and suggest the patient allow as "normal" a certain amount of time between request and delivery before using the call light.
- **Express genuine regret with the reality of the situation,** such as the need to remain fasting for still another test or procedure, despite hunger or thirst.
- **Use prn medications as ordered.** Explain to patients what prn medications have been ordered and when and how to request them. Ask the treating team to write orders to help manage distressful symptoms.

BOX 40-2 QUESTIONS TO ASK AT TIME OF DIAGNOSIS

- What has the doctor told you about your or your child's illness?
- How can I help you understand what the doctors have told you?
- What seems to be worrying you now?
- How do you usually deal with stress?
- Do you have any religious beliefs that may help you?
- Who do you usually talk with about how you are feeling?
- Would you like a counselor, therapist, social worker, or chaplain to talk with you?
- What is the best that you are hoping for?
- What is the worst that you are afraid of?
- Do you know someone who has been through something like this?
- What can I do for you now to help ease your mind?
- Who can I contact to come visit you?

- **Make time to simply sit with the patient or family members.** Give them the opportunity to initiate conversation or speak of nonmedical matters. Patients often associate nurse visits to their bedside as being task oriented and may welcome non–treatment-related presence. Plan this time into your busy schedule. You may discover something significant such as a physical symptom, a death anniversary, another family member who is ill, or financial concerns that can be used in providing care.

Box 40-2 lists some sample questions that may help disclose concerns at the time of diagnosis. The nurse's language should be adapted to the developmental level, culture, spiritual beliefs, and educational level of the patient and to the communication style of the nurse.

Patients often share information about their illness with friends or relatives. Patients and family members also seek out information on medical conditions and treatments on the Internet. Nurses should direct them to reputable and accurate websites, such as the National Institutes of Health (www.nih.gov) or the National Cancer Institute (www.cancer.gov). Many of these sites have information in Spanish or other languages.

Critical Reasoning A patient tells you he is confused by the many sites on the Internet with information about his illness. What guidelines would you give him on how to select and evaluate the quality of a website?

PSYCHOSOCIAL AND MENTAL HEALTH CARE

Patients being treated for life-threatening illness are often anxious, depressed, or angry. Nurses should assess for these responses and seek help or counseling for their patients. Treating the emotional responses that accompany life-threatening illness helps to improve the patient's quality of life and satisfaction with care and provides comfort and relief to worried family members and nursing staff alike (Shubha, 2007).

A psychiatric consultation liaison nurse can be very helpful in addressing the mental health needs of these patients and their caregivers. A **psychiatric consultation liaison nurse (PCLN)** is an advanced practice nurse who practices psychiatric and mental health nursing in a medical setting, providing consultation and education to patients, families, the health care team, and the community. A PCLN may provide assessment, recommendations, and/or supportive therapy to patients who are having difficulty coping.

Anxiety

Pharmacological treatment with benzodiazepines for anxiety associated with medical illness is common practice, and nurses should initiate requests for an order if the patient does not already have one. Clinical indicators of anxiety in the medically ill person include expressions of fear or dread, persistent tachycardia or hypertension, hyperventilation, frightening dreams, difficulty sleeping, anorexia, or excessive worry. If a family caregiver appears overly stressed and anxious, the nurse may suggest that the caregiver ask his or her primary care provider for a short-term prescription to help cope.

Nonpharmacological interventions for anxiety reduction, such as soothing music, progressive muscle relaxation, or visualization exercise instruction, are readily available on CD or DVD.

Patient education materials designed to inform and change mistaken beliefs may allay anxiety. Some treatment programs have a list of former patients who are available to meet with newly diagnosed patients to describe their own coping experience.

Depression

Several symptoms of major depression are also symptoms of medical illness. Medically ill people may experience fatigue, have trouble sleeping, lose their appetite, or find it difficult to concentrate, yet not have clinical depression. One myth seen in health care is that if a person has a reason to be depressed, such as having cancer, no treatment is needed because this is a normal response. However, this myth denies the patient necessary and effective treatment.

Because selective serotonin reuptake inhibitors (SSRIs) and the newer classes of antidepressants have more tolerable side effects, clinicians are usually willing to prescribe antidepressants for seriously ill patients. If an antidepressant is abruptly stopped because the patient has become NPO (e.g., having surgery, being put on a ventilator), the nurse should be alert for uncomfortable and sometimes serious signs and symptoms of antidepressant discontinuation syndrome (see Chapter 26).

If a patient's "prominent and persistent" depressed mood is believed to be related to the medical condition, antidepressant therapy is indicated. If patients show vegetative symptoms that interfere with self-care or if the able patient refuses to get out of bed or ignores meals, psychostimulants may improve appetite and provide energy and motivation. Patients who have had life-sustaining surgery that radically alters their physical appearance are especially prone to depression and lowered self-esteem and will benefit from antidepressants.

The nurse who observes a patient who is frequently tearful, irritable, fatigued, or apathetic; has a depressed mood; is socially withdrawn; wants the room kept dark; expresses hopelessness; or refuses to participate in rehabilitation efforts

such as physical therapy should suspect depression. For inpatients, the nurse should request a psychiatric evaluation by a PCLN or psychiatrist. For an outpatient or long-term care facility resident, the nurse should make a referral to an available mental health provider. The following questions are helpful in assessing a medically ill patient for depression:

- How would you describe your mood these past few weeks?
- Are you feeling sad, "blue," "down," or depressed?
- Do you find yourself tearful or crying sometimes?
- Do you ever feel you or others would be better off without you? If yes, how long have you felt this way?
- Have you ever thought of helping yourself to die?
- Are you feeling suicidal now?
- Have you been treated for depression in the past?
- Would you like some help to feel more like your old self?

In addition to pharmacotherapy, patients may find comfort in a visit from a minister, pastor, rabbi, imam, or priest if the patient uses faith to cope. Some patients may experience spiritual distress and have doubts, fears, or other concerns involving their religious faith, beliefs, or practice. Others may feel guilty and believe their illness is punishment. Although the nurse may uncover these concerns, they are best addressed by referral to a spiritual advisor.

Caregiver Stress, Anger, and Sleep Deprivation

Caregiver stress is the emotional and physical strain experienced by a person caring for someone with a chronic debilitating disease or life-threatening condition. **Caregivers may become patients themselves, especially if they neglect meeting their own needs**. Nurses should inquire whether caregivers are remembering to eat, rest, or take prescribed medications and encourage them to take care of their own needs as part of caring for the person who is ill.

Those caregivers who have not developed coping skills needed for situations in which they are powerless to change the process or outcome may exhibit behavior nurses sometimes label as "controlling." Skillful nurses offer them choices whenever possible to lessen the patient's or family's feelings of powerlessness and helplessness and to help them feel more in control.

Caregiver stress often is expressed as criticism or complaints. It is helpful for nurses to recognize this and not take these grievances personally or react with defensiveness or controlling behavior in response to them. Patients or family members may react with anger when a diagnostic procedure is delayed or postponed, a second or third round of chemotherapy is not working, or aspects of the patient's environment are disturbing.

Stress becomes unmanageable when the family member has sleep deprivation. **Sleep deprivation** is a state of physical and mental exhaustion brought on by lack of sleep in which the abilities to concentrate and reason are disturbed and judgment is diminished. Nursing strategies for helping patients and family members with stress, anger, and sleep deprivation are outlined in Box 40-3.

BOX 40-3 HELPING PATIENTS AND FAMILY MEMBERS

- Patients often hear what you say through their mental filters of pain, fear, or anxiety and misinterpret or misunderstand what they are told. They may translate messages into what they wish to hear or are afraid they will hear. Ask them to repeat back to you what they have heard. You may need to repeat information several times.
- Set limits if the patient repeatedly puts on the call light after you have just been in the room and asked before leaving if the patient had any other needs. State firmly a length of time when you will check on the patient (15 to 30 minutes), and keep to that schedule. For consistency, document your approach in the care plan.
- Although it is helpful when family members stay with the ill person to provide moral support, it may pose a problem to either the patient or the nurse. Many caregivers are afraid that if their loved one dies while they are not there, they will somehow be negligent or may be seen as unloving. Empathize with the caregiver who may not have felt able to leave the hospital for days, but remind the person to get some sleep as well. Suggest to family members that they go home to sleep in their own bed or to take care of children, pets, plants, laundry, personal grooming, or bills.

Critical Reasoning The spouse of your patient is constantly calling for nurses and complaining about how "no one is here to help." She threatens to report you to the state board of nursing. How might you best respond to her?

SYMPTOM MANAGEMENT AND PALLIATIVE CARE

Whether they are undergoing treatment for cure and recovery or are clearly at their life's end, patients will experience burdensome symptoms that require management. Nurses have the opportunity and obligation to patients and their families to help ensure freedom from unnecessary suffering (Adriaansen et al, 2008; Brunnhuber et al, 2008; Casey, 2010; Emanuel et al, 2010).

Palliative care is the medical and nursing care that provides comfort and relief to a suffering or dying person without prolonging the dying process. Clinical practice guidelines that describe the core precepts and structures for clinical palliative care programs have been developed and are a useful resource for the nurse (Lentz, 2009; National Consensus Project for Quality Palliative Care, 2009).

Pain

One of the symptoms most feared by patients and their families is unrelieved pain. **Pain is the "fifth vital sign" and should be assessed regularly and managed appropriately.** Pain medicine can be administered by mouth (oral, buccal, or sublingual routes), by intramuscular injection, through gastroscopy or jejunostomy tubes, by intravenous transfusion, by intrathecal or epidural infusion, via rectal suppository, via

dermal patch, and by patient-controlled anesthesia (PCA) pumps. Intensive care units (ICUs) have laminated cards with pictures that intubated patients can point to and indicate whether they are experiencing pain.

The nurse needs to reassess and document the patient's pain level after administering pain medication to check the effectiveness of the medication and ensure adequate dosing. Adult patients are asked to rate pain on a 1 to 10 scale, with 10 being the most excruciating pain. Using the Wong-Baker FACES Pain Rating Scale, pediatric patients 3 years of age and older can be asked to choose the face that best describes their pain—from a smiley face to a tearful one. The Wong-Baker scale instructions are available in several languages, including Spanish, Japanese, and Chinese.

Analgesics may be given to augment opioids or nonsteroidal antiinflammatory drugs (NSAIDs). Some commonly used medications are the tricyclic antidepressants (e.g., amitriptyline, venlafaxine), anticonvulsants (e.g., gabapentin), corticosteroids, benzodiazepines, and ketamine (for patients in refractory pain). Patients who are sedated and receiving paralytic drugs while on a ventilator or who are in a comatose state may experience pain and be unable to indicate this. The ICU nurse learns to recognize restlessness, agitation, grimacing, moaning, or increasing tachycardia as a sign of pain in the unconscious patient.

> **Critical Reasoning** Why do you think that pain is referred to as the *fifth vital sign*?

Constipation and Diarrhea

Constipation occurs in as many as two thirds of patients receiving palliative care. Patients taking narcotic pain medications on a regular basis must have prophylactic treatment for constipation, such as a bowel regimen, stool softeners, and laxatives or enemas as needed. Bowel hygiene is extremely important in preventing painful constipation or opioid-induced bowel obstruction.

Medications, treatments, diet, infection, or intestinal obstruction may cause diarrhea. Besides discomfort and embarrassment, diarrhea can lead to painful skin breakdown or electrolyte imbalance. Patients also may fall while rushing to the bathroom. Frequent loose stools should be reported to the physician so that diagnostic testing and treatment can be initiated.

Nausea and Vomiting

Nausea and vomiting are common, unwelcome side effects of some life-sustaining treatments. Antiemetic medications provide the first line of relief. Lorazepam may relieve some chemotherapy-related nausea as well as the accompanying anxiety. Other measures that provide psychological comfort to patients are management of odors in the sick room, provision of only foods tolerated by the patient, and frequent mouth and lip care.

Hiccups and Other Troublesome Symptoms

Persistent or intractable **hiccups** are disturbing to both patients and their families. Some conditions that may precipitate hiccupping are advanced human immunodeficiency virus (HIV) infection, uremia of end-stage renal disease, fever, hyponatremia, and gastric distention. Breath holding, swallowing a spoonful of sugar, breathing into a paper bag, rapidly drinking a glass of water, and nasopharynx stimulation are some conservative measures used to interrupt hiccups. Chlorpromazine (Thorazine) is the most often used medication and is approved by the U.S. Food and Drug Administration (FDA) for treating hiccups. Baclofen, valproic acid, and nifedipine are other drugs that may provide relief.

Itching or tingling may be caused by the elevated bilirubin of jaundice, by various rashes, or as an allergic reaction to a new medication. Antihistamines are the treatment of choice and may also help the patient get some rest.

Chemotherapy-induced **mucositis,** which is the painful inflammation and ulceration of the mucous membranes lining the digestive tract, affects both the mouth and the anal-rectal area. The nurse should provide numbing medicines and gentle mouth and perianal care.

Mental status changes are common in the acutely ill or dying person. Caregivers are often dismayed by a patient's audiovisual hallucinations and inability to process information or to remember names and faces. Some causes of delirium at the end of life are fever, brain metastases, encephalopathy, and anticholinergic and pain medications. Providing explanations of altered mental status and reassurance to both patient and family is comforting. Patients should have access to their eyeglasses and hearing aids when appropriate to help sensory perception. Treating the underlying organic condition with antipsychotic drugs such as haloperidol, olanzapine, risperidone, aripiprazole, or ziprasidone aids in clearing the sensorium. Some medications are available as oral disintegrating tablets for the patient who has difficulty swallowing. Benzodiazepines should be avoided for treating delirium, because they can increase agitation.

Dyspnea, or shortness of breath, occurs in many chronic and end-stage diseases, such as obstructive lung disease, progression of lung cancer, heart failure, pleural effusion, pneumonia, and obstruction caused by ascites. Nurses can assist the conscious patient to find a comfortable, elevated position for sitting or sleeping. Bronchodilators and anxiolytic medication may provide some relief. The presence of calm and reassuring nurses and family members, guided imagery, music, massage, and prayer are examples of nonpharmacological treatments. Nasal or face mask oxygen may be provided for comfort in the event of terminal dyspnea and will not prolong the dying process. In addition, morphine, nebulized fentanyl, and anticholinergic medications may be used to relieve dyspnea associated with end-stage disease.

TRANSITIONING TO END-OF-LIFE CARE

Advocating for the Patient

End of life is generally accepted as the probable last 6 months of life. When recovery is in doubt or the patient has chosen to forego further life-sustaining treatments, the plan for care changes. Family conferences provide a forum for the medical

and nursing teams, the patient (if able) or the patient's surrogate, and family members to express their thoughts and feelings about, rationale for, and wishes regarding the new plan of care.

As an advocate, the nurse's primary commitment is to the patient. The purpose of the family meeting is to seek consensus, explore options, and begin decision making toward the new goals. Nurses should encourage patient surrogates and families to voice honest emotions and ask questions about the benefits and burdens of treatments, palliative care, and ethical choices concerning withdrawal of treatments. Family satisfaction with clinician communication is improved when members are given more opportunity than clinicians to speak during conferences.

It is essential that the nurse be culturally competent and respectful, especially when caring for families whose ethnic identity differs from that of the treatment team. For example, many African Americans, Latinos, homeless persons, and persons of other ethnic or minority groups may distrust the health care system or have values that do not fit with standard practices of Western medicine. Some non-Western cultures believe that the welfare of the family takes precedence over individual autonomy, and health care decisions may be made by family consensus rather than by the patient alone.

If there is a decisional conflict or moral dilemma, the nurse or team may initiate an ethics consultation. Every institution certified by The Joint Commission is required to have a mechanism for addressing ethical concerns. The institution also should ensure that anyone who requests an ethics consultation may do so without fear of intimidation or reprisal.

The Changing Focus of Hope

Patients, family members, nurses, and other clinicians often find it emotionally difficult if the illness is not responding to treatment. For example, when cancer is discovered at a late, metastatic stage, human nature sometimes offers a secret hope that a "miracle" healing will occur. This "hope against hope" may not mean that the patient or family are in denial of the illness's terminal trajectory but rather that they are using denial as an adaptive defense mechanism.

Nurses who are uncomfortable with the patient's or family's lack of acknowledgment of the poor prognosis or imminence of death should ask themselves what purpose confrontation would serve at this time. Forcing patients and families to acknowledge medical predictions or probabilities may be devastating to those who are struggling to maintain a sense of hope and ego integrity.

However, the nurse should not reinforce false beliefs or unrealistic hopes. Simply ignoring or discouraging such statements at first and then later reassessing and gently asking about the patient's plans may be a skillful way to deal with this ego defense. Often it is the patient who first understands and accepts the finality of the situation.

The transition from hope for recovery to hope for a peaceful, comfortable, dignified death usually happens gradually. The new focus of hope is for a "good death" (Hahn, 2002). When treatments are uncomfortable and have unpleasant side effects, or when multiple organ systems begin to fail, patients may begin to question their present or projected quality of life. They or their surrogate may then request "Do not resuscitate" status as the new plan of care.

> **Critical Reasoning** Do you believe that patients should never give up hope? Why or why not?

Decision Making and Health Care Ethics

Before patients or surrogates can make decisions and give informed consent or informed refusal, certain conditions must be met (see Chapter 8). First, the person must possess **decision-making capacity.** This is sometimes mistakenly referred to in health care as competence, which is a legal term that can be determined only in a court of law. Decisional capacity for health care decisions can be determined by the agreement of two physicians. The other conditions required are that the decision maker be given information about the disease process; the prognosis, including risks and benefits of each choice; and the likely effect of no treatment. Finally, the consent must be voluntary and free from coercion.

When there is limited hope for recovery, the switch of focus to palliative care should be explained to the patient and family. Terminal palliative care includes pain medication, stomach ulcer prevention, skin and mouth care, and other comfort measures. These will not prolong the dying process. Rather, they help ensure that the patient is allowed to die with comfort and dignity.

When patients lack decision-making capacity, their surrogate is morally obligated to choose as the patient would choose if able, which is the **substituted-judgment standard.** Lacking that knowledge, a surrogate must decide what is best for the patient, using the **best interests standard,** based on what would promote the welfare of the "average" patient (American Nurses Association and American Medical Association, 2011). Reminding surrogates that they are choosing as the patient would, not as they themselves might, is often very helpful when the surrogate is deciding either to not start or to stop lifesaving treatment.

The best interests standard is also used when making treatment decisions for infants, children, and those who never were able to make their own decisions, such as patients with severe mental retardation. A combination of both standards may be used for emancipated minors or "mature minor" patients, depending on the case and the decision at hand. Mature minors who have been ill for some time, have spent time in an ICU, and have seen fellow patients dying may ethically and legally be allowed to give significant input into deciding whether to forego further life-sustaining medical treatment.

> **Critical Reasoning** Which standard is a family using when they direct care based on the advance directive of their loved one?

Withholding and Withdrawing Life-Sustaining Treatment

Life-sustaining treatment is medical treatment designed to keep a person alive when vital organ systems are failing or

have failed. It may include renal dialysis, most medications, chemotherapy, and medically provided ventilation, nutrition, and hydration.

Although withholding and withdrawing life-sustaining treatment carry equal moral and ethical weight, deciding to terminate treatments already begun is often more difficult emotionally. Noticing family or surrogate discomfort when a choice about withholding or withdrawing treatment is being considered, the nurse may reflect that, "This decision seems hard for you. Please tell me more about that so I can understand and help you."

Withholding or withdrawing life-sustaining treatment is always an option when the patient, surrogate, or physician believes that the burdens of treatment exceed the benefits. If a patient wishes not to have further aggressive treatment but is not yet ready to stop current treatment, treatments such as renal dialysis, artificial nutrition, and hydration may provide some quality time for the patient. The patients may wish life to be sustained because of a goal such as seeing a child graduate or marry, seeing an expected grandchild, taking a dream vacation, going fishing, working in the garden, or taking time to say goodbye to family and friends. Deciding to forego or stop tube feedings, ventilator use, or dialysis may be more difficult for family members than for patients. Deciding to withhold or withdraw treatment for infants and children is psychologically very difficult for nurses and parents alike.

Medically Ineffective Treatment

"When further intervention to prolong life becomes futile, physicians have an obligation to shift the intent of care toward comfort and closure" (American Medical Association, 2011). Organizational policies regarding medically ineffective or futile treatment provide guidance for due process when family wishes conflict with medical assessment and judgment.

Family members may demand medically futile treatment if they do not understand the meaning of "brain dead." If the patient or surrogate does not agree with the physician's position, an ethics consultation may help with an acceptable resolution, including possible patient transfer to another health care facility (Luce and White, 2007).

Life-prolonging treatments that may be withheld or withdrawn include the following:

- Chemotherapy or radiation (unless for comfort)
- Diagnostic tests
- Invasive procedures
- Blood pressure–stabilizing medications
- Antibiotics
- Artificial ventilation, hydration, and nutrition
- Renal dialysis
- Admittance to an ICU

After a decision has been made to stop life-sustaining treatment, the family is given time to gather and say goodbye. Family members may or may not choose to be present at the time of withdrawal. The nurse's reassurance that either choice is acceptable will help each family member decide.

Many ICUs waive visiting restrictions so that families can keep vigil at the bedside. ICU monitors may be turned off or left on depending on the preference of the family. A nurse may remain at the bedside if no family member is present so that the patient does not die alone. The presence of a spiritual counselor is usually requested and provided if the family wishes.

Extubating a dying or brain-dead patient from a ventilator is called *terminal weaning*. Families need to be made aware that patients may linger hours or occasionally days after life-sustaining treatment is withdrawn. In this case, the patient will be kept comfortable. To conserve limited ICU resources, the patient is usually moved to a conventional hospital room where family members may gather and keep vigil at the bedside.

Morphine or other opioid agonists prevent any possible gasping for air or terminal dyspnea during ventilator withdrawal. Nurses must use effective doses of medications prescribed for symptom control and nurses have a moral obligation to advocate on behalf of the patient when prescribed medication is insufficiently managing pain and other distressing symptoms. The increasing titration of medication to achieve adequate symptom control is "ethically justified" (American Nurses Association, 2009).

Patients with chronic pain often become medically dependent on opioids and develop tolerance, requiring more frequent and higher dosing for effective pain relief. The nurse should feel comfortable with very high doses of narcotics not used elsewhere in practice when providing end-of-life care to terminally ill patients.

Hospice

Hospice care offers an alternative to dying in a health care facility (Clift, 2011). Two decades ago, three fourths of new hospice patients had cancer diagnoses. Today, patients with end-stage renal, cardiac, and other terminal illnesses, including infants and children, use hospice services (Palliative Care Psychiatric Program, 2009; National Association for Home Health and Hospice, 2010).

Eligibility requires the patient have a prognosis of 6 months or less of life remaining. If dying patients are stable enough to leave the hospital, they may choose hospice services in the home or in a special facility. Services that hospice provides to adult and pediatric patients and their families include the following:

- Pain and other symptom management
- Nutritional counseling
- Physical, occupational, and speech therapies
- Home health services for personal care
- Psychosocial emotional support
- Grief and bereavement counseling
- Crisis care during medical emergencies

Unfortunately, many patients are not referred to hospice until their condition is well advanced (Mintzer and Zagrabbe, 2007). **Early referral to a hospice program improves quality of life for both patients and their families at the end of life.**

> **Critical Reasoning** Why do you think more patients are not referred to a hospice for end-of-life care? What might help families take greater advantage of this resource?

PREPARING FOR DEATH

Anticipatory Grief

Anticipatory grief is emotional work begun before the actual loss. **Anticipatory grief is an adaptive response to an expected loss and helps prepare both patients and families for the actual moment of death.** As family members come to the understanding that the patient is in the process of dying, they will begin to "let go."

Adult patients may grieve the loss of their plans for the future, such as seeing a grandchild born, relaxing in retirement, or taking a long-postponed dream vacation. Family members start adapting to their loss by beginning to say goodbye and trying to imagine how their lives will be changed by their loved one's absence.

The nurse may facilitate anticipatory grieving by asking adult patients to reminisce or family members to recall milestones in their lives, such as where they grew up, how they met, the birth of children, pets they have had, or how they have dealt with other losses in their lives. It may be helpful to ask how the deaths of pets have been explained to young children or to inquire about family religious beliefs.

Parents of dying infants and children may grieve the loss of their child's potential. Siblings of a dying child should be made aware of the severity of the illness in a manner and at a time appropriate for their developmental age. Before the age of 6 years, attitudes toward death are often a matter of fact rather than emotion.

Children may benefit from play therapy or counseling both before and after an anticipated death. They may express grief by altered behavior as well as altered emotions. The nurse can coach a responsible adult to alert the child's school about the situation in the family and can remind family members that public libraries offer books for helping children understand and deal with death.

Siblings should be offered the choice of whether to see the patient one last time to say goodbye and whether to attend a funeral, burial, or memorial service. Older children should be told that they have permission to change their minds about a last visit or attending a service for a sibling, parent, or grandparent.

Many areas have grief support groups for parents and siblings. Nurses should know local resources and how to refer surviving family members to them. It is most important to let children and adults know that sadness and mourning are a normal response to the loss of a loved one.

The Dying Process

Patients and family members alike are curious and want to know what to expect of the dying process. As death approaches, they will notice certain physiological changes as body systems shut down. Patients may lose their appetites. Keeping lips moistened or giving small amounts of favorite foods provides comfort if the patient requests this.

Patients who are near death may imagine they see or hear loved ones who have died before them. Other signs of imminent death are difficulty arousing, restlessness, and altered breathing patterns with periods of apnea.

Unfortunately, families at home may panic if patients are moaning or have labored breathing and call for emergency assistance. Hospice nurses provide counseling about ways to manage situations that are frightening to caregivers in the home or long-term care facility. Dying at home is not the choice or option for some. Patients who do not die in an ICU cannot be considered for organ donation because life support for the vital organs cannot be initiated.

CONCERNS OF NURSES WORKING WITH PATIENTS WITH LIFE-THREATENING ILLNESS

Deaths of Infants and Children

Many nurses find it particularly difficult to deal with the deaths of infants and children. When an infant or child is born with devastating anomalies, experiences a significant loss of oxygen perfusion to the brain, is diagnosed with a life-threatening disease or condition, or is rescued from a motor vehicle collision, near-drowning, or fire, the parent or parents face difficult choices.

Decisions made at this time affect not only the child's possible future and life but also the parent or family's future quality of life. Critical pediatric nursing interventions include support of the family unit, communication with the child and family about treatment goals and plans, shared decision making, and continuity of care.

Witnessing a child who is dying elicits feelings of injustice and loss of possibilities for that child's life. **If a nurse believes a treatment decision is not in the best interests of a child and discussions with physicians and peers fail to reassure, an ethics consultation may be requested.**

Identifying With the Patient or Family

When a patient is near the same age as the nurse or the nurse's child, parent, partner, or grandparent or has the same condition as a loved one who has died, it may be challenging for the nurse to maintain professional boundaries (Gerow et al, 2010). Nurses who themselves in this position should discuss the conflict with an experienced nurse or supervisor or seek reassignment until they can adapt emotionally.

Nurses who notice potential boundary violations in themselves or others may request an in-service consultation to help put compassion into perspective with professional behavior. Shedding tears with the family on the death of a patient with whom the nurse has worked over time does not violate boundaries. In fact, families often express appreciation for this show of emotion and perceive the nurse's tears as a sign of compassion.

Medically Provided Nutrition and Hydration

Medically provided nutrition and hydration are life-sustaining treatments. As such, they may ethically be withheld or withdrawn from patients who are no longer receiving curative medical treatment. Research has shown that patients who are dying do not experience hunger or thirst. However, providing

nourishment often makes withdrawal of artificial feeding emotionally difficult for caregivers.

Professional Integrity

If, because of religious or other beliefs, nurses feel participating in any aspect of patient care would compromise their personal or professional integrity, they should address this through appropriate channels. Whenever possible, the nurse's issues should be made known in advance so that alternative arrangements can be made for patient care.

Nurses are often the first caregivers to be aware of a patient's expressed wish to hasten death. **A nurse's participation in assisted suicide or active euthanasia (actively causing a death) violates the Code of Ethics for Nurses and violates the covenant nurses have with society** (American Nurses Association, 2009). Instead, the nurse may interpret the patient's wish as a cry for help with relief from intolerable symptoms. When burdensome symptoms and depression are adequately treated, patient requests to hasten death diminish. Some reasons why patients may wish to hasten death are as follows:

- Loss of autonomy or dignity
- Unrelieved pain or other burdensome symptoms
- Fatigue
- Fear of dying alone
- Fear of one's future
- Untreated depression

Table 40-1 presents a summary of aspects of care for patients with life-threatening illness. Working with patients

TABLE 40-1 ASPECTS OF CARE FOR PATIENTS WITH LIFE-THREATENING ILLNESS

PHASE	EMOTION OR ATTITUDE	NURSING INTERVENTIONS
Symptoms or suspicious diagnostic test results	Shock Fear Disbelief Curiosity Hope	Help refocus on present. Provide presence. Suspend judgment. Be watchfully aware. Offer website information.
Waiting for diagnosis	Anxiety Worry Hope Fear	Treat anxiety as needed. Focus on what patient can control. Help deal with uncertainty. Provide distraction.
Benign diagnosis or resolution of threat	Relief	Educate. Celebrate.
Life-threatening diagnosis	Determination to fight Fear Denial Hopefulness Hopelessness Anger Guilt Depression Not being in control	Give information about the disease and treatment options. Provide therapeutic presence. Ask about advance care planning. Help balance hope with pragmatism. Discuss options and choices. Encourage reminiscing and positive attitude. Explore expressions of anger with patient and family. Offer spiritual advisor. Assess for depression. Help patient maintain some control over situation.
Attempt for recovery or cure	Feeling more in control Courage Hope for cure Faith Discouragement Depression	Answer questions honestly. Give positive feedback for coping skills. Teach patient about laboratory values and their significance. Ask about spiritual beliefs. Remain cautiously optimistic. Suggest patient and family display meaningful mementos in room. Treat depression. Keep window blinds open.
Palliation/dying process	Denial Anticipatory grief Anger Acceptance Appreciation of comfort Hope for a "good death"	Introduce "what if" ideas. Begin life review. Address anger. Inquire about family or pastoral support. Reframe hope. Gently teach about DNR order and "no ICU" options. Discuss hospice and dying at home options/choices. Offer palliative measures, and relieve bothersome symptoms. Explain to patient and family what to expect in the final days and moments. Do not avoid discussion of who needs to be notified, funeral arrangements, autopsy, or organ donation.

DNR, Do not resuscitate; *ICU,* intensive care unit.

whose life expectancy is in doubt or who are dying can be one of the most satisfying experiences of one's nursing career. Helping patients and family members in their transition from hope for recovery to hope for a comfortable death is both challenging and rewarding and is perhaps the ultimate act of compassion. This is reflected in the words of two different families. The first is the mother of a 30-year-old patient who had leukemia and a bone marrow transplant and who spent the last weeks of his life in an ICU:

> *At first when we got the diagnosis I thought, "This has to be a bad dream." Then I felt overwhelmed, very, very sad, and I prayed a lot. Other emotions I felt during those 13.5 months were helplessness, fear, shock, anxiety, and determination to beat the leukemia. The nursing care I found most compassionate was the kindness shown toward my son. Their words and actions showed that the nurses really did care, such as by moving him carefully when he was in pain or trying to find some food that appealed to him when he was able to eat. My husband and I appreciated positive explanations for things that were happening in the ICU. We also valued when the nurses took a few minutes to talk with our son about something he cared about—such as his dog or his college football team's performance in the latest game. Small actions perhaps, but they had a major impact on our son and his family.*

The second note was written to a PCLN by the daughter of a patient admitted to the hospital with a life-threatening illness:

> *You are someone I will never forget. When I was going through the agony of seeing my mother near death, you were there to talk to when I could not talk to my dad. Now surely I didn't agree with you when you said I may have to face the fact that my mother was very ill and could possibly die. But I knew in my heart that she was not going to die that time, in that hospital. Actually, my mother is still with us today. She is a functional, sporty woman. She was able to see me graduate from college and launch into my professional career. So I just wanted to let you know that your stress ball and listening skills impacted my life. I am currently working as a care coordinator for the disabled, elderly population. I am able to give hope to people who are in need and bring a level of empathy to those I serve because of you. Thank you so very much.*

COMPETENT CARING

A Clinical Exemplar of a Psychiatric Nurse

Penelope Chase, MSN, MEd, RN, CS

This letter was written to Dear Abby, the noted newspaper columnist.

Dear Abby,

I am a clinical ethics consultant and an advanced practice psychiatric nurse. I work in a medical hospital counseling patients and families with their emotional responses to their physical illnesses. All too often I am asked to help family members of unconscious and dying people make choices about withholding or withdrawing life-sustaining treatments. All too often these otherwise loving and caring family members find that they have never talked with each other about "what if" so the surrogate or substitute decision maker has to guess what the patient would want. This usually comes when the family member is in the height of shock or despair and is often sleep deprived and not able to think or process clearly.

Please tell your readers to make sure that they tell several people they love and trust to speak up should the time come, and tell the nurses and doctors what treatment they would want or not want. Better yet, write down your instructions in case you cannot speak for yourself, and put a copy on your refrigerator door or in your wallet with your driver's license. Don't hide this vital information in an office file with a mound of other papers or in a safe deposit box where it is inaccessible when most needed. Sadly, young and healthy people can have life-threatening or fatal accidents, so everyone needs to have these discussions. You also need to designate a person as your durable power of attorney for health care.

Don't just think about resuscitation and breathing or feeding tubes or when to ask the doctor for a DNR (do not resuscitate) order. Rather, talk about kidney dialysis, special tests, and even antibiotics. Also let them know your preference about being an organ donor. Some people hope for a miracle when a person has been kept "alive" on a breathing machine (ventilator) and with drugs for a long time. I may have seen a couple of miracles, but those were after the man-made machines were turned off.

A young widow said to me in a grief follow-up phone call, "I miss him so much. I know that he loved me, but I wish he could have told me just one more time before he died." So be sure to tell those you care about that you love them today.

I encourage everyone to make a copy of this letter, share it with others and set aside a time and place to talk about these issues with those you love while you still can. Keep a written, dated, and witnessed record of what was said and requested. I call this "vital tough love," and it may be the most loving act of your life.

Sincerely,
Penelope Chase

CHAPTER IN REVIEW

- Nurses working in many different settings may find themselves caring for a person with a life-threatening illness. Doing so with skill and compassion is part of the art of nursing.
- Working with patients who have life-threatening illness and with their families requires sensitivity to issues of uncertainty; the importance of advance directives; and respectful responses to patient and family fears, emotions, and requests for information.
- Treating the emotional responses, such an anxiety, depression, and anger, that may accompany life-threatening illness helps improve the patient's quality of life, provide comfort and satisfaction to worried family members, and relieve caregiver stress.
- A psychiatric consultation liaison nurse (PCLN) can be very helpful in addressing the mental health needs of these patients.
- Mental health care includes medications and psychosocial interventions.
- Palliative care is the medical and nursing care that provides comfort to a dying person without prolonging the dying process.
- Advance care planning helps patients, families, caregivers, surrogates, and the clinical team with decision making at the end of life.
- Transitioning to end-of-life care involves advocating for the patient, refocusing issues of hope, and enhancing decision making of the patient and family related to withholding and withdrawing life-sustaining treatment, resisting medically ineffective treatment, and considering hospice placement.
- Anticipatory grief is an adaptive response to an expected loss and helps prepare both patients and families for the dying process and the actual moment of death.
- Nurses may have difficulty dealing with the dying patient and maintaining professional boundaries. If nurses find themselves in this position, it is advisable to discuss the conflict with an experienced nurse or supervisor or to seek reassignment.
- Nurse participation in euthanasia (actively intending to cause a death) or physician-assisted suicide (e.g., aiding a patient in taking an intentionally lethal dose of prescribed medication) is prohibited by the Code of Ethics for Nurses.

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APPENDIX

Nanda-I Nursing Diagnoses 2012-2014

Domain 1: Health Promotion

Class 1: Health Awareness
Deficient Diversional Activity (00097)
Sedentary Lifestyle (00168)
Class 2: Health Management 153
Deficient Community Health (00215)
Risk-Prone Health Behavior (00188)
Ineffective Health Maintenance (00099)
Readiness for Enhanced Immunization Status (00186)
Ineffective Protection (00043)
Ineffective Self-Health Management (00078)
Readiness for Enhanced Self-Health Management (00162)
Ineffective Family Therapeutic Regimen Management (00080)

Domain 2: Nutrition

Class 1: Ingestion
Insufficient Breast Milk (00216)
Ineffective Infant Feeding Pattern (00107)
Imbalanced Nutrition: Less Than Body Requirements (00002)
Imbalanced Nutrition: More Than Body Requirements (00001)
Readiness for Enhanced Nutrition (00163)
Risk for Imbalanced Nutrition: More Than Body Requirements (00003)
Impaired Swallowing (00103)
Class 2: Digestion
Class 3: Absorption
Class 4: Metabolism
Risk for Unstable Blood Glucose Level (00179)
Neonatal Jaundice (00194)
Risk for Neonatal Jaundice (00230)
Risk for Impaired Liver Function (00178)
Class 5: Hydration
Risk for Electrolyte Imbalance (00195)
Readiness for Enhanced Fluid Balance (00160)
Deficient Fluid Volume (00027)
Excess Fluid Volume (00026)
Risk for Deficient Fluid Volume (00028)
Risk for Imbalanced Fluid Volume (00025)

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Domain 3: Elimination and Exchange

Class 1: Urinary Function
Functional Urinary Incontinence (00020)
Overflow Urinary Incontinence (00176)
Reflex Urinary Incontinence (00018)
Stress Urinary Incontinence (00017)
Urge Urinary Incontinence (00019)
Risk for Urge Urinary Incontinence (00022)
Impaired Urinary Elimination (00016)
Readiness for Enhanced Urinary Elimination (00166)
Urinary Retention (00023)
Class 2: Gastrointestinal Function
Constipation (00011)
Perceived Constipation (00012)
Risk for Constipation (00015)
Diarrhea (00013)
Dysfunctional Gastrointestinal Motility (00196)
Risk For Dysfunctional Gastrointestinal Motility (00197)
Bowel Incontinence (00014)
Class 3: Integumentary Function
Class 4: Respiratory Function
Impaired Gas Exchange (00030)

Domain 4: Activity/Rest

Class 1: Sleep/Rest
Insomnia (00095)
Sleep Deprivation (00096)
Readiness for Enhanced Sleep (00165)
Disturbed Sleep Pattern (00198)
Class 2: Activity/Exercise
Risk for Disuse Syndrome (00040)
Impaired Bed Mobility (00091)
Impaired Physical Mobility (00085)
Impaired Wheelchair Mobility (00089)
Impaired Transfer Ability (00090)
Impaired Walking (00088)
Class 3: Energy Balance
Disturbed Energy Field (00050)
Fatigue (00093)
Wandering (00154)
Class 4: Cardiovascular/Pulmonary Responses
Activity Intolerance (00092)
Risk for Activity Intolerance (00094)
Ineffective Breathing Pattern (00032)
Decreased Cardiac Output (00029)
Risk for Ineffective Gastrointestinal Perfusion (00202)
Risk for Ineffective Renal Perfusion (00203)

Impaired Spontaneous Ventilation (00033)
Ineffective Peripheral Tissue Perfusion (00204)
Risk for Decreased Cardiac Tissue Perfusion (00200)
Risk for Ineffective Cerebral Tissue Perfusion (00201)
Risk for Ineffective Peripheral Tissue Perfusion (00228)
Dysfunctional Ventilatory Weaning Response (00034)
Class 5: Self-Care
Impaired Home Maintenance (00098)
Readiness for Enhanced Self-Care (00182)
Bathing Self-Care Deficit (00108)
Dressing Self-Care Deficit (00109)
Feeding Self-Care Deficit (00102)
Toileting Self-Care Deficit (00110)
Self-Neglect (00193)

Domain 5: Perception/Cognition

Class 1: Attention
Unilateral Neglect (00123)
Class 2: Orientation
Impaired Environmental Interpretation Syndrome (00127)
Class 3: Sensation/Perception
Class 4: Cognition
Acute Confusion (00128)
Chronic Confusion (00129)
Risk for Acute Confusion (00173)
Ineffective Impulse Control (00222)
Deficient Knowledge (00126)
Readiness for Enhanced Knowledge (00161)
Impaired Memory (00131)
Class 5: Communication
Readiness for Enhanced Communication (00157)
Impaired Verbal Communication (00051)

Domain 6: Self-Perception

Class 1: Self-Concept
Hopelessness (00124)
Risk for Compromised Human Dignity (00174)
Risk for Loneliness (00054)
Disturbed Personal Identity (00121)
Risk for Disturbed Personal Identity (00225)
Readiness for Enhanced Self-Concept (00167)
Class 2: Self-Esteem
Chronic Low Self-Esteem (00119)
Situational Low Self-Esteem (00120)
Risk for Chronic Low Self-Esteem (00224)
Risk for Situational Low Self-Esteem (00153)
Class 3: Body Image
Disturbed Body Image (00118)

Domain 7: Role Relationships

Class 1: Caregiving Roles
Ineffective Breastfeeding (00104)
Interrupted Breastfeeding (00105)
Readiness for Enhanced Breastfeeding (00106)
Caregiver Role Strain (00061)
Risk for Caregiver Role Strain (00062)
Impaired Parenting (00056)
Readiness for Enhanced Parenting (00164)
Risk for Impaired Parenting (00057)
Class 2: Family Relationships
Risk for Impaired Attachment (00058)
Dysfunctional Family Processes (00063)
Interrupted Family Processes (00060)
Readiness for Enhanced Family Processes (00159)
Class 3: Role Performance
Ineffective Relationship (00223)
Readiness for Enhanced Relationship (00207)
Risk for Ineffective Relationship (00229)
Parental Role Conflict (00064)
Ineffective Role Performance (00055)
Impaired Social Interaction (00052)

Domain 8: Sexuality

Class 1: Sexual Identity
Class 2: Sexual Function
Sexual Dysfunction (00059)
Ineffective Sexuality Pattern (00065)
Class 3: Reproduction
Ineffective Childbearing Process (00221)
Readiness for Enhanced Childbearing Process (00208)
Risk for Ineffective Childbearing Process (00227)
Risk for Disturbed Maternal–Fetal Dyad (00209)

Domain 9: Coping/Stress Tolerance

Class 1: Post-Trauma Responses
Post-Trauma Syndrome (00141)
Risk for Post-Trauma Syndrome (00145)
Rape-Trauma Syndrome (00142)
Relocation Stress Syndrome (00114)
Risk for Relocation Stress Syndrome (00149)
Class 2: Coping Responses
Ineffective Activity Planning (00199)
Risk for Ineffective Activity Planning (00226)
Anxiety (00146)
Defensive Coping (00071)
Ineffective Coping (00069)
Readiness for Enhanced Coping (00158)
Ineffective Community Coping (00077)
Readiness for Enhanced Community Coping (00076)
Compromised Family Coping (00074)
Disabled Family Coping (00073)
Readiness for Enhanced Family Coping (00075)
Death Anxiety (00147)
Ineffective Denial (00072)
Adult Failure to Thrive (00101)
Fear (00148)
Grieving (00136)
Complicated Grieving (00135)
Risk for Complicated Grieving (00172)
Readiness for Enhanced Power (00187)
Powerlessness (00125)
Risk for Powerlessness (00152)
Impaired Individual Resilience (00210)
Readiness for Enhanced Resilience (00212)

Risk for Compromised Resilience (00211)
Chronic Sorrow (00137)
Stress Overload (00177)
Class 3: Neurobehavioral Stress
Autonomic Dysreflexia (00009)
Risk for Autonomic Dysreflexia (00010)
Disorganized Infant Behavior (00116)
Readiness for Enhanced Organized Infant Behavior (00117)
Risk for Disorganized Infant Behavior (00115)
Decreased Intracranial Adaptive Capacity (00049)

Domain 10: Life Principles

Class 1: Values
Readiness for Enhanced Hope (00185)
Class 2: Beliefs
Readiness for Enhanced Spiritual Well-Being (00068)
Class 3: Value/Belief/Action Congruence
Readiness for Enhanced Decision-Making (00184)
Decisional Conflict (00083)
Moral Distress (00175)
Noncompliance (00079)
Impaired Religiosity (00169)
Readiness for Enhanced Religiosity (00171)
Risk for Impaired Religiosity (00170)
Spiritual Distress (00066)
Risk for Spiritual Distress (00067)

Domain 11: Safety/Protection 415

Class 1: Infection 417
Risk for Infection (00004)
Class 2: Physical Injury 421
Ineffective Airway Clearance (00031)
Risk for Aspiration (00039)
Risk for Bleeding (00206)
Impaired Dentition (00048)
Risk for Dry Eye (00219)
Risk for Falls (00155)
Risk for Injury (00035)
Impaired Oral Mucous Membrane (00045)
Risk for Perioperative Positioning Injury (00087)
Risk for Peripheral Neurovascular Dysfunction (00086)
Risk for Shock (00205)
Impaired Skin Integrity (00046)
Risk for Impaired Skin Integrity (00047)
Risk for Sudden Infant Death Syndrome (00156)
Risk for Suffocation (00036)
Delayed Surgical Recovery (00100)
Risk for Thermal Injury (00220)
Impaired Tissue Integrity (00044)
Risk for Trauma (00038)
Risk for Vascular Trauma (00213)
Class 3: Violence 447
Risk for Other-Directed Violence (00138)
Risk for Self-Directed Violence (00140)
Self-Mutilation (00151)
Risk for Self-Mutilation (00139)
Risk for Suicide (00150)
Class 4: Environmental Hazards 454
Contamination (00181)
Risk for Contamination (00180)
Risk for Poisoning (00037)
Class 5: Defensive Processes 461
Risk for Adverse Reaction to Iodinated Contrast Media (000218)
Latex Allergy Response (00041)
Risk for Allergy Response (00217)
Risk for Latex Allergy Response (00042)
Class 6: Thermoregulation 467
Risk for Imbalanced Body Temperature (00005)
Hyperthermia (00007)
Hypothermia (00006)
Ineffective Thermoregulation (00008)

Domain 12: Comfort

Class 1: Physical Comfort
Class 2: Environmental Comfort
Class 3: Social Comfort
Impaired Comfort (00214)
Readiness for Enhanced Comfort (00183)
Nausea (00134)
Acute Pain (00132)
Chronic Pain (00133)
Social Isolation (00053)

Domain 13: Growth/Development

Class 1: Growth
Risk for Disproportionate Growth (00113)
Class 2: Development
Delayed Growth and Development (00111)
Risk for Delayed Development (00112)
Nursing Diagnoses Retired from the NANDA-I Taxonomy 2009-2014:
Health-seeking Behaviors (00084) Retired 2009-2011
Disturbed Sensory Perception (Specify: Visual, Auditory, Kinesthetic, Gustatory, Tactile, Olfactory) (00122) Retired 2012-2014

APPENDIX

DSM-IV-TR Diagnostic Criteria for Mental Disorders

DSM-IV-TR CLASSIFICATION

NOS: Not otherwise specified

An *x* appearing in a diagnostic code indicates that a specific code number is required.

An ellipsis (...) is used in the names of certain disorders to indicate that the name of a specific mental disorder or general medical condition should be inserted when recording the name (e.g., 293.0 Delirium Due to Hypothyroidism).

If criteria are currently met, one of the following severity specifiers may be noted after the diagnosis:

- Mild
- Moderate
- Severe

If criteria are no longer met, one of the following specifiers may be noted:

- In Partial Remission
- In Full Remission
- Prior History

DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD, OR ADOLESCENCE

Mental Retardation

Note: These are coded on Axis II.

317 Mild Mental Retardation
318.0 Moderate Mental Retardation
318.1 Severe Mental Retardation
318.2 Profound Mental Retardation
319 Mental Retardation, Severity Unspecified

Learning Disorders

315.00 Reading Disorder
315.1 Mathematics Disorder
315.2 Disorder of Written Expression
315.9 Learning Disorder NOS

Motor Skills Disorder

315.4 Developmental Coordination Disorder

Communication Disorders

315.31 Expressive Language Disorder
315.32 Mixed Receptive-Expressive Language Disorder
315.39 Phonologic Disorder
307.0 Stuttering
307.9 Communication Disorder NOS

Pervasive Developmental Disorders

299.00 Autistic Disorder
299.80 Rett's Disorder
299.10 Childhood Disintegrative Disorder
299.80 Asperger's Disorder
299.80 Pervasive Developmental Disorder NOS

Attention-Deficit and Disruptive Behavior Disorders

314.xx Attention-Deficit/Hyperactivity Disorder
.01 Combined Type
.00 Predominantly Inattentive Type
.01 Predominantly Hyperactive-Impulsive Type
314.9 Attention-Deficit/Hyperactivity Disorder NOS
312.xx Conduct Disorder
.81 Childhood-Onset Type
.82 Adolescent-Onset Type
.89 Unspecified Onset
313.81 Oppositional Defiant Disorder
312.9 Disruptive Behavior Disorder NOS

Feeding and Eating Disorders of Infancy or Early Childhood

307.52 Pica
307.53 Rumination Disorder
307.59 Feeding Disorder of Infancy or Early Childhood

Tic Disorders

307.23 Tourette's Disorder
307.22 Chronic Motor or Vocal Tic Disorder
307.21 Transient Tic Disorder
Specify if Single Episode/Recurrent
307.20 Tic Disorder NOS

Elimination Disorders

—.— Encopresis
787.6 With Constipation and Overflow Incontinence

From American Psychiatric Association: *Diagnostic and statistical manual of mental disorders*, ed 4, text revision, Washington, DC, 2000, The Association.

307.7 Without Constipation and Overflow Incontinence
307.6 Enuresis (Not Due to a General Medical Condition)
Specify type: Nocturnal Only/Diurnal Only/Nocturnal and Diurnal

Other Disorders of Infancy, Childhood, or Adolescence

309.21 Separation Anxiety Disorder
Specify if Early Onset
313.23 Selective Mutism
313.89 Reactive Attachment Disorder of Infancy or Early Childhood
Specify type: Inhibited Type/Disinhibited Type
307.3 Stereotypic Movement Disorder
Specify if With Self-Injurious Behavior
313.9 Disorder of Infancy, Childhood, or Adolescence NOS

DELIRIUM, DEMENTIA, AND AMNESTIC AND OTHER COGNITIVE DISORDERS

Delirium

293.0 Delirium Due to … *[Indicate the General Medical Condition]*
—.— Substance Intoxication Delirium *(refer to Substance-Related Disorders for substance-specific codes)*
—.— Substance Withdrawal Delirium *(refer to Substance-Related Disorders for substance-specific codes)*
—.— Delirium Due to Multiple Etiologies (code each of the specific etiologies)
780.09 Delirium NOS

Dementia

294.xx Dementia of the Alzheimer's Type, With Early Onset *(also code 331.0 Alzheimer's disease on Axis III)*
.10 Without Behavioral Disturbance
.11 With Behavioral Disturbance
294.xx Dementia of the Alzheimer's Type, With Late Onset *(also code 331.0 Alzheimer's disease on Axis III)*
.10 Without Behavioral Disturbance
.11 With Behavioral Disturbance
290.xx Vascular Dementia
.40 Uncomplicated
.41 With Delirium
.42 With Delusions
.43 With Depressed Mood
Specify if With Behavioral Disturbance

Code presence or absence of a behavioral disturbance in the fifth digit for Dementia Due to a General Medical Condition:
0 = Without Behavioral Disturbance
1 = With Behavioral Disturbance

294.1x Dementia Due to HIV Disease *(also code 042 HIV on Axis III)*
294.1x Dementia Due to Head Trauma *(also code 854.00 head injury on Axis III)*
294.1x Dementia Due to Parkinson's Disease *(also code 332.0 Parkinson's disease on Axis III)*
294.1x Dementia Due to Huntington's Disease *(also code 333.4 Huntington's disease on Axis III)*
294.1x Dementia Due to Pick's Disease *(also code 331.1 Pick's disease on Axis III)*
294.1x Dementia Due to Creutzfeldt-Jakob Disease *(also code 046.1 Creutzfeldt-Jakob disease on Axis III)*
294.1x Dementia Due to … *[Indicate the General Medical Condition not listed above] (also code the general medical condition on Axis III)*
—.— Substance-Induced Persisting Dementia *(refer to Substance-Related Disorders for substance-specific codes)*
—.— Dementia Due to Multiple Etiologies *(code each of the specific etiologies)*
294.8 Dementia NOS

Amnestic Disorders

294.0 Amnestic Disorder Due to … *[Indicate the General Medical Condition]*
Specify if Transient/Chronic
—.— Substance-Induced Persisting Amnestic Disorder *(refer to Substance-Related Disorders for substance-specific codes)*
294.8 Amnestic Disorder NOS

Other Cognitive Disorders

294.9 Cognitive Disorder NOS
Mental Disorders Due to a General Medical Condition Not Elsewhere Classified

MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED

293.89 Catatonic Disorder Due to … *[Indicate the General Medical Condition]*
310.1 Personality Change Due to … *[Indicate the General Medical Condition]*
Specify type: Labile Type/Disinhibited Type/Aggressive Type/Apathetic Type/Paranoid Type/Other Type/Combined Type/Unspecified Type
293.9 Mental Disorder NOS Due to … *[Indicate the General Medical Condition]*

SUBSTANCE-RELATED DISORDERS

The following specifiers may be applied to Substance Dependence as noted:

[a]With Physiological Dependence/Without Physiological Dependence
[b]Early Full Remission/Early Partial Remission/Sustained Full Remission/Sustained Partial Remission
[c]In a Controlled Environment
[d]On Agonist Therapy

The following specifiers apply to Substance-Induced Disorders as noted:

[I]With Onset During Intoxication
[W]With Onset During Withdrawal

Alcohol-Related Disorders

Alcohol Use Disorders

303.90 Alcohol Dependence[a,b,c]
305.00 Alcohol Abuse

Alcohol-Induced Disorders

303.00 Alcohol Intoxication
291.81 Alcohol Withdrawal
Specify if With Perceptual Disturbances
291.0 Alcohol Intoxication Delirium
291.0 Alcohol Withdrawal Delirium
291.2 Alcohol-Induced Persisting Dementia
291.1 Alcohol-Induced Persisting Amnestic Disorder
291.x Alcohol-Induced Psychotic Disorder
.5 With Delusions[I,W]
.3 With Hallucinations[I,W]
291.89 Alcohol-Induced Mood Disorder[I,W]
291.89 Alcohol-Induced Anxiety Disorder[I,W]
291.89 Alcohol-Induced Sexual Dysfunction[I]
291.89 Alcohol-Induced Sleep Disorder[I,W]
291.9 Alcohol-Related Disorder NOS

Amphetamine- (or Amphetamine-like-) Related Disorders

Amphetamine Use Disorders

304.40 Amphetamine Dependence[a,b,c]
305.70 Amphetamine Abuse

Amphetamine-Induced Disorders

292.89 Amphetamine Intoxication
Specify if With Perceptual Disturbances
292.0 Amphetamine Withdrawal
292.81 Amphetamine Intoxication Delirium
292.xx Amphetamine-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Amphetamine-Induced Mood Disorder[I,W]
292.89 Amphetamine-Induced Anxiety Disorder[I]
292.89 Amphetamine-Induced Sexual Dysfunction[I]
292.89 Amphetamine-Induced Sleep Disorder[I,W]
292.9 Amphetamine-Related Disorder NOS

Caffeine-Related Disorders

Caffeine-Induced Disorders

305.90 Caffeine Intoxication
292.89 Caffeine-Induced Anxiety Disorder[I]
292.89 Caffeine-Induced Sleep Disorder[I]
292.9 Caffeine-Related Disorder NOS

Cannabis-Related Disorders

Cannabis Use Disorders

304.30 Cannabis Dependence[a,b,c]
305.20 Cannabis Abuse

Cannabis-Induced Disorders, cont'd

292.89 Cannabis Intoxication
Specify if With Perceptual Disturbances
292.81 Cannabis Intoxication Delirium
292.xx Cannabis-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.89 Cannabis-Induced Anxiety Disorder[I]
292.9 Cannabis-Related Disorder NOS

Cocaine-Related Disorders

Cocaine Use Disorders

304.20 Cocaine Dependence[a,b,c]
305.60 Cocaine Abuse

Cocaine-Induced Disorders

292.89 Cocaine Intoxication
Specify if With Perceptual Disturbances
292.0 Cocaine Withdrawal
292.81 Cocaine Intoxication Delirium
292.xx Cocaine-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Cocaine-Induced Mood Disorder[I,W]
292.89 Cocaine-Induced Anxiety Disorder[I,W]
292.89 Cocaine-Induced Sexual Dysfunction[I]
292.89 Cocaine-Induced Sleep Disorder[I,W]
292.9 Cocaine-Related Disorder NOS

Hallucinogen-Related Disorders

Hallucinogen Use Disorders

304.50 Hallucinogen Dependence[b,c]
305.30 Hallucinogen Abuse

Hallucinogen-Induced Disorders

292.89 Hallucinogen Intoxication
292.89 Hallucinogen Persisting Perception Disorder (Flashbacks)
292.81 Hallucinogen Intoxication Delirium
292.xx Hallucinogen-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Hallucinogen-Induced Mood Disorder[I]
292.89 Hallucinogen-Induced Anxiety Disorder[I]
292.9 Hallucinogen-Related Disorder NOS

Inhalant-Related Disorders

Inhalant Use Disorders

304.60 Inhalant Dependence[b,c]
305.90 Inhalant Abuse

Inhalant-Induced Disorders

292.89 Inhalant Intoxication
292.81 Inhalant Intoxication Delirium
292.82 Inhalant-Induced Persisting Dementia
292.xx Inhalant-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]

Inhalant-Related Disorders, cont'd

292.84 Inhalant-Induced Mood Disorder[I]
292.89 Inhalant-Induced Anxiety Disorder[I]
292.9 Inhalant-Related Disorder NOS

Nicotine-Related Disorders

Nicotine Use Disorder

305.1 Nicotine Dependence[a,b]

Nicotine-Induced Disorder

292.0 Nicotine Withdrawal
292.9 Nicotine-Related Disorder NOS

Opioid-Related Disorders

Opioid Use Disorders

304.00 Opioid Dependence[a,b,c,d]
305.50 Opioid Abuse

Opioid-Induced Disorders

292.89 Opioid Intoxication
Specify if With Perceptual Disturbances
292.0 Opioid Withdrawal
292.81 Opioid Intoxication Delirium
292.xx Opioid-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Opioid-Induced Mood Disorder[I]
292.89 Opioid-Induced Sexual Dysfunction[I]
292.89 Opioid-Induced Sleep Disorder[I,W]
292.9 Opioid-Related Disorder NOS

Phencyclidine-Related or Phencyclidine-like Disorders

Phencyclidine Use Disorders

304.60 Phencyclidine Dependence[b,c]
305.90 Phencyclidine Abuse

Phencyclidine-Induced Disorders

292.89 Phencyclidine Intoxication
Specify if With Perceptual Disturbances
292.81 Phencyclidine Intoxication Delirium
292.xx Phencyclidine-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Phencyclidine-Induced Mood Disorder[I]
292.89 Phencyclidine-Induced Anxiety Disorder[I]
292.9 Phencyclidine-Related Disorder NOS

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

Sedative, Hypnotic, or Anxiolytic Use Disorders

304.10 Sedative, Hypnotic, or Anxiolytic Dependence[a,b,c]
305.40 Sedative, Hypnotic, or Anxiolytic Abuse

Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders

292.89 Sedative, Hypnotic, or Anxiolytic Intoxication
292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal
Specify if With Perceptual Disturbances
292.81 Sedative, Hypnotic, or Anxiolytic Intoxication Delirium
292.81 Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium
292.82 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia
292.83 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder
292.xx Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
292.84 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder[I,W]
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder[W]
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction[I]
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder[I,W]
292.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS

Polysubstance-Related Disorder

304.80 Polysubstance Dependence[a,b,c,d]

Other (or Unknown) Substance-Related Disorders

Other (or Unknown) Substance Use Disorders

304.90 Other (or Unknown) Substance Dependence[a,b,c,d]
305.90 Other (or Unknown) Substance Abuse

Other (or Unknown) Substance-Induced Disorders

292.89 Other (or Unknown) Substance Intoxication
Specify if With Perceptual Disturbances
292.0 Other (or Unknown) Substance Withdrawal
Specify if With Perceptual Disturbances
292.81 Other (or Unknown) Substance–Induced Delirium
292.82 Other (or Unknown) Substance–Induced Persisting Dementia
292.83 Other (or Unknown) Substance–Induced Persisting Amnestic Disorder
292.xx Other (or Unknown) Substance–Induced Psychotic Disorder
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
292.84 Other (or Unknown) Substance–Induced Mood Disorder[I,W]
292.89 Other (or Unknown) Substance–Induced Anxiety Disorder[I,W]
292.89 Other (or Unknown) Substance–Induced Sexual Dysfunction[I]
292.89 Other (or Unknown) Substance–Induced Sleep Disorder[I,W]
292.9 Other (or Unknown) Substance–Related Disorder NOS

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

295.xx Schizophrenia

The following Classification of Longitudinal Course applies to all subtypes of Schizophrenia:

Episodic With Interepisode Residual Symptoms (*specify if* With Prominent Negative Symptoms)/Episodic With No Interepisode Residual Symptoms

Continuous (*specify if* With Prominent Negative Symptoms)

Single Episode in Partial Remission (*specify if* With Prominent Negative Symptoms)/Single Episode In Full Remission

Other or Unspecified Pattern

.30 Paranoid Type
.10 Disorganized Type
.20 Catatonic Type
.90 Undifferentiated Type
.60 Residual Type

295.40 Schizophreniform Disorder
Specify if Without Good Prognostic Features/With Good Prognostic Features

295.70 Schizoaffective Disorder
Specify type: Bipolar Type/Depressive Type

297.1 Delusional Disorder
Specify type: Erotomanic Type/Grandiose Type/Jealous Type/Persecutory Type/Somatic Type/Mixed Type/Unspecified Type

298.8 Brief Psychotic Disorder
Specify if With Marked Stressor(s)/Without Marked Stressor(s)/With Postpartum Onset

297.3 Shared Psychotic Disorder

293.xx Psychotic Disorder Due to … *[Indicate the General Medical Condition]*
.81 With Delusions
.82 With Hallucinations

—.— Substance-Induced Psychotic Disorder *(refer to Substance-Related Disorders for substance-specific codes)*
Specify if With Onset During Intoxication/With Onset During Withdrawal

298.9 Psychotic Disorder NOS

MOOD DISORDERS

Code current state of Major Depressive Disorder or Bipolar I Disorder in fifth digit:

1 = Mild
2 = Moderate
3 = Severe Without Psychotic Features
4 = Severe With Psychotic Features
Specify: Mood-Congruent Psychotic Features/Mood-Incongruent Psychotic Features
5 = In Partial Remission
6 = In Full Remission
0 = Unspecified

The following specifiers apply (for current or most recent episode) to Mood Disorders as noted:

[a]Severity/Psychotic/Remission Specifiers
[b]Chronic
[c]With Catatonic Features
[d]With Melancholic Features
[e]With Atypical Features
[f]With Postpartum Onset

The following specifiers apply to Mood Disorders as noted:

[g]With or Without Full Interepisode Recovery
[h]With Seasonal Pattern
[i]With Rapid Cycling

Depressive Disorders

296.xx Major Depressive Disorder
.2x Single Episode[a,b,c,d,e,f]
.3x Recurrent[a,b,c,d,e,f,g,h]

300.4 Dysthymic Disorder
Specify if Early Onset/Late Onset
Specify: With Atypical Features

311 Depressive Disorder NOS

Bipolar Disorders

296.xx Bipolar I Disorder
.0x Single Manic Episode[a,c,f]
Specify if Mixed
.40 Most Recent Episode Hypomanic[g,h,i]
.4x Most Recent Episode Manic[a,c,f,g,h,i]
.6x Most Recent Episode Mixed[a,c,f,g,h,i]
.5x Most Recent Episode Depressed[a,b,c,d,e,f,g,h,i]
.7 Most Recent Episode Unspecified[g,h,i]

296.89 Bipolar II Disorder[a,b,c,d,e,f,g,h,i]
Specify (current or most recent episode): Hypomanic/Depressed

301.13 Cyclothymic Disorder

296.80 Bipolar Disorder NOS

293.83 Mood Disorder Due to … *[Indicate the General Medical Condition]*
Specify type: With Depressive Features/With Major Depressive-Like Episode/With Manic Features/With Mixed Features

—.— Substance-Induced Mood Disorder *(refer to Substance-Related Disorders for substance-specific codes)*
Specify type: With Depressive Features/With Manic Features/With Mixed Features
Specify if With Onset During Intoxication/With Onset During Withdrawal

296.90 Mood Disorder NOS

ANXIETY DISORDERS

300.01 Panic Disorder Without Agoraphobia
300.21 Panic Disorder With Agoraphobia
300.22 Agoraphobia Without History of Panic Disorder

300.29 Specific Phobia
Specify type: Animal Type/Natural Environment Type/Blood-Injection-Injury Type/Situational Type/Other Type
300.23 Social Phobia
Specify if Generalized
300.3 Obsessive-Compulsive Disorder
Specify if With Poor Insight
309.81 Posttraumatic Stress Disorder
Specify if Acute/Chronic
Specify if With Delayed Onset
308.3 Acute Stress Disorder
300.02 Generalized Anxiety Disorder
293.84 Anxiety Disorder Due to … *[Indicate the General Medical Condition]*
Specify if With Generalized Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms
—.— Substance-Induced Anxiety Disorder *(refer to Substance-Related Disorders for substance-specific codes)*
Specify if With Generalized Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms/With Phobic Symptoms
Specify if With Onset During Intoxication/With Onset During Withdrawal
300.00 Anxiety Disorder NOS

SOMATOFORM DISORDERS

300.81 Somatization Disorder
300.82 Undifferentiated Somatoform Disorder
300.11 Conversion Disorder
Specify type: With Motor Symptom or Deficit/With Sensory Symptom or Deficit/With Seizures or Convulsions/With Mixed Presentation
307.xx Pain Disorder
.80 Associated With Psychological Factors
.89 Associated With Both Psychological Factors and a General Medical Condition
Specify if Acute/Chronic
300.7 Hypochondriasis
Specify if With Poor Insight
300.7 Body Dysmorphic Disorder
300.82 Somatoform Disorder NOS

FACTITIOUS DISORDERS

300.xx Factitious Disorder
.16 With Predominantly Psychological Signs and Symptoms
.19 With Predominantly Physical Signs and Symptoms
.19 With Combined Psychological and Physical Signs and Symptoms
300.19 Factitious Disorder NOS

DISSOCIATIVE DISORDERS

300.12 Dissociative Amnesia
300.13 Dissociative Fugue
300.14 Dissociative Identity Disorder
300.6 Depersonalization Disorder
300.15 Dissociative Disorder NOS

SEXUAL AND GENDER IDENTITY DISORDERS

Sexual Dysfunctions

The following specifiers apply to all primary Sexual Dysfunctions:
Lifelong Type/Acquired Type
Generalized Type/Situational Type
Due to Psychological Factors/Due to Combined Factors

Sexual Desire Disorders

302.71 Hypoactive Sexual Desire Disorder
302.79 Sexual Aversion Disorder

Sexual Arousal Disorders

302.72 Female Sexual Arousal Disorder
302.72 Male Erectile Disorder

Orgasmic Disorders

302.73 Female Orgasmic Disorder
302.74 Male Orgasmic Disorder
302.75 Premature Ejaculation

Sexual Pain Disorders

302.76 Dyspareunia (Not Due to a General Medical Condition)
306.51 Vaginismus (Not Due to a General Medical Condition)

Sexual Dysfunction Due to a General Medical Condition

625.8 Female Hypoactive Sexual Desire Disorder Due to … *[Indicate the General Medical Condition]*
608.89 Male Hypoactive Sexual Desire Disorder Due to … *[Indicate the General Medical Condition]*
607.84 Male Erectile Disorder Due to … *[Indicate the General Medical Condition]*
625.0 Female Dyspareunia Due to … *[Indicate the General Medical Condition]*
608.89 Male Dyspareunia Due to … *[Indicate the General Medical Condition]*
625.8 Other Female Sexual Dysfunction Due to … *[Indicate the General Medical Condition]*
608.89 Other Male Sexual Dysfunction Due to … *[Indicate the General Medical Condition]*
—.— Substance-Induced Sexual Dysfunction *(refer to Substance-Related Disorders for substance-specific codes)*

Specify if With Impaired Desire/With Impaired Arousal/With Impaired Orgasm/With Sexual Pain
Specify if With Onset During Intoxication
302.70 Sexual Dysfunction NOS

Paraphilias

302.4 Exhibitionism
302.81 Fetishism
302.89 Frotteurism
302.2 Pedophilia
Specify if Sexually Attracted to Males/Sexually Attracted to Females/Sexually Attracted to Both
Specify if Limited to Incest
Specify type: Exclusive Type/Nonexclusive Type
302.83 Sexual Masochism
302.84 Sexual Sadism
302.3 Transvestic Fetishism
Specify if With Gender Dysphoria
302.82 Voyeurism
302.9 Paraphilia NOS

Gender Identity Disorders

302.xx Gender Identity Disorder
.6 In Children
.85 In Adolescents or Adults
Specify if Sexually Attracted to Males/Sexually Attracted to Females/Sexually Attracted to Both/ Sexually Attracted to Neither
302.6 Gender Identity Disorder NOS
302.9 Sexual Disorder NOS

EATING DISORDERS

307.1 Anorexia Nervosa
Specify type: Restricting Type; Binge-Eating/Purging Type
307.50 Eating Disorder NOS
307.51 Bulimia Nervosa
Specify type: Purging Type/Nonpurging Type

SLEEP DISORDERS

Primary Sleep Disorders

Dyssomnias

307.42 Primary Insomnia
307.44 Primary Hypersomnia
Specify if Recurrent
307.45 Circadian Rhythm Sleep Disorder
Specify type: Delayed Sleep Phase Type/Jet Lag Type/Shift Work Type/Unspecified Type
307.47 Dyssomnia NOS
347 Narcolepsy
780.59 Breathing-Related Sleep Disorder

Parasomnias

307.46 Sleep Terror Disorder
307.46 Sleepwalking Disorder
307.47 Nightmare Disorder
307.47 Parasomnia NOS

Sleep Disorders Related to Another Mental Disorder

307.42 Insomnia Related to … *[Indicate the Axis I or Axis II Disorder]*
307.44 Hypersomnia Related to … *[Indicate the Axis I or Axis II Disorder]*

Other Sleep Disorders

780.xx Sleep Disorder Due to … [Indicate the General Medical Condition]
.52 Insomnia Type
.54 Hypersomnia Type
.59 Parasomnia Type
.59 Mixed Type
—.— Substance-Induced Sleep Disorder *(refer to Substance-Related Disorders for substance-specific codes)*
Specify type: Insomnia Type/Hypersomnia Type/Parasomnia Type/Mixed Type
Specify if With Onset During Intoxication/With Onset During Withdrawal

IMPULSE-CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED

312.34 Intermittent Explosive Disorder
312.32 Kleptomania
312.33 Pyromania
312.31 Pathologic Gambling
312.39 Trichotillomania
312.30 Impulse-Control Disorder NOS

ADJUSTMENT DISORDERS

309.xx Adjustment Disorder
.0 With Depressed Mood
.24 With Anxiety
.28 With Mixed Anxiety and Depressed Mood
.3 With Disturbance of Conduct
.4 With Mixed Disturbance of Emotions and Conduct
.9 Unspecified
Specify if Acute/Chronic

PERSONALITY DISORDERS

Note: These are coded on Axis II.
301.0 Paranoid Personality Disorder
301.20 Schizoid Personality Disorder
301.22 Schizotypal Personality Disorder
301.7 Antisocial Personality Disorder

301.83	Borderline Personality Disorder
301.50	Histrionic Personality Disorder
301.81	Narcissistic Personality Disorder
301.82	Avoidant Personality Disorder
301.6	Dependent Personality Disorder
301.4	Obsessive-Compulsive Personality Disorder
301.9	Personality Disorder NOS

OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

Psychological Factors Affecting Medical Condition

316 … *[Specified Psychological Factor]* Affecting … *[Indicate the General Medical Condition]*
Choose name based on nature of factors:
Mental Disorder Affecting Medical Condition
Psychological Symptoms Affecting Medical Condition
Personality Traits or Coping Style Affecting Medical Condition
Maladaptive Health Behaviors Affecting Medical Condition
Stress-Related Physiological Response Affecting Medical Condition
Other or Unspecified Psychological Factors Affecting Medical Condition

Medication-Induced Movement Disorders

332.1	Neuroleptic-Induced Parkinsonism
333.92	Neuroleptic Malignant Syndrome
333.7	Neuroleptic-Induced Acute Dystonia
333.99	Neuroleptic-Induced Acute Akathisia
333.82	Neuroleptic-Induced Tardive Dyskinesia
333.1	Medication-Induced Postural Tremor
333.90	Medication-Induced Movement Disorder NOS

Other Medication-Induced Disorder

995.2	Adverse Effects of Medication NOS

Relational Problems

V61.9	Relational Problem Related to a Mental Disorder or General Medical Condition
V61.20	Parent-Child Relational Problem
V61.10	Partner Relational Problem
V61.8	Sibling Relational Problem
V62.81	Relational Problem NOS

Problems Related to Abuse or Neglect

V61.21	Physical Abuse of Child *(code 995.5 if focus of attention is on victim)*
V61.21	Sexual Abuse of Child (code 995.5 if focus of attention is on victim)
V61.21	Neglect of Child *(code 995.5 if focus of attention is on victim)*
—.—	Physical Abuse of Adult
V61.12	(if by partner)
V62.83	(if by person other than partner) *(code 995.81 if focus of attention is on victim)*
—.—	Sexual Abuse of Adult
V61.12	(if by partner)
V62.83	(if by person other than partner) *(code 995.83 if focus of attention is on victim)*

Additional Conditions That May Be a Focus of Clinical Attention

V15.81	Noncompliance With Treatment
V65.2	Malingering
V71.01	Adult Antisocial Behavior
V71.02	Child or Adolescent Antisocial Behavior
V62.89	Borderline Intellectual Functioning *Note: This is coded on Axis II.*
780.9	Age-Related Cognitive Decline
V62.82	Bereavement
V62.3	Academic Problem
V62.2	Occupational Problem
313.82	Identity Problem
V62.89	Religious or Spiritual Problem
V62.4	Acculturation Problem
V62.89	Phase of Life Problem

ADDITIONAL CODES

300.9	Unspecified Mental Disorder (nonpsychotic)
V71.09	No Diagnosis or Condition on Axis I
799.9	Diagnosis or Condition Deferred on Axis I
V71.09	No Diagnosis on Axis II
799.9	Diagnosis Deferred on Axis II

AXIS II: PERSONALITY DISORDERS

301.0	Paranoid Personality Disorder
301.20	Schizoid Personality Disorder
301.22	Schizotypal Personality Disorder
301.7	Antisocial Personality Disorder
301.83	Borderline Personality Disorder
301.50	Histrionic Personality Disorder
301.81	Narcissistic Personality Disorder
301.82	Avoidant Personality Disorder
301.6	Dependent Personality Disorder
301.4	Obsessive-Compulsive Personality Disorder
301.9	Personality Disorder NOS

AXIS III: ICD-9-CM GENERAL MEDICAL CONDITIONS

Infectious and Parasitic Diseases (001-139)
Neoplasms (140-239)
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
Diseases of the Blood and Blood-Forming Organs (280-289)

Diseases of the Nervous and Sense Organs (320-389)
Diseases of the Circulatory System (390-459)
Diseases of the Respiratory System (460-519)
Diseases of the Digestive System (520-579)
Diseases of the Genitourinary System (580-629)
Complications of Pregnancy, Childbirth, and the Puerperium (630-676)
Diseases of the Skin and Subcutaneous Tissue (680-709)
Diseases of the Musculoskeletal System and Connective Tissue (710-739)
Congenital Anomalies (740-759)
Certain Conditions Originating in the Perinatal Period (760-779)
Symptoms, Signs, and Ill-Defined Conditions (780-799)
Injury and Poisoning (800-999)

AXIS IV: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS

Problems With Primary Support Group (Childhood [V61.9], Adult [V61.9], Parent-Child [V61.2]), such as death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of sibling

Problems Related to the Social Environment (V62.4), such as death or loss of friend, inadequate social support, living alone, difficulty with acculturation, discrimination, adjustment to life cycle transition (such as retirement)

Educational Problems (V62.3), such as illiteracy, academic problems, discord with teachers or classmates, inadequate school environment

Occupational Problems (V62.2), such as unemployment, threat of job loss, stressful work schedule, difficult work conditions, job dissatisfaction, job change, discord with boss or co-workers

Housing Problems (V60.9), such as homelessness, inadequate housing, unsafe neighborhood, discord with neighbors or landlord

Economic Problems (V60.9), such as extreme poverty, inadequate finances, insufficient welfare support

Problems With Access to Health Care Services (V63.9), such as inadequate health care services, transportation to health care facilities unavailable, inadequate health insurance

Problems Related to Interaction With the Legal System/Crime (V62.5), such as arrest, incarceration, litigation, victim of crime

Other Psychosocial and Environmental Problems (V62.9), such as exposure to disasters, war, other hostilities; discord with non-family caregivers such as counselor, social worker, or physician; unavailability of social service agencies

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE*

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical or environmental limitations. (*Note:* Use intermediate codes when appropriate, such as 45, 68, 72.)

Code

100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his many positive qualities. No symptoms.
91

90 Absent or minimal symptoms (e.g., mild anxiety before an examination), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
81

80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
71

70 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
61

60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g, few friends, conflicts with peers or co-workers).
51

*The rating of overall psychological functioning on a scale of 0-100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: Clinicians' judgments of mental health, *Arch Gen Psychiatry* 7:407-417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J et al: The global assessment scale: a procedure for measuring overall severity of psychiatric disturbance, *Arch Gen Psychiatry* 33:766-771, 1976). A modified version of the GAS was included in DSM-III-R as the Global Assessment of Functioning (GAF) Scale.

50	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
41	
40	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
31	
30	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
21	
20	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
11	
10	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain personal hygiene OR serious suicidal act with clear expectation of death.
1	
0	Inadequate information.

Outline for Cultural Formulation

The following outline for cultural formulation is meant to supplement the multiaxial diagnostic assessment and to address difficulties that may be encountered in applying *DSM-IV-TR* criteria in a multicultural environment. The cultural formulation provides a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect and cultural differences they may have on the relationship between the individual and the clinician.

The clinician must take into account the individual's ethnic and cultural context in the evaluation of each of the *DSM-IV-TR* axes. The suggested cultural formulation provides an opportunity to describe systematically the individual's cultural and social reference group and ways in which the cultural context is relevant to clinical care. The clinician may provide a narrative summary for each of the following categories:

Cultural identity of the individual. Note the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).

Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition, the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This includes stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

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